Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Document Type: **POLICY**		**Unique Identifier:** CORP/POL/547
Title: **Risk Management Policy**		**Version Number:** 1
		Status: Ratified
Target Audience: Trust Wide		**Divisional and Department:** Corporate Assurance
Author / Originator and Job Title: Matthew Burrow, Head of Corporate Assurance		**Risk Assessment:** Not Applicable
Replaces: Version 11 - CORP/STRAT/006 Version 10 - CORP/PROC/006 Version 4 - SURG/STRAT/001 Version 4 - MED/STRAT/001 Version 12.1 - OBS/GYNAE/STRAT/001	**Description of amendments:** Inclusion of Divisional Risk Management Policies Inclusion of the new corporate governance structure Incorporates risk assessment and risk register management	
Validated (Technical Approval) by: Risk Committee	**Validation Date:** 17th November 2015	**Which Principles of the NHS Constitution Apply?** 1 - 4
Ratified (Management Approval) by: Board of Directors	**Ratified Date:** 25/11/2015	**Issue Date:** 25/11/2015
Review dates and version numbers may alter if any significant changes are made		**Review Date:** 01/11/2018

Blackpool Teaching Hospitals NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that they are not placed at a disadvantage over others. The Equality Impact Assessment Tool is designed to help you consider the needs and assess the impact of your policy in the final Appendix.

CONTENTS

1 Purpose

The purpose of this risk management policy is to:

- Set out respective responsibilities for strategic and operational risk management for the board of directors and staff throughout the organisation; and
- Describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of critical success factors.

The objectives of the risk management policy are to:

- Minimise chances of adverse incidents, risks and complaints by effective risk identification, prioritisation, treatment and management;
- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;
- Maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- Ensure that risk management is an integral part of the Trusts culture;
- Maintain robust systems for addressing externally issued alerts and for monitoring changes implemented;
- Minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy;
- Ensure that the Trust meets its obligations in respect of health and safety.

2 Target Audience

This policy covers the management of strategic and operational risks. Strategic risks are significant risks that have the potential to impact across the organisation and are raised and monitored by the executive team and the Board of Directors on the Board Assurance Framework. Operational risks are keys risks that impact on individual departments or programme areas and are managed by senior managers and the executive team. This policy applies to those members of staff that are directly employed by the Trust and for whom the Trust has legal responsibility.

3 POLICY

3.1 Risk Management Process

3.1.1 Identification, Documentation, Management and Escalation

The process for assessing and escalating risk assessments throughout the Trust is explained below. This process is used for all types of risk and for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation.

3.1.2 Identification of risks

'Risk' can be described as 'an uncertainty of outcome whether a positive opportunity or negative threat.' It is evaluated by considering the possibility of an event and its consequences; this is documented on the form in Appendix 1.

Risks can be identified both reactively (after an event) or by proactive methods (as part of a quality process).

Reactive methods;

- Incident reporting
- Complaints
- Claims

Proactive methods;

- Risk assessment
- Monitoring of compliance with relevant standards
- Information from external agencies (Care Quality Commission Recommendations)

3.1.3 Documentation - Risk Management Tools

3.1.3.1 Risk Assessment Template

A Risk Assessment Template (Appendix 1) has been developed for service, ward, department and directorate managers to assist them in documenting the activity, hazards, controls, assurances and action plan for each risk. The information required to undertake a risk assessment using the Trust standardised risk assessment form will include the following:

- Department Reference Number
- Date
- Location
- Ward / Department / Area

- Identify the activity / Task (what is causing the risk and the effect of the risk).

  The reason for including 'cause-risk-effect' assists in clearly explaining the risk.

- Identify what might cause harm and the risks associated with the hazard

  Describe the risks associated with the identified hazard.

- Who might be harmed and how

  Staff, Visitor, Patient or Other i.e. Contractors / Organisation.

- What are you doing now to manage the risk (Existing control measures)

  What arrangements do have in place currently that are working to manage the risk.

- Evaluation of Risk

  Risks are calculated by reviewing the;

  1. The consequence of exposure to the hazard; and
  2. The likelihood of this happening, bearing in mind the arrangements in place currently that are working to manage the risk.

  To assist in the determining the consequence and likelihood scoring process, see Tables 1, 2 and 3 in Appendix 1.

- Do you need to do anything else to control the risk (Additional controls measures required to reduce the risk)

  Are any existing arrangements not working adequately, or have up plans to try and implement new arrangements to manage the risk. This may include training; changing a work practice; employing staff. Please indicate the time scale for any actions and the person responsible; ensuring the person responsible is aware of the time scale for action.

- What would be the risk if all the additional actions were implemented (Residual risk)

  This is the target score for the risk if all the additional arrangements were completed; see Tables 1, 2 and 3 in Appendix 1 to determine the new consequences and likelihood values. Remember: in most cases that any arrangements usually reduced the likelihood not the consequence.

- Review and Signature

  The person developing the risk assessment must sign the risk assessment form along with their line manager. The line manager therefore acknowledges the risk assessment and should ensure the Governance Lead / Quality Manager or Deputy/Assistant Director or equivalent is aware so it can be presented to the relevant committee or be escalated, where necessary.

- Review of this assessment

  Yellow / Green Scoring Risks - must be reviewed on an annual basis or after any significant change.

  Amber Scoring Risks - must be reviewed at least on a bi-monthly or after any significant change by the Divisional Director and/ or Deputy/Assistant Director or equivalent.

  Red Scoring Risk or Risks on the Board Assurance Framework - must be reviewed at least on a bi-monthly or after any significant change by the relevant Executive Director.

The Risk Assessment will be used as an input document prior to recording on the Risk Register.

3.1.3.2 Risk Register

The Risk Register (Appendix 1) provides a mechanism for recording details of amber and red risks so that risk records can be analysed and facilitate effective oversight of risk management at all levels. All amber and red risk assessments must be entered onto the Risk Register.

3.1.4 How risks are assessed

All risk assessments use the standard Trust Risk Assessment Form (Appendix 1) or a modified risk assessment form as identified below. The risk management process is based on the Australia / New Zealand Risk Management System (Appendix 3) and the following risk level estimator;

Risk Level Estimator						
Consequence Rating / Likelihood Rating		Almost Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Catastrophic	5	25	20	15	10	5
Major	4	20	16	12	8	4
Moderate	3	15	12	9	6	3
Minor	2	10	8	6	4	2
Insignificant	1	5	4	3	2	1

Key:
High Risk
Significant risk
Moderate risk
Low risk

(See Appendix 1 for guidance on determining the consequence and likelihood ratings).

A risk assessment should be undertaken by the staff within the Community Service, Ward or Department both clinical and non-clinical, who are familiar with the tasks and possibly in partnership with expert knowledge from the Clinical Risk Department or Health and Safety Department where the risks faced are complex.

There is a defined assessment process for managing all types of risk in the Trust to ensure a consistent approach, as outlined below:

Action Table	
Risk Colour	**Action**
GREEN	• Accept the Risk • No further action is required. • Supervision is required to ensure that the all the controls are actually used ensure the risk remains within this colour band. • Assessment form should be kept in local risk folder which demonstrates an awareness of a potential hazard and assessment of risk.
YELLOW	• Retaining the risk at department level, if the controls identified cannot be implemented. • If the risk can be reduced further consideration may be given to a more cost effective solution or improvement that imposes no or limited additional cost burden. • If no additional controls can be implemented or the risk cannot be reduced further, supervision must be in place to ensure that the controls are used and remain effective to ensure that the risk remains within this colour band. • Assessment form should be kept in local risk folder which demonstrates an awareness of a potential hazard and assessment of risk.

Action Table	
Risk Colour	**Action**
AMBER	• Immediately escalate to Governance Lead/Quality Manager, Divisional Director / Head of Department or Deputy/Assistant Director / Head of Service level for escalation to the Divisions Senior Management Team. • Escalate on to the appropriate risk register via the Divisional Governance Committee or equivalent, as the departments controls identified cannot be implemented. • Risk reduction measures should be implemented within a defined time period. • If the risk can be reduced further efforts should be made to reduce the risk, but the costs, time and effort necessary for prevention should be measured and be in proportion to the risk. • If no additional controls can be implemented or the risk cannot be reduced further, appropriate levels of supervision must be in place to ensure that the controls are used and remain effective to ensure that the risk remains within this colour banding. • If necessary the Clinical Risk or Health and Safety Departments should be contacted for further advice on risk reduction measures.
RED	• Immediately escalate to the Governance Lead/Quality Manager, Divisional Director / Head of Department or Deputy / Assistant Director / Head of Service and the Corporate Assurance Team for escalation to the Executive Directors Meeting. • Escalate to the Risk Committee for inclusion on the Corporate Risk Register via the Divisional Governance Committee or equivalent, as the departments controls identified cannot be implemented. • Where the risk involves work in progress, urgent remedial action to avoid or reduce the risks should be taken. • Work should not be started until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk to an acceptable level. • Contact the Corporate Assurance, Clinical Risk or Health and Safety Departments for further advice.

3.1.5 How is the risk managed (Risk Response)

The management of risk falls within one of the following 5 categories;

- Take (if cost-benefit analysis in the long term determines the cost to mitigate risk is higher than cost to bear the risk, then the best response is to accept and continually monitor the risk);
- Tolerate (if cost-benefit analysis in the short term determines the cost to mitigate risk is higher than cost to bear the risk, then the best response is to accept and continually monitor the risk);
- Terminate (activities with a high likelihood of loss and large financial impact. The best response is to avoid the activity);
- Treat (activities with a high likelihood of occurring, but financial impact is small. The best response is to use management control systems to reduce the risk of potential loss); or
- Transfer (activities with low probability of occurring, but with a large financial impact. The best response is to transfer a portion or all of the risk to a third party by purchasing insurance, hedging, outsourcing, or entering into partnerships).

3.1.6 Mandatory Risk Assessments

Risk assessments will be carried out for the following types of risks on at least an annual basis utilising the Trust's standardised risk assessment form and will include the following:

- Health and safety risk assessments
- Environmental risk assessments
- Infection prevention risk assessments
- Moving and handling of objects risk assessments
- Physical security of premises and assets risk assessments
- Slips, trips, and falls risk assessments for staff, and others including falls from height
- Violence and aggression risk assessments
- Information/security/system risk assessments

Risk assessments will be carried out for the following types of risks for in-patients on admission and will include the following:

- Slips, trips and falls for patients risk assessments (excluding maternity and paediatrics) *
- Venous Thrombo-embolism (VTE) risk assessments *

Risk assessments will be carried out for the following types of risks on any patient who poses a risk to staff and / or patients and will include the following:

- Moving and handling of patients risk assessments*
- Violence and aggression risk assessments
- Slips, trips and falls for maternity and paediatric patients.

Risk Assessments will be carried out for the prevention and management of work related stress using a modified risk assessment process as outlined in the Work Related Stress Policy (CORP/POL/217).

- Stress Health and Safety Executive (HSE) modified risk assessments *

Risk Assessments will be carried out utilising a modified risk assessment form for the following:

- Visual Display Unit (VDU) Self-Assessment

  A VDU specific risk assessment must be completed by a member of staff who works on Display Screen Equipment and at a VDU workstation. The risk assessment process for VDU specific usage and a link to the VDU risk assessment form can be found in Implementation of the Health and Safety (Display Screen Equipment) Regulations 1992 (CORP/PROC/417).

- Pregnant Women Risk Assessment

  New and expectant mothers should advise their managers in writing as soon as their pregnancy is known in order that a risk assessment can be carried out. The risk assessment process for new and expectant mothers together with an example of the risk assessment form can be found in Pregnancy Risk Assessments (CORP/PROC/201).

Specific risk assessments applicable to an individual patient will be filed in the patient's case notes.

3.1.7 Risk Management Training

3.1.7.1 Mandatory Training – All Staff

This policy recognises that training will be required to effectively manage risks in line with the process set out above. All staff shall receive Mandatory Risk Management Training as part of their introduction to the Trust; this is detailed in the 'Mandatory Risk Management Training' policy (CORP/POL/354). The training is delivered through 3 routes; full risk management training day arranged by practice development sisters in some divisions, a workbook or e-learning.

Service, Ward and Departmental Managers will have more detailed risk management process training incorporating how to use the Ulysses Safeguard Incident Reporting database before access to the database is enabled and Root Cause Analysis training.

Failure to complete Risk Management Awareness Training may affect increments or pay progression.

The Learning and Development team will extract monthly from the electronic staff records system a database of all staff including Board Members and Senior Managers, who require risk management awareness training via the Oracle Learning Management System (OLM).

3.1.7.2 Board of Directors and Senior Managers

The Board of Directors and Senior Managers will receive training and/or briefings on the risk management process on appointment through the 'Mandatory Risk Management Training' policy (CORP/POL/354). In addition, supplementary briefings will be provided on an 'as required' basis following publication of new guidance or relevant legislation through Board Seminars.

3.1.8 Process for Monitoring Compliance

The following indicators shall form the Key Performance Indicators by which the effectiveness of the Risk Management Policy shall be evaluated:

- The Board Assurance Framework and Corporate Risk Register are reported to the Board of Directors at each formal meeting;
- The Board Assurance Framework and Corporate Risk Register are reported to and reviewed as a standing agenda item at each meeting of the Risk Committee;
- All new red risks are reported to and reviewed at each meeting of the Risk Committee;
- Risk registers are in place, maintained and available for inspection at divisional level; and
- Risk registers show details of controls, location, owner, action plan (where necessary) and review dates

The process for monitoring compliance with this policy is;

- Evidence of monthly reporting of significant risks to Divisional Governance Meetings or equivalent, the Board Committees and the Board of Directors;
- Periodic internal audit of aspects of the risk management process as determined by the Audit Committee.

3.2 Duties and Responsibilities

3.2.1 Board of Directors

The Executive and Non-Executive Directors share responsibility for the success of the Trust's Risk Management Policy, including the effectiveness and the compliance with relevant legislation. In relation to risk management the Board of Directors is responsible for:

- Managing and monitoring the principal risks identified in the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) that may prevent the Trust achieving its objectives;
- Review and approve the Risk Management Policy;
- Receive and review risk management reports from the Risk Committee;
- Ensure the approach to risk management is consistently applied;
- Determine the risk appetite for the Trust;
- Protect the reputation of the Trust;
- Provide leadership on the management of risk
- Ensure that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately.

3.2.2 Board Committees and Sub-Committees

3.2.2.1 Audit Committee

The Audit Committee is responsible for reviewing the adequacy and effectiveness of:

- Trusts internal control systems, including risk management;
- All risk and control related disclosure statements (in particular the Annual Governance Statement), prior to endorsement by the board of directors;
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of disclosure documents.

3.2.2.2 Risk Committee

The Risk Committee is the board committee with overarching responsibility for risk that is implemented and monitored. It is also responsible for:

- The effectiveness of risk management systems;
- Reviewing and monitoring Risk Assessments, Risk Registers, the Corporate Risk Register and the Board Assurance Framework.

3.2.2.3 Quality Committee

The Quality Committee is the board committee with responsibility for quality risks and is responsible for:

- Monitoring quality risks on the Board Assurance Framework;
- For advising the Board of Directors and Risk Committee on quality risks respectively.

3.2.2.4 Strategic Workforce Committee

The Strategic Workforce Committee is the board committee with responsibility for workforce risks and is responsible for:

- Monitoring workforce risks on the Board Assurance Framework;
- For advising the Board of Directors and Risk Committee on workforce risks respectively.

3.2.2.5 Finance Committee

The Finance Committee is the board committee with responsibility for finance and performance risks and is responsible for:

- Monitoring finance and performance risks on the Board Assurance Framework;
- For advising the Board of Directors and Risk Committee on finance and performance risks respectively.

3.2.2.6 Health and Safety and Environmental Governance Committee

The Health and Safety and Environmental Governance Committee is the board sub-committee with responsibility for health and safety risks and is responsible for:

- Monitoring health and safety risks;
- For advising the Risk Committee on health and safety risks respectively.

3.2.2.7 Health Informatics Committee

The Health Informatics Committee is the board sub-committee with responsibility for information risks and is responsible for:

- Monitoring information risks;
- For advising the Finance Committee on information risks respectively.

3.2.2.8 Learning from Incidents and Risks Committee

The Learning from Incidents and Risks Committee is the board sub-committee with responsibility for patient safety incidents, complaints, claims and patient experience and is responsible for:

- Monitoring patient safety incidents, complaints, claims and patient experience risks;
- For advising the Quality Committee on patient safety incidents, complaints, claims and patient experience risks respectively.

3.2.2.9 Medical Devices Steering Committee

The Medical Devices Steering Committee is the committee with responsibility for medical device risks and is responsible for:

- Monitoring medical device risks;
- For advising the Health and Safety and Environmental Governance Committee on medical device risks respectively.

