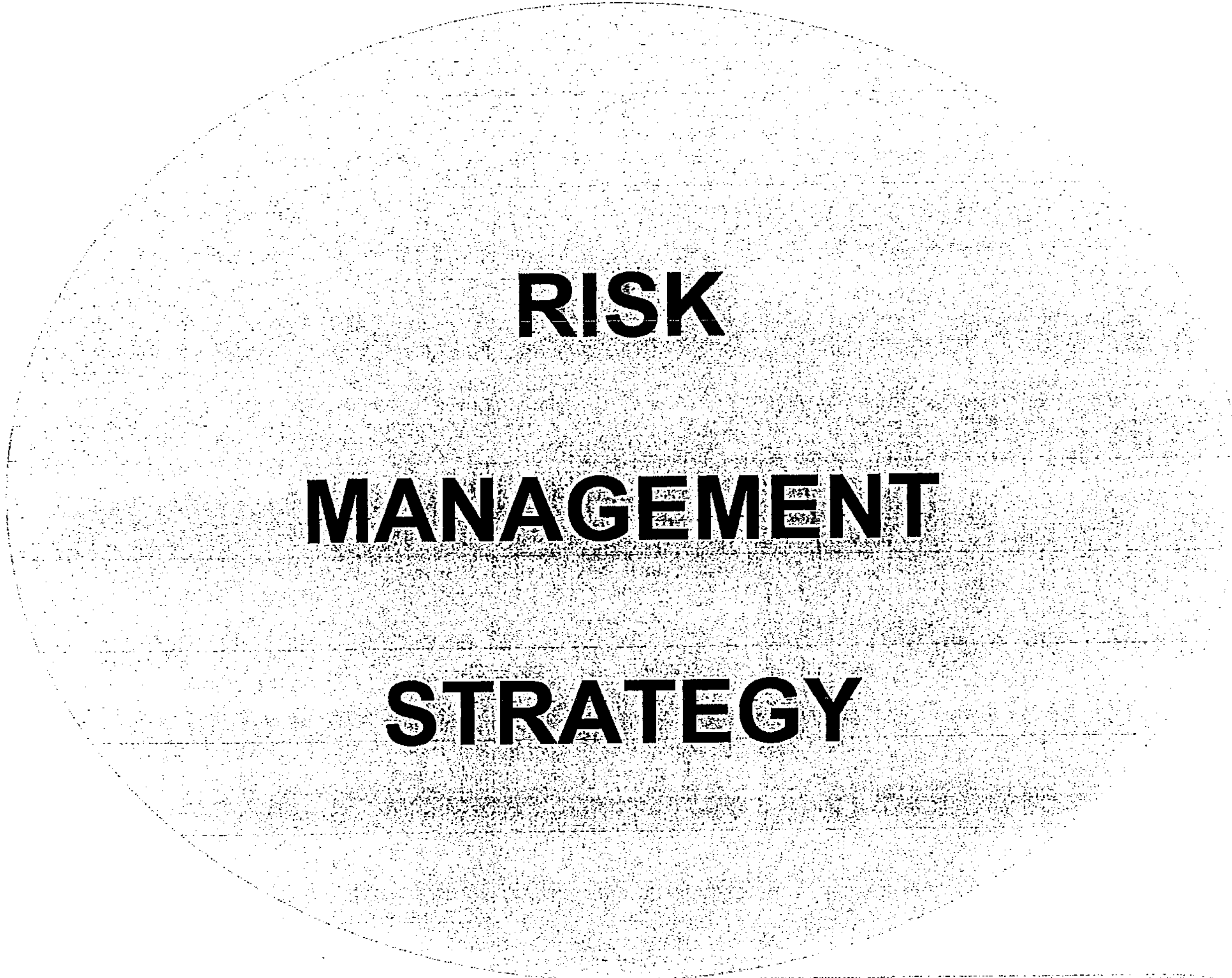
KBH000587-0001

Portsmouth Hospitals NHS

NHS Trust



RISK MANAGEMENT STRATEGY

To err is human
To cover up is unforgivable
To fail to learn is inexcusable

Sir Liam Donaldson

Contents

	Page
WHY DO WE NEED THIS STRATEGY	5
WHOSE RESPONSIBILITY IS RISK MANAGEMENT	6
STATEMENT OF INTENT	7
AIMS OF THE STRATEGY	8
OVERVIEW OF KEY PRIORITIES	9
IMPLEMENTING RISK MANAGEMENT	10
PROCESSES FOR RISK MANAGEMENT	
Risk Identification	11
Incident Reporting	12
RISK ASSESSMENTS	13
TRUST RISK REGISTER	14
ASSURANCE FRAMEWORK	15/16
BUSINESS PLANNING	17
TRAINING	18
ORGANISATIONAL LEARNING AND FEEDBACK	19
MONITORING	20
KEY PRIORITIES/PERFORMANCE INDICATORS	21 - 24
ASSOCIATED DOCUMENTATION	25

APPENDICES

A. Responsibilities of Key Committees
B. Committee Structure
C. Roles and Responsibilities within the Risk Management Framework
D. Risk Severity Matrix
E. Process for the Reporting and Management of Adverse Events
F. Simple Guide to Risk Assessment
G. Risk Registers
H. Assurance/Risk Register Protocol
I. Complaints, Litigation, Incidents and PALS (CLIP) report
J. Terms of Reference and Membership – key committees/groups
 J1 Audit Committee
 J2 Finance Committee
 J3 Governance & Quality Committee

J4 Health & Safety Steering Group
J5 Hospital Management Committee
J6 Information Governance Steering Group
J7 Risk Assurance Committee
J8 Serious Incident Review Group

K. List of Specialist Advisers and Contact Details

VERSION	DATE RATIFIED	BRIEF SUMMARY OF CHANGES	AUTHOR
1.0	Trust Board June 2008	NHSLA/Internal Audit informed review	Head of Risk Management, Complaints and Legal Services

Why do we need this Strategy?

This document outlines the strategy for the management of risk throughout the Trust.

It sets out the:

- Aims and priorities for risk management
- Structure for risk management
- Responsibilities for Risk Management
- Processes for Managing Risk

The intention is to provide a framework for the implementation of an effective risk management system. It should be seen as providing a structure for our staff – managerial, clinical and non-clinical – for addressing issues of identifiable risks within their area.

The Strategy is a source of guidance to ensure consistency of approach when prioritising conflicting issues.

Successful implementation will result in a better quality of care for our patients, a safer environment for our staff and visitors and a reduction in unnecessary expenditure

Whose Responsibility is Risk Management?

The day-to-day management of risk is the responsibility of everyone in our organisation and the identification and management of risks requires the active engagement and involvement of staff at all levels. Our staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Trust Board as a whole.

The Board is ultimately responsible for managing the organisation's risks and needs to have a sound understanding of the principle risks facing the organisation. It receives assurance of this through the risk management reporting structure. The Trust's Assurance Framework, Trust Risk Register and Performance Report, also provide evidence that the appropriate risk management policies, procedures and systems are operating effectively.

Critical Success Factors

Ongoing success will depend on a number of factors:

- Commitment from all staff to achieve the stated aims;
- Integrating risk management practices into the normal activities and business of the Trust;
- All staff being encouraged and supported to take a proactive role in identifying risks and acting on the results to resolve problems at source wherever possible;
- Open and honest reviews of actual and potential adverse events or situations, within an honest, 'just' environment;
- Sharing information about identified risks where necessary and relevant, whilst respecting the need for an individual's confidentiality; and
- Sharing best practices for managing risks.

Statement of Intent

Portsmouth Hospitals NHS Trust is committed to achieving excellence in the delivery of patient-centred care in an environment that promotes safety, well-being and satisfaction for our patients, staff and visitors whilst safeguarding the continuity of services, assets and reputation of the Trust.

The Board recognises that to achieve this level of excellence, effective risk management arrangements and processes are essential and that risk must be managed in a holistic manner so that all types of risk – clinical, financial, environmental and organisational – are addressed in planning, decision-making and day-to-day management activities.

Our aim, therefore, is to promote a risk awareness culture in which all risks are identified, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the culture of the organisation and becomes an integral part of the Trust's objectives, plans, practices and management systems.

As indicated, the management of risk is the responsibility of all managers and staff throughout the Trust. This can only be achieved within a progressive, honest, open and 'just' environment, where risks, accidents, mistakes and 'near misses' are identified quickly and acted upon in a positive and constructive way. No disciplinary action will result from identifying risks or from reporting incidents, accidents, mistakes or 'near misses', except where there has been criminal or malicious activities, professional malpractice or acts of gross misconduct. However, disciplinary action may be considered where incidents or violations have not been reported.

Implementation of this strategy will help create the environment necessary to identify and manage the risks inherent in everything we do. We believe that an innovative 'can do' culture is crucial to achieving improvements in healthcare. Healthcare is a 'risky business' and those risks need to be fully understood and well managed – they need to be reduced to a tolerable level or eliminated altogether and the Board needs assurance that this is happening.

When unexpected or unintended events do happen, a structured risk management approach can help bring about an understanding of what went wrong and why, it can inform what action is necessary to reduce the impact and reduce the possibility of similar incidents happening in the future.

Aims of the Strategy

This Strategy is aimed at supporting good governance by further developing a comprehensive approach to risk management, which achieves a common framework of internal control for:

- Providing assurance that key processes and structures are in place to provide reliable and robust information to enable management to make appropriate decisions in relation to the management of risk;
- The development of a culture in which all risks, clinical, financial, environmental and organisational, are identified, understood and managed;
- The integration of risk management and assessment into the policy making, business development and decision-making processes of the Trust;
- Utilising internal and external audit, and other external regulatory and assessment bodies, to provide additional assurance that our risks are being managed appropriately; and
- Developing a clearer understanding of the roles and responsibilities of directors, clinicians, managers and all other employees of the Trust, with regard to their responsibilities within the risk management framework;

Our overall aim is to provide a proactive framework for the development of robust risk management processes, to ensure that the services the Trust provides are effectively managed, safe and reliable.

Overview of Key Priority Areas

For 2008/2009, the Trust will focus on four key priority areas to further improve risk management practice.

- Further embed the Risk Management culture
- Continue to develop and implement an effective Risk Assessment process
- Ensure risk management continues to inform individual and organisational learning, to improve patient, staff and visitor safety
- Patient Focus

These key priory areas and this Strategy will be reviewed annually to ensure they reflect the risk management requirements of the Trust as they change and develop.

Implementing Risk Management

The Trust's risk management, governance and assurance processes reflect the structured framework for risk management developed by the National Health Service Litigation Authority (NHSLA). The framework focuses on effective risk management activities and in March 2008 the Trust achieved NHSLA accreditation at level I. It is this framework that informs the Trust's processes for risk management.

The Trust's processes also reflect the requirements for risk management identified through the Core Standards for Better Health, introduced by the Department of Health in 2004. Compliance with the core standards is monitored by the Trust throughout the reporting year and the Trust completes a self-assessment and declaration to the Healthcare Commission on an annual basis.

Risk management arrangements are also informed by legislative requirements that govern specific areas of risk, such as Safeguarding Children, Medicines Management, Health and Safety.

The Trust participates in and adheres to where appropriate, recommendations generated from the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD), the Confidential Enquiry into Maternal and Child Health (CEMACH), the National Institute for Health and Clinical Excellence (NICE), the requirements of the National Service Frameworks (NSFs) and other high level reports.

In addition, the Trust responds as appropriate to the wide range of other risk issues raised by the programme of external assessments, surveys, standards and targets, these include:

- Key Performance Targets
- Annual Patient Survey
- Annual Staff Survey
- External/Internal Audit
- Improving Working Lives
- Local Delivery Plan
- Health and Safety Inspections

The structure for risk management is based on the organisation of key committees focusing on specific areas of activity to provide the assurance required by the Board that all areas of risk are being adequately managed.

Appendix A outlines the key responsibilities of committees with a responsibility for managing risk and Appendix B provides the high level committee structure for the Trust. The roles and responsibilities that contribute to an effective risk management framework are detailed in Appendix C.

Processes for Risk Management

Risk Identification

This strategy sets out a systematic approach across the Trust to identify risks and to manage them once they have been identified. This will promote certainty at all levels of the Trust that all risks are being identified and, once identified, they are actively dealt with in a consistent and appropriate manner.

