LIVERPOOL WOMEN'S HOSPITAL NHS TRUST

Risk Management Strategy 2003-2004

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SECTION 1: INTRODUCTION

1.1 Purpose

This document sets out the Trust's approach to the management of risk and implementation of a system, which enables informed management decisions in the identification, assessment, treatment, and monitoring of risk. This strategy provides the framework and the plan by which the organisation can further develop its capability to meet the demands of effective risk management.

1.2 Risk Management – *a definition*

Risk management (RM) is a framework for the systematic identification, assessment, treatment and monitoring of risks. Its purpose is to prevent or minimise the possibility of recurrence of risks and their associated consequences.

A structured and systematic approach supports better informed management decision making by providing a greater understanding of risks and their impact. Effective management of risk has the potential for reducing the frequency and severity of adverse incidents, complaints and claims.

There are three areas of risk which have the potential to adversely affect the Trust's patients, staff, services, resources and reputation;

- Clinical
- Corporate (non-clinical)
- Financial

1.3 Policy Statement

The Trust is committed to establishing an organisational philosophy which ensures RM is an integral part of corporate objectives, plans and management systems.

1.4 Controls Assurance

Controls Assurance (CA) is the process by which Trust Boards can reassure the public that the Trust operates an effective system of internal control covering the three key risk areas:

- Clinical
- Corporate (non-clinical)
- Financial

HSG (97)17 `Corporate Governance in the NHS: Controls Assurance Statements` requires comprehensive controls assurance statements for each of the above areas to be in place by 1999/2000.

The Trust's Risk Management System is the mechanism by which these controls are effected and co-ordinated throughout the Trust and consists of mechanisms for identifying and prioritising risks, identifying the appropriate level at which RM action

should be taken, implementing a means by which the organisation can learn from its risks and incidents, and assuring the Trust Board that appropriate decisions in the management of risks have been taken.

1.5 Strategic Vision

The vision of this strategy will be the establishment of an effective Risk Management System in which:

- **all staff** are trained in and are aware of risk management to a level which enables them to fulfil their responsibilities in protecting others, themselves and the organisation from risks.

- **lead clinicians and managers** will utilise an assessment framework to assess their management of risk with a view to identifying and agreeing actions as part of the planning process, in order to minimise risk. They will ensure that staff within their area of control understand and fulfil their individual responsibility.

- **corporate management** will establish systems which provide lead clinicians and managers with effective risk control mechanisms which are co-ordinated by the Executive Group. The Executive Group will establish standards of practice, audit compliance and provide assurance to the Trust Board.

1.6 Acceptable Levels of Risk

It is accepted that it is neither realistic nor possible to totally eliminate all areas of risk. It is, however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated.

The Trust aims to provide an environment geared to innovation and service development and recognises that risk taking can achieve some benefits. However, risk taking without evaluation or management can result in adverse outcomes for patients, staff, resources and reputation.

The Trust utilises an accepted system for grading risks which takes into account parameters which include probability of occurrence and impact on the organisation.

The system covers clinical and non-clinical reporting of incidents and the level of authority required for managing the different grades of incidents is described in the procedure.

A grading system enables a method of quantification which can be used to prioritise risk treatment at all levels. The following table indicates the authority of managers to act in accordance with the quantification of risk.

Table 1: Managerial Authority to act on risks

This table indicates the level of individual(s) who would normally be involved in agreeing and taking action.

	Ward Manager	Dept Manager	Directorate Manager	Clinical Director	CEO and Executives	Trust Board
Low	✓	✓	x	x	x	x
Moderate	✓	✓	✓	x	x	x
High	✓	✓	✓	✓	x	x
Extreme	✓	✓	✓	✓	✓	x
Major Incident	✓	✓	✓	✓	✓	✓

In the event of incidents classified as `high` the Executive Directors and/or the Chief Executive should be informed.