The Terms of Reference for the Board Committees are held in the Board Manual accessible via the Foundation Trust Secretary.

The Terms of Reference for divisional governance meetings can be found in Appendices 5 onwards.

3.2.3 Trust Chair

The responsibility of the Trust Chair is to:

- Lead the board of directors, ensuring its effectiveness on all aspects of its role and setting its agenda;
- Ensure the provision of accurate, timely and clear information to Board members;
- Ensure effective communication with staff, patients and the public;
- Arrange regular evaluation of the performance of the Board, its committees and individual Directors;
- Facilitate the effective contribution of Non-Executive Directors and ensure constructive relationships between Executive and Non-Executive Directors.

3.2.4 Non- Executive Directors

The Non–Executive Directors have been allocated specific responsibilities for sitting on various board committees.

3.2.5 Chief Executive

As Accounting Officer, the Chief Executive Officer has overall accountability and responsibility for having an effective risk management system in place within the Trust for the achievement of the Trusts objectives and for meeting all statutory requirements.

To fulfil this responsibility the Chief Executive will:

- Ensure that management processes fulfil the responsibilities for risk management as set out in this policy;
- Ensure that full support and commitment is provided and maintained in every activity relating to risk management;
- Plan for adequate staffing, finances and other resources, to ensure the management of those risks which may have an adverse impact on the staff, finances or stakeholders of the Trust;
- Ensure an appropriate Board Assurance Framework (BAF) and Corporate Risk Register (CRR) is prepared and regularly updated and receives appropriate consideration;
- Ensure that an Annual Governance Statement, adequately reflecting the risk management issues within the Trust, is prepared and signed off each year.

3.2.6 Executive Directors

The Executive Team will;

- Act as senior responsible officers for their respective areas of the business and will ensure that within their directorates all risk management issues and risk registers are coordinated, managed, monitored and reviewed;
- Updating and ensuring mitigating actions are in place for the Board Assurance Framework and Corporate Risk Register risks allocated to them by the Risk Committee and the Board of Directors for each meeting;
- Ensuring staff comply with all organisational policies and procedures;
- Leading the management of risk by devising short, medium and long-term strategies to tackle identified risk, including the production of any action plans;
- Ensuring all staff fulfil their responsibility for risk management by identifying, reporting, monitoring and managing risk;
- Ensuring that all activities undertaken within their divisions/directorates are consistent with the safe operation of the Trust.

3.2.6.1 Director of Finance and Performance

The Director of Finance and Performance has an additional specific responsibility as the Security Management Director within the Trust.

3.2.6.2 Medical Director

The Medical Director has additional specific responsibilities as the Caldecott Guardian within the Trust and as the nominated director for health and safety management.

3.2.6.3 Director of Nursing and Quality

The Director of Nursing and Quality has additional specific responsibilities for infectious diseases risks as the Director of Infection Prevention Control within the Trust.

3.2.6.4 Chief Information Officer - CIO

The Chief Information Officer is the nominated Senior Information Risk Owner (SIRO) for the Trust and has responsibility for information and cyber security risk including the annual review of the information risk assessment to support the statement of internal control.

3.2.7 Divisional Managers

3.2.7.1 Deputy Director / Assistant Director / Head of Service

The Deputy Director / Assistant Directors / Head of Service have overall responsibility for risk management within the Division. They will ensure that systems are in place to identify and manage risks. They will ensure;

- Coordination of all aspects of risk management;
- That systems are in place to identify and manage risks;
- Support the reporting and investigation of untoward incidents and the development on risk assessments;
- Maintain a risk registers presented in a standard format (Appendix 2);
- Ensure that any agreed local risks that the amber are reviewed and managed by the Divisions Senior Management Team and Divisional Management Board or equivalent meeting and this is formally minuted;
- Any red risks should be escalated to the Corporate Assurance Team via e-mail and to the Executive Team
- Support the training and development of staff in risk management;
- Attend the Risk Committee when requested according to the annual schedule;
- Ensure lessons are learnt from incidents, claims and complaints;
- They will communicate between the Division and Executive Directors on all aspects of risk management.

3.2.7.2 Director of Pharmacy

The Director of Pharmacy has assigned responsibility for ensures that all medicines management policies and procedures are adhered to, in addition to the above in 3.2.7.1.

3.2.7.3 Divisional Directors / Heads of Department / Assistant Directors of Nursing

The Divisional Directors / Heads of Department / Assistant Directors of Nursing have the responsibility for risk management systems and processes within the Division. It is their responsibility to:

- Ensure systems are in place to identify risks within the Division through a process of risk assessment and this will be prioritised, minimised and where possible eliminated;
- Ensure development and maintenance of an up to date Risk Register;
- Have an overview of all untoward incidents, claims and complaints, and any identified trends or areas for retrospective action;
- Ensure that clinical risks are reported through the appropriate structures;
- Ensure outcomes from clinical investigations and recommendations are implemented;
- Ensure that recommendations arising from untoward incident analysis, complaints and medico-legal claims are cascaded back to the clinical area.

3.2.7.4 Nominated Professional Leads for Risk

The Nominated Clinical Leads for Risk within the Division are supported by the Governance Lead / Quality Manager. Together they have responsibility for overseeing clinical risk management throughout the Division. They will work in conjunction with the Heads of Department / Divisional Directors, Head of Service / Deputy Director / Assistant Director and Associate Director of Nursing and the Trust's Governance, Risk and Patient Safety Manager, demonstrating robust risk management systems and clear lines of communication and accountability.

3.2.7.5 Governance Lead / Quality Manager

The Clinical Governance Lead / Quality Manager are the identified individual with responsibility for coordinating risk management activities within the Division. They will work in conjunction with the Divisional Management Team to:

- Provide leadership and expert advice on Clinical Governance and coordinate all aspects of Governance across the Division;
- Coordinate the delivery and implementation of Clinical Governance and Risk Management strategies and work programmes for the Division;
- Act as Divisional lead for NHS Litigation Authority (NHSLA);
- Implement and monitor risk management policies to ensure their effectiveness. Review and amend local policies and procedures when required;
- Identify and ensure appropriate responses to recommendations from national and regional bodies are reported to the Divisional Board and ensure that appropriate plans are made to address these, i.e. National Institute for Health and Care Excellence (NICE), Care Quality Commission, Department of Health;

- Ensure there are appropriate systems in place within the Division on the reporting, management and investigation of clinical incidents, including root cause analysis as required. Ensure that learning is shared throughout the Division/wider organisation;
- Support the training and development of all staff groups in investigation of incidents, root cause analysis and complaints management;
- Develop and coordinate the Risk Register and escalate where appropriate to the Corporate Risk Register.

3.2.7.6 Service, Ward and Departmental Managers

All Community Service, Ward and Departmental managers will be responsible for;

- Actively implement the Risk Management Policy in their areas of responsibility;
- Identifying risks within their service, ward or department, ensuring that comprehensive risk assessments for local risks are undertaken in their area of responsibility by completing the Trust Risk Assessment Form (Appendix 1);
- Ensuring low level risks (green and yellow) are held in a risk assessment folder (electronic or paper) on the Ward, Department or Community Services Reception which is available for all staff to access;
- That risk assessments must be reviewed on an annual basis or after any significant change by the manager to ensure actions are implemented to mitigate the risk;
- That any risk assessments that are identified as amber or red should be escalated to the Divisional Director and / or Deputy/Assistant Director or equivalent and Governance Lead / Quality Manager for action;
- Ensure staff participate in incident reporting;
- Ensure staff attend all mandatory training;
- Seek advice on risk management issues as required;
- Investigate untoward incidents, claims and complaints and implement the lessons learnt.

3.2.7.7 Head of Corporate Assurance

The Head of Corporate Assurance has assigned responsibility to oversee the development of the risk management policy.

3.2.7.8 Head of Risk, Health, Safety and Security

The Head of Risk, Health, Safety and Security has assigned responsibility for ensuring Health and Safety Policy is adhered to (CORP/POL/069).

3.2.7.9 Governance, Risk and Patient Safety Manager

The Governance, Risk and Patient Safety Manager has assigned responsibility for ensuring the Patient Safety including Being Open and Duty of Candour Policy is adhered to (CORP/POL/538).

3.2.7.10 Infection Prevention Nurse Consultant

The Infection Prevention Nurse Consultant has assigned responsibility for ensuring the Infection Prevention Strategy 2013-2016 is adhered to (CORP/STRAT/023).

3.2.7.11 Head of Claims

The Head of Claims has assigned responsibility for ensuring the Handling Clinical Negligence and Personal Injury Claims is adhered to (CORP/POL/007).

3.2.7.12 Head of Information Governance

The Head of Information Governance has assigned responsibility for ensuring the Information Governance Framework Strategy is regularly reviewed and adhered to (CORP/STRAT/010).

3.2.7.13 All Staff, Partners and Contractors

All are obliged to follow this policy and to identify risks to managers under the Health and Safety at Work Act 1974, Section 7 (General Duties of the Employee). This includes:

- Taking reasonable care for the health and safety of themselves and others who may be affected by the acts or omissions;
- Ensure that all policies and procedures are adhered to;
- Immediately advising the line manager of risks and taking part in the risk assessment process;
- Reporting of Untoward Incidents and Serious Incidents and Near Misses to the Clinical Risk Department;
- Attend all mandatory and other relevant training courses.

3.2.8 Internal Auditors

The internal auditors are responsible for;

- Agreeing (with the Audit Committee) a programme of audits which assess the exposures and adequacy of mitigation of the principal risks affecting the organisation. The priorities contained in the internal audit programme should reflect the risk evaluation set out in the Board Assurance Framework.
- The reports and advice produced by internal audit should inform the management of risk by directorates although responsibility remains with the relevant risk owners, as set out in the following paragraphs.

Appendix 4 outlines the management responsibility and shows the flow of risk between risk registers.

Appendices 5 onwards contain the specific divisional roles and responsibilities, and will be updated in line with local procedural ratification as they do not impact on other divisions.

4 Attachments	
Appendix Number	**Title**
1	Risk Assessment Template and Risk Register Template
2	Corporate Committee Structure
3	Description of the Risk Management Process
4	Risk Register Flowchart
5	Scheduled Care Division Clinical Risk Management Reporting Structure
6	Unscheduled Care Division Clinical Risk Management Reporting Structure
7	Families Risk Management Structure
8	Research And Development Risk Management Reporting Structure
9	Adults And Long Term Conditions Risk Management Reporting Structure
10	Estates Risk Management Reporting Structure
11	Pharmacy Risk Management Reporting Structure
12	Equality Impact Assessment

5 Procedural Document Storage (Hard and Electronic Copies)
Electronic Database for Procedural Documents
Held by Procedural Document and Leaflet Coordinator

6 Locations this Document Issued to		
Copy No	**Location**	**Date Issued**
1	Intranet	25/11/2015
2	Wards, Departments and Service	25/11/2015

7 Other Relevant / Associated Documents	
Unique Identifier	**Title and web links from the document library**
CORP/POL/007	Handling Clinical Negligence and Personal Injury Claims http://fcsharepoint/trustdocuments/Documents/CORP-POL-007.docx
CORP/POL/045	Corporate and Local Induction Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-045.docx
CORP/POL/065	Information Governance Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-065.doc
CORP/POL/069	Health and Safety Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-069.docx
CORP/POL/106	Freedom of Information Act 2000 and Environmental Information Regulations 2004 http://fcsharepoint/trustdocuments/Documents/CORP-POL-106.doc
CORP/POL/155	The Systematic Approach to Managing Incidents, Complaints and Claims http://fcsharepoint/trustdocuments/Documents/CORP-POL-155.docx

7 Other Relevant / Associated Documents	
Unique Identifier	**Title and web links from the document library**
CORP/POL/214	Whistleblowing Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-214.docx
CORP/POL/217	Work Related Stress http://fcsharepoint/trustdocuments/Documents/CORP-POL-217.docx
CORP/POL/354	Mandatory Risk Management Training Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-354.docx
CORP/POL/402	Management of External Agency Visits, Inspections and Accreditations http://fcsharepoint/trustdocuments/Documents/CORP-POL-402.docx
CORP/POL/538	Patient Safety Including Being Open and Duty of Candour http://fcsharepoint/trustdocuments/Documents/CORP-POL-538.docx
CORP/PROC/101	Untoward Incident and Serious Incident Reporting Procedure http://fcsharepoint/trustdocuments/Documents/CORP-PROC-101.docx
CORP/PROC/107	Repair and Maintenance of Medical Devices http://fcsharepoint/trustdocuments/Documents/CORP-PROC-107.docx
CORP/PROC/133	Staff Training and Competency Assessment in the Use of medical Devices http://fcsharepoint/trustdocuments/Documents/CORP-PROC-133.doc
CORP/PROC/201	Pregnancy Risk Assessment http://fcsharepoint/trustdocuments/Documents/CORP-PROC-201.docx
CORP/PROC/403	Operational Procedure - Patient Relations Department http://fcsharepoint/trustdocuments/Documents/CORP-PROC-403.docx
CORP/PROC/417	Implementation of the H&S (Display Screen Equipment) Regulations 1992 http://fcsharepoint/trustdocuments/Documents/CORP-PROC-417.doc
CORP/STRAT/007	Clinical Governance Strategy http://fcsharepoint/trustdocuments/Documents/CORP-STRAT-007.doc
CORP/STRAT/010	Information Governance Framework Strategy 2012 - 2013 http://fcsharepoint/trustdocuments/Documents/CORP-STRAT-010.doc
CORP/STRAT/023	Infection Prevention Strategy http://fcsharepoint/trustdocuments/Documents/CORP-STRAT-023.docx
CORP/STRAT/024	Standards for Better Health - National Standards Strategy http://fcsharepoint/trustdocuments/Documents/CORP-STRAT-024.doc

8 Supporting References / Evidence Based Documents
References In Full
Crown. (1974). Health and Safety at Work etc. Act 1974, Section 7 (General duties of employees at work). Available: http://www.legislation.gov.uk/ukpga/1974/37/section/7 . Last accessed 16/09/2015.
Crown. (1992). The Health and Safety (Display Screen Equipment) Regulations 1992. Available: http://www.legislation.gov.uk/uksi/1992/2792/contents/made . Last accessed 16/09/2015.
SAI Global. (2014, 3rd Edition). AS/NZS ISO 31000:2009, Risk management - Principles and guidelines . Available: http://infostore.saiglobal.com/EMEA/Details.aspx?ProductID=1378670 . Last accessed 16/09/2015.