A risk can be identified in a number of different ways - the following provide some examples:

- **A risk can be identified during the course of your working day:**

You are working on a ward and notice a pool of water next to a patient's bed

- **A risk can be identified as a result of a discussion about a problem:**

A clinical audit reveals there is a very low compliance with the Patient Identification Policy

- **A risk can be identified as a result of an incident, a complaint or as a result of a legal claim**

Mr G felt he had insufficient information given to him on what he should do following his discharge from hospital

- **A risk can be identified as a result of an external recommendation**

A Healthcare Commission Report raises concerns about Privacy and Dignity

Once a risk has been identified it will need to be assessed for severity. To achieve consistency of assessing, analysing, reporting and investigating the Trust uses the nationally recognised 5 x 5 risk severity matrix for grading all types of risks, however they are identified. (Appendix D)

Once a risk has been identified a risk assessment form should be completed in accordance with the Trust's Risk Assessment Policy and the appropriate protocols followed.

Incident Reporting and Investigation

As already mentioned, risks can be identified as the result of an incident. Therefore, incident reporting and investigation are integral parts of risk management. To ensure the Trust has a co-ordinated approach to the management of risk, incidents are graded using the same 5 x 5 matrix as that used for risk assessment.

Incident Reporting
The aim of incident reporting is to collect information about all adverse events, hazards or near misses: clinical or non-clinical. This helps facilitate wider organisational learning and effective risk management.

Any member of staff who is involved in, or witnesses, an incident has a responsibility to ensure that it is properly documented, using the Trust Adverse Incident Form. Incident forms are available in all areas.

To demonstrate the Trust Board's commitment to incident reporting the organisation supports a 'just and open' culture where staff can report and learn, and where blame is rarely and fairly used. It is acknowledged that such a culture helps to encourage a high level of reporting and the more frequently incidents and near misses are reported, the easier it becomes to address the underlying causes and manage the identified risks

Incident Investigation
This is an area that clearly provides an opportunity to improve risk management practice and is essential in order to effectively learn from adverse events.

Using the Trust's risk matrix, individual managers will be able to determine the severity of an incident reported in their area. Untoward incidents graded red (serious) are reported immediately to the Risk Management Department and will trigger a full root cause analysis investigation. Incidents graded green, yellow or amber will be investigated at departmental level.

Divisional Governance Committees receive regular reports on the incidents which have occurred in their areas and have responsibility for ensuring that action plans to reduce the identified risks are implemented in a timely manner.

The process for the reporting and management of adverse events is described in Appendix E and more detailed information is available in the Trust Policy for the Management of Adverse and Near Misses (including Serious Untoward Incidents)

Risk Assessment

The Trust has adopted a single methodology for risk assessments to ensure consistency of approach. More detailed information can be found in the Trust's Risk Assessment Policy that provides clear instructions and specific criteria for the identification, assessment and management of risks.

As indicated previously, risks can be identified in a number of ways. It is important not to just rely on the reactive approach: risks should, when possible, be identified proactively. This means that staff in divisions and departments must undertake clinical and non-clinical risk assessments on a regular basis, and at least annually.

Proactive risk assessments reinforce the responsibility of local teams to assess clinical, environmental, financial, and performance related risks against the care that they are responsible for delivering. Each department is responsible for maintaining a local register of risks, which will be reviewed and updated regularly. Departmental risk registers will be reviewed by the Divisional Governance Committees to determine whether they are being appropriately managed locally or require escalation to the Divisional Risk Register. If the potential impact is wider, the Divisional Governance Committee should consider whether the risk requires escalation to the Trust Risk Register.

The following provides a brief outline of the grading of risks;

Low: (Green) Managers are encouraged to take action on low risks, particularly when these risks can be easily minimised or eliminated. Whether action is taken or not, low risks should be monitored regularly and/or when circumstances change.

Moderate (Yellow): Managed locally and action taken within six months to reduce the risk to an acceptable level. If the risk cannot be managed or reduced then it is the manager's responsibility to escalate the risk to the appropriate group/committee

High (Amber): Managed locally and action taken with three months to reduce the risk to an acceptable level. If the risk cannot be managed or reduced then it is the manager's responsibility to escalate it to the Divisional Management Team (DMT). If the risk can still not be managed, then it is the responsibility of DMT to escalate it to the Risk Assurance Committee for consideration

Extreme (Red): Immediate action must be taken to reduce the risk to an acceptable level, as there could be a serious impact on the Trust. Managers must notify the DMT of such risks. The DMT will then review the risk and, if necessary, forward it to the Risk Assurance Committee for inclusion on the Trust Risk Register

A simple guide to risk assessment is provided in Appendix F.

Trust Risk Register

Registering significant clinical or non-clinical risks centrally on the Trust's Risk Register is vital to ensure that appropriate strategies for managing those risks are developed and implemented.

Significant risks are those which cannot be managed locally (ie in departments or divisions) and/or have the potential to impair or affect the operational or financial ability of the Trust to deliver core services, or those which may adversely affect the Trust's profile or reputation.

A risk adviser, based within the Trust's Risk Management Department is responsible for maintaining the Trust's Risk Register and ensuring it is kept up-to-date. However, it is the responsibility of the lead manager for each risk to ensure the Risk Adviser is informed of any changes to the risk, its associated action plan or target completion date.

The Risk Assurance Committee monitors the Trust's Risk Register and regular reports will be provided to the Governance & Quality Committee, which will consider and recommend to the Trust Board the escalation to the Assurance Framework of any risks it deems appropriate.

The Trust Risk Register can be accessed on the Trust Intranet. Go to Departments -> Governance -> Links to Key Home Pages -> Risk Register. This site also contains risks that have passed their target date for action and require immediate attention. Alternatively, ask your line manager or the Risk Management Department (ext 7700 3278/2424) for a paper copy

For more information on Risk Registers, see Appendix G.

Assurance Framework

The Assurance Framework is linked to the Trust Risk Register and provides the Trust with a comprehensive method for managing the high level risks identified as having the potential to prevent the achievement of the Trust's strategic objectives.

The Assurance Framework is developed through the following key steps:

1. The Board agrees the Trust's strategic objectives as part of the business planning cycle
2. An Executive Director is assigned to each strategic objective and takes responsibility for:
   - Agreeing the principal risks that may threaten the achievement of these objectives;
   - Identifying and evaluating the design of the key controls in place to manage the risks and achieve delivery of the objective;
   - Identifying the arrangements for obtaining assurance on the effectiveness of key controls across all the areas of principal risk;
   - Evaluating the assurance across all areas of principal risk, i.e. identifying sources of assurance that the Trust is managing the risks to an acceptable level of tolerance;
   - Identifying areas where there are gaps in controls - where the Trust is failing to implement controls or failing to make them effective;
   - Identifying areas where there are gaps in assurances – where the Trust does not have the evidence to assure that the controls are effective;
   - Agreeing a residual risk rating which is determined by the impact and likelihood of the risk.
3. The relevant senior manager for the activities required to deliver the strategic objective supports the Executive Director in determining the risks, gaps and controls and risk advisers provide guidance and support;
4. The Assurance Framework is cross-referenced against each Standard for Better Health and reviewed by the Trust Board;
5. A committee is assigned to each risk and takes responsibility for overseeing the controls and assurances and the associated action plans;
6. Once agreed the Framework is formally adopted by the Board and will inform the Trust Board agenda for the reporting year;

The controls obtained through the Assurance Framework are enhanced through the submission to the Board of a Performance and Quality Report each month.

The Trust Board has agreed the following arrangements for managing the risks identified on the Assurance Framework:

- The Assurance Framework and associated action plans to address any identified gaps in assurance or control will be submitted to the Trust Board monthly. The Framework will be supplemented by a balanced scorecard showing all risks and a summary highlighting those risks that require in-depth review by the Trust Board i.e. those considered by the responsible leads to have the potential to threaten achievement of the organisation's strategic objectives.

- The Risk Assurance Committee will undertake ongoing scrutiny and monitoring of risks identified in the Assurance Framework and the Trust Risk Register. In particular the Committee will ensure that action plans associated with risks are progressing to eliminate or reduce the impact of the risk. The Risk Assurance Committee will make recommendations to the Governance and Quality Committee about risks that require escalation or de-escalation.

The Audit Committee, as a Sub-Committee of the Trust Board, has oversight of the processes through which the Board gains assurance in relation to the management of the Assurance Framework.

The Assurance Framework Protocol flowchart can be found at Appendix H.

Business Planning

The success of risk management is dependent on its integration with all key activities of the organisation.

The Trust Board will review its strategic risks regularly. These will support the business planning and reporting process, which sets priorities for the organisation and identifies key targets.

The relationship between the Trust's business planning process and risk management is two-way:

- The business plan should be informed by the identification of risks, in order to identify organisational priorities;
- The business planning process should further identify and assess risks to clearly defined organisational aims and objectives.

To meet these objectives the business plan should aim to address significant risks identified within the Risk Register and Assurance Framework. Furthermore, all aims and objectives should be risk assessed and actions prioritised as a result. Thus, risk assessment and prioritisation will be included within the capital spending and equipment purchase programme.

To support this process there is a requirement for risks to be explicitly identified as part of any Outline Business Case presented to the Trust Planning Group and in any papers seeking support for decisions which go before the Trust Board, Governance & Quality Committee, Divisional Governance Committees, or other committee meetings. In addition, information from the local or Trust Risk Register will be used as one of the tools to inform the Trust Planning Group agenda.

Training

The Trust recognises that training and communication are central to the successful implementation of this strategy and to staff understanding their roles and responsibilities for risk management across the organisation.

Training
The Trust Board is committed to the education and development of all its staff, and recognises its legal and ethical responsibility to create and maintain a work environment that will ensure the welfare and health and safety of staff, patients, carers and others.

The essential training needs of staff are identified through an annual training needs analysis and plan. Delivery of this plan provides staff at all levels with an understanding of the principles of risk management, and will equip them with the appropriate skills to be able to effectively undertake risk management activities within their work area.

It is the responsibility of the Divisional Training Groups to address areas of non-compliance with attendance at essential training and provide an action plan on how this will be improved.

Risk Management training is provided in a number of ways:

- Trust induction
- Junior Doctors induction
- *Risky Business*
- E-learning
- Workshops
- Updates

(For further information, please see the Learning and Development Policy and the Essential Training Plan available on the Learning Zone of the Trust's intranet site or the annually published *'Learning Pages'*)

Training will also be provided to Trust Board and Non-Executive Directors so that they are able to properly execute their risk management responsibilities.

Organisational Learning and Feedback

No risk management strategy will be effective unless there is organisational learning and feedback on the lessons learned from the identification and management of risks. The organisation has introduced a number of processes to enable learning and feedback and continued strengthening of these processes will be key to the implementation of this strategy.

These include

- A systematic approach to the recording and analysis of incidents, complaints and claims through the use of an electronic database
- Complaints, Litigation, Incidents and PALS (CLIP) reports are provided by the Risk Management Team to the Governance & Quality Committee and Trust Board. PALS form part of this reporting process as it is considered that concerns raised through this service provide a further opportunity for learning and feedback. For more information on the CLIP report see Appendix I.
- All patient safety incidents are reported to the National Patient Safety Agency (NPSA), as part of the National Reporting and Learning System (NRLS). The reports produced by the NPSA, are used for both benchmarking and learning across the Trust.
- A Risk Management intranet site that holds all relevant documents and reports, for access by all staff
- Rolling reporting programmes by, and to, relevant Committees
- Production of reports specifically tailored to the needs of staff groups
- The production of 'Bite Size Best Practice': a regular publication, which is disseminated Trust-wide and includes: information on adverse events; complaints; evidence based changes to practice; and relevant risk management articles

Monitoring

Trust Board
The Board will receive the Assurance Framework each month, together with a balanced scorecard and summary highlighting key issues, as indicated previously. In addition, it will receive regular exception reports on the status of the Trust Risk Register so that it can be assured of the progress in the management of all risks

Governance & Quality Committee
The Governance & Quality Committee, via the authority delegated to it by the Hospital Management Committee, has an overarching responsibility for ensuring that there is continuous and measurable improvement in the quality of services provided. Through regular monitoring of its own work and the work of groups and committees from which it receives reports, it will assure the Board of progress in the management of risks associated with its activities of all types – clinical, financial, environmental and organisational – and that those risks are being appropriately managed. The Committee will receive from the Risk Assurance Committee a quarterly report on progress relating to the risks recorded on the Trust Risk Register, including progress on action plans and associated targets.