Table 2: Authority for deciding on acceptable levels of risk

A grading system also enables decision making on the basis of what is an acceptable level of risk for the organisation to sustain. The following table gives an indication as to where the authority lies for decisions relating to acceptable levels of risk.

The table indicates the level of authority of individual(s) who would normally be involved in deciding the level of risk relating to an issue which the organisation is prepared to accept.

	Ward Manager	Dept Manager	Directorate Manager	Clinical Director	CEO and Executives	Trust Board
Low	✓	✓	✓	✓	✓	✓
Moderate	✓	✓	✓	✓	✓	✓
High	x	✓	✓	✓	✓	✓
Extreme	x	x	✓	✓	✓	✓

SECTION 2: ROLES AND RESPONSIBILITIES

It is primarily important to clarify that every member of the Trust's staff has an individual responsibility for risk management activities.

It is important to make explicit how the responsibility of the individual contributes to the lines of management accountability through to the Trust Board.

There are 4 identifiable tiers:

- 1st - Trust Board
- 2nd - Corporate management
- 3rd - Lead clinicians and managers
- 4th - All staff, in undertaking daily duties

2.1 Trust Board

The Trust Board has overall responsibility for the RM framework, systems and activities of the organisation.

2.2 Corporate Management

Corporate management responsibility is held by the Chief Executive who delegates responsibility and action to senior managers and clinicians;

Key area of risk	***Responsible Senior Manager/ Executive Director***
• Clinical	Director of Nursing & Midwifery
• Corporate (non-clinical)	Director of Corporate Services
• Financial	Director of Finance & Information

It is the responsibility of the Chief Executive and Executive team to ensure that standards of RM are applied at all levels within the Trust and that controls assurance mechanisms are in place to assure the Trust Board. The team will co-ordinate these mechanisms and through the relevant committees will;

- provide advice to lead clinicians and managers on effective risk control mechanisms;
- establish standards of responsible RM practice;
- monitor progress and arrange for audit of compliance with standards.

The Executive Group has responsibility for advising on the allocation of resources, co-ordination, overview and prioritisation of RM activities and will report to the Trust Board. (Terms of reference and membership see Appendix 8.2)

2.3 Lead Clinicians and Managers

Lead clinicians and managers will ensure that

- they accept an appropriate method to communicate the principles outlined in the RM Strategy to all staff within their sphere of responsibility;
- all staff within their area of control understand and carry out their individual responsibility for the management of risk;
- undertake appropriate risk assessments for their area of control in order to identify key risks and generate prioritised action plans for the minimisation of these risks;
- the outcomes of risk assessments are used as part of the business planning process to aid the planning and resourcing of risk minimisation and management;
- the information captured by complaints, litigation and incident reporting is used as a means of continuous monitoring and review, leading to risk reduction in services within their sphere of control.

2.4 Staff

- RM will form part of daily duties. Staff will be able to identify and assess risk, take action to reduce risks to an acceptable level and inform appropriate lead clinicians and managers of unacceptable risks outside of their sphere of responsibility.
- Staff will be required to participate in activities which are commensurate with the Trust's RM strategy or statutory requirements.
- Also, all staff have a responsibility to report incidents, which is a key source of information to lead clinicians and managers on the nature and level of adverse activity within their sphere of responsibility.

Further information relating to the roles of key individuals in the organisation can be found in Appendix 8.3.

2.5 Accountability

The Chief Executive assumes overall responsibility for RM activities. The senior managers noted in 2.2 are accountable to the Chief Executive and report to the Trust Board for the areas of risk indicated, and it is their responsibility to ensure that systems are in place. Responsibilities roll out through the organisation as follows:

Clinical Risk

Area of Activity	*Accountable Manager*
• Clinical practice	Clinical Director
• Medicines Management	Chief Pharmacist
• Control of Infection	Control of Infection Manager
• Radiological protection	Imaging Department Manager
• Blood Transfusion	Clinical Director – Theatres & Anaesthesia