9 Consultation / Acknowledgements with Staff, Peers, Patients and the Public		
Name	**Designation**	**Date Response Received**
Anders Coleman	Quality Manager	26/10/2015
Debra Mathlouthi	Head of Health and Safety	
Colin Norris	Health and Safety Advisor	12/11/2015
David Webster	Fire Officer	
Vanya Fidling	Assistant Director of Pharmacy	
Liane Moorhouse	Quality Manager	12/11/2015
Angela McKeane	Associate Director of Nursing – Scheduled Care	
Helena Lee	Head of Patient Safety	
Susan Wild	Quality Manager	
Louise Dowell	Clinical Governance and Quality Manager	14/10/2015
Neil Upson	Deputy Director of Operations – Unscheduled Care	
Lisa Horkin	Associate Director of Nursing – Unscheduled Care	
Ann Conley	Deputy Director of Operations – Scheduled Care	
Pauline Tschobotko	Head of Midwifery	
Nicola Parry	Associate Director of Nursing – Midwifery	
Liz Holt	Director of Adult Community Services	
Carole McCann	Associate Director of Nursing – Community Health	
Steven Bloor	Chief Information Officer – Senior Information Risk Owner/Deputy Director of Information	
Patricia Butcher	Head of Information Governance	10/11/2015
Shaun Bucknill	ICT Manager	
Philip Davies	Head of Estates	
Dawn Goodall	Trust Solicitor	
Paula Roles	Deputy Director of Workforce and Organisational Development	15/10/2015

9 Consultation / Acknowledgements with Staff, Peers, Patients and the Public		
Name	**Designation**	**Date Response Received**
Jane Meek	Associate Director of People Effectiveness and Development	23/10/2015
Simone Anderton	Deputy Director of Nursing and Quality	
Victoria Ellarby	Deputy Director of Strategy and Business Development	
Rebecca Ferguson	Deputy Head of Fundraising	
Michelle Stephens	Research and Development Manager	23/10/2015
Jane Rowley	Head of Planning and Performance	
Tracy Burrell	Assistant Director of Nursing – Quality	23/10/2015
Rajan Sethi	Head of Procurement	
Paul Cunday	Assistant Director of Finance	
Nigel Fort	Assistant Director of Facilities	
Jo Lickiss	Nurse Consultant Infection Prevention	23/10/2015
Alex Latham	Learning and Development Manager	26/10/2015

10 Definitions / Glossary of Terms	
Assurance Framework	A framework consisting of systems and processes that are able to demonstrate adequate controls are in place so that the Trust can meet its statutory responsibilities for high quality healthcare
BAF	Board Assurance Framework
Control measure	A system, process or both that maintain pre-defined standards
CNST	Clinical Negligence Scheme for Trusts
CRR	Corporate Risk Register
DPA	Data Protection Act
DH	Department of Health
FHSAU	Family Health Services Appeal Unit
FOI	Freedom of Information Act
Hazard	A source of potential harm or a situation with a potential to cause loss
HSE	Health and Safety Executive
KPI's	Key Performance Indicators
Likelihood	Used as a qualitative description of probability or frequency
Mitigate	To make less severe
Negligence	The failure to do something a reasonable person would or doing something that a reasonable person would not do in the same circumstances.
NICE	National Institute for Health and Care Excellence
NHSLA	National Health Service Litigation Authority
OLM	Oracle Learning Management System
PALS	Patient Advisory Liaison Service
Risk	Uncertainty of outcome (whether positive opportunity or negative threat).
Risk Assessment	A process that involves the identification, analysis and evaluation of risks
Risk identification	The process of determining what can happen, why and how

10 Definitions / Glossary of Terms	
Risk management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects
Risk register	A system used to maintain information on all the identified risks pertaining to a particular activity (project or programme)
Risk tolerance	The level at which risk is considered acceptable/unacceptable
Risk treatment / response	Selection and implementation of appropriate options for dealing with risk
Senior manager	Senior managers are those persons who report directly to an Executive Director.
Strategic Risk	Risk concerned with where the organisation wants to go, how it plans to get there, and how it can ensure survival.
The Risk Management process	The Risk Management process is “the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk”.
VDU	Visual Display Unit
VTE	Venous Thrombo-embolism

11 Author / Divisional / Directorate Manager Approval			
Issued By	Matthew Burrow	**Checked By**	Wendy Swift
Job Title	Head of Corporate Assurance	**Job Title**	Deputy Chief Executive/ Director of Strategy
Date	November 2015	**Date**	November 2015

APPENDIX 1: RISK ASSESSMENT TEMPLATE AND RISK REGISTER TEMPLATE

The Trust Risk Assessment Form is available on the link below.

http://fcsharepoint/divisions/corporateservices/clinicalgovernance/riskmanagement/Pages/RiskAssessments.aspx

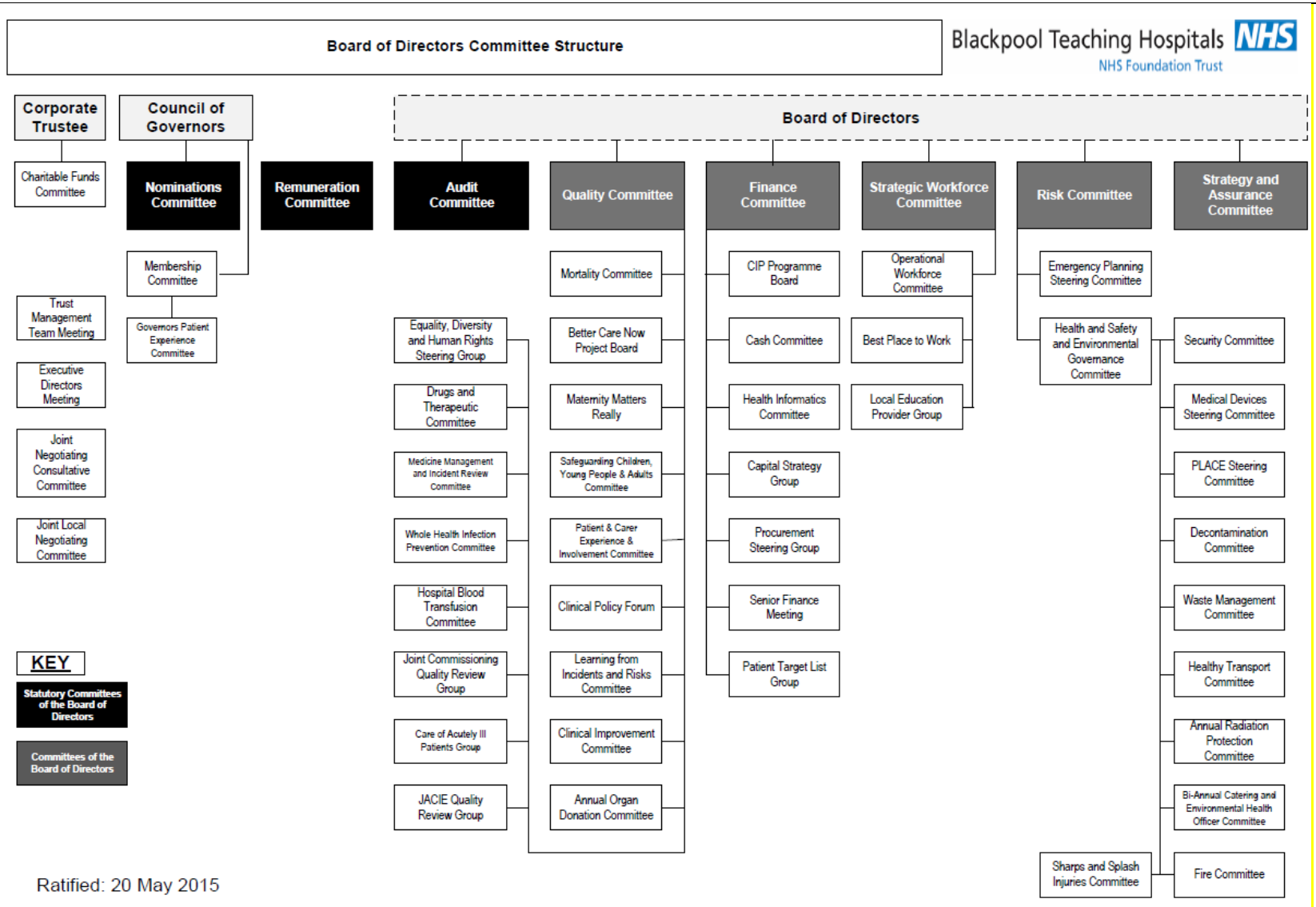
The Trust Risk Register template is available on the link below.

http://fcsharepoint/divisions/corporateservices/clinicalgovernance/riskmanagement/Pages/RiskAssessments.aspx

The Corporate Assurance Team maintains a log of all submitted Risk Registers from each Risk Committee below;

http://fcsharepoint/divisions/corporateservices/clinicalgovernance/riskmanagement/Pages/DepartmentDivisionalRiskRegisters.aspx

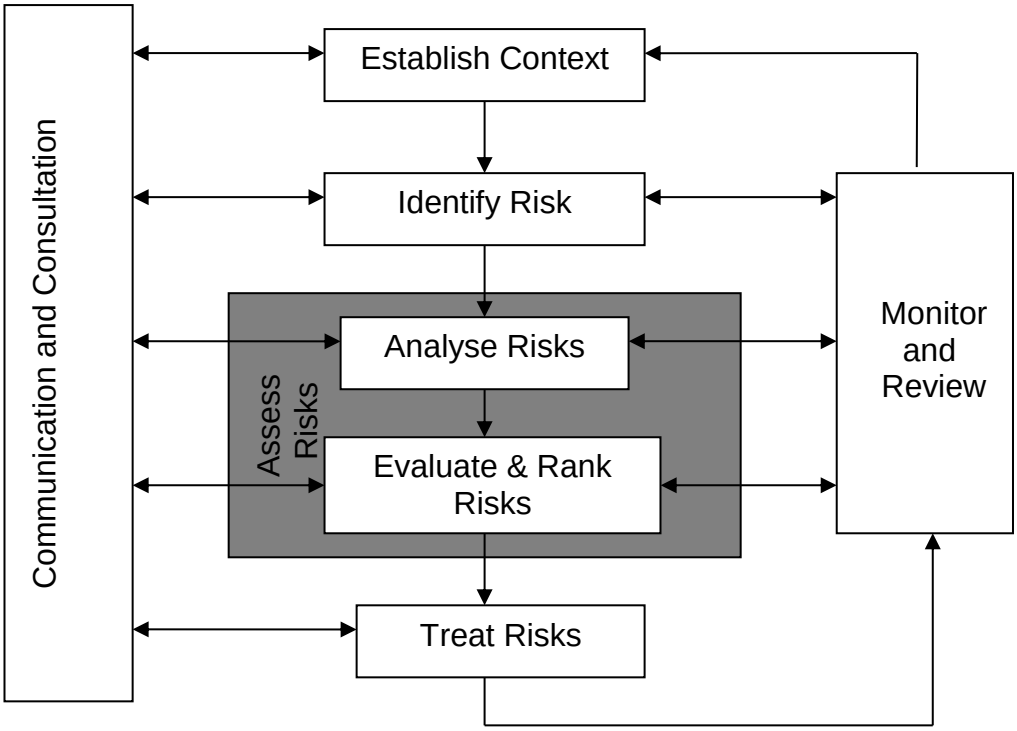
APPENDIX 2: CORPORATE COMMITTEE STRUCTURE



APPENDIX 3: DESCRIPTION OF THE RISK MANAGEMENT PROCESS

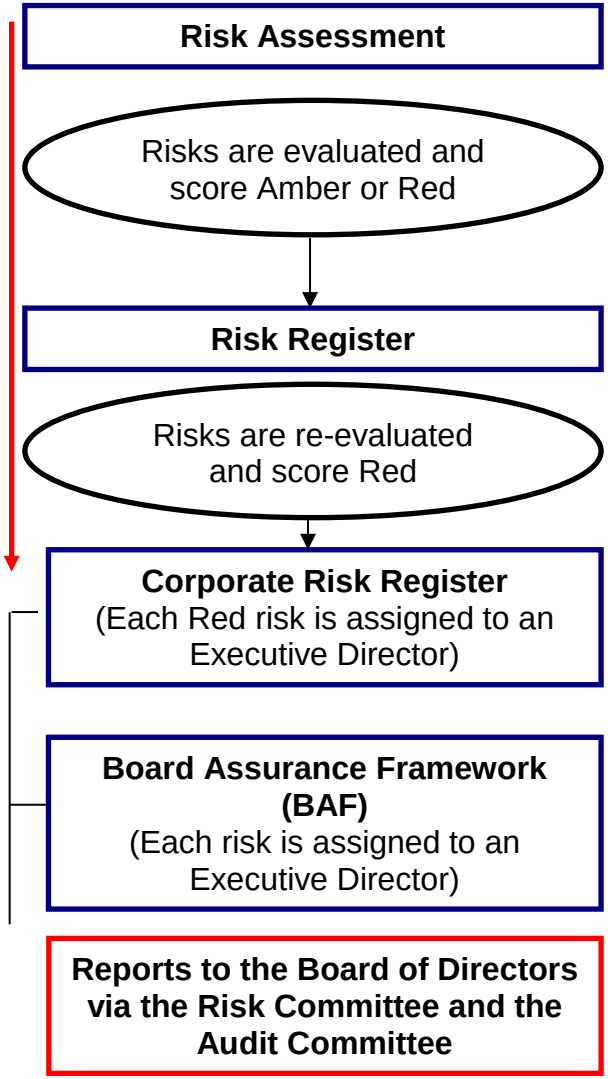
Adapted from the Australian/New Zealand standard AS/NZS 4360:1999

Risk Management Process describes "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk". It is described in the following diagram:



Risk Management Overview from AS/NZS 4360:1999

APPENDIX 4: RISK REGISTER FLOWCHART



A collection of risk assessments which are managed by Service, Ward or Departmental Manager utilising the corporate format and have a low level risk score – Green/Yellow

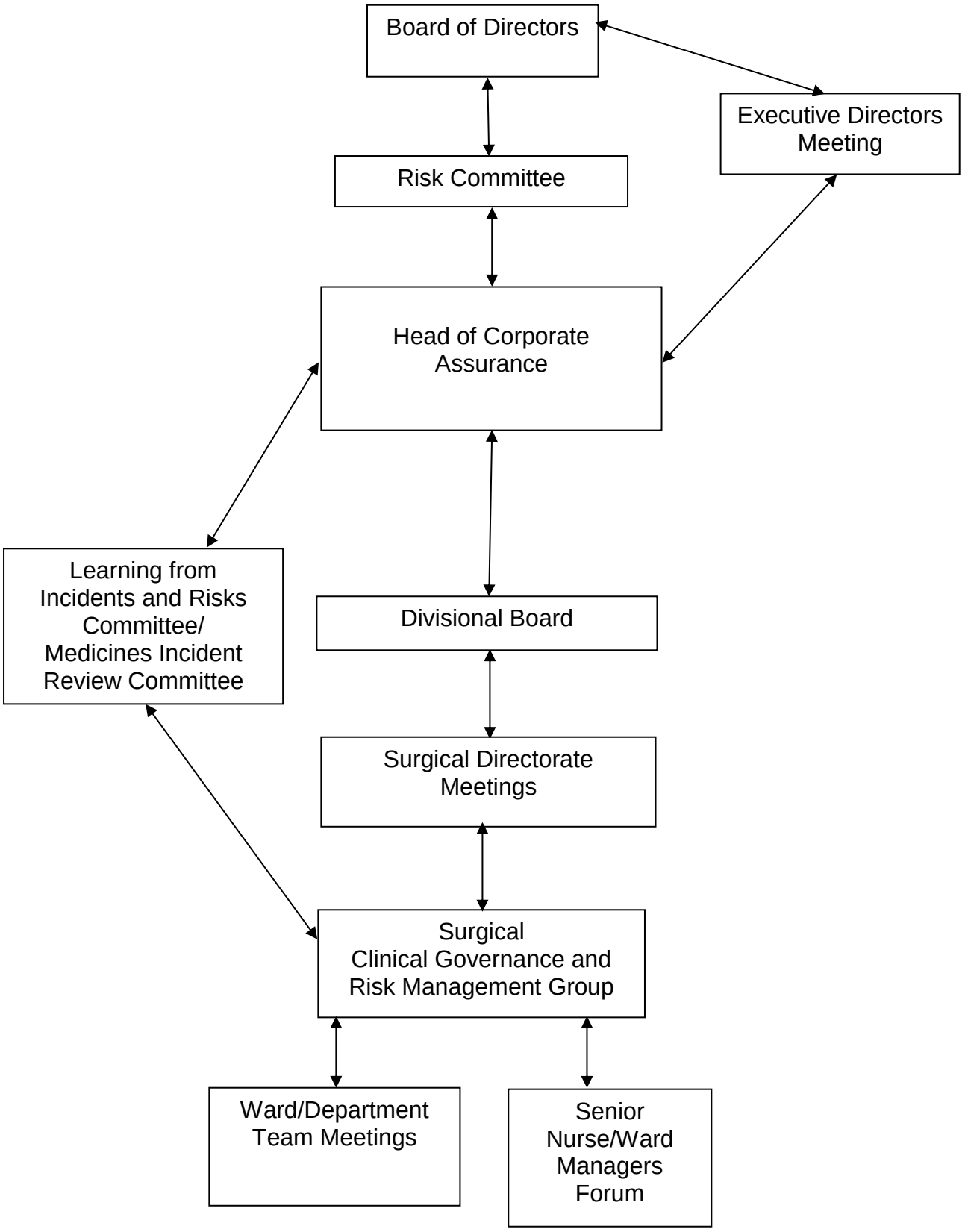
Records Divisional/Directorate wide moderate level risks score – Amber and Red which are reported by the Service, Ward or Departmental Manager utilising the corporate format to the Deputy/Assistant Director or equivalent. The Divisions manage these risks. These risks must be reviewed at the Divisional Governance Meeting at least on a bi-monthly basis.

CRR records organisation wide high level operational risks – Red risks. Red risks are referred by the Divisions utilising the corporate format. The Risk Committee monitors these risks on a bi-monthly basis. Every risk on the Corporate Risk Register will be assigned to an Executive Director who will be responsible for reporting on progress to the Risk Committee.

BAF records organisation wide strategic risks identified in relation to the Trust's strategic objectives. The BAF enables the Board to demonstrate how it has identified and met its assurance needs. Every risk on the BAF will be assigned to an Executive Director who will be responsible for reporting on progress to the Risk Committee.

Risks can move up and down between risk registers, as control measures are implemented and the risk level reduces.

APPENDIX 5: SCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE



APPENDIX 5: SCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Surgical Trigger Factors

Completing an incident form to agreed trigger factors is not just a paper exercise. It allows the Trust to be pro-active as it helps to obtain adequate resources by monitoring safety. Above all, it can ensure the best outcome for patients and staff. If you identify an area for improvement please use this system to make your opinion known.