Risk Assurance Committee
The Risk Assurance Committee has responsibility for monitoring the development and implementation of this Strategy and achievement of the key priorities. It will discharge these duties by monitoring and reviewing: progress against the success measures/key performance indicators; the Assurance Framework and the Risk Register; compliance against the NHSLA Risk Management Standards; and action plans to reduce any risks to the Trust's activities: however those risks may have been identified. The Committee will also ensure that all requirements are met to enable the Chief Executive to sign the Statement on Internal Control.

Local Monitoring
Local monitoring is undertaken at a number of levels: ward, specialty, departmental and divisional. It includes: regular review of complaints, incidents, claims, risk assessments and risk registers and the escalation of any appropriate issues to the Divisional Governance Committees or Divisional Management Teams. It is the overarching responsibility of the Divisional Management Teams to ensure that all risks are being monitored, managed and, where necessary reported upon by exception to the Risk Assurance Committee.

Key Priorities

Key Priority Area 1:	A risk management culture, which contributes towards the aims of a learning organisation, is embedded at all levels within the Trust

Standards for Better Health Compliance: C1, C7a, b; C8a; C11a, b; D4b

Success Measures/Key Performance Indicators

- Staff surveys demonstrate they are aware of this Strategy
- Updates to risks identified on the Assurance Framework and/or the Risk Register are provided in a timely manner by responsible managers
- 100% of departments, units and wards have suitable and up-to-date advice for staff on risk management
- The Risk Management web-site consistently holds accurate, comprehensive and up-to-date information
- An action plan for compliance with level 2 of the NHSLA risk management standards is in place and monitored monthly by the Risk Assurance Committee
- Action plans against the Standards for Better Health are reviewed regularly by the Governance & Quality Committee

Our Local Standards

- Patients are treated in an environment in which they feel safe
- Staff work in an environment in which they feel safe
- An open, just and fair culture for the reporting of incidents is apparent across all levels of the organisation
- All staff are aware of their personal responsibilities towards risk management, together with the expectations of the Trust
- All staff are aware of their own level of responsibility within the scope of their role, as part of the competency profile within the Knowledge and Skills Framework

Actions and Deliverables

- This revised Strategy to be officially 'launched' and placed on the Trust's Internet and Intranet
- A trust-wide survey to obtain a baseline evaluation of staff attitude towards, and their knowledge of, risk management
- The Risk Management web-site is reviewed and updated regularly, and especially when legislation changes
- Introduction of a risk management newsletter
- Implementation of the NHSLA level 2 compliance project plan
- Ensuring ongoing compliance with the core Standards for Better Health
- The appropriate level of risk management training (including health & safety) is incorporated into induction for all staff
- Risk Management training is included in the Trust's mandatory training programme
- Risk Management training will be provided for staff as part of their 'essential' training requirements
- Risk Management training will provided for all senior managers
- Risk Management training will be provided for members of the Trust Board, through targeted updated and workshops
- All job descriptions and personal objectives include risk management requirements relevant to the post

Key Priority Area 2:	Continue to develop and implement an effective risk assessment process

Standards for Better Health Compliance: C1a, D1; C7a, c; C11a,D4b; D13c; D20a

Success Measures/Key Performance Indicators

- Standard documentation for identifying and reporting risks is in use throughout the organisation
- Assessment of all identified risks is undertaken and appropriate prioritised actions plans are in place, to address those risks, including consideration of cost versus benefit
- A robust mechanism for the integrated prioritisation of all risks is in place, including a cost/benefit analysis
- Any risks identified through external assessments are acted upon accordingly
- The Risk Register and associated action plans are monitored monthly by the Risk Assurance Committee
- The Assurance Framework and associated action plans are reviewed monthly by the Risk Assurance Committee
- The Assurance Framework, balanced score-card and action plans are reviewed monthly by the Trust Board

Our Local Standards

- Patients are treated in an environment in which they feel safe
- Staff work in an environment in which they feel safe
- All identified risks will be reduced to a low a level as possible
- There is coordinated management of risk throughout the organisation
- All relevant staff are aware of their role within the risk assessment process and are are able to identify and assess risks associated with their activities and working environment, and feel confident to do so
- Full assessment of all identified risks is undertaken, to ensure improved safety for staff and patients
- The risk register and assurance framework provide a comprehensive database of risks to ensure they support the business planning process; identify significant development needs; and identify and address processes or systems which require review
- The Trust Board is fully informed of the risks to achievement of its objectives

Actions and Deliverables

- Undertake a trust-wide survey to obtain a baseline evaluation of staff attitude towards, and their knowledge of, risk assessment
- Full assessments of identified risks are undertaken prior to placing on the risk register
- All identified risks are placed on the Risk Register or Assurance Framework, together with action plans
- All identified risks are graded and monitored in a consistent, systematic manner and appropriate action plans are in place
- Active monitoring of risks occurs at departmental, divisional and corporate levels
- The Assurance Framework Protocol is fully embedded, to ensure effective reporting and appropriate transfer of risks from the Risk Register to the Assurance Framework
- Divisional Governance Committees review their Risk Registers regularly and report to the Risk Assurance Committee
- A database of 'resolved' risks is maintained and reviewed
- Risk assessment training is made available to all staff, appropriate to their level of involvement in the process

Key Priority Area 3:	Risk Management informs individual and organisational learning to improve patient, staff and patient safety

Standards for Better Health Compliance: C1a, D1; C7a, c; C11a,D4b; D13c; D20a

Success Measures/Key Performance Indicators

- Lessons learned from patient safety, complaints, claims and other reportable incidents are implemented, monitored and recorded
- 95% of all patient safety notices, alerts and other communications regarding patient, staff and organisational safety, which require action, are acted upon within the required timescales
- 90% of serious untoward incident investigations are completed within 60 working days
- The Serious Untoward Incident Review Group will meet every two months
- 75% attendance is achieved by members of key committees

Our Local Standards

- Improved safety in the workplace and in the quality of the patient experience through the implementation of lessons learned
- A robust mechanism for the reporting incidents is in place and staff feel confident to do so
- Staff are not afraid to report mistakes, unsafe conditions or methods of work that may (or have) put patients or staff at risk
- Staff are confident that they will be treated fairly during the investigation of an incident, complaint or claim and are offered support following an incident, complaint or claim, as appropriate

Actions and Deliverables

- Undertake a trust-wide survey to obtain a baseline evaluation of staff attitude towards the reporting of incidents
- A risk management analyst is appointed
- Develop an audit mechanism to monitor the implementation of lessons emerging from local and national experience
- Agree a revised model for the dissemination of lessons emerging from incidents, claims and complaints
- Secure administrative support to further improve the Serious Untoward Incident investigation process
- Continue to participate in the Strategic Health Authority risk management network
- Evaluate the recent initiatives from the Institute for Health Improvement with a view to implementing in the Trust
- Participate in the Strategic Health Authority initiative for the collection of data and implement any recommendations, where appropriate
- Root Cause Analysis training will be provided for staff, at a level appropriate to their responsibilities

Key Priority Area :	Patient Focus

Standards for Better Health Compliance: C1a, D1; C6; C7a,C11b,D4b; C13a, b, c; D20b

Success Measures/Key Performance Indicators

- 100% of departments, units and wards display suitable and up-to-date information about the procedures to access complaints
- 100% of departments, units and wards have suitable and up-to-date advice for staff on how to deal with a complaint
- The Complaints Department web-site consistently holds accurate, comprehensive and up-to-date information
- Lessons learned from patient safety incidents, complaints and claims are implemented, monitored and recorded
- 85% of complaints are responded to within the 25-day working target
- Divisional Governance Committees review complaints on a monthly basis, identifying those at risk of being over target
- Appropriate consent is obtained for all contacts with patients, when required

Our Local Standards

- Patients, relatives and carers have suitable and clear access to procedures to register formal complaints
- Patients, relatives and carers are not discriminated against when making a complaint
- Patients, relatives and carers are assured that the Trust acts appropriately on any concerns and, where appropriate, makes changes to ensure improvements in service delivery
- Complaints are handled in the most appropriate manner, to affect a successful, timely outcome
- All staff are aware of their own level of responsibility towards complaints handling, within the scope of their role
- Complaint responses are written in clear and understandable language
- The patient experience is continuously improved, based on feedback from patients, carers and relatives
- Appropriate consent is obtained for all contact with patients, when required
- Patient information is treated confidentially, except where legislation deems otherwise
- All patients, relatives and carers are encouraged to be involved in decisions regarding the management of risks associated with their care

Actions and Deliverables

- Undertake a trust-wide survey to obtain a baseline evaluation of staff knowledge of the complaints handling process
- Undertake a complainant survey to obtain an evaluation of satisfaction with the handling of their individual complaint
- Review and amend the Complaints Department web-site every 3 months, unless legislation changes
- Agree a revised model for the dissemination of lessons to be learned from complaints
- Develop an audit mechanism to monitor the implementation of lessons learned from complaints
- Continue to monitor the implementation of the Trust's *'Being Open'* Policy
- Continue to participate in the local economy complaints network, including reporting to the Strategic Health Authority and Primary Care Trusts
- Complaints handling is included in the Trust's mandatory training programme
- Ensure delivery of an annual consent audit
- Ensure issues of breach of confidentiality are reported to the Information Governance Manager

Associated Documentation

Internal – these can be found on the Trust's Intranet site.

Being Open Policy
Claims Policy for Clinical Negligence, Employer, Public Liability and Property Claims
Fire Policy
Major Incident Response Policy
Maternity Risk Management Strategy
Maternity Policy for the Management of Adverse Events and Near Misses
Risk Assessment Policy
Policy for the Management of Adverse Events and Near Misses, including Serious Untoward Incidents
Policy for the Management of Complaints and Plaudits
Security Operational Policy
Whistleblowing Policy

External
An Organisation with a Memory: *Department of Health 2000* www.dh.gov.uk
Building a Safer NHS: *Department of Health 2002* www.dh.gov.uk
Building a Memory: preventing harm, reducing risks and improving patient safety: *National Patient Safety Agency 2005* www.npsa.nhs.uk
Being Open: *National Patient Safety Agency 2005* www.npsa.nhs.uk
National Standards, Local Action, Health and Social Care Standards and Planning Framework: *Department of Health 2004* www.dh.gov.uk
NHSLA Risk Management Standards: *NHSLA 2006* www.nhsla.com
Standards for Better Health: *Department of Health 2006* www.dh.gov.uk

Appendix A

Responsibilities of Key Committees

The Board

The Trust Board is responsible for reviewing the effectiveness of internal controls: clinical; financial; environmental and organisational. The Board is required to meet its statutory obligations on financial management, the quality of healthcare and on health and safety. In addition, it is required to produce a 'statement of assurance' that it is doing its reasonable best to manage the Trust's affairs efficiently and effectively through the implementation of internal controls to manage risk.

The Audit Committee

The purpose of the Audit Committee is to provide the Trust Board with an independent and objective review of internal control. The Committee will primarily utilize the work of Internal Audit, External Audit but will not be limited to these audit functions. It will also seek reports and assurances from Directors and Managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work.

The Finance Committee

The purpose of the Finance Committee is to: consider the Trust's financial position; approve and monitor the Trust's Treasury Management policy, interest rate and relevant benchmarks for measuring performance; review and monitor investment and borrowing; ensure proper safeguards are in place for the security of funds; approve external funding arrangements; and agree the charitable funds investment strategy and appointment of fund advisors.

Hospital Management Committee

The primary function of the Hospital Management Committee is to ensure the Trust is able to meet its obligations to patients and staff, through an effective operational performance management framework. The Committee interprets and translates the strategic plans of the Trust into tactical and operational plans, within a governance structure that ensures risks are managed and quality monitored.