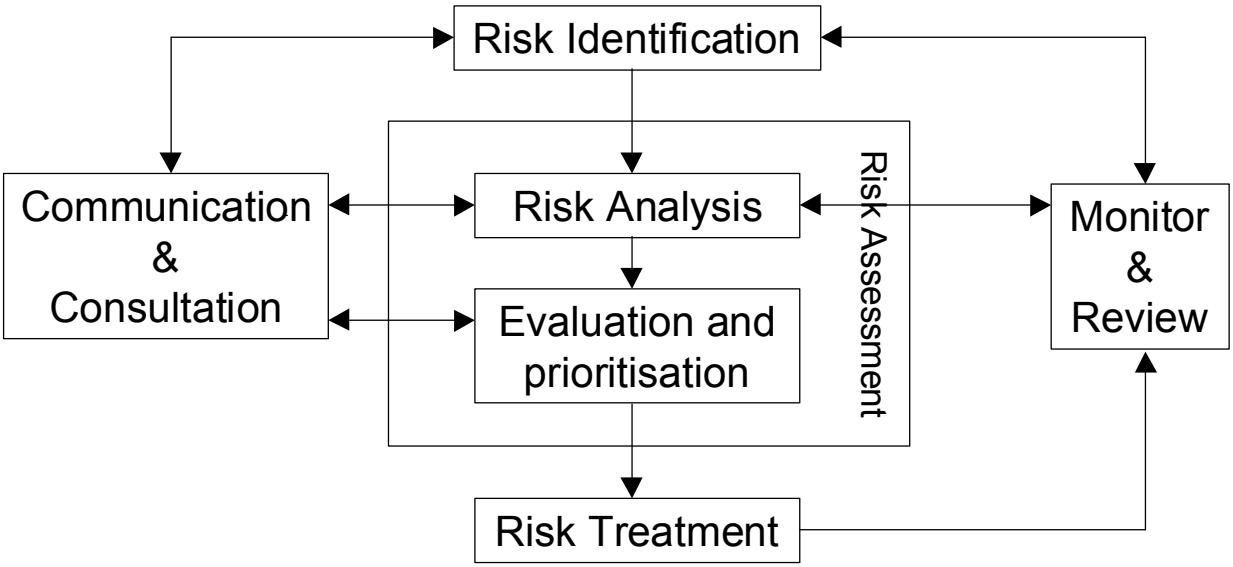
Non-clinical Risk

Area of Activity	*Accountable Manager*
• Risk Management	Director of Corporate Services
• Medical Devices	Director of Corporate Services
• Human Resources	Director of Human Resources
• Emergency Preparedness	Director of Nursing & Midwifery
• Fire Safety	Estates Manager
• Environment Management	Estates Manager
• Buildings, plant & non-medical equipment	Estates Manager
• Health & Safety	Risk/Health & Safety Advisor
• Waste Management	Operational Services Manager
• Security	Operational Services Manager
• Catering & Food Hygiene	Operational Services Manager
• Records	Head of IM&T
• Information Management & Technology	Head of IM&T
• Management of Purchasing & Supply	Director of Finance
• Professional and Product Liability	Director of Finance
• Financial Management	Director of Finance
• Corporate Governance	Director of Finance
• Decontamination	Directorate Manager – Theatres

SECTION 3: THE RISK MANAGEMENT PROCESS

The Trust will adopt the RM framework described in the NHS Executive's Controls Assurance Risk Management System standard.

Management of risk can be described by the following process:



3.1 Risk Identification

This is the process of identifying what can happen, why and how.

The Trust will adopt the following methods to identify risks:

a) ***Incident reporting***

The reporting of incidents by staff is the most efficient and effective system for identifying risk.

This allows rapid alert to ascertain why and how incidents occurred, and facilitates a fast response in the case of adverse events which may lead to a complaint or litigation.

It enables lessons to be learnt and may therefore prevent recurrence.