There are general corporate trigger factors and trigger factors specific to your area.

General Trigger Factors

TREATMENTS
1. Drug error
2. Intravenous infusion error
3. Blood Transfusion error

PROCEDURES
1. Lack of consent / incorrect procedure
2. Breech of confidentiality
3. Inappropriate action to protocol / guideline

RECORDS
1. Unavailability of health record
2. Delay / error actioning investigation result

INFECTIONS
1. Hospital acquired infection
2. Loss of clinical material e.g. swabs

STAFFING
1. Staffing level below agreed level
2. Incident of violence / aggression.
3. Staff injury / accident

OTHER
1. Potential complaint
   ("Verbal complaint form" in use, rather than incident sheet)
2. Unavailability of any equipment or facility.

Surgical Triggers Factors

- Short notice cancellation of operations
- Incorrect use of medical equipment
- Patient injury or accident
- Any near miss
- Missing persons
- Incorrect documentation
- Equipment failure

APPENDIX 5: SCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Surgical Directorate Meetings / Audit and Educational Meetings

1. Purpose:
To undertake the decision-making function for the directorate, ensuring that senior clinicians and managers participate in the directorate's strategic development. The members of the individual Directorate meetings are responsible for ensuring the Terms of Reference are adhered to.

2. Terms of Reference:

- To ensure that effective communication systems are in place within the directorate;
- To ensure that the directorate places patients at the centre of its activity, encouraging effective multi-agency working and active patient/public participation in service improvement/developments;
- To ensure that robust systems are in place for clinical governance, audit and risk management within the directorate;
- To ensure that clinical practice is based on sound research/evidence;
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Directorate and to ensure that these are utilised efficiently.
- To receive reports from the Surgical Clinical Governance and Risk management Group.

3. Membership:

- Clinical Director (Chair)
- Consultants
- Directorate Manager
- Matron
- Finance representative
- Human Resource representative

4. Frequency of Meetings:

- Monthly

5. Agenda Items:

- Items for the agenda should be submitted to the Divisional Personal Assistant a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

6. Reports to:

- Surgical Divisional Board

7. Distribution of Minutes:

- Minutes of the meetings will be forwarded to the Surgical Directorate Meeting members. Items of relevance will be referred to the Divisional Board as appropriate.

8. Reviews and Evaluation:

- The membership of the group and Terms of Reference will be reviewed bi-annually.

For review by October 2013

APPENDIX 5: SCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Surgical Clinical Governance and Risk Management Group

1. Purpose:
The Surgical Directorate Meetings Clinical Governance and Risk Management Group are responsible for ensuring the Terms of Reference are adhered to.

2. Terms of reference:
- To ensure that the principles of risk management are applied effectively, coherently and systematically;
- To review and discuss adverse events, clinical incidents and near misses, identify system failures, gaps in clinical practice and make recommendations for change/service development;
- To review the incidents occurring in other areas within the Health Economy, which relate to Surgical Services;
- To identify trends and make recommendations for change, incorporating any relevant issues raised within complaints and litigation.
- To produce quarterly reports and action plans for the Directorate Management Team;
- To review the report and action plan at each meeting ensuring the actions recommended have been completed;
- To identify audit topics;
- To produce an annual report on risk management activity.

3. Membership:
- Divisional Lead for Risk (Chair)
- The Nominated Professional Leads for Clinical Governance and Risk
- Associate Director of Operations for Surgical Services
- Associate Director of Nursing/Directorate Managers
- Matrons / Departmental leads
- Clinical Directors

4. Deputy Attendance:
- It is the responsibility of each member of the committee to nominate a deputy. However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed.

5. Frequency of Meetings:
- Every 2 months

6. Agenda Items:
- Items for the agenda should be submitted to the Divisional Personal Assistant a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.
- Members will be expected to provide reports as required within the dates agreed.

7. Report to:
- Surgical Directorate Meetings

8. Distribution of Minutes:
- All the members of the group will receive a copy of the minutes via the email; the Chair will hold a paper copy.
- Clinical Directors
- Associate Director of Corporate Affairs
- Copies circulated to each ward, department and teams.

9. Reviews and Evaluation:
- The membership of the group and terms of reference will be reviewed bi-annually.

For review by October 2013

APPENDIX 5: SCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Senior Nurse/Ward Managers meetings

1. Purpose:

The purpose of the meeting is to consider all issues relating to all the clinical and operational areas within the Division. The group is responsible for assuring the Terms of Reference for their meetings are implemented.

2. Terms of Reference:

- To ensure that effective communication systems are in place within the directorate;
- To ensure that the directorate places patients at the centre of its activity, encouraging effective multi-agency working and active patient/public participation in service improvement/developments;
- To ensure that robust systems are in place for clinical governance, audit and risk management within the directorate;
- To ensure that clinical practice is based on sound research/evidence;
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Directorate and to ensure that these are utilised efficiently.
- To receive reports from the Surgical Clinical Governance Committee
- Mandatory training/education
- Risk Management - risk assessments;
- To consider issues arising from complaints, untoward incidents, audits and surveys;
- Professional issues
- Service delivery and developments
- Infection control
- Patient information

3. Membership:

- Matron / Departmental leads / Ward manager (Chair)
- All band 7 staff / Ward and Department staff as relevant
- Practice development nurses

4. Deputy Attendance:

It is the responsibility of each member of the committee to nominate a deputy. However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed.

5. Reports to:

- Items of relevance will be referred to the Surgical Directorate meetings, or the Trust's Clinical Governance Committee or Matrons Forum as appropriate.

6. Frequency of Meetings:

- Monthly

7. Agenda Items:

- Items for the agenda should be submitted a minimum of 5 working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

8. Distribution of Minutes:

- All members of the Forum will receive the minutes.

9. Reviews and Evaluation:

- The membership of the group and terms of reference will be reviewed bi-annually.

For review by October 2013

APPENDIX 5: SCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Ward / Departmental Team Meetings

1. Purpose:
The purpose of the ward/ departmental team meetings is to consider all issues relating to the specific area. The ward managers are responsible for assuring the Terms of Reference for their meetings are implemented.

2. Terms of Reference:
The meeting provides the forum for the ward managers to disseminate information, address concerns and build effective clinical teams to meet the corporate and local objectives related to the following core issues: -

- Mandatory training / education
- Risk Management
    - Risk assessments;
    - To consider issues arising from complaints, untoward incidents, audits and surveys;
- Professional issues
- Service delivery and developments
- Infection control
- Patient information

3. Membership

- All staff working in the appropriate areas across surgery

4. Reports to:

- Items of relevance will be referred to the Directorate meeting or the Clinical Governance Committee as appropriate.

5. Meetings:

- Meetings will take place every month

6. Agenda Items:
All agenda items must be submitted a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

7. Distribution of Minutes:

- Minutes of the meetings will available within the location and will be forwarded to the Matrons / Departmental Leads and Associate Director of Nursing.

8. Reviews and Evaluation:

- The membership of the group and terms of reference will be reviewed bi-annually.

For review by October 2013

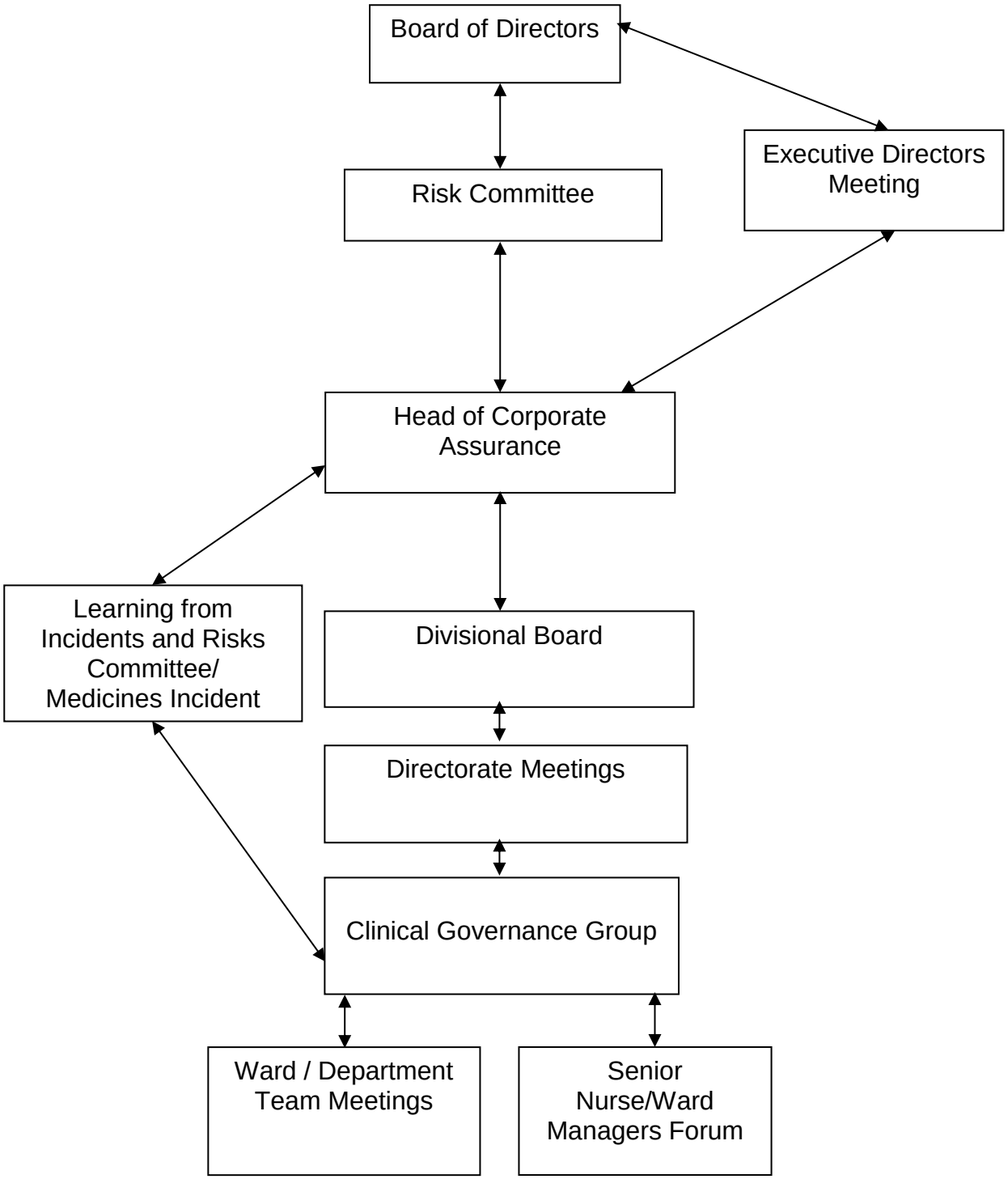
APPENDIX 5: SCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Divisional Measurable Objectives

Objective	Action
1. To ensure all staff are aware of the Trust Risk Management Strategy and Divisional risk management strategy.	The strategy will be introduced at the Corporate and local induction and reinforced at annual risk management training.
Process for Monitoring: Annual Audit	
Objective	**Action**
2. To ensure all staff are aware of the process for assessing all types of risk	Ward /Departmental managers will ensure staff use the Trust standardised risk assessment form for the appropriate types of risk for completion of risk assessments for the following: • Health and Safety risk assessments • Environmental risk assessments • Infection control risk assessments • Moving and handling of objects risk assessments • Moving and handling of patients risk assessments • Physical security of premises and assets risk assessments • Slips, trips and falls for staff and others risk assessments • Violence and aggression risk assessments
Process for Monitoring: Annual Audit	
Objective	**Action**
3. Ensure staff are aware of the process for the management of risk locally Ensure Ward/Departmental Managers manage and monitor risks by way of a Risk Register Folder	A Ward/Departmental Risk Register Folder will be developed by the Ward/Departmental Manager and Risk Assessments will be undertaken in accordance with the Trust Risk Management Strategy and Corp/Proc/006. A Divisional Risk Register will be formulated

Ensure staff manage and monitor risks by way of a Divisional Risk Register.	by the nominated professional lead for clinical governance and risk (Associate Director of Nursing) and monitored by the Divisional Clinical Governance Risk Management Group at least on a quarterly basis and by the Trust's Healthcare Governance Committee on a quarterly basis.
Process for Monitoring: Annual Audit	
Objective	**Action**
4. Ensure staff are aware of the process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation	Demonstrate the escalation of risks from the Ward/Department (Risk > 8) are escalated onto the Divisional Risk Register and (Risks > 12) are escalated onto the Corporate Risk Register and/or Board Assurance Framework.
Process for Monitoring: Annual Audit	
Objective	**Action**
5. Ensure staff are aware to add onto the Divisional Risk Register the 'Source' of the risk (including, but not limited to, incident reports, risk assessments and directorate risk registers)	Record the source of the risk onto each of the risks identified within the Divisional Risk Register
Process for Monitoring: Annual Audit	
Objective	**Action**
6. Ensure those with responsibility for risk, attend the Divisional Clinical Governance and Risk Management Group and other risk related meetings as defined in the terms of reference.	Record attendance of Committee Members and deputies in minutes. Ensure monitoring attendance sheets are maintained Terms of Reference must define lines of communication
Process for Monitoring: Annual Audit	

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE



APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Unscheduled Care
(Acute Medicine) Trigger Factors

Completing an incident form to agreed trigger factors is not just a paper exercise. It allows the Trust to be pro-active as it helps to obtain adequate resources by monitoring safety. Above all, it can ensure the best outcome for patients and staff. If you identify an area for improvement please use this system to make your opinion known.

There are general corporate trigger factors and trigger factors specific to your area.

General Trigger Factors

TREATMENTS
1. Drug error
2. Intravenous infusion error
3. Blood Transfusion error

PROCEDURES
1. Lack of consent / incorrect procedure
2. Breech of confidentiality
3. Inappropriate action to protocol /

RCORDS
1. Unavailability of health record
2. Delay / error actioning investigation result

INFECTIONS
1. Hospital acquired infection
2. Loss of clinical material e.g. swabs

STAFFING
1. Staffing level below agreed level
2. Incident of violence / aggression.
3. Staff injury / accident

OTHER
1. Potential complaint
   ("Verbal complaint form" in use, rather than incident sheet)
2. Unavailability of any equipment or facility.

Specific Triggers Factors

- Environmental failure / ventilation / temperature
- Equipment failure i.e. Gastro Washers
- Short notice cancellation of Scope lists
- Incorrect use of medical equipment
- Patient injury or accident
- Any near miss
- Missing persons
- Incorrect documentation
- Equipment failure

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Care of the Elderly and Rehabilitation Trigger factors

Completing an incident form to agreed trigger factors is not just a paper exercise. It allows the Trust to be pro-active as it helps to obtain adequate resources by monitoring safety. Above all, it can ensure the best outcome for patients and staff. If you identify an area for improvement please use this system to make your opinion known.

There are general corporate trigger factors and trigger factors specific to your area.

General Triggers Factors

TREATMENTS
1. Drug error
2. Intravenous infusion error
3. Blood Transfusion error

PROCEDURES
1. Breech of confidentiality
2. Inappropriate action to protocol / guideline

RECORDS
1. Unavailability of health record
2. Delay / error actioning investigation result

INFECTIONS
1. Hospital acquired infection
2. Loss of clinical material e.g. swabs

STAFFING
1. Staffing levels below agreed level
2. Incident of violence / aggression.
3. Staff injury / accident

OTHER
1. Potential complaint
   ("Verbal complaint form" in use, rather than incident sheet)
2. Unavailability of any equipment or facility.

Specific Trigger Factors

- Environmental failure / ventilation / temperature
- Equipment failure
- Failure in security measures
- Failure of delivery of facilities services i.e. catering
- Stock control
- Incorrect use of medical equipment
- Patient injury or accident
- Any near miss
- Missing persons
- Incorrect documentation
- Unsafe patient discharge

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Specialist Trigger factors

Completing an incident form to agreed trigger factors is not just a paper exercise. It allows the Trust to be pro-active as it helps to obtain adequate resources by monitoring safety. Above all, it can ensure the best outcome for patients and staff. If you identify an area for improvement please use this system to make your opinion known.

There are general corporate trigger factors and trigger factors specific to your area.

General Triggers Factors

TREATMENTS
1. Drug error
2. Blood Transfusion
3. Intravenous infusion error
4. UVA/UVB therapy error
5. Errors in administration of Chemotherapy

PROCEDURES
1. Lack of consent / incorrect procedure
2. Breech of confidentiality
3. Inappropriate action to protocol /

RECORDS
1. Unavailability of health record
2. Delay / error actioning investigation result

INFECTIONS
1. Hospital acquired infection
2. Loss of clinical material e.g. swabs

STAFFING
1. Staffing levels below agreed level
2. Incident of violence / aggression.
3. Staff injury / accident

OTHER
1. Potential complaint
   ("Verbal complaint form" in use, rather than incident sheet)
2. Unavailability of any equipment or facility.