Governance and Quality Committee

The Governance and Quality Committee ensures that there is continuous and measurable improvement in the quality of the services provided and provides assurance to the Trust Board that the risks associated with its activities are appropriately managed through the Assurance Framework and Risk Register. In addition, the Committee is responsible for the implementation of the governance agenda and for the ongoing monitoring of compliance with national standards and requirements, including: Standards for Better Health; Clinical Negligence Scheme for Trusts; and the National Health Service Litigation Authority (NHSLA) Risk Management Standards.

The Risk Assurance Committee

The Risk Assurance Committee will ensure good risk management across the Trust, promoting local responsibility and accountability and scrutinising risk assessment and risk assurance arrangements in departments and divisions. In particular the Committee will undertake the detailed scrutiny of the Trust's Assurance Framework and Risk Register to ensure that the risks identified are being actively managed and mitigated. This will ensure an effective level of internal control, safety and quality. In addition, it will monitor compliance against the NHSLA Risk Management Standards and compliance with the Maternity CNST standards.

Divisional Governance Committees
The role of Divisional Governance Committees in relation to risk management is to ensure all aspects of risk are appropriately managed within the division through robust review of departmental and divisional risk registers. The Committees will identify to the Risk Assurance Committee those risks that should be escalated to the Trust Risk Register.

In particular the Divisional Governance Committees will identify risks associated with the delivery of key performance targets, taking into account intelligence on staffing issues, complaints, litigation claims and incidents and any emerging trends. The Divisional Committees will oversee the implementation of action plans necessary to mitigate the risks and ensure cross organisation learning as necessary. The Divisional Governance Committees will report on a quarterly basis to the Risk Assurance Committee on the management of risks across the division. This should not prevent any issues of note being reported to the Risk Assurance Committee.

Health and Safety Steering Group
The purpose of the Health and Safety Steering Group is to: monitor and advise on health and safety and periodically review and audit the effectiveness of associated systems; and produce, monitor and review the annual health and safety plan and associated policies.

Information Governance Steering Group
The purpose of the Information Governance Steering Group is to: ensure the Trust's activities comply with requirements for high standards of Information Governance, including ensuring effective policies and management arrangements are in place; and the promotion of Information Governance across the organisation.

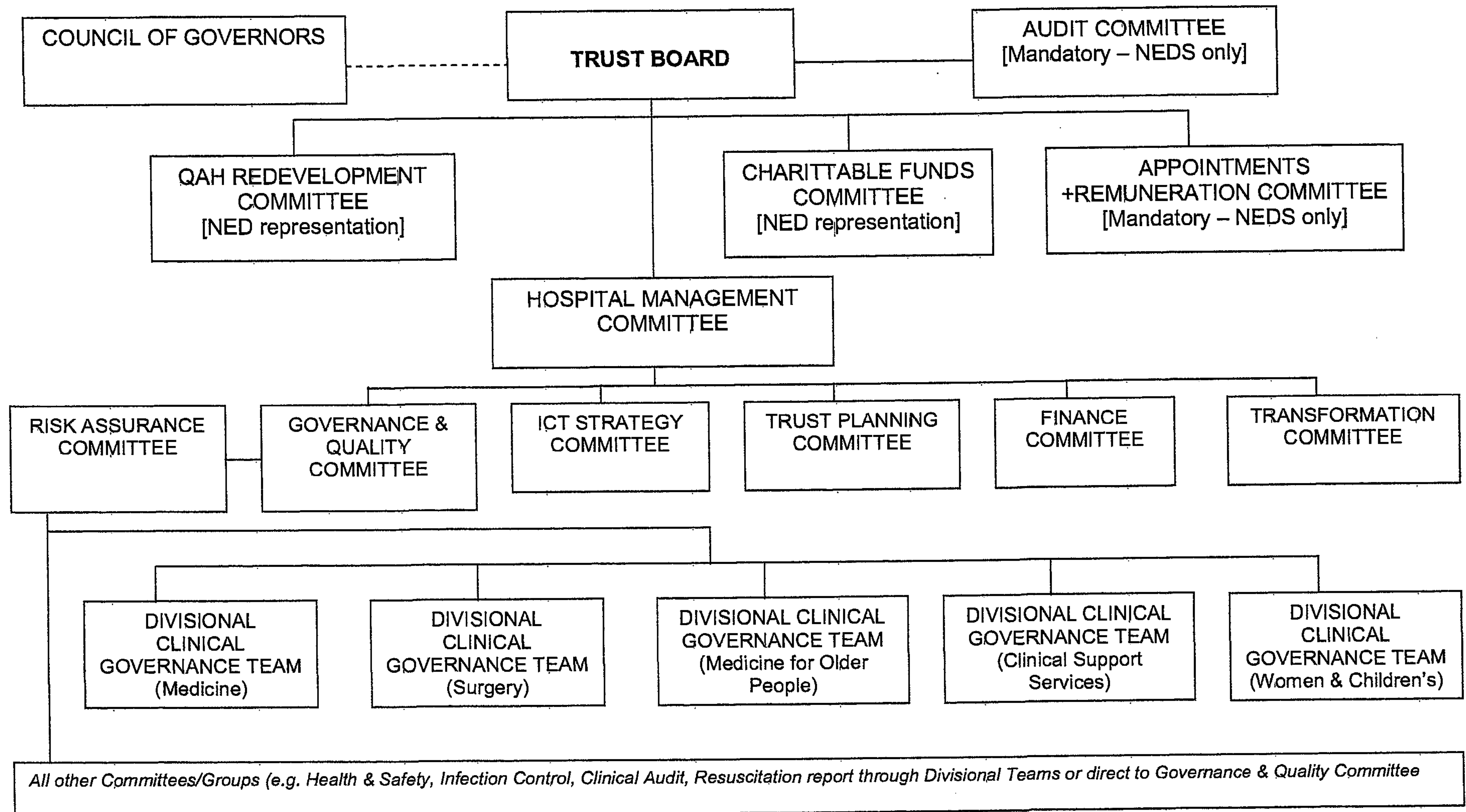
Serious Untoward Incident Review Group
The Serious Untoward Incident Review Group provides a high level forum in which to oversee and monitor the reporting and review of serious untoward incidents. The Group ensures that associated recommendations are implemented across the Trust. It also reviews the outcomes of investigations into clinical practice that have occurred as a result of concerns over individual practice and receives details of relevant external enquiry reports and recommendations, monitoring progress on the implementation of those recommendations.

In addition to the above there are a number of activity specific committees that monitor risks associated with activities such as Safeguarding Children, Health and Safety, Medication Safety.

Terms of reference for the above committees/groups, with the exception of the Board and the Divisional Governance Committees, are included at Appendix J

Appendix B

COMMITTEE STRUCTURE TO SUPPORT THE MANAGEMENT OF RISK



Appendix C

Roles and Responsibilities within the Risk Management Framework

Responsibility of the Chief Executive

The Chief Executive has responsibility for risk management as part of her overall responsibilities and statutory duties for running the Trust. Her role is to:

- Ensure that systems are in place for the management of risk and that key responsibilities are defined and implementation is supported through the organisation's risk management structure;
- Ensure systems are in place for the ratification of risk management policies and procedures;
- Ensure communication with stakeholders and other interested parties on risks of mutual concern

Responsibility of Directors

Whilst the Chief Executive retains overall accountability she delegates various aspects of risk management, including implementation of this strategy, as follows:

Area of Risk Management Responsibility	Director
Clinical Governance and Clinical Standards	Medical Director
Education, Training and Continuing Professional Development	Director of Workforce and Human Resources
Environmental	Director of Workforce and Human Resources
Financial	Director of Finance and Investment
Information Technology	Director of Finance and Investment
Major Incident Planning	Director of Strategy and Partnerships
Research and Development	Medical Director
Risk Management and Assurance	Company Secretary
Staffing and Staff Management	Director of Workforce and Human Resources

The fundamental role of the Directors is to ensure that the strategies and methodologies for the management of risks for which they are responsible are developed and communicated across the organisation.

Specifically, the roles and responsibilities of Directors are to:

- Ensure through their offices, the implementation of this Risk Management Strategy;
- Ensure there are in place policies and strategies to ensure risks within their area of responsibility are known, assessed and managed;
- Ensure implementation and monitoring of risk management assessments and control measures within their designated area(s) and scope of responsibility;
- Ensure staff are given the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trust's operations, including agency staff, sub-contractors, members of the public and visitors;
- Inform the appropriate committee or Trust Board of significant risks which cannot be managed at divisional or departmental level;

Directors should also ensure that:

- They have adequate knowledge and/or access to all legislation relevant to their area and, as advised by appropriate experts, ensure that compliance with legislation is maintained, nominating staff to be responsible for specific areas as required;
- Clinical, financial, organisational and environmental risks are understood and managed;
- Risks to the achievement of the performance objectives are understood and managed;
- Adequate resources are provided, within available funds, to enable a safe working environment and safe systems of work;
- Discussions take place with managers and employees on how 'risks' related to achievement of their objectives are prioritised and addressed;
- Risk management and health & safety awareness is raised amongst all staff;
- There is a core of available statutory and mandatory training and updates for employees on matters including: Health Safety; Fire, Moving and Handling; Control of Infection; Counter Fraud; Handling of Blood and Blood Products
- Emergency Planning responsibilities are clear and accessible

Responsibility of Non-Executive Directors
As independent directors, non-executives have a responsibility to scrutinise and, where necessary challenge the robustness of systems and processes that the organisation has in place for risk management, in order to be assured of their effectiveness.

Responsibility of the Company Secretary
The Company Secretary has executive responsibility for ensuring an effective system of internal control, supported by effective risk and control activities.

Responsibility of Head of Governance
The Head of Governance has management responsibility for implementing the Governance Agenda, including Risk Management

Responsibility of the Head of Risk Management, Complaints and Legal Services
The Head of Risk Management, Complaints and Legal Services has management responsibility for the operational delivery and implementation of the risk management strategy and associated processes.

The Risk Management Team and the Specialist Advisers
The Risk Management Team is responsible for providing support and advice on risk management issues across the Trust. In addition there are a number of specialist advisers within the Trust who provide advice on specific areas of risk management. These include: Fire; Health & Safety; Infection Control; Information Governance; Medical Devices; Radiation Protection; and Resuscitation. (Further details are at Appendix K)

Responsibility of Clinical Directors and General Managers
For Clinical Directors and General Managers, the management of risks in their areas and departments is one of their key responsibilities and should be explicit in their agreed objectives and reflected in their job descriptions.

Their roles and responsibilities are to:

- Clarify local risk management roles and responsibilities, raising the overall profile of risk management and identifying a lead coordinator for risk management, as appropriate;
- Communicate to all staff the content of this strategy and the importance of managing risk;
- Support the identification of risks through a process of risk assessment and as a routine part of the development of plans and intended actions. Risks should be prioritised, managed, minimised and, where possible, eliminate;
- Ensure the development and maintenance of an up-to-date risk register, which will demonstrate a systematic and consistent approach to risk management;
- Facilitate staff training to support the implementation of risk management procedures;
- Highlight to the appropriate committee those significant risks that cannot be managed locally;
- Ensure all incidents are reported and that incidents are reviewed and, if necessary, investigated locally;
- Regularly review data from incidents, claims and complaints, to identify any trends and areas for action; and
- Ensure information given to patients is accurate, appropriate and contains information regarding risks and benefits of treatment.

Responsibility of Sisters, Charge Nurses, Heads of Department and First Line Managers
Their roles and responsibilities are to:

- Accept personal responsibility for the active implementation of risk assessment and risk management in the ward or department concerned, supporting the maintenance of the local risk register;
- Ensure that documented risk management procedures and systems are in place and adhered to;
- Ensure attendance of staff at appropriate risk management and other mandatory and statutory training sessions;
- Raise risk awareness amongst staff at operational level;
- Seek advice on risk management issues, as required;

- Notify the appropriate manager of identified and assessed risks; and

- Ensure that they cascade to relevant staff the outcomes and actions taken as a result of incidents, complaints or litigation claims.