This is best achieved in a supportive management environment where a `blame-free` culture is advocated and makes explicit the circumstances in which disciplinary action may be considered.

b) ***Complaints and Litigation***

This information can also be used to identify risks and is currently collected on a register.

c) ***Risk Profiling***

This is a method of identifying risk in greater depth. The Trust will be required to develop a system of profiling to supplement current activities.

d) ***Staff concerns about health care issues***

An organisational procedure (Raising Concerns) has existed for a number of years to enable staff to voice concerns. The Trust has reviewed this policy to facilitate the confidential reporting of issues/incidents about which staff feel the organisation should know, but which they may feel anxious about via another route. A copy of the policy is available in departmental policy files, the HR department or any senior manager.

3.2 Risk Assessment

This is an all encompassing term for risk analysis and risk evaluation.

Risk analysis - *addresses frequency and impact*

Currently, the Risk Management information system collects certain information enabling simple analysis. The Trust needs to develop links between incidents, complaints and claims and to expand on data collected to include how/why an event occurred, other prevailing factors and what impact/outcome was realised.

The Trust also uses a systematic hazard identification and risk analysis procedure.

Risk evaluation - *determines priorities by comparing against criteria/standards.*

The Trust will utilise both CNST (clinical) and controls assurance (non-clinical) standards as evaluation tools. The Trust is developing a `risk register` to assist the Board in identifying acceptable or unacceptable levels of risk. An annual rolling programme of risk assessment has been implemented. This is undertaken by department and directorate managers and co-ordinated by the Health and Safety/Risk Manager. This programme covers clinical and non-clinical risk assessment. Organisational risk assessments are undertaken by the Trust Board and Executive Team. Further details on the process of risk assessment are highlighted in the Health and Safety Policy.

3.3 Risk Treatment

This is the selection and implementation of appropriate options for the management of identified risks ie physical changes to environment, production of policies, standards or procedures or staff training for example.

Clinical Risks

The Clinical Governance Committee will work with Clinical Governance Directorate representatives, Clinical Directors and Directorate Managers to assess compliance with CNST RM standards and will draw up action plans for achievement. They will

also use information accrued from incidents, complaints and claims to contribute to action plans.

Corporate Risks (non-clinical)

The Corporate Governance Committee will work with directorates and departments to draw up action plans to address risks identified by the Controls Assurance Standards self-assessment, and from departmental risk assessments.

3.4 Monitoring & Reviewing

This is an essential component to ensure maintenance and development of standards.

Internal monitoring will be undertaken by the systematic review of progress against action plans. This activity will be directed and overseen by the Clinical Governance Committee and Corporate Governance Committee for clinical and non-clinical activity respectively. (For terms of reference and membership, see Appendix 8.4 /8.5)

Additionally, those two committees will report progress to the Executive group whose responsibilities include monitoring performance and providing operational guidance. The Board will also receive regular reports.

External monitoring of non-clinical activities will be undertaken by the Mersey Internal Audit Agency (MIAA) whose current work for the Trust will be extended to cover RM activities. MIAA will be engaged to monitor the non-clinical aspects of RM under controls assurance.

The external monitoring of clinical activities will be undertaken by two bodies. Performance against clinical risk management standards which the Trust is currently working on will be assessed by the Clinical Negligence Scheme for Trusts. Attainment of a particular level/standard is reviewed every 3 years. Additionally, the Commission for Health Improvement will undertake a formal review of activities and services on a 3 yearly basis.

Other external bodies who have a statutory remit for monitoring specific standards will be brought in where appropriate, eg Health and Safety Executive (see Appendix 8.6)

3.5 Risk Prevention

The above generally describes a reactive approach to risks. The organisation must be proactive in the area of risk prevention.

Risk assessments and the production of a risk register feed the production of action plans which, in the full knowledge of where our risks lie, will enable us to participate in essential risk prevention.

SECTION 4: CURRENT POSITION

The Trust's RM strategy was last reviewed in 2002. This document updates the last review by incorporating organisational changes and national developments in clinical and non-clinical risk management, and controls assurance systems.