Specific Trigger Factors

- Environmental failure / ventilation / temperature
- Equipment failure
- Failure in security measures
- Failure of delivery of facilities services
- Stock control
- Incorrect use of medical equipment
- Patient injury or accident
- Any near miss
- Missing persons
- Incorrect documentation
- Non availability of Chemotherapy

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Unscheduled Care Division Board Meetings

1. Purpose:
To undertake the decision-making function for the Medical Division, ensuring that senior clinicians and managers participate in the Division's strategic development. The members of the Medical Division meetings are responsible for ensuring the Terms of Reference are adhered to.

2. Terms of Reference:
- To ensure that effective communication systems are in place within the Division;
- To ensure that the Division places patients at the centre of its activity, encouraging effective multi-agency working and active patient/public participation in service improvement/developments;
- To ensure that robust systems are in place for clinical governance, audit and risk management within the Division;
- To ensure that clinical practice is based on sound research/evidence;
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Division and to ensure that these are utilised efficiently.
- To receive reports from the Medical Division Clinical Governance Meetings.

3. Membership:
- Divisional Director (Chair)
- Head of Departments (Deputy Chair)
- Deputy Director of Operations for Unscheduled Care
- Associate Director of Nursing
- Directorate Managers
- Divisional Financial Accountant
- Divisional Human Resources Manager
- Planning representative

4. Quorum:
- Five members constitute a quorum

5. Frequency of Meetings:
- Monthly

6. Agenda Items:

- Items for the agenda should be submitted to the Divisional Personal Assistant a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

7. Reports to:
- Executive Directors

8. Distribution of Minutes:
- Minutes of the meetings will be forwarded to the Divisional Meeting members. Items of relevance will be referred to members of the three directorate specialty meetings/members as appropriate and reported to the Quality Governance Committee Meeting.

9. Reviews and Evaluation:
- The membership of the group and Terms of Reference will be reviewed bi-annually.

For review by October 2013

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Acute Medicine Directorate Meetings

1. Purpose:
To undertake the decision-making function for the Directorate, ensuring that senior clinicians and managers participate in the Directorate's strategic development. The members of the Acute Medicine Directorate meetings are responsible for ensuring the Terms of Reference are adhered to.

2. Terms of Reference:
- To ensure that effective communication systems are in place within the Directorate;
- To ensure that the directorate places patients at the centre of its activity, encouraging effective multi-agency working and active patient/public participation in service improvement/developments;
- To ensure that robust systems are in place for clinical governance, audit and risk management within the directorate;
- To ensure that clinical practice is based on sound research/evidence;
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Directorate and to ensure that these are utilised efficiently.
- To receive reports from the Medical Clinical Governance Meetings.

3. Membership:
- Clinical Director Acute (Chair)
- Consultants Physicians (Deputy Chair)
- Directorate Manager
- Matron
- Heads of Service
- Divisional Finance Accountant

4. Quorum:
- The Chair and a representative from each specialist clinical team constitute a quorum

5. Frequency of Meetings:
- Monthly

6. Agenda Items:
- Items for the agenda should be submitted to the Directorate Personal Assistant a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

7. Reports to:
- Medical Division Board

8. Distribution of Minutes:
- Minutes of the meetings will be forwarded to the members of the group and to the Divisional Board for ratification.

9. Reviews and Evaluation:
- The membership of the group and Terms of Reference will be reviewed annually.

For review by October 2013

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Care of the Elderly and Rehabilitation Directorate Meetings

1. Purpose:
To undertake the decision-making function for the Directorate, ensuring that senior clinicians and managers participate in the Directorate's strategic development. The members of the Care of the Elderly and Rehabilitation Directorate meetings are responsible for ensuring the Terms of Reference are adhered to.

2. Terms of Reference:
- To ensure that effective communication systems are in place within the Directorate;
- To ensure that the directorate places patients at the centre of its activity, encouraging effective multi-agency working and active patient/public participation in service improvement/developments;
- To ensure that robust systems are in place for clinical governance, audit and risk management within the directorate;
- To ensure that clinical practice is based on sound research/evidence;
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Directorate and to ensure that these are utilised efficiently.
- To receive reports from the Medical Clinical Governance Meetings.

3. Membership:
- Clinical Director (Chair)
- Consultants Care of the Elderly Physicians (Deputy Chair)
- Directorate Manager
- Matron
- Middle Grade Doctors
- Discharge Co-ordinator
- Divisional Finance Accountant

4. Quorum:
- Five members constitute a quorum

5. Frequency of Meetings:
- Bi-Monthly

6. Agenda Items:
- Items for the agenda should be submitted to the Directorate Personal Assistant a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

7. Reports to:
- Medical Division Board

8. Distribution of Minutes:
- Minutes of the meetings will be forwarded to the members of the group and to the Divisional Board for ratification.

9. Reviews and Evaluation:
- The membership of the group and Terms of Reference will be reviewed annually.

For review by October 2013

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Specialist Medicine Directorate

1. Purpose:
To undertake the decision-making function for the Directorate, ensuring that senior clinicians and managers participate in the Directorate's strategic development. The members of the Specialist Medicine Directorate meetings are responsible for ensuring the Terms of Reference are adhered to.

2. Terms of Reference:
- To ensure that effective communication systems are in place within the Directorate;
- To ensure that the directorate places patients at the centre of its activity, encouraging effective multi-agency working and active patient/public participation in service improvement/developments;
- To ensure that robust systems are in place for clinical governance, audit and risk management within the directorate;
- To ensure that clinical practice is based on sound research/evidence;
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Directorate and to ensure that these are utilised efficiently.
- To receive reports from the Medical Clinical Governance Meetings.

3. Membership:
- Clinical Director (Chair)
- Consultant Dermatologists (Deputy Chair)
- Consultants Rheumatologists
- Directorate Manager
- Matron
- Divisional Finance Accountant

4. Quorum:
- Five members constitute a quorum

5. Frequency of Meetings:
- Bi-Monthly

6. Agenda Items:
- Items for the agenda should be submitted to the Directorate Personal Assistant a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

7. Reports to:
- Medical Division Board

8. Distribution of Minutes:
- Minutes of the meetings will be forwarded to the members of the group and to the Divisional Board for ratification.

9. Reviews and Evaluation:
- The membership of the group and Terms of Reference will be reviewed annually.

For review by October 2013

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Terms of Reference for the Medical Division Clinical Governance Group

1. Purpose:

The Medical Division Clinical Governance Group are responsible for ensuring the Terms of Reference are adhered to.

2. Terms of reference:

- To ensure that the principles of risk management are applied effectively, coherently and systematically;
- To review and discuss adverse events, clinical incidents and near misses, identify system failures, gaps in clinical practice and make recommendations for change/service development;
- To review the incidents occurring in other areas within the Health Economy, which relate to the three directorates of the Medical Division;
- To identify trends and make recommendations for change, incorporating any relevant issues raised within complaints and litigation.
- To review the report and action plan at each meeting ensuring the actions recommended have been completed;
- To identify audit topics;
- To produce an annual report on risk management activity.

3. Membership:

- Divisional Director (Chair)
- Clinical Director (Specialist Medicine)
- Clinical Director (Care of the Elderly Medicine)
- Clinical Director (Acute Medicine)
- Associate Director of Operations for Unscheduled Care
- Associate Director of Nursing
- Directorate Managers
- Matrons
- Control of Infection representative

4. Deputy Attendance:

- It is the responsibility of each member of the committee to nominate a deputy. However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed.

5. Quorum:

- Five members constitute a quorum

6. Frequency of Meetings:

- Monthly

7. Agenda Items:

- Items for the agenda should be submitted to the Divisional Personal Assistant a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.
- Members will be expected to provide reports as required within the dates agreed.

8. Report to:

- Executive Directors

9. Distribution of Minutes:

- All the members of the group will receive a copy of the minutes via email; the Division will hold a paper copy.
- Minutes of the meetings will be forwarded to members of the group
- Deputy Director of Corporate Affairs and Governance

10. Reviews and Evaluation:

- The membership of the group and terms of reference will be reviewed annually.

For review by October 2013

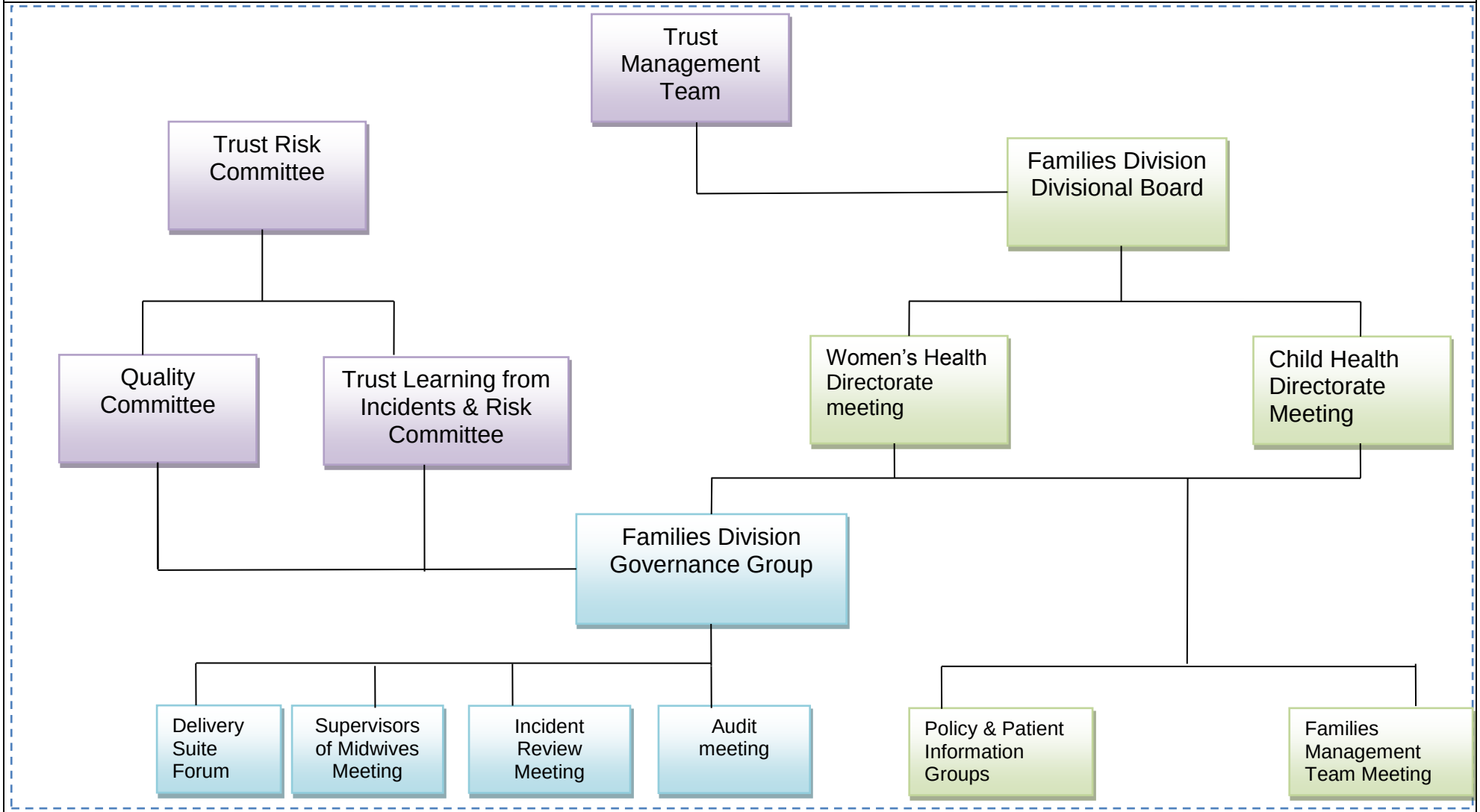
APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE

Divisional Measurable Objectives

Objective	Action
1. To ensure all staff are aware of the Trust Risk Management Strategy and Divisional risk management strategy.	The strategy will be introduced at the Corporate and local induction and reinforced at annual risk management training.
Process for Monitoring: Annual Audit	
Objective	**Action**
2. To ensure all staff are aware of the process for assessing all types of risk	Ward /Departmental managers will ensure staff use the Trust standardised risk assessment form for the appropriate types of risk for completion of risk assessments for the following: • Health and Safety risk assessments • Environmental risk assessments • Infection control risk assessments • Moving and handling of objects risk assessments • Moving and handling of patients risk assessments • Physical security of premises and assets risk assessments • Slips, trips and falls for staff and others risk assessments • Violence and aggression risk assessments
Process for Monitoring: Annual Audit	
Objective	**Action**
3. Ensure staff are aware of the process for the management of risk locally Ensure Ward / Departmental Managers manage and monitor risks by way of a Risk Register Folder	A Ward/Departmental Risk Register Folder will be developed by the Ward/Departmental Manager and Risk Assessments will be undertaken in accordance with the Trust Risk Management Strategy and Corp/Proc/006.

APPENDIX 6: UNSCHEDULED CARE DIVISION CLINICAL RISK MANAGEMENT REPORTING STRUCTURE	
Ensure staff manage and monitor risks by way of a Divisional Risk Register.	A Divisional Risk Register will be formulated by the nominated professional lead for clinical governance and risk (Associate Director of Nursing) and monitored by the Divisional Clinical Governance Risk Management Group at least on a quarterly basis and by the Trust's Healthcare Governance Committee on a quarterly basis.
Process for Monitoring: Annual Audit	
Objective	**Action**
4. Ensure staff are aware of the process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation	Demonstrate the escalation of risks from the Ward/Department (Risk > 8) are escalated onto the Divisional Risk Register and (Risks > 12) are escalated onto the Corporate Risk Register and/or Board Assurance Framework.
Process for Monitoring: Annual Audit	
Objective	**Action**
5. Ensure staff are aware to add onto the Divisional Risk Register the 'Source' of the risk (including, but not limited to, incident reports, risk assessments and directorate risk registers)	Record the source of the risk onto each of the risks identified within the Divisional Risk Register
Process for Monitoring: Annual Audit	
Objective	**Action**
6. Ensure those with responsibility for risk, attend the Divisional Clinical Governance and Risk Management Group and other risk related meetings as defined in the terms of reference.	Record attendance of Committee Members and deputies in minutes. Ensure monitoring attendance sheets are maintained Terms of Reference must define lines of communication
Process for Monitoring: Annual Audit	

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE



APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

Process for Monitoring Compliance

Minimum requirement to be monitored Standard 1 Criterion 2 Risk Management Strategy Organisation		Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
a)	The maternity services has measurable objectives for managing risk	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
b)	The management of the Maternity Services risk register which reflects both the maternity service and the organisation wide risk management strategies	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
c)	The maternity services risk management structure, details all the committees' sub-committees/groups within the organisation (not just the maternity service), which have some responsibility for risk within the maternity service	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
d)	The Division immediately escalates risk management issues from maternity services to board level	Audit	HOM	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
e)	The Board Lead executive communicates with and obtains assurance from the maternity service	Audit	DON / HOM	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
f)	Duties of the named individuals with responsibility for risk within the maternity service which must include the following: • Lead Executive at Board Level • Professional Leads • Clinical Risk Coordinator • Lead Consultant for labour ward matters • Clinical Midwife Manager for labour ward matters • Lead Obstetric Anaesthetist for anaesthetic services • Supervisor of Midwives	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

Minimum requirement to be monitored Standard 1 Criterion 8 Risk Management Strategy Organisation		Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group / committee for monitoring of action plan and Implementation
a)	Maternity specific dataset for incident reporting	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
b)	Maternity services processes for learning from experience including case reviews	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
c)	Arrangements for the regular review and discussion of all incidents, complaints and claims by the relevant local group	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
d)	Arrangements for ensuring that all serious untoward incidents undergo a root cause analysis, involving as appropriate unbiased external input	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
e)	Arrangements for ensuring that lessons learned from all incidents complaints and claims are actively disseminated to all staff	Audit	Clinical Director – Risk Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group
f)	Process for providing board assurance that lessons learned from SUIs are implemented and monitored.	Audit	Clinical Governance Lead	Annual	Families Division Clinical Governance Group	Families Division Clinical Governance Group	Families Division Clinical Governance Group

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE	
Families Divisional Risk Strategy - Measurable Objectives	
Objective	**Action**
1. To ensure all staff are aware of risk management strategy.	The strategy will be introduced at local induction and reinforced at annual risk management training.
Process for Monitoring Annual Audit	
Objective	**Action**
2. To ensure all staff are aware of the process for assessing all types of risk	Ward /Departmental managers will ensure staff use the Trust standardised risk assessment form for the appropriate types of risk for completion of risk assessments for the following: • Health and Safety risk assessments • Environmental risk assessments • Infection control risk assessments • Moving and handling of objects risk assessments • Moving and handling of patients risk assessments • Physical security of premises and assets risk assessments • Slips, trips and falls for staff and others risk assessments • Violence and aggression risk assessments
Process for Monitoring Annual Audit	
Objective	**Action**
3. Ensure all staff are aware of the process for the management of risk locally Ensure ward and departmental managers manage and monitor risks by way of a risk register folder	A ward/ departmental risk register folder will be in place and risk assessments will be undertaken in accordance with the Trust Risk Management Strategy Corp/Proc/006 A Divisional Risk Register will be in place and updated by the Clinical Governance Lead / Quality Manager and monitored by the Families

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE	
Manage and monitor risks by way of a Divisional Risk Register.	Governance Group on a monthly basis and by the Trust's Risk Committee on a quarterly basis.
Process for Monitoring Annual Audit	
Objective	**Action**
4. Ensure staff are aware of the process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation	Demonstrate the escalation of risks from the Ward/Department (Risk > 8) are escalated onto the Divisional Risk Register and (Risks > 12) are escalated onto the Corporate Risk Register and/or Board Assurance Framework
Process for Monitoring Annual Audit	
Objective	**Action**
5. Woman's Health risk management issues are escalated to Board level.	The Head of Midwifery reports directly to the Board Executive Lead when serious risk management issues arise. A risk management communication form will be completed recording this discussion and archived by the Head of Midwifery to provide evidence of direct discussion
Process for Monitoring Annual Audit	
Objective	**Action**
6. Assure the Executive Board Risk Lead of robust risk management systems	Ensure 1:1 meetings are held between the Board Executive Lead for risk and the Head of Midwifery
Process for Monitoring Annual Audit	
Objective	**Action**
7. Ensure those with responsibility for risk, attend the Divisional Clinical	Record attendance of Committee Members and deputies in minutes. Ensure monitoring attendance sheets are

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE	
Governance and Risk Management Group and other risk related meetings as defined in the terms of reference	maintained Terms of Reference must define lines of communication

Process for Monitoring

Annual Audit

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

IMPLEMENTATION OF RISK MANAGEMENT PROCESS

All staff working within the Families Division are aware of the risk triggers and are actively encouraged to report incidents on the untoward incident report form. The recommended risk triggers for each clinical area are described below (this list is not exhaustive).