Responsibility of Employees
All employees should:

- Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks;

- Report incidents, accidents, mistakes and 'near misses' and actions taken, in accordance with Trust policy;

- Ensure their own safety and the safety of all others who may be affected by the Trust's business;

- Comply with Trust strategies, policies and procedures in order to protect the health, safety and welfare of anyone affected by the trust's business;

- Maintain confidentiality of patient and Trust information;

- Be aware of their individual roles in complying with emergency procedures e.g. resuscitation, evacuation and fire precautions, as relevant to the employee's particular work area;

- Raise any concerns about particular risks/incidents with their line manager. Where this may not be possible, the alternative mechanism is the Trust's Policy and Protocol for Whistle-blowing; and

- Attend statutory and mandatory training sessions, as appropriate to their role.

Appendix D

Risk Severity Matrix

Risk = Consequence x Likelihood

MEASURES OF CONSEQUENCE

Level	Impact on Person(s Affected	No Affected	Impact on Organisation
Insignificant 1	Minor injury – not requiring first aid Locally resolved complaint	Nil	Short-term low staffing levels (<1 day) No disruption to service delivery Small financial loss
Minor 2	Minor injury – first aid required Justified complaint, peripheral to clinical care	1 - 2	Ongoing low staffing levels – minor reduction in quality of care Short-term disruption to service with minor impact on care Litigation < £50K
Moderate 3	Semi-permanent harm (up to one year) Injury requiring >3 days off work Justified complaint involving lack of appropriate care	3 - 15	Some service disruption with unacceptable impact on patient care Local adverse publicity/moderate loss of confidence in organisation Increased length of stay 1 – 7 days Moderate environmental implications Litigation £50 - £500K
Major 4	Increased degree of harm • injuries or long-term incapacity • fracture major bone, loss of limb Multiple justified complaints	16 - 50	Increased service disruption with longer-term affect on patient care National adverse publicity/major loss of reputation Litigation £500 - £1million
Extreme 5	Incident leading to death or major permanent incapacity Infant abduction Removal of wrong body part	> 50	Non-delivery of key objective/service Multiple or single litigation >1million Extended service closure Extreme loss of reputation

MEASURES OF LIKELIHOOD

Level	Descriptor	Description
1	Rare	Not expected to occur
2	Unlikely	Occurs infrequently
3	Possible	Once or twice a year
4	Likely	Will occur but not persistent. There are no issues of custom and practice
5	Certain	Constant threat. Is custom and practice

RISK ASSESSMENT MATRIX

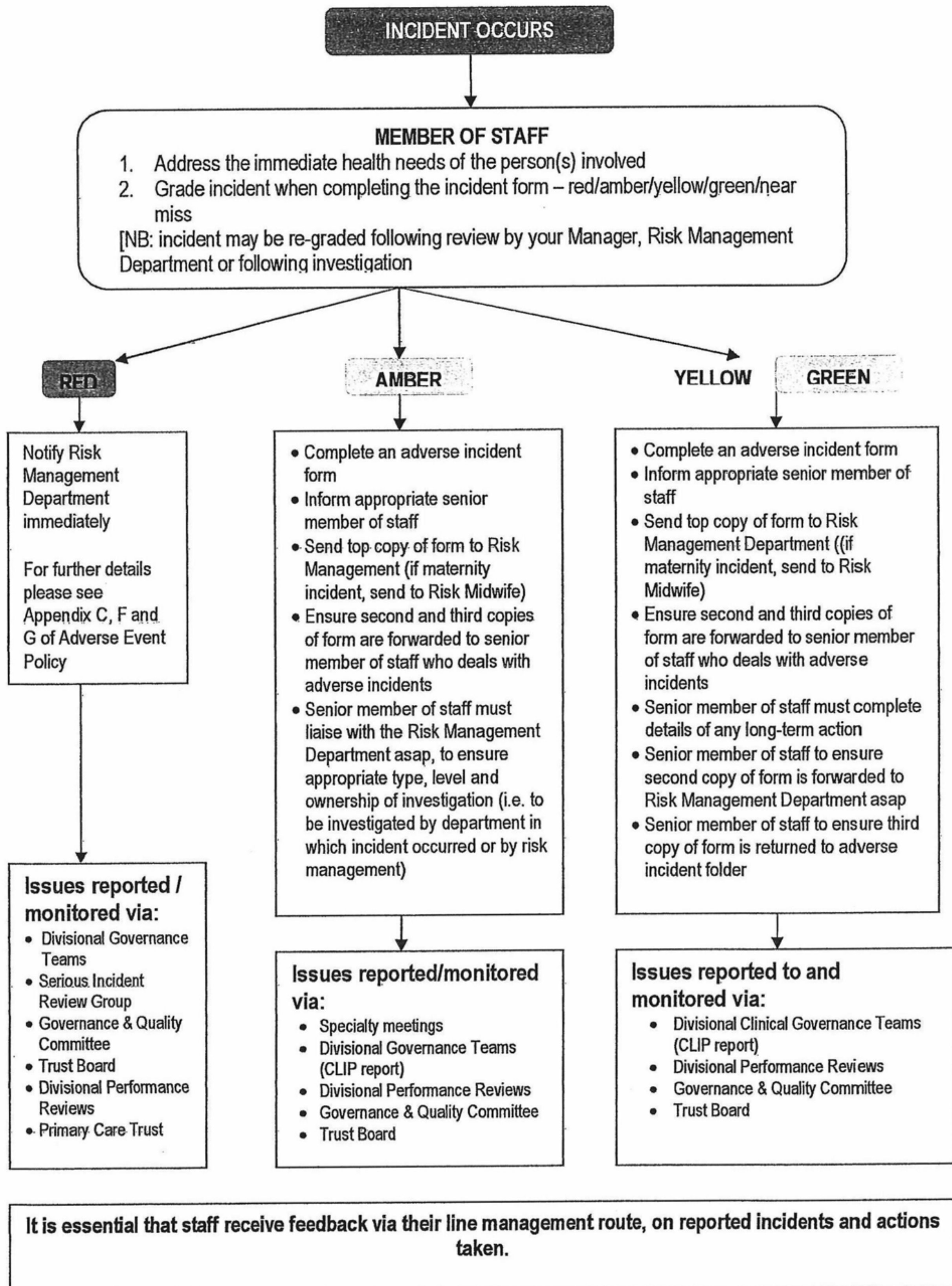
LIKELIHOOD (frequency)	**CONSEQUENCE (impact/severity)**				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25

Risk Ranking

Green	Low Risk (1 – 3)
Yellow	Moderate Risk (4 – 6)
Amber	High Risk (8 – 12)
Red	Extreme Risk (15 – 25)

Appendix E

Process for the Reporting and Management of Adverse Incidents



It is essential that staff receive feedback via their line management route, on reported incidents and actions taken.

Appendix F

A SIMPLE GUIDE TO RISK ASSESSMENT
(for full details see the Trust Risk Assessment Policy and Protocol – available on the Intranet or from you Line Manager)

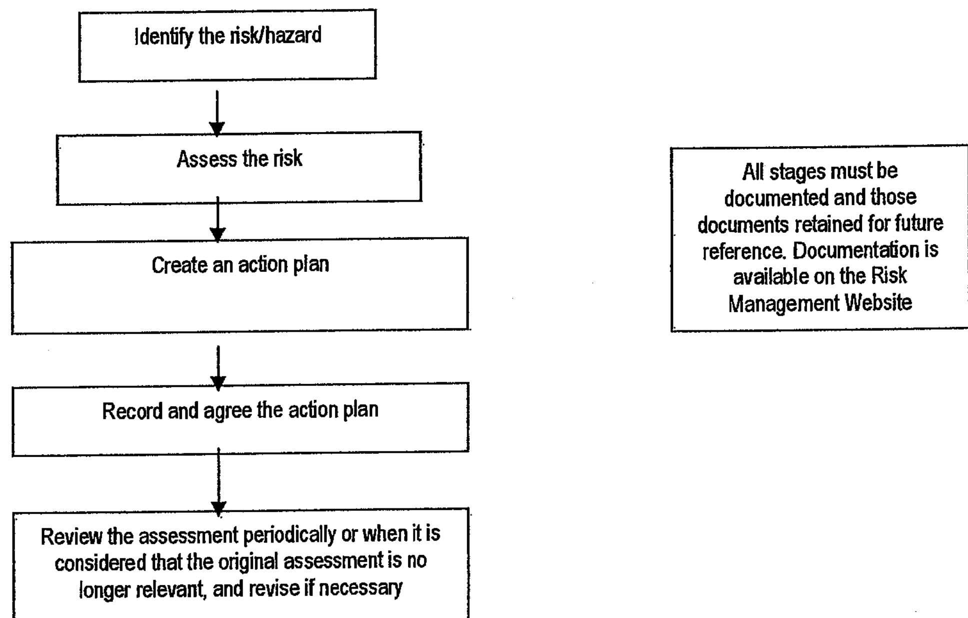
A risk assessment is simply a careful, recorded, examination of what, in your work, could cause harm to our reputation and assets as well as to staff, patients, visitors and others using our premises. The assessment helps you weigh up whether enough controls and precautions have been implemented and what further preventative measures are necessary.

The purpose of risk assessment is to provide a systematic and methodical tool for identifying risks – clinical, financial, environmental and organisational – removing them where possible, or otherwise adopting all the control measures and precautions that are reasonable and practical in the circumstances.

The greatest benefit may be obtained by making this a very positive process, by aiming to produce assessments that are consistent, neat, clear and informative and thus provide a practical and useful response for training and reinforcing the safety message throughout the Trust. Risk assessment is also an essential element of this Strategy, to help in the prevention of accidents, incidents, ill health and to achieve Trust objectives.

Most checks are common sense, but necessary, and should be consistent: a detailed knowledge of legislation is not necessary to carry out a risk assessment. However, knowledge of the potential risks and the essentials required by law to control those risks *is* necessary. Managers and clinicians must take positive steps to inform themselves.

These are the stages to follow:



Appendix G

RISK REGISTERS

Risk registers are logs of risks of all kinds that threaten the safety of patients, staff, visitors and others, including the Trust's success in achieving its declared aims and objectives. They are valuable tools to assist the Trust in:

- Providing a comprehensive database of recognised risks, which have the propensity to cause harm to patients, staff or the public and/or threaten achievement of the Trust's aims and objectives
- Enabling all significant risks to be prioritised, monitored and reviewed, as part of the Trust's risk management system
- Producing an annual service plan, which accurately reflects its priorities
- Identifying and addressing significant development needs
- Identifying and addressing processes or systems which require review

Low (Green) Risk

Managers are encouraged to take action on low risks, particularly when these risks can be easily minimised or eliminated. Examples are frequent, low consequence events such as minor property loss and damage, injuries requiring minimum first aid only or potentially serious events that are unlikely to occur and for which reasonable preventative measures can be put in place. These risks should be actioned locally and entered as a directorate/divisional risk on the risk register. *It should be remembered that research has indicated that a serious accident/incident is very often preceded by a number of minor incidents or near misses, so it is important to capture and monitor trends and that appropriate action is taken to avoid a serious accident/incident.*

Moderate (yellow) Risk

Identified risks that fall into the moderate (yellow) area require action within six months to reduce the risk to an acceptable level. The risks and an agreed action plan should be considered by the directorate/divisional governance team. These risks will be actioned locally and entered on the local risk register. The directorate/division will monitor the application of the action plan, review the risk grading and, if required, adjust.

High (amber) Risk

These require action within three months, to reduce the risk to an acceptable level. These risks and an agreed action plan should be considered by the directorate/divisional governance team. These risks will be actioned locally and entered onto the local risk register.

The directorate/division will monitor the application of the action plan, review and, if required, adjust the risk grading. Risks that cannot be reduced locally should be forwarded to the Divisional Management Team who will review the risk and, if agreed, forward it to the Risk Management Team for inclusion on the Trust Risk Register.

Extreme (red) Risk

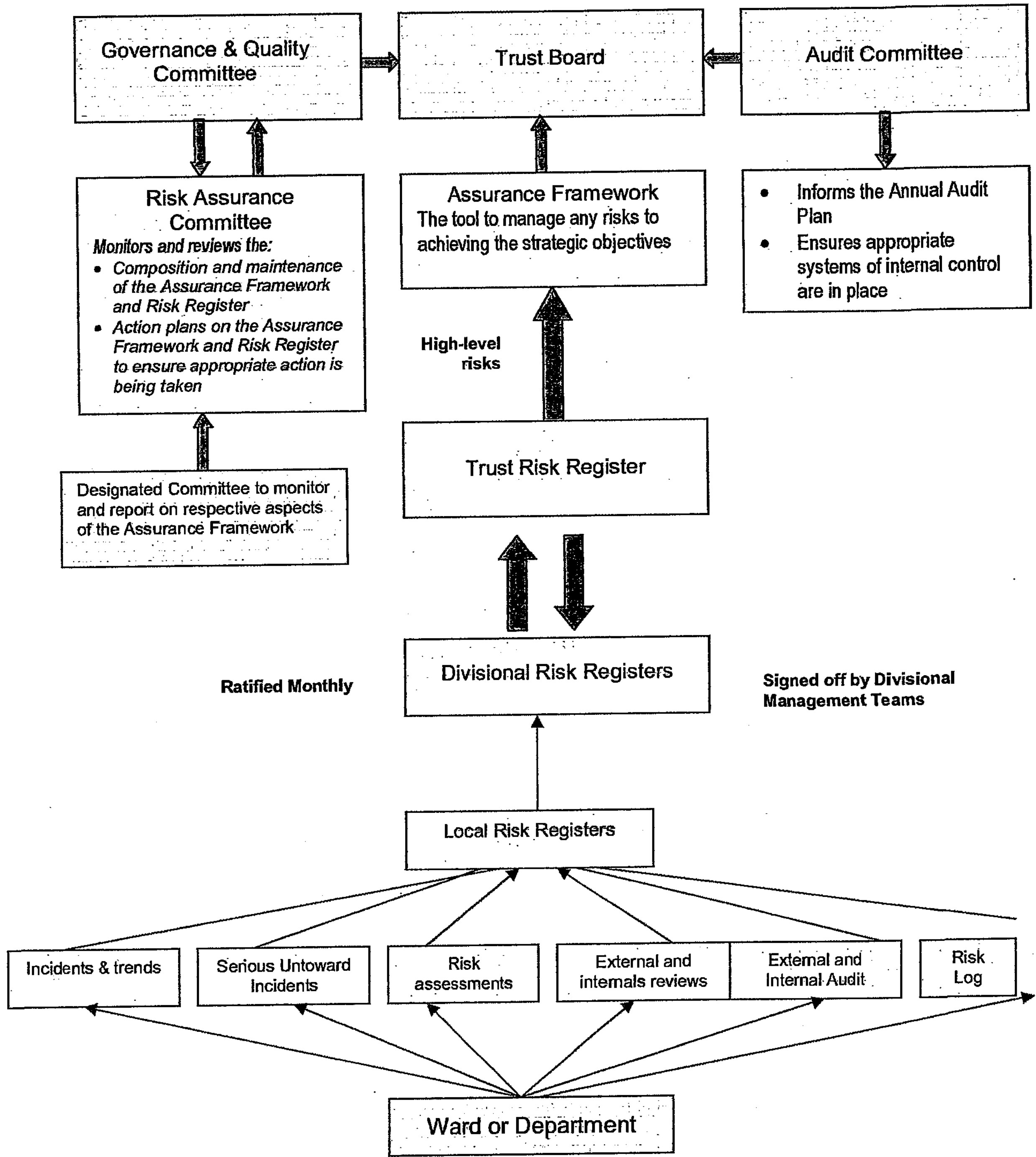
These must be actioned immediately to reduce the risk to an acceptable level as they could have a serious impact on the Trust and threaten its objectives. Examples are accidental death, major fire, or major disruption to services. This category may also include risks that are individually manageable but cumulatively serious, such as a series of similar injuries.

These risks will be notified to the Divisional Management Team who will review the risk and, if agreed, forward it to the Risk Management Team for inclusion on the Trust Risk Register.

The above are only broad classifications and can only reflect a reasonable estimate or potential risk. For example, a patient may fall and sustain no injury, or may sustain a laceration or fatal skull fracture. When estimating risks, the most probable outcome will often be informed by past experience.

Appendix H

ASSURANCE FRAMEWORK/RISK REGISTER PROTOCOL FLOWCHART



Appendix I

THE COMPLAINTS, LITIGATION, INCIDENTS AND PALS (CLIP) REPORT

COMPLAINTS

- Number of complaints per rolling year
- Number of complaints received for current and previous year, per month
- Total number of complaints received: by division
- Top 6 complaints: by main subject
- Total number of complaints received: by severity
- Time taken to close complaints
- Delayed responses
- Healthcare Commission status
- Health Service Ombudsman

LITIGATION

- Claims closed
- Potential claims
- Total number of claims
- Inquests
- Small claims paid/not paid

INCIDENTS

- Total number of reported incidents: by division
- Top 6 reported incidents: Trust-wide
- Top 6 reported incidents: by division
    - Clinical Support Services
    - Medicine for Older People
    - Executive
    - Facilities Management
    - Medicine
    - Surgery
    - Women & Children
- Total number of reported incidents: by severity
- Total number of reported incidents: by severity, by division
    - Clinical Support Services
    - Medicine for Older People
    - Executive
    - Facilities Management
    - Medicine
    - Surgery
    - Women & Children
- Serious adverse event summary

PALS

- Total number of reported concerns: by quarter
- Total number of reported concerns: by quarter, by division
- Top 6 reported concerns: by quarter, by subject
- Total number of contacts with Health Information Centre, QAH
- Total number of contacts with Health Information Centre, RHH

PLAUDITS
ORGANISATIONAL LEARNING
RECENT/FUTURE DEVELOPMENTS

Appendix J

AUDIT COMMITTEE

Terms of Reference

Constitution
The Trust Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee. The Committee is a non-executive sub-committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Purpose
The purpose of the Audit Committee is to provide the Trust Board with an independent and objective review of internal control

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), which supports the achievement of the Trust's objectives. In particular the Committee will review the adequacy of:

- All risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for Better Health)
- The underlying assurance processes that indicate the degree of the achievement of strategic objectives and the effectiveness of the management of the principal risks
- The implementation of the Assurance Framework protocol
- The Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board
- The effectiveness of the management of the principal risks via the Assurance Framework prior to endorsement by the Trust Board
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption and security management, as set out in the Secretary of State directives and as required by the NHS Counter Fraud and Security Management Services

In carrying out this work the Committee will primarily utilize the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and Managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work

Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets statutory NHS Internal Audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Considering the provision of the Internal Audit service and the cost and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operation plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response) and ensure coordination between Internal and External Auditors to optimize audit resources
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organization
- Annual review of the effectiveness of internal audit

External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Trust Board and consider the implications and management responses to their work. This will be achieved by:

- Consideration of the provision of the External Audit service, the cost of the audit and any questions of resignation and dismissal
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and coordination, as appropriate, with other External Auditors, in the local health economy
- Discussion with the External Auditors of their local evaluation of audit risks and overall assessment of the Trust and associated impact on the audit fee
- Reviewing all External Auditor reports, including agreement of the annual audit letter before submission to Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organization, and consider the implications to the governance of the Trust

This will include, but will not be limited to: any reviews by the Department of Health; Arms Length Bodies or Regulators/Inspectors (e.g. Healthcare Commission, NHSA Litigation Authority etc) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc).

In addition the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Governance & Quality Committee and its sub-committees and the agreement of the Committee annual plans as set out in the Assurance Framework Protocol.

In reviewing the work of the Governance & Quality Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained form the clinical audit function.

Financial Reporting

The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Major judgmental areas
- Significant adjustments resulting from the audit

The Committee shall receive reports in respect of its control function incorporated into the Standing Financial Instructions, namely regular reports on:

- Losses and compensation payments
- Waiver and tendering process and competitive quotations
- Any allegation or suspected fraud notified to the Trust and an Annual Report on the use of days regarding the approved Fraud and Corruption plan.

Authority
The Committee is authorized by the Trust Board to investigate or approve any activity within its Terms of Reference. It is authorized to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorized by the Trust Board to obtain outside legal or any other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Reporting
The minutes of the Committee meetings shall be formally recorded by the Committee Secretary and submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or require executive action.

The Committee will report to the Trust Board annually on its work in support of the Statement on Internal Control, commenting on the fitness for purpose of the Assurance Framework, the completeness and integration of risk management arrangements and the appropriateness of the self-assessment against the Standards for Better Health.

The Chair of the Committee will report on the adequacy of systems for internal control to the Trust Board at least every six months.

The Committee will:

- Receive a report from the Governance & Quality Committee on the number of gaps in control and assurance identified in the Assurance Framework and outline the progress made towards closing those gaps.

- Consider on a quarterly basis the extent to which the key committees are fulfilling their functions in providing assurance to the Trust Board

Membership
The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. The Trust Board will appoint one of the members to be Chair of the Committee. The Chairman of the organization shall not be a member of the Committee.

The Committee shall consist of:

Voting Membership
3 Non-Executive Directors

In attendance
Director of Finance
External Audit
Financial Controller
Head of Governance
Head of Internal Audit
Local Counter Fraud Specialist

Attendance
Attendance is required at all meetings. Members unable to attend should indicate in writing to the Committee Secretary 7 days in advance of the meeting (except in extenuating circumstances of absence).

The Director of Finance, the Financial Controller, Head of Governance and appropriate Internal Audit and External Audit representatives shall normally attend meetings. However, at least once a year the Committee should meet privately with the external and internal auditors.

Executive Directors and Senior Managers shall be invited to attend, but particularly where the Committee is discussing areas of risk or operation that are the responsibility of that Director or Senior Manager.

The Chief Executive should be invited to attend at least annually, to discuss the Audit Committee process for the assurance that supports the Statement on Internal Control.

The Director of Finance PA shall be the Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

Meetings
- Meetings will be held on at least a bi-monthly basis
- Meetings will be for a minimum length of 1.5 hours and a maximum of 2 hours.
- The meeting will have a pre-determined agenda that will be sent out to the Committee members one week before the scheduled meeting date
- Items for the agenda must be sent to the Committee Secretary 2 weeks prior to the meeting: urgent items may be raised under any other business
- The External Auditor or Head of Internal Audit may request the Chair to call a special meeting if this is considered necessary

Quorum
The meeting will be quorate with two members in attendance

Other matters
The Chair of the Committee will take advice on the content of the agenda and will be responsible for ensuring actions are taken forward through appropriate dissemination of the minutes. The Chair of the Committee may also invite or co-opt other members as appropriate.

The Committee shall be supported administratively by the Secretary, whose duty in this respect will include:

- Drafting the agenda for the agreement of the Chairman, and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee on scheduled agenda items
- Drafting of the annual plan for agreement of the Chair

Review
The Terms of Reference will be reviewed on an annual basis and ratified by the Trust Board

Appendix J2

FINANCE COMMITTEE

Terms of Reference

Constitution
The Trust Board hereby resolves to establish a Committee of the Board to be known as the Finance Committee. The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Purpose/Objectives
The purpose of this Committee is to:

- Consider the Trust's financial position on a regular basis with particular regard to the achievement of its statutory break-even duty, including delivery of cost improvements (CIP), control of expenditure, and adequacy of forecasting.

- Approve the Trust's Treasury Management policy.

- Approve the Trust's interest rate and foreign exchange risk management strategy and policies when necessary.

- Approve the relevant benchmarks for measuring performance.

- Review and monitor investment and borrowing policy and performance against the relevant benchmarks.

- Ensure proper safeguards are in place for security of the Trust's funds by:

    - agreeing a list of permitted institutions;
    - setting investment limits for each permitted institution;
    - agreeing permitted investment types; and
    - ensuring approved bank mandates are in place for all accounts and they are updated regularly for any changes in signatories and authority levels.

- Monitor compliance with treasury policies and procedures on investment/borrowing/interest rate/foreign exchange management in respect of limits, approved counter parties and types of investments/instruments.

- Approve external funding arrangements within delegated authority.
- Delegate responsibility for treasury operations to the Director of Finance. The Director of Finance (and the Financial Controller) will consider any points that should be brought to the attention of the Committee.

- Evaluate, scrutinise and monitor investments.

- Agree the charitable funds investment strategy and the appointment of fund advisors.

Authority
The Committee is authorised by the Trust Board to investigate or approve any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Reporting
The minutes of the Committee meetings shall be formally recorded by the Committee Secretary and submitted to the Trust Board.