Trigger list for incident reporting in Families Division

Maternal Incident	Fetal /neonatal Incident	Gynaecology Incident
Maternal death	Still birth	Damage to structures (e.g. ureter, uterine perforation, bowel , vessel)
Undiagnosed breech	Neonatal death	Delayed or missed diagnosis (ruptured ectopic)
Shoulder Dystocia	Apgar score < 7 at 5 minutes	Anaesthetic complication
Blood loss > 1500mls	Birth trauma	Venous thromboembolism
Return to theatre	Fetal laceration at caesarean section	Failed procedures
Eclampsia/ eclamptic fit	Cord pH < 7.05 arterial or < 7.1 venous	Unplanned intensive care admission
Hysterectomy / laparotomy	Neonatal seizures	Omission of planned procedures
Anaesthetic complications	Unexpected admission to NNU	Unexpected operative blood loss > 500mls
Intensive care admission	Undiagnosed fetal anomaly	Procedure performed without consent
Venous thromboembolism		Unplanned return to theatre
Pulmonary embolism		Unplanned return to hospital within 30 days
Third / fourth degree tears		Blood transfusion > 4 units
Unsuccessful forceps or ventouse		
Uterine rupture		
Incorrect diagnosis		
Unplanned home birth		
Readmission of mother		
Severe infection / wound breakdown		

Trigger List for reporting incident reporting in Families Division

Paediatric Incident	Organisational Incident
Death of a child	Unavailability of health record
Respiratory or cardiac arrest of a child in hospital	Delay in responding to call for assistance
	Faulty equipment

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

Accident to child in hospital

Readmission of a baby within 28 days of life

Child protection issues including multi-agency concerns

Paediatric Surgery Incidents

Circumcision – readmission in < 28days

Herniotomy – readmission in < 28 days

Tonsillectomy – readmission in < 28 days

Other surgery – readmission in < 28 days

Unexpected overnight admission

Cancelled operations prior to admission

Cancelled operations on day of op

Elective surgery - 28 day mortality rate

Admission to CCU/HDU post-surgery

Conflict over case management

Potential service user complaint

Medication error

Blood transfusion error

Retained swab or instrument

Hospital acquired infection

Violation of local protocol

Lack of consent

Safeguarding issues

Information governance issues

Violence and aggression

Staff injury

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE FAMILIES DIVISIONAL BOARD

1. Constitution:
To undertake the decision-making function for the Division, ensuring that Senior Clinicians and Managers participate in the Division's strategic development. To monitor and have overall responsibility for the function of the reporting groups or committees and assure the Board of operational and clinical effectiveness. The members of the Divisional Board are responsible for ensuring the terms of reference are adhered to.

2. Membership:
Head of Service *
Head of Department Child Health*
Head of Department Woman's Health*
Head of Midwifery / Associate Director of Nursing *
Head of Safeguarding
Head of Targeted Services
Head of Universal Services
Head of Maternity and Gynaecology
Divisional Finance Manager
Divisional HR Manager
Clinical Governance and Quality Manager

* Decision-making members

3. Quorum:
Five members constitute a quorum to include the Head of Service or the Heads of Department and one other decision making member

4. Attendance:
Other members of the Trust may be asked to attend as and when required

5. Frequency:
Monthly

6. Duties:

- To oversee the management of financial resources within the Division and to ensure that these are utilised efficiently
- To act as the Executive decision-making forum for the Division
- To ensure that effective communication systems are in place within the Division.
- To ensure that Clinicians within the Division are fully engaged in the development of the Trust and Divisional strategic direction
- To ensure effective management processes are in place within the Division and that decision-making authority is delegated to appropriate levels within the Division
- To ensure that the Division places patients at the centre of its activity, encouraging effective multi-agency working.
- To ensure that robust systems are in place for Clinical Governance, audit and Risk Management within the Division. To ensure that clinical practice is based on sound research/evidence.
- To monitor compliance with performance indicators
- To ensure that plans are in place within Departments to achieve the highest possible levels of cleanliness and hygiene at all times
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To co-ordinate, evaluate, and prioritise, proposals for service development as part of the business planning process
- To performance manage the contribution of individual departments to the overall success of the

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

Division and the Trust

- To encourage the further development of relationships with external agencies and to promote effective multi-agency working
- To promote research and evidence based practice in all of the Division's operations
- To receive reports from Divisional groups and other department's professional and departmental meetings as required

7. Deputy Attendance:

It is the responsibility of each member of the Families Divisional Board to nominate a deputy.

8. Reporting Arrangements:

The Divisional Board has regular reporting arrangements with the following:

- The Trust Management Team
- The Families Division Governance Group
- The Woman's Health Departmental Meeting
- The Child Health Departmental Meeting

9. Agenda Items:

Standing items will include:

- Reports from the Board, Departmental and Corporate Meetings for information/action
- Matters arising from Departmental minutes for information/action/ratification
- Performance reports - Activity, Finance, HR, Clinical Governance and Risk, Education and Audit.
- Service Developments for information/discussion/action/ratification.

10. Distribution of Minutes:

- Minutes of the meetings will be forwarded to the Divisional Board members.

11. Reviews and Evaluation:

- The membership of the Divisional Board and terms of reference will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE WOMAN'S HEALTH DIRECTORATE MEETING

1. Constitution:
To undertake the decision-making function for the Department, ensuring that Senior Clinicians and Managers participate in strategic development. The members of the Department Meeting are responsible for ensuring the terms of reference are adhered to.

2. Membership:
Head of Department (Chair)
Head of Service
Head of Midwifery/ Associate Director of Nursing
All Consultant Obstetrician and Gynaecologists
Head of Maternity and Gynaecology
Divisional Finance Manager
Assistant Divisional Manager
Clinical Governance and Quality Manager

3. Quorum:
Five members constitute a quorum (including 2 Consultant Obstetrician and Gynaecologists)

4. Attendance:
Other members of the Trust may be asked to attend as and when required

5. Frequency:
Monthly

6. Duties:
- To ensure that effective communication systems are in place within the Department
- To provide assurance on all aspects of governance, audit and risk management. To ensure that clinical practice is based on sound research/evidence, and that guidelines are verified
- To monitor compliance with clinical and operational performance targets
- To ensure that effective systems are in place for the development and training of staff
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Department and to ensure that these are utilised efficiently

7. Deputy Attendance:
It is the responsibility of each member of the group to nominate a deputy.

8. Reporting Arrangements
The Departmental Meeting has regular reporting arrangements with the following:
- The Families Divisional Board
- The Families Division Governance Group

9. Agenda Items:
- Items for the agenda should be submitted to the secretary of the committee a minimum of five working days prior to the meeting.

10. Distribution of Minutes:
- Minutes of the meetings will be forwarded to the members.

11. Reviews and Evaluation:
- The membership of the meeting and terms of reference will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE CHILD HEALTH DIRECTORATE MEETING

1. Constitution:

To undertake the decision-making function for the Department, ensuring that senior clinicians and managers participate in the strategic development. The members of the Departmental Meeting are responsible for ensuring the terms of reference are adhered to.

2. Membership:

Head of Department (Chairperson)
Head of Service
Head of Midwifery / Associate Director of Nursing
Consultant Paediatricians
Assistant Divisional Manager
Head of Safeguarding (as required report monthly)
Divisional Finance Manager
Head of Targeted Services
Head of Universal Services
Clinical Governance and Quality Manager

3. Quorum:

Five members constitute a quorum

4. Attendance:

Other members of the Trust may be asked to attend as and when required

5. Frequency:

Monthly

6. Duties:

- To ensure that effective communication systems are in place within the Department.
- To ensure that the Department places patients at the centre of its activity, encouraging effective multi-agency working.
- To ensure that robust systems are in place for clinical governance, audit and risk management. To ensure that clinical practice is based on sound research/evidence;
- To ensure that effective systems are in place for the development and training of staff.
- To co-ordinate, evaluate, and prioritise proposals for service development as part of the business planning process
- To oversee the management of financial resources within the Department and to ensure that these are utilised efficiently.

7. Deputy Attendance:

It is the responsibility of each member of the group to nominate a deputy.

8. Reports

The Departmental Meeting has regular reporting arrangements with the following:

- The Families Divisional Board
- The Families Division Governance Group

9. Agenda Items:

- Items for the agenda should be submitted to the secretary of the committee a minimum of five working days prior to the meeting.

10. Distribution of Minutes:

- Minutes of the meetings will be forwarded to the members.

11. Reviews and Evaluation:

- The membership of the meeting and terms of reference will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE FAMILIES DIVISION GOVERNANCE GROUP

1. Constitution:

The Families Division Governance Group is responsible for ensuring the Division has in place an effective and efficient Risk Management framework.

2. Membership:

- The Nominated Professional Leads for Risk in Women's Health Services and Child Health (Chairperson)
- Lead Consultant for Delivery Suite
- Consultant Anaesthetist – Maternity Lead
- Clinical Governance and Quality Manager
- Head of Midwifery / Associate Director of Nursing
- Head of Maternity and Gynaecology
- Lead Nurse, Neonatal Unit
- Lead community Midwife
- Supervisor of Midwives
- Obstetric Ultrasound Lead (as required)
- Practice Development Midwife
- Safeguarding Lead (as required, report quarterly)
- Head of Targeted Services
- Head of Universal Services

3. Quorum:

Four members of the group constitute a quorum

4. Attendance:

Other members of the Trust may be asked to attend as and when required

5. Frequency of Meetings:

Monthly

6. Duties:

- To ensure that the principles of Risk Management are applied effectively, coherently and systematically
- To review and discuss adverse events, clinical incidents, complaints and near misses, identify system failures, gaps in clinical practice and make recommendations for change/service development
- To identify trends and make recommendations for change, incorporating any relevant issues raised within complaints and litigation
- To monitor achievements of, and compliance with Safety and Learning Group Standards
- To receive and review assurance reports from the Division
- To produce a monthly report for the Divisional Board
- To produce an annual report on risk management activity

7. Deputy Attendance:

It is the responsibility of each member of the committee to nominate a deputy.

8. Reporting Arrangements

The Group has regular reporting arrangements with the following:

- Trust Learning from Incidents and Risks Committee
- Directorate Meetings
- Supervisors of Midwives Meeting
- Delivery Suite Forum

9. Agenda Items:

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

- Items for the agenda should be submitted to the chair a minimum of five working days prior to the meeting.
- An annual plan identifies which reports are to be presented at a specific meeting. Appendix 8.1

10. Distribution of Minutes:

- All the members of the group will receive a copy of the minutes

11. Reviews and Evaluation:

- The membership of the group and terms of reference will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

Governance Annual Plan – 2015 – 2016

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
CMAE/NCEPOD							✓					
Incidents Monthly Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Serious Untoward incidents (SUI)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complaints	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quarterly Incident News Letter	✓			✓			✓			✓		
Quarterly Claims – Legals	✓			✓			✓			✓		
Quarterly Cancer Patient Experience (PT)	✓			✓			✓			✓		
Multidisciplinary Audit / Feedback from Clinical Audit Meeting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Training and Competency Report	✓			✓			✓			✓		
Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
National Alert Medical Devices	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NICE Guidelines	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Delivery Forum Suite	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Safeguarding	✓			✓			✓			✓		
SOM Update	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SOM Annual Report												✓
Safety & Learning Committee Update	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mortality Report – Quarterly	✓			✓			✓			✓		

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE DELIVERY SUITE FORUM

1. Constitution:
To ensure that there is a clear documented system of management and communication regarding intrapartum care, inter-professional communication and teamwork**.**

2. Membership:
Lead Consultant Obstetrician, Delivery Suite (Chair)
Delivery Suite Manager (Deputy Chair)
Consultant Anaesthetist
Consultant Paediatrician
Clinical Governance and Quality Manager
Lead Nurse, Neonatal Unit
Junior Doctor, Obstetrics
Practice Development Midwife
Supervisor of Midwives
Lay member

3. Quorum
Five members constitute a quorum.

4. Attendance
Other members of the Trust or the public may be invited to attend as and when required.

5. Frequency
The meetings will be held bi-monthly.

6. Duties:
- To develop, review and update policies/guidelines/protocols relevant to Delivery Suite practice.
- To review all aspects of Delivery Suite activity, local, professional and organisational.
- To ensure multidisciplinary education/training programmes are provided to meet local and national recommendations and to evaluate their effectiveness.
- To identify appropriate topics for audit and to make recommendations to the Audit Lead within the division
- To consider issues arising from complaints and untoward incidents within Delivery Suite.

7. Deputy Attendance:
It is the responsibility of each member of the committee to nominate a deputy.

8. Reports to:
Families Governance Group Bi monthly
Items of relevance will be referred to the Maternity and Gynaecology Directorate meeting and as appropriate

9. Agenda items:
Items for the agenda should be submitted to the Lead Midwife, Delivery Suite a minimum of 5 working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

10. Distribution of minutes:
All members of the delivery suite forum will receive the minutes**.**

11. Reviews and evaluation:
The membership of the group and terms of reference will be reviewed annually.

For review February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE SAFETY AND LEARNING GROUP

1. Constitution:
The Maternity Safety and learning Group identifies and monitors safety standards

2. Membership:

- Families Clinical Governance and Quality Manager
- Head of Midwifery
- Head of Department Families Division
- Associate Director of Corporate Affairs (Chairperson)
- Maternity Services Matron
- Community Midwifery Manager
- NNU Manager
- Maternity Day Unit Manager
- Mental Health Specialist Midwife
- Clinical Governance Coordinator
- Safeguarding Midwife

3. Quorum:
Four members constitute a quorum

4. Attendance:
Other members of the Trust may be invited to attend as and when required.

5. Frequency
The meetings will be held monthly

6. Duties:

- To undertake a gap analysis to meet compliance with safety Standards and identify deficiencies and opportunities for development
- To develop and implement processes to address identified deficiencies/opportunities
- To monitor progress towards compliance.