The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board, or require executive action.

Membership
The Trust Board Chairman will appoint the Chair and Deputy Chair of the Committee. The Chairman of the organisation shall not be a member of the Committee.

The Committee shall consist of:

Voting Membership

3 Non-executive Directors
2 Executive Directors – Director of Finance and Chief Executive (or nominated

representative)

Non-voting Membership

Chief Accountant
Director of Redevelopment
Financial Controller
Head of Internal Audit (or nominated representative)
Representative of External Audit

Attendance
Attendance is required at all meetings. Members unable to attend should indicate in writing to the Committee Secretary 7 days in advance of the meeting (except in extenuating circumstances of absence).

The Director of Finance PA shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

Meetings
- Meetings shall normally be held on a monthly basis, however they may be held more or less frequently as required.
- Meetings will be for no longer than 2 hours when stand alone and no longer than 1 hour when held in conjunction with Audit Committee.
- The meeting will have a predetermined agenda that will be sent out to Committee members one week before the scheduled meeting date.

- Items for the agenda must be sent to the Committee Secretary 2 weeks prior to the meeting, urgent items may be raised under any other business.

Quorum
The meeting shall be quorate with 3 members to include at least one Non-executive Director and one Executive Director (or nominated representative).

Other Matters
The Chair of the Committee will take advice on the content of the agenda and will be responsible for ensuring actions are taken forward through appropriate dissemination of the minutes. The Chair of the Committee may also invite or co-opt other members as appropriate.

The Committee shall be supported administratively by the Secretary, whose duties in this respect will include:

- Drafting of the agenda for agreement with the Director of Finance and Financial Controller and collation of papers.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on scheduled agenda items.

Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Trust Board.

Appendix J3

GOVERNANCE AND QUALITY COMMITTEE

Terms of Reference

Constitution
The Hospital Management Committee hereby resolves to establish a Committee to be known as the Governance and Quality Committee. The Committee is a non-executive committee of the Hospital Management Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

Purpose/Objectives
The purpose of this Committee is to ensure that there is continuous and measurable improvement in the quality of the services provided and that the Trust Board is assured that the risks associated with its activities are appropriately managed through the Assurance Framework and the Risk Register. The Committee is responsible for the delivery of the Trust's Governance Strategy and for the ongoing monitoring compliance with national standards and requirements, including Standards for Better Health and NHSLA Risk Standards.

The objectives of the Governance and Quality Committee are to:

- Ensure all aspects of risk are appropriately managed across the Trust, through oversight of the work of the Risk Assurance Committee and that appropriate review and assurance mechanisms are in place.
- Review the Trust's compliance with the core and developmental domains as set out in Standards for Better Health.
- Promote a just and open culture in which risk management will continue to develop as an integral, seamless component in the delivery of safe and effective healthcare.
- On a quarterly basis, receive a report from the Risk Assurance Committee on the Assurance Framework, the Risk Register and implementation of associated actions plans
- Review the implementation of the Governance Strategy and associated strategies, including those of Risk Management, and Clinical Audit.
- Receive and consider reports on patient involvement in service improvement and planning.
- Inform future educational requirements for the Trust and external organisations
- Receive and consider the Annual Report on Research and Development, ensuring research and development activity informs high quality patient care
- Ensure National Guidance (e.g. NICE, NSFs) is implemented as required and that best practice informs delivery of care and development of services.

An Action Grid will support the implementation and monitoring of the achievement of the above objectives.

Authority
The Committee is authorised by the Hospital Management Committee to which it is accountable to investigate any activity within its terms of reference. It is authorized to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Hospital Management Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Reporting

The minutes of the Committee meetings will be formally recorded by the Committee Clerk and submitted to the Trust Board and Audit Committee when approved.

The Chair of the Committee shall draw to the attention of the Hospital Management Committee any issues that require disclosure to the full Trust Board, or require executive action.

The Committee will provide a regular, exception report to the Hospital Management Committee, in addition to any issues that require disclosure as above

Communication

The members of the Committee will ensure timely dissemination of information.

The Governance and Quality Committee is accountable to the Hospital Management Committee and also to the Audit Committee on all aspects of Assurance.

The Governance and Quality Committee will receive a quarterly report from the Risk and Assurance Committee and Governance reports and progress on compliance with Standards for Better Health from the Divisional Governance Teams and other groups/committees as identified in Appendix 1.

The Governance and Quality Committee will seek assurance from clinical divisions that they implement the activity required to achieve compliance with service and corporate governance standards.

Membership

The Committee shall consist of the following members:

- Medical Director (Chair)
- Company Secretary
- Acting Head of Nursing
- Director of Workforce & HR
- Head of Governance
- Director of Finance (or designated Deputy)
- Divisional Governance representatives from Medicine, Surgery, Clinical Support Services, Women & Children and Medicine for Older People
- Head of Training and Development
- Haslar representative
- Head of Public and Patient Involvement
- Head of Risk Management, Complaints & Legal Services
- Representative from Retained Estates
- Military representation.
- Representative from Hampshire PCT
- Representative from Portsmouth City PCT

Attendance

Attendance is required at all meetings. Members unable to attend should indicate in writing to the Committee Clerk 3 days in advance of the meeting (except in extenuating

circumstances of absence). Members are advised to nominate a deputy to attend who is appropriately briefed to participate in the meeting.

A register of attendance will be maintained and reviewed on a six-monthly basis.

Meetings

The meeting will last three hours and will be held monthly on the third Wednesday of the month.

The meetings shall be reviewed regularly for effectiveness and to ensure they reflect the aims and functions as set out in these Terms of Reference

The Chair will set the standard for the length of the meeting and ensure the agenda is realistic in content to achieve this by allocating fixed timescales for each item.

Items for the agenda should be submitted to the Committee secretary a minimum of one week prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

A summary of agreed actions (the Action Grid) will be distributed two weeks in advance of the meeting.

Progress on the Action Grid will be reported by those tasked one week prior to the meeting.

Quorum
A quorum is one third of the members.

Other Matters
The Chair of the Committee will take advice on the content of the agenda and will be responsible for ensuring actions are taken forward through appropriate dissemination of the minutes.

The Committee will be supported administratively by the Clerk, whose duties in this respect will include:

- Drafting of the agenda for the agreement of the Chair and collation of papers.
- Taking the minutes and keeping a summary of agreed action.
- Advising the Committee on scheduled agenda items.
- Inviting or co-opting attendees as required.

Review
The Terms of Reference shall be reviewed annually and ratified by the Trust Board.

Appendix J4

HEALTH AND SAFETY STEERING GROUP

Terms of Reference

Purpose/Objectives
The purpose of the group is to:

- Produce and monitor and review policies to ensure high and consistent standards are being maintained and that these policies are effective and relevant.
- Monitor and advise specific persons within the organisation on health and safety and consult with staff and safety representatives effectively.
- Produce an annual health and safety plan that reviews health and safety action plans against performance standards, priorities, and risk assessments.
- Monitor and advise on the implementation of the health and safety plan ensuring adequate resources, communication and co-operation between interested parties and ensuring priority is given to high risk situations.
- Measure the effectiveness of health and safety systems the through reactive and proactive means, ensuring compliance with relevant legislation,
- Audit health and safety management systems and make recommendations to Trust Board.
- Periodically review the health and safety systems to ensure that they are operating correctly and learn from success and failures equally.

Authority
This Group has delegated authority to undertake action on issues relating to health and safety as outlined above and will make recommendations directly to the Trust Board or via the Governance & Quality Committee.

Reporting
The minutes of the Group meetings shall be formally recorded by the Group Secretary (HR Officer – management representative)

The Group reports to the Governance & Quality Committee and minutes of the Committee shall be formally recorded by the Group Secretary and submitted to the Trust Board, and copies sent to the Divisional General Managers

The Group will receive reports from the Site Health and Safety Committee

In addition, the activities of the Group and any current health and safety issues will be featured in the "Link" and on the Trust Intranet site.

Membership
Director with Lead Responsibility (Chair)
Site Committee Staff Side Chairs
Occupational Nurse Manager/Physician
Back Care Advisor
FM Services Manager (THC)
Development Team Manager
Health & Safety Advisor
Representative from the Risk Management Department
Fire Safety Advisor
Infection Control Manager

Other members may be co-opted as required. For example: Divisional General Managers; Radiation Protection Advisor Royal Hospital Haslar Safety Officer; Improving Working Lives Coordinator or any other individual with required specialist expertise or knowledge. In addition, other Health & Safety representatives may attend, providing they give due notice to the Secretary

Attendance
Attendance is a statutory duty for named persons or parties as stated in the Trust Health and Safety Policy. In the event that you are unable to attend then a suitably briefed deputy should attend. Management will release Safety Representatives to attend these committee meetings without prejudice

Meetings
Meetings will be held bi-monthly. Extraordinary meetings may be called at the discretion of the Chair or at the request of any three members of the Group

Quorum
The meeting will be quorate with four members in attendance

Appendix J5

HOSPITAL MANAGEMENT COMMITTEE (HMC)

TERMS OF REFERENCE

1. Purpose

The primary function of the HMC is to ensure that the Trust is able to meet its obligations to patients and staff. This has to be fulfilled by meeting the aims and objectives of the Trust through an effective operational performance management framework. The HMC interprets and translates the strategic plans of the Trust into tactical and operational achievement, whilst informing and influencing their development in accordance with policies and statute. The HMC will receive the strategic direction from the Trust Board and Executive; and

2. Objectives

To ensure the Trust meets the key corporate and strategic objectives

To approve the divisional performance framework and oversee delivery_and take action on non-compliance.

To ensure the Trust addresses risks as set out in the Assurance Framework

To deliver the operational elements of the NHS Healthcare Standards

To ensure that key messages regarding current issues arising at HMC within the Trust are cascaded throughout the organisation by members of HMC using the CEO Team.

3. Responsibility And Accountability

The HMC has a responsibility to the Trust Board. It also recognises its responsibilities and interaction with other internal and external groups.

Working groups will be asked to undertake specific work requiring consultation or in-depth activity, reporting and presenting to the full HMC for ratification before dissemination or implementation through a wider audience.

4. Constitution

Meetings of the HMC will take place monthly.

Agenda items should be sent to the Trust Business Manager, 10 days before the meeting. For items that require a decision, written documentation should be included for distribution with the agenda prior to the meeting.

5. Membership

The Chief Executive will chair the meeting. The Trust Business Manager will take minutes of meetings and distribute them.

The membership of HMC will be representative of the operational management of the Trust. The suggested membership is attached.

The meeting will be quorate provided each Clinical Division is represented.

6. Deputisation Of Members

6.1 If members are unable to attend formal meetings, they may send a deputy. However, this should be in exceptional circumstances only. It is expected that the named members will attend all meetings. However, in the event that a Deputy is to attend, that person must be informed and able to make decisions as appropriate. Any apologies should go to the Trust Business Manager.

7. Co-Opted Members

7.1 Other staff may be co-opted on to the group either for additional work or for the purposes of communication or presentation.

8. Review

8.1 These terms of reference will be reviewed at least annually, or in the event of further management changes.

Date of Issue **Jan 08** **Date of Review** **Jan 09**

Appendix J6

INFORMATION GOVERNANCE STEERING GROUP
Terms of Reference

Purpose/Objectives
The purposes of the Group are to:

- Ensure compliance with the national standards and guidance provided in the Information Governance Toolkit

- Develop and monitor an annual Information Governance Improvement Plan arising from assessment against the Information Governance Toolkit.

- Identify any resources incurred from the implementation of the Improvement Plan and where approved submit to Service Planning with business case.

- Provide a consistent and effective approach to coordinating the following components of Information Governance across the organisation:

  - Information governance management
  - Confidentiality and data protection
  - Clinical information assurance
  - Corporate information assurance
  - Information quality assurance
  - Information security assurance

- Ensure that the Trust has effective policies and management arrangements covering all aspects of Information Governance in line with the Trust's overarching Information Governance Policy.

- Ensure that the Trust undertakes or commissions annual assessments and audits of its Information Governance policies and arrangements.

- Liaise with other Trust Committees and working groups in order to promote Information Governance issues.