7. Deputy Attendance:
It is the responsibility of each member of the committee to nominate a deputy.

8. Reports to:

- Families Division Governance Group
- Trust's Clinical Governance Committee
- Health Care Governance Committee

9. Agenda Items:
Items for the agenda should be submitted a minimum of five working days prior to the meeting.

10. Distribution of Minutes:

- All members of the Maternity Safety and Learning Group

11. Reviews and Evaluation:

- The membership of the group and terms of reference will be reviewed annually

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE SUPERVISORS OF MIDWIVES MEETING

1. Constitution:
To ensure that there is a clear documented system of midwifery supervision throughout maternity care.

2. Membership:
All supervisors of midwives

3. Quorum:
Five members constitutes a quorum

4. Attendance
Other members of the Trust or the public may be invited to attend as and when required

5. Frequency:
The meeting will be held monthly

6. Duties:

- Provide a local framework to support the statutory function of Supervision.
- Provide an Annual Report relating to the Supervision of Midwives for the Local Supervising Authority (LSA)
- Audit the National Standards for Statutory Supervision
- Monitor any action plans provided following the annual LSA Audit visit and address any gaps.
- Contribute to the formation of action plans via the Families Division Governance Group, making recommendations and proposing change.

7. Deputy Attendance:
There is no system to deputise for Supervisors

8. Reports to:
The representative Supervisor will provide a Supervisory report to the Families Division Governance Group on a quarterly basis.

9. Agenda Items:
Items for the agenda should be submitted to the Chairperson a minimum of 5 working days prior to the meeting.

10. Distribution of Minutes:
All members of the Group will receive the minutes

11. Reviews and Evaluations:
The membership of the group and terms of reference will be reviewed annually.

For review February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE WOMAN'S HEALTH AUDIT GROUP

1. Constitution:
To monitor clinical audits undertaken in the Women's Health Department and the subsequent action plans.

2. Membership:
Clinical Audit Lead
Head of Department
Head of Midwifery
Midwifery Audit Lead
Obstetric Audit Lead
Practice Development Midwife
Clinical Governance Lead
Junior Doctor

3. Quorum:
Four members constitute a quorum

4. Attendance:
Other members of the Trust may be asked to attend as and when required

5. Frequency:
Monthly

6. Duties:
- To ensure relevant clinical audits are undertaken in the Department
- To develop an annual audit plan prioritised using CNST standards and National guidelines
- To ensure that the audit department are aware of all the audits that are undertaken
- To allocate audits to the appropriate multi – disciplinary team member
- To develop audit presentation timetable and ensure clinical audits are presented in a multi-disciplinary forum
- To ensure audits are monitored at the appropriate multi disciplinary meeting
- To ensure action plans following the presentation of clinical audits are developed
- To monitor the process of the action plans

7. Deputy Attendance:
It is the responsibility of each member of the Group to nominate a deputy.

8. Reports to:
The Families Governance Group has regular reporting arrangements with the following:
- Divisional Board
- Departmental Meeting
- Governance Meeting

9. Agenda Items:
- Items for the agenda should be submitted to the secretary of the committee a minimum of five working days prior to the meeting.

10. Distribution of Minutes:
- Minutes of the meetings will be forwarded to the Obstetric and Gynaecology Audit Group members.

11. Reviews and Evaluation:
- The membership of the Board and terms of reference will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE INCIDENT REVIEW GROUP

1. Constitution:
The purpose of the Incident Review Group is to regularly review incident reports with clinical staff within the Families Division

2. Membership:
Open membership with core members to include:

- Clinical Governance Lead
- Midwifery and Gynaecology Manager
- Supervisors of Midwives
- Community Midwifery Manager
- Neonatal Lead Nurse

3. Quorum:
Three members constitute a quorum

4. Attendance:
Other members of the Division or the Trust may be asked to attend as and when required.

5. Frequency:
Meetings will be held on a weekly basis

6. Duties:

- The meeting provides a forum to discuss clinical incidents.
- To ensure that the process to produce an action plan has commenced
- To ensure that incidents are reported in a timely manner
- To support summarised incident reports for reporting committees and groups

7. Deputy Attendance:
It is the responsibility of each member of the committee to nominate a deputy.

8. Reports to:

- Families Division Governance Group
- Supervisors of Midwives
- Delivery Suite Forum
- Department meeting

9. Agenda Items:
All agenda items must be submitted a minimum of two working days prior to the meeting.

10. Distribution of Minutes:
Minutes of the meetings will be distributed to the core members, managers and consultants

11. Reviews and Evaluation:
The membership of the group and terms of reference will be reviewed annually

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE POLICY AND PATIENT INFORMATION GROUP WOMEN'S HEALTH

1. **Constitution:**
The Policy and Patient Information Group is responsible for overseeing the development of policies, procedures, guidelines and patient information documentation/leaflets within Woman's Health.

2. Membership:
- Clinical Governance and Quality Manager (Chair)
- Head of Midwifery
- Consultant Obstetrician/Gynaecologist
- Practice Development Midwife
- Community-based Midwife
- Supervisor of Midwives
- Policy Coordinator/Archivist
- Librarian

3. **Quorum:**
Four members constitute a quorum

4. **Attendance:**
Other members of the Trust may be asked to attend as and when required.

5. **Frequency of Meetings:**
Monthly / two monthly dependent on demand

6. **Duties**
- To identify deficiencies and opportunities for the development of policies, procedures, guidelines and patient information
- Ensure policies, procedures, guidelines and patient information is evidence-based and reflect best-practice recommendations

7. **Deputy Attendance:**
It is the responsibility of each member of the committee to nominate a deputy.

8. **Reports to:**
Woman's Health Departmental Meeting

9. **Agenda Items**
Items for the agenda should be submitted to the Chair a minimum of five working days prior to the meeting.

10. **Distribution of Minutes:**
- All members of the Policy and Patient Information Group.

11. **Review and evaluation:**
- The Terms of Reference and membership of the group will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE FAMILIES COMMUNITY POLICY AND PATIENT INFORMATION GROUP COMMUNITY SERVICES.

1. **Constitution:**
The Policy and Patient Information Group is responsible for overseeing the development of policies, procedures, guidelines and patient information documentation/leaflets within Community Services.

2. **Membership:**
Head of Universal Services (Chair)
Team leaders (one from each area)
Development Facilitator North Lancashire
Safeguarding representative
Staff side Representative

3. **Quorum:**
Four members constitute a quorum

4. **Attendance:**
Other members of the Trust may be asked to attend as and when required.

5. **Frequency of Meetings:**
Bi - monthly dependent on demand

6. **Duties**
- To identify deficiencies and opportunities for the development of policies, procedures, guidelines and patient information
- Ensure policies, procedures, guidelines and patient information is evidence-based and reflect best-practice recommendations
- Policy review and standardisation
- Ensure the relevant audits are carried out

7. **Deputy Attendance:**
It is the responsibility of each member of the committee to nominate a deputy.

8. **Reports to:**
Families Division Policy Group

9. **Agenda Items**
Items for the agenda should be submitted to the Chair a minimum of five working days prior to the meeting.

10. **Distribution of Minutes:**
- All members of the Community Policy and Patient Information Group.

11. **Review and evaluation:**
- The Terms of Reference and membership of the group will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE NEONATAL POLICY AND PATIENT INFORMATION DEVELOPMENT GROUP

1. **Constitution:**
The Policy and Patient Information Group is responsible for overseeing the development of policies, procedures, guidelines and patient information documentation/leaflets within Neonatal Unit.

2. Membership:

- Midwifery Manager
- Advance Neonatal Practitioner (ANNP)
- Consultant Paediatrician
- Neonatal nurse Lead
- Unit based nurses
- Archivist
- Clinical Librarian
- Practice Development Nurse
- Outreach Coordinator (Co opted as required)
- Safeguarding (Co opted as required)

3. **Quorum:**
Four members constitute a quorum

4. Attendance:
Authors of policies must attend to present policy
Other members of the Trust may be asked to attend as and when required.

5. Frequency of Meetings:
Bi - monthly dependent on demand

6. Duties

- To identify deficiencies and opportunities for the development of policies, procedures, guidelines and patient information
- Ensure policies, procedures, guidelines and patient information is evidence-based and reflect best-practice recommendations
- Policy review and standardisation

7. Deputy Attendance:
It is the responsibility of each member of the committee to nominate a deputy.

8. Reports to:
Child Health and Woman's Directorate Meeting

9. Agenda Items
Items for the agenda should be submitted to the Chair a minimum of five working days prior to the meeting.

10. Distribution of Minutes:

- All members of the Community Policy and Patient Information Group.

11. Review and evaluation:

- The Terms of Reference and membership of the group will be reviewed annually.

For review by February 2016

APPENDIX 7: FAMILIES RISK MANAGEMENT STRUCTURE

TERMS OF REFERENCE FOR THE FAMILIES MANAGEMENT TEAM MEETINGS

1. Constitution:
The purpose of the Families Management Team meeting is to consider issues relating performance and contracting issues specific to the Families Division.

2. Membership:
Head of Service
Head of Midwifery/Associate Director of Nursing
Head of Families Division
Head of Targeted Services
Head of Universal Services
Head of Maternity and Gynaecology
Head of Safeguarding
Clinical Governance and Quality Manager
Assistant Head of Contracts
Business Manager
Data Assurance Manager
Human Resource Business Partner (as required)

3. Quorum:
Attendance of 4 members of the team

4. Attendance:
Other members of the Division or the Trust may be asked to attend as and when required.

5. Frequency:
Meetings will take place monthly

6. Duties:
The meeting provides the forum to review and address concerns including: -

- Contract issues
- Operational performance
- Service developments

7. Deputy Attendance:
Non required

8. Reports to:
Items of relevance will be referred to the relevant departmental meeting

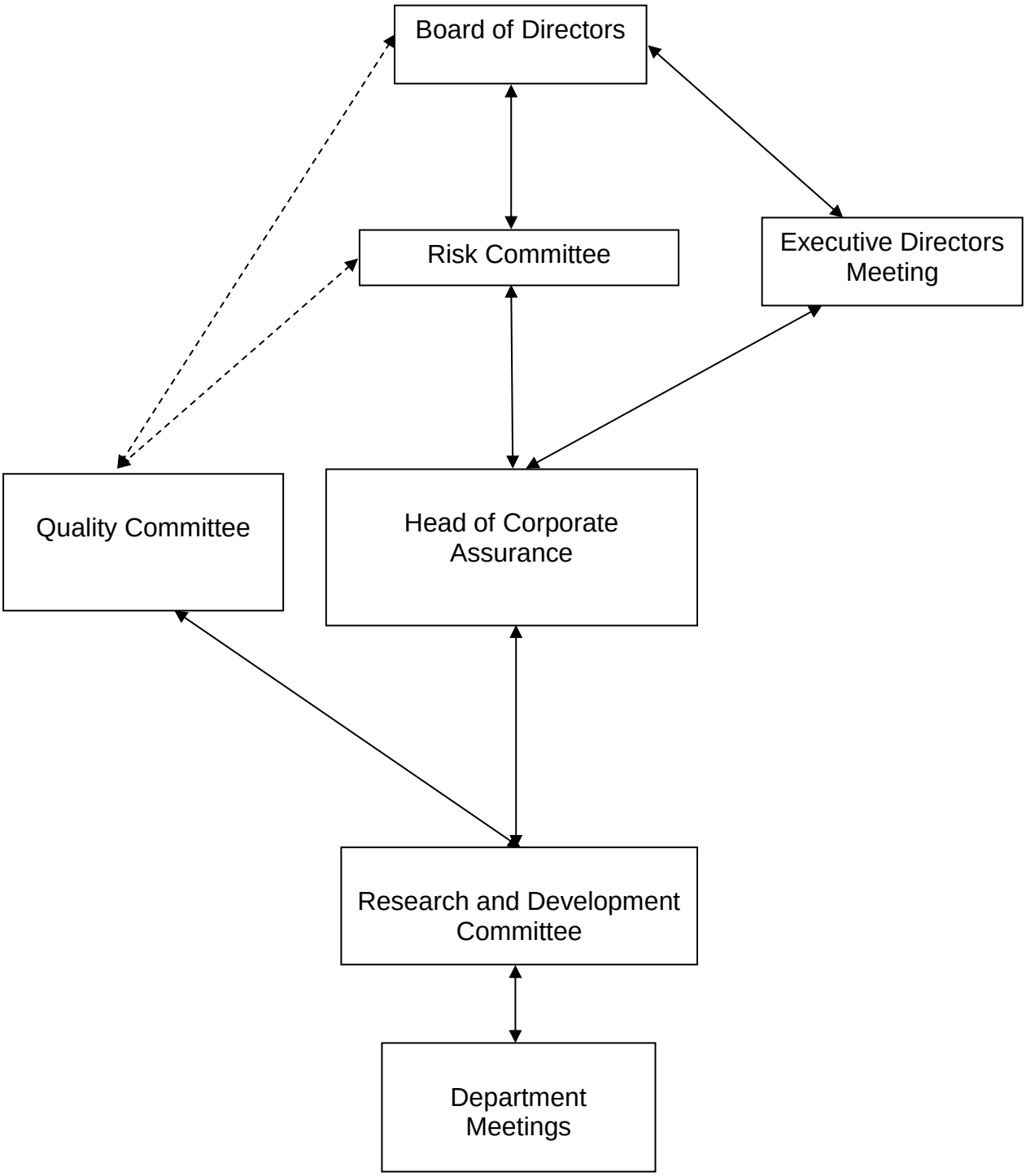
9. Agenda Items:
All agenda items must be submitted a minimum of five working days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

10. Distribution of Minutes:
Minutes of the meetings will be distributed to all members of the Families Management Team

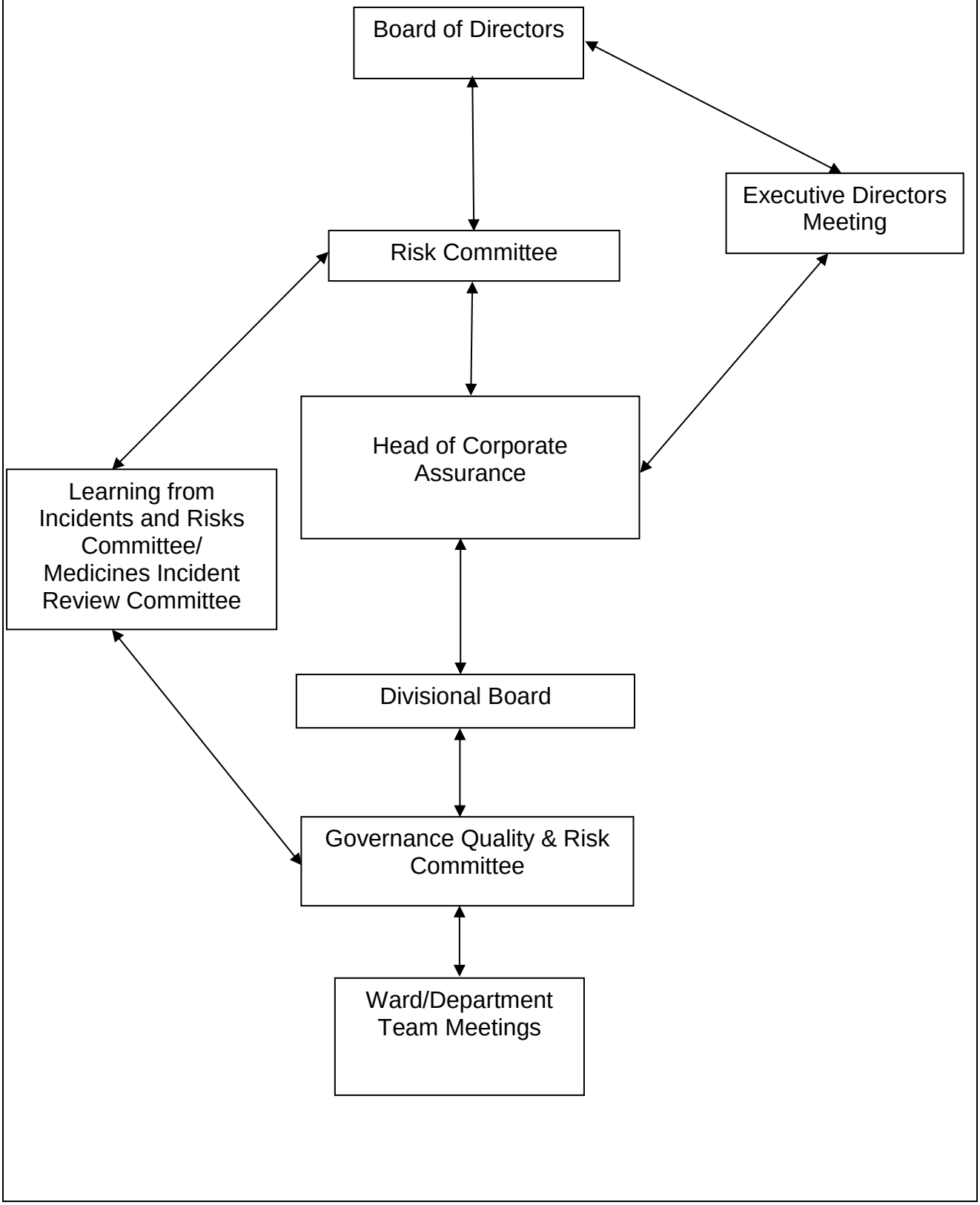
11. Reviews and Evaluation:
The membership of the group and terms of reference will be reviewed annually.

For review by February 2016

APPENDIX 8: RESEARCH AND DEVELOPMENT RISK MANAGEMENT REPORTING STRUCTURE



APPENDIX 9: ADULTS AND LONG TERM CONDITIONS RISK MANAGEMENT REPORTING STRUCTURE



APPENDIX 9: ADULTS AND LONG TERM CONDITIONS RISK MANAGEMENT REPORTING STRUCTURE

New risk assessments (RA) are submitted to the Governance Quality & Risk Committee for approval.

On approval, the RA is then submitted to Divisional Board for ratification.
Following approval, leads are to send the RA to Governance Support (GS) for recording onto the Risk Register.

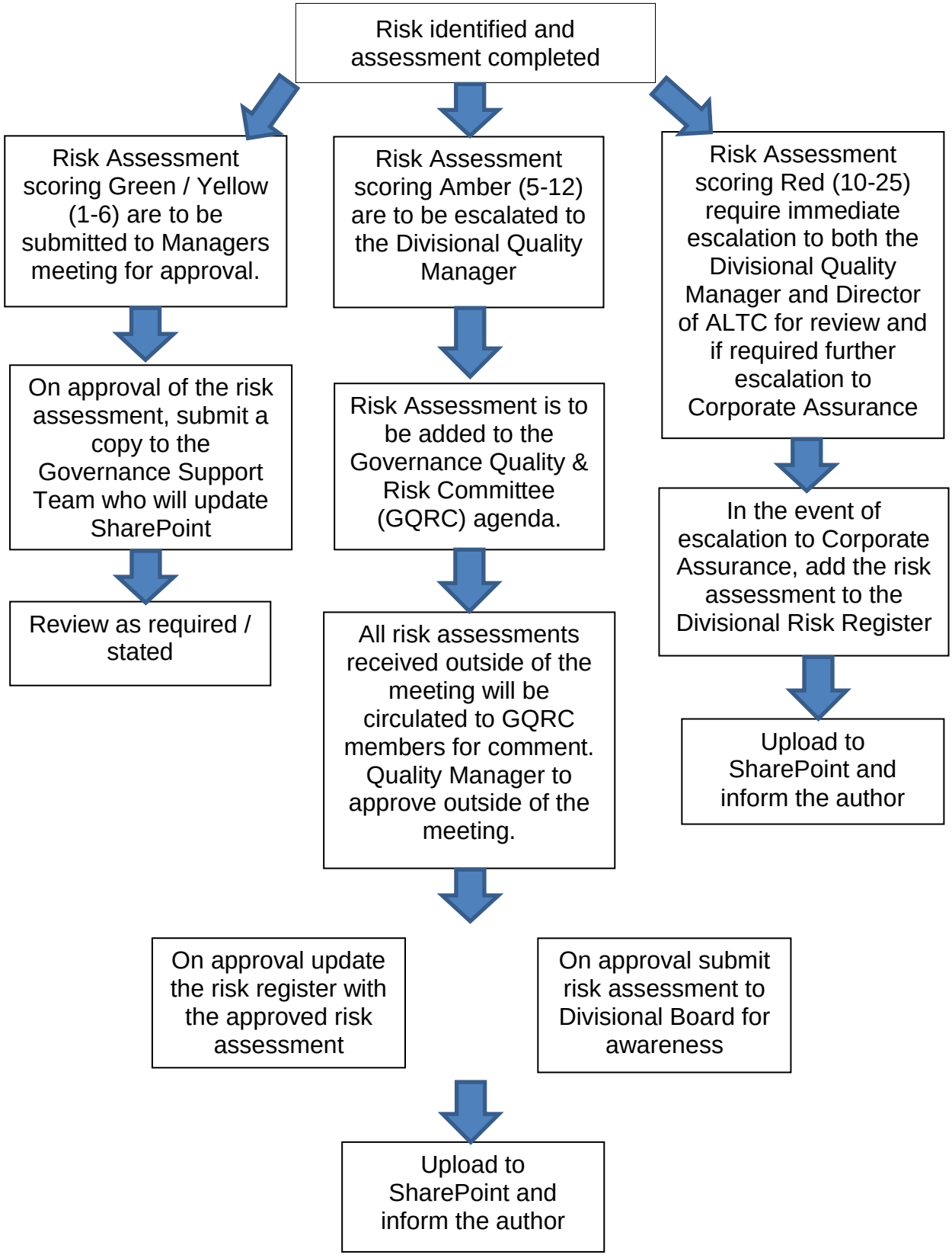
GS to load the RA to the Risk Register with information obtained from the RA.

Record the current risk with the highest score if there is more than one on the RA.

Risk Assessments that score within the red area below are to be sent to Matthew Burrow to submit to an ED meeting as urgent after gaining approval from both the Quality Manager and Director of ALTC.

Likelihood Rating / Consequence Rating	Almost Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Catastrophic 5	**25**	**20**	**15**	**10**	**5**
Major 4	**20**	**16**	**12**	**8**	**4**
Moderate 3	**15**	**12**	**9**	**6**	**3**
Minor 2	**10**	**8**	**6**	**4**	**2**
Insignificant 1	**5**	**4**	**3**	**2**	**1**

APPENDIX 9: ADULTS AND LONG TERM CONDITIONS RISK MANAGEMENT REPORTING STRUCTURE



APPENDIX 9: ADULTS AND LONG TERM CONDITIONS RISK MANAGEMENT REPORTING STRUCTURE

Terms or Reference	Governance Quality & Risk Committee
Date of Issue	May 2015
Review Date	May 2016
Minutes received at	ALTC Divisional Board

Purpose

The purpose of the Committee is to provide assurance to the Divisional Board that the highest possible standards in the quality of care, patient safety and potential risks are monitored, reviewed and achieved by the Division.

The committee will ensure that effective systems and process for the governance, quality and risk agenda are embedded and under constant review and improvement.

The committee will identify potential risks and oversee the management of the Divisional Risk Register and escalate potential risks to the Divisional Board

The Committees also incorporates the Trusts values and visions.

Membership

The Quality Manager shall be the Chairperson of the Committee. The Associate Director of Nursing shall be the Deputy Chair. In the absence of both the Quality Manager or Deputy a decision will be taken in advance of the meeting to identify a Chair.

Attendance

To allow decisive decision making to take place, the Division has identified the roles below as appropriate the allow the committee to function.

- Quality Manager
- Head of Locality x 3 (or Deputy)
- Associate Director of Nursing
- Infection Prevention Specialist Nurse
- Head of Performance
- Dental Service Manager
- CIT Representative
- Non-Medical Prescribing Lead
- Health & Safety Representative
- Staff Side Representative
- HR Representative

APPENDIX 9: ADULTS AND LONG TERM CONDITIONS RISK MANAGEMENT REPORTING STRUCTURE

- Clifton Hospital Manager – or Representative
- Head of Therapies
- Head of Extensive Care Service
- Head of Integrated Mental Health & Learning Disabilities
- Attendance - Dependant on agenda.
    - Assistant Head of Contracts
    - Divisional Business Manager

Frequency of Meetings

The group shall meet no less than 6 times per year (bi – monthly). When necessary meetings may be held as and when required.

Quorum

In order for decisions taken by the group to be valid, the meeting must be quorate. For the meeting to quorate there must be a Chair or Deputy, representation from localities, and 50% of remaining group members.

Main Priorities and Objectives

- To provide assurance to the Divisional Board that the highest possible standards in quality, governance and risk management are monitored
- To champion and promote, via members, a highly effective risk management system and ensure that the committee monitors the Divisional Risk Register and potential risks are identified and acted upon
- To identify patient harms through the Ulysses Incident Management System and provide updates to members (Locality Leads & Service Leads)
- To produce a monthly Governance & Quality Report in conjunction with the Corporate Divisional Quality Assurance Report (Top 3 Risks Paper)
- To monitor Divisional systems and processes and provide assurance they are adequate and 'fit for purpose'
- To monitor and review training needs and provide training where relevant (CIT Team)
- To escalate potential risks to the Divisional Board
- To promote a culture of openness and honesty in conjunction with the requirement for duty of candour
- To respond to external reports and recommendations
- To members to provide leadership and advice on aspects on the quality and risk agenda
- To review and discus adverse events, clinical incidents and SUI's / RCS's and

receive assurance that this is reflected in lessons learnt with colleagues

- Provide terms of reference

Agenda Items

The following items are standing agenda items and MUST be discussed at every meeting.

- Governance Quality & Risk Report
- Risk Register
- Patient Harms Report
- Escalated Incidents / Issues to Board

Distribution of minutes

The minutes of the Governance Quality & Risk Committee will be received at Divisional Board.

Minutes Received

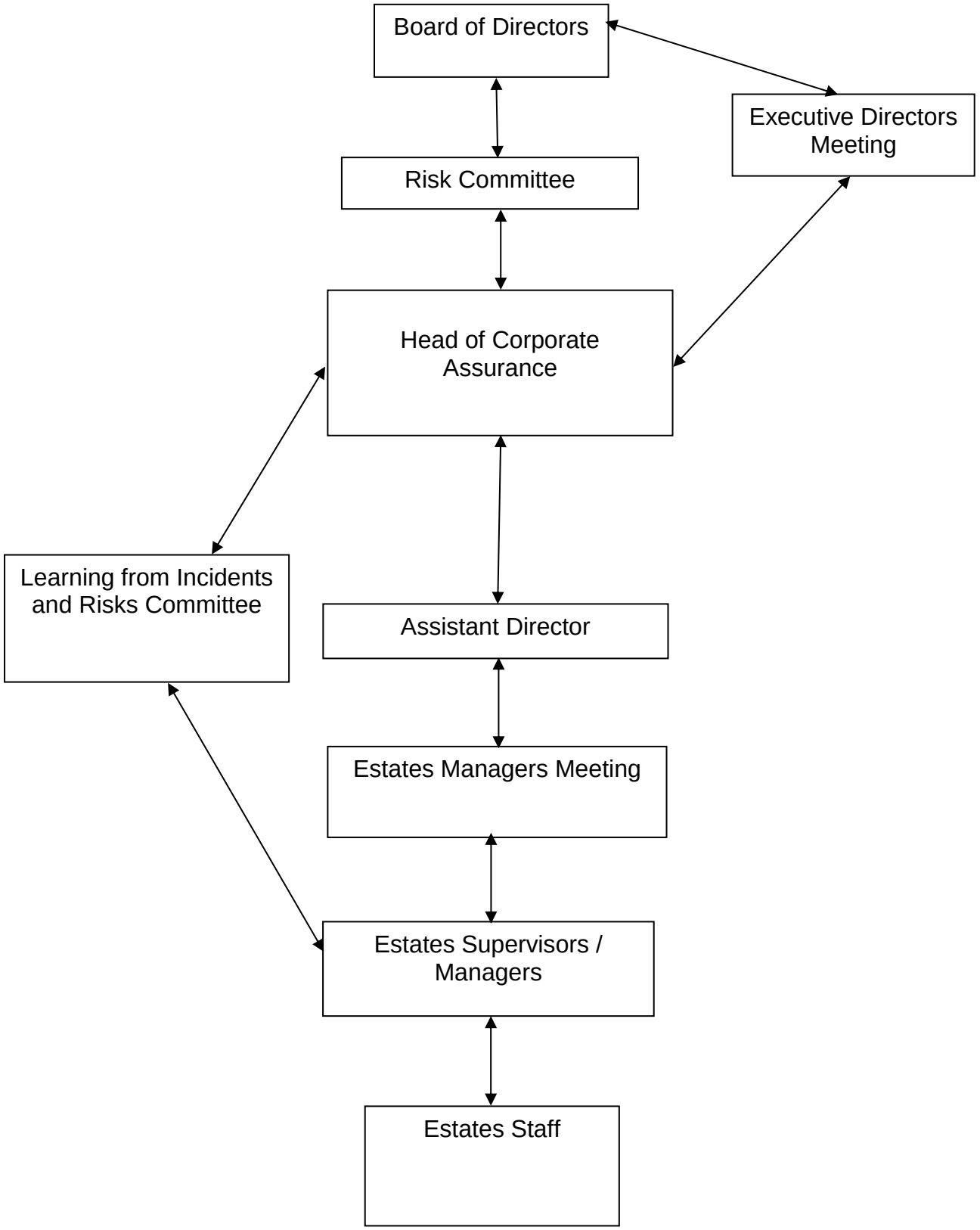
Clinical Policy Working Group

Review of terms of reference

Committee members will review the TOR every year or when required.

ToR's next review May 2016.

APPENDIX 10: ESTATES RISK MANAGEMENT REPORTING STRUCTURE



APPENDIX 11: PHARMACY RISK MANAGEMENT REPORTING STRUCTURE

PHARMACY QUALITY & GOVERNANCE MEETING

TERMS OF REFERENCE

INTRODUCTION

The Pharmacy Quality and Governance meeting is responsible for determining the strategic direction for clinical governance within the Directorate.

PURPOSE

The meeting is primarily concerned with the delivery of safe, high quality patient centred care. This will be achieved through ensuring that the appropriate structures, processes and controls are in place to assure quality in clinical care.

TERMS OF REFERENCE

To be responsible for developing the strategic framework for clinical governance and to ensure compliance with local and national standards

To ensure that robust systems are in place for clinical governance, audit and risk management within the directorate for a safe effective and quality service to patients

To use national and local performance indicators to continuously improve quality of services and safety of patients.

To develop a risk awareness culture in all Directorate staff, with an open attitude to incident reporting and complaints and to provide timely feedback and support to staff involved.

To report on key risks to the Risk Committee.

To report on Untoward Incidents and monitor appropriate action plans.

To report on and monitor the progress and completion of complaints and to establish structures for sharing Lessons Learnt.

To identify policy issues relating to governance and to approve Directorate policies and procedures and risk assessments

To monitor compliance with relevant national standards and statutory requirements within the Directorate.

To approve and monitor the outputs and action plans from the Directorate's annual audit plan

To ensure that effective systems are in place for the development and training of pharmacy staff

APPENDIX 11: PHARMACY RISK MANAGEMENT REPORTING STRUCTURE

To receive reports and monitor progress from the Pharmacy Communication group

MEMBERSHIP

Director of Pharmacy
Assistant Director of Pharmacy - Support Services
Assistant Director of Pharmacy - Clinical Services
Chief Technician
Senior Pharmacist Risk Management
Administrative & Clerical Assistant - Pharmacy Production Unit

QUORUM

A quorum shall consist of 3 members.

MEETINGS

Meetings will be held monthly.

AGENDA ITEMS

Items for the agenda should be submitted to the Administrative & Clerical Assistant - Pharmacy Production Unit a minimum of one week prior to the meeting.

DISTRIBUTION OF MINUTES

Minutes of the meeting will be forwarded to:

- All members of staff within the Pharmacy Department

REVIEW AND EVALUATION

The membership and terms of reference for the group will be reviewed every 2 years.

Date: November 2015

APPENDIX 12: EQUALITY IMPACT ASSESSMENT FORM

Department	Organisation Wide	**Service or Policy**	Procedure	**Date Completed:**	

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	**RESPONSE**		**IMPACT**	
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	The Procedural Document is to ensure that all members of staff have clear guidance on processes to be followed. The target audience is all staff across the Organisation who undertakes this process.	Raise awareness of the Organisations format and processes involved in relation to the procedural document.	Yes – Clear processes identified	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	Not applicable to community safety or crime	N/A	N/A	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No	N/A	N/A	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No	N/A	N/A	
How does the service, leaflet or policy/ development promote equality and diversity?	Ensures a cohesive approach across the Organisation in relation to the procedural document.	All policies and procedural documents include an EA to identify any positive or negative impacts.		
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The Procedure includes a completed EA which provides the opportunity to highlight any potential for a negative / adverse impact.			
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Our workforce is reflective of the local population.			
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	N/A			
Does the service, leaflet or policy/ development promote equity of lifelong learning?	N/A			
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	N/A			
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	N/A			
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	N/A			
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	None identified			

APPENDIX 12: EQUALITY IMPACT ASSESSMENT FORM

Does the policy/development promote access to services and facilities for any group in particular?	No			
Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	No			

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis	~~**Yes**~~	**No**	**(Please delete as appropriate)**

Name of Author: **Signature of Author:**	Matthew Burrow	**Date Signed:**	November 2015
Name of Lead Person: **Signature of Lead Person:**		**Date Signed:**	
Name of Manager: **Signature of Manager**	Wendy Swift	**Date Signed:**	November 2015