- Promote awareness of the importance of Information Governance across the organisation.

Reporting
The minutes of the Group shall be formally recorded by the Group Secretary.

The Group will report twice yearly to the Governance & Quality Committee on Information Governance issues and annually to the Trust Board. This will provide assurance to the Board on Information Governance compliance

Membership
Information Governance Manager (Chair)
Head of Governance
Finance Director (or nominated representative)
Head of Risk Management, Complaints & Legal Services
ICT representative
Head of Nursing
Divisional representative(s)

HR representative
Clinician representative
Communications Manager
Health Records Manager
Performance Team Representative (IQA)
Information Governance Coordinators
Patient representative

All members have responsibility to:

- Contribute to and review all policies relating to information handling activities as requested by the Chair.
- Contribute to the Information Governance work programme.
- Feedback to group, actions taken as identified within the summary of agreed actions (Action Grid) within specified timescale.
- Provide timely reports to the Group as indicated by the reporting schedule

Attendance
Attendance is required at all meetings. Members unable to attend should indicate in writing to the Group Secretary 7 days in advance of the meeting (except in exceptional extenuating circumstances of absence)

Meetings

- Meetings will be held bi-monthly. However, they may be held more or less frequently as required
- Meetings will be no longer than 2 hours
- The meeting will have a pre-determined agenda that will be sent out to Committee members one week before the scheduled meeting date
- Items for the agenda must be sent to the Group Secretary 2 weeks prior to the meeting; urgent matters may be raised under any other business

Quorum
The meeting will be quorate with 8 members

Other matters
The Chair of the Group will take advice on the content of the agenda and will be responsible for ensuring actions are taken forward through appropriate dissemination of the minutes and associated action grid. The Chair may also invite or co-opt other members as appropriate.

The Group shall be supported administratively by the Secretary, whose duties in this respect will include:

- Drafting of the agenda for agreement with the Chair, and collation of papers
- Taking the minutes and keeping a record of matters arising and issue to be carried forward
- Advising the group on scheduled agenda items

Appendix J7

RISK ASSURANCE COMMITTEE
Terms of Reference

1. Constitution

The Hospital Management Committee hereby resolves to establish a Committee to be known as the Risk Assurance Committee (RAC). The Committee is a non-executive committee of the Hospital Management Committee and has no executive powers, other than those specifically delegated in these Terms of Reference

2. Purpose

The purpose of the Risk Assurance Committee is to promote good risk management and to establish and maintain an assurance framework and a risk register through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality.

It will promote local level responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of Trust activity where robust controls are not evident.

3. Objectives

The objectives of the Committee are to:

a) Oversee the development and maintenance of the Trust's annual Risk Management Strategy;

b) Develop, and review progress against, an annual Risk Management action plan, ensuring it supports the achievement of corporate objectives;

c) Coordinate the identification of all risks: clinical; financial and organisational, and ensure that systems are in place to manage those risks effectively;

d) Monitor and review the composition and maintenance of the Trust's Assurance Framework, the control and assurance mechanisms in place and the additional actions being taken to address gaps in control and assurance;

e) Monitor and review the Trust's Risk Register ensuring action is taken as appropriate and that unacceptable or serious risks (risk score of 15 and above) are reported to the Trust Board for consideration;

f) Receive and review progress reports on the implementation of action plans resulting from risk assessments of the Trust's activities;

g) Receive regular reports in relation to outstanding complaints, claims adverse events and near misses, including the identification of trends, and monitor or recommend action as appropriate, to ensure the Trust learns and improves its performance;

h) Ensure that all requirements are met to enable the Chief Executive to sign the Statement on Internal Control

i) Monitor compliance against the NHSLA Risk Management Standards

4. Authority

The Group is authorised by the Hospital Management Committee, to which it is accountable, to investigate or approve any activity within its terms of reference. It is also authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee

5. Reporting

The minutes of the Committee meetings shall be formally recorded by the Committee Secretary and submitted to the Governance & Quality Committee.

The Risk and Assurance Committee will also provide a quarterly report to the Governance & Quality Committee in support of its work on promoting good risk management and assurance processes. The Chair of the Committee shall draw to the attention of the Governance & Quality Committee any issues that it considers necessary.

6. Membership

- Company Secretary (Chair)
- Deputy Director of Workforce and Organisational Development
- Deputy Director of Finance
- Head of Governance
- Head of Risk Management, Complaints & Legal Services
- Head of Learning and Development (or designated deputy)
- Health & Safety Manager
- Complaints Manager
- Legal Services Manager
- Divisional Representatives
- Assurance Risk Advisor
- Representative, Corporate Nursing Team
- Representative, Duty Managers Forum
- Representative, Royal Hospital Haslar
- Representative, Retained Estates
- Representative, Military

Other members may be co-opted on to the committee as required: either for additional work or for the purpose of communication or presentation

7. Attendance

Attendance is required 75% of meetings. Members unable to attend should indicate in writing to the Committee secretary 7 days in advance of the meeting (except in extenuating circumstances of absence). Any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardize the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

The Secretary to the Committee shall attend to take minutes of the meeting and to provide appropriate support to the Chair and Committee members

8. Meetings

- Meetings will be held on a monthly basis
- Meetings will be no longer than 2 hours
- The meeting will have a predetermined agenda that will be sent out to the Committee members one week before the scheduled meeting date
- Items for the agenda must be sent to the Committee Secretary a minimum of one week prior to the meeting: urgent items may be raised under another business

9. Quorum

A quorum is one third of the members in attendance

10. Other Matters

The Chair of the Committee will take advice on the content of the agenda and will be responsible for ensuring actions are taken forward through appropriate dissemination of the minutes. The Chair may also invite or co-opt other members as appropriate

The Committee shall be supported by the Secretary, whose duties in this respect will include:

- Drafting of the agenda for agreement by the Chair of the Committee and collation of papers
- Taking the minutes and keeping a record of matters arising and issue to be carried forward
- Advising the group on scheduled agenda items

11. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Trust Board

12. Monitoring Effectiveness

The Committee shall, at least once a year by self-assessment, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary recommend any changes to the Governance & Quality Committee.

Twice a year the Committee Secretary will be responsible for ensuring a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed one week prior to the meetings;
- Minutes of the meetings were distributed within 5 working days of the meeting;

Appendix J8

SERIOUS INCIDENT REVIEW GROUP
Terms of Reference

Purpose
The Serious Incident Review Group (SIRG) will provide a high level forum in which to oversee and monitor the reporting and review of serious untoward incidents, as defined in the Trust's policy on Reporting and Reviewing Incidents.

The group will ensure recommendations arising from internal reviews and enquiries of serious untoward incidents are implemented across the Trust and progress monitored accordingly.

The group will provide a forum in which to consider incidents in which outcomes have not been expected, but for which there is disagreement as to the severity of the incident and the required level of investigation/scrutiny.

The group will provide a monitoring function in relation to the outcomes of investigations of clinical practice which have occurred as a result of concerns over individual practice and which may be linked to a serious untoward incident, and which have invoked relevant trust policies (e.g. Trust Policy for the handling of concerns and disciplinary procedures relating to the conduct and performance of Doctors and Dentists and Trust Capability Policy).

A further function of the group will be to receive details of external enquiry reports and recommendations in relation to incidents of relevance to the services of the Portsmouth Hospitals NHS Trust, and to ensure reports and recommendations are considered for their applicability to the Trust and its services. Where external recommendations are required to be implemented within the Portsmouth Hospitals NHS Trust, the Serious Incident Review Group will monitor and receive reports on the progress of implementation.

Duties The duties of the Serious Incident Review Group shall be to:

a) Ensure that initial management reports on all serious untoward incidents are completed within the timescales identified in the Trust's policy;

b) Ensure that internal/clinical review has been carried out and requirements of external reporting are met;

c) Ensure responsibility for taking forward recommendations within the Trust has been allocated;

d) Monitor progress on implementing recommendations;

e) Liaise with other Trust Committees as appropriate, e.g. Governance, Research and Development, Training and Development, etc;

f) Produce annual report to be incorporated into the Annual Governance Report to the Trust Board, Chief Executive and Governance leads of PCTs, Social Services and Health Authority;

g) Identify any patterns or trends that may be evident from the incidence and analyses of serious untoward incidents;

h) Receive and consider 'near miss' reports that may be classified as serious clinical incidents;

i) Review external reports such as National Confidential Inquiry Reports and ensure local action plans are developed and implemented as considered appropriate.

j) Liaise with primary and social care to ensure comprehensive investigation of serious clinical incidents and multi-agency implementation of recommendations.

Authority
The Group is a sub-committee of the Governance & Quality Committee and is authorized to investigate or approve any activity within it terms of reference. It is authorized to The Group will consider all serious untoward incidents as defined in the Policy on Incident Reporting and may seek any information it requires from any employee.

Reporting
The Group will be accountable to the Governance & Quality Committee and will contribute to the reporting schedule of that Committee, via submission of the Serious Untoward Incident Summary and by reporting annually

In addition the group will also contribute to the reporting schedule of the Trust Board, via submission of the Serious Untoward Incident Summary and by reporting annual to the Board on Learning From Experience.

Membership
- Non-Executive Director (Chair)
- Chief Executive
- Director of Clinical Services, Nursing and Midwifery
- Medical Director
- Head of Governance
- Head of Risk Management, Complaints & Legal Services
- Litigation Manager
- Serious Untoward Incident Coordinator
- Clinical Audit Facilitator
- Control of Infection
- Patient representative.

For incidents related to midwifery, the Head of Midwifery will be invited and Divisional Senior Nurses will be invited as required

Attendance
Attendance is required at all meetings. Members unable to attend should indicate in writing to the Group secretary 7 days in advance of the meeting (except in extenuating circumstances of absence)

The PA to the Head of Risk Management, Complaints & Legal Services will be the Secretary to the Group and shall attend to take minutes of the meeting and to provide appropriate support to the Chair and Group members

Meetings
- Meetings will be held on a bi-monthly basis
- Meetings will be no longer than 2 hours
- The meeting will have a predetermined agenda that will be sent out to the Group members one week before the scheduled meeting date

- Items for the agenda must be sent to the Group Secretary 2 weeks prior to the meeting: urgent items may be raised under another business

Quorum

The meeting shall be quorate with 6 members in attendance

APPENDIX K

LIST OF CONTACTS/SPECIALIST ADVISORS

Advice, support and information about training is always available from the Risk Management Department or other Specialist Advisors across the Trust.

Title	Available Advice	Contact Details
Head of Governance	All aspects of governance	7700 6207
Risk Management, Complaints and Legal Services		
Head of Risk Management, Complaints & Legal Services	All aspects of risk management, complaints & legal services and associated policies and procedures, the Risk Register and Assurance Framework	7701 2424
Risk Advisor	All aspects of risk management and risk reporting but specifically training and SUIs	7701 2476
Risk Advisor	All aspects or risk management and risk reporting but specifically SUIs and NHSLA Risk Management Standards	7701 2476
Risk Advisor	All aspects of risk management and risk reporting but specifically the Risk Register and the Assurance Framework	7701 3278
Complaints Manager	All aspects of complaints handling, monitoring and training	7701 2467
Litigation Manager	Claims and clinical negligence	7701 2421
Governance Compliance Manager	NHSLA Risk Management Standards and Standards for Better Health	7701 2469
Other Specialist Advisors		
Control of Infection – Lead Nurse	All aspects of control of infection: operational and strategic	7701 3274 Pager: 07623 942526
Counter Fraud	All aspects of counter fraud	7701 3941
Fire Officer	All aspects of fire safety	7701 3389
Health & Safety	All aspects of health & safety	7701 2491
Information Governance	All aspects of information governance	7700 2469
IV Team	All aspect of intravenous therapy	7701 3276 Pager: 07623 947981
Manual Handling Advisor	All aspects of manual handling	7701 3491
Medical Devices	All aspects of medical devices	7701 3468
Pharmacy Advisor	All aspects of medication management	7700 5284
Radiation Protection	All aspects of radiation protection	7701 2461
Resuscitation Advisor		7700 6293 Bleep 1668
Risk Advisor – Maternity	All aspects of maternity risk and maternity CNST standards	7701 3520

KBH000587-0063