This document describes the Trust's Risk Management System which integrates risks from all sources into a single controls assurance framework. Management arrangements clarify and reinforce areas of responsibility and the Executive Group oversees the whole system, on behalf of the Trust Board.

The key groups in the next tier include the Clinical Governance and Corporate Governance Committees whose role it is to co-ordinate operational activity of the directorates/departments and specialist groups. These committees direct the identification and agreement of corrective action and the identification of significant risk which in some instances may require higher level action to resolve.

4.1 Clinical Risk

The Clinical Governance Committee was established in the summer of 1999. Membership and Terms of Reference have been recently reviewed. (Appendix 8.4). An organisational baseline audit was undertaken in September 1999 which produced the Trust's action plan. Reviews of progress have been undertaken quarterly.

Key tasks

- **Clinical Information Systems**

  The baseline audit recognised the difficulties in obtaining information to support clinical audit and research using the Meditech computer system. A number of actions have been produced which are being addressed by management and the HISS Working Group. A number of staff have been trained in report writing and further training is planned.

  Other areas of on-going capability development are identified in the Clinical Governance Action Plan which is monitored quarterly and revised with actions updated annually.

- **Risk Management**

  Clinical Negligence Scheme for Trusts

  The Trust achieved Level 1 status against the clinical risk management standards outlined in the Clinical Negligence Scheme for Trusts (CNST) in 1996.

  The mandatory reassessment at three yearly intervals were undertaken and passed in February 1999 and February 2002 which enabled the Trust to retain its Level 1 status.

A review of standards at level 2 was undertaken across both sites in February 2002. Deferred issues resulting from this exercise were addressed for a re-assessment in July 2002. This resulted in successful achievement of CNST Level 2.

Incident Reporting

The Trust is committed to improving data capture through its incident reporting system. A new system for reporting clinical incidents was introduced in February 2002. This will be the subject of on-going review, revision and improvement in order to develop and respond to initiatives emanating from the National Patient Safety Agency (NPSA).

- **Clinical Risk Assessment (CRA)**

  A programme of annual risk assessment has been implemented which incorporates a broad range of clinical and non-clinical key performance indictors in each area. This process is managed locally in departments and directorates and co-ordinated by the Risk/Health and Safety Manager.

- **Training and Education**

  The Trust has provided a number of new and recent training opportunities for clinical and non-clinical RM training and is developing a rolling programme of events to support evidence based practice and clinical risk management activities for all groups of staff. Clinical leadership training programmes are an on-going element of this programme.

  A Personal Development Review system is in place for all non-medical staff and Consultant appraisal was established in early 2000.

- **Clinical Quality**

  Improvements have been made in the identification of trends from claims and complaints reports and the provision of feedback to managers. Both of these areas report quarterly to the Clinical Governance Committee and Trust Board. The Trust is working on the monitoring of trends linking claims and complaints to reported incidents.

  Clinical outcome indicators for specialties are under development.

  Changes to clinical audit planning activities should realise benefits from the implementation of audit outcomes.

4.2 Corporate/Non-Clinical Risk

As part of the Controls Assurance System, a number of specialist areas are now integrated into the risk management system;

- Risk Management
- Corporate Governance (new standard in 2002)
- Health and Safety
- Human Resources
- Fire Safety
- Emergency preparedness
- Environment management
- Security
- Records
- Catering & Food hygiene
- Management of Purchasing and Supply (was Contracts and Contractor Control)
- Information management and technology
- Waste management
- Professional and product liability
- Buildings, plant and non-medical equipment
- Financial Management (new standard in 2002)
- Infection Control
- Medicines Management
- Medical Devices
- Decontamination
- Transport (not applicable to this Trust)

Each of the above specialist areas has been required to self-assess its activities against standards issued under Control Assurance Statements. This self-assessment exercise is completed annually and the results enabled an action plan to be drawn up. The action plan is given Board approval. Progress is reviewed quarterly and forms the basis of an annual report to the Trust Board.

Activities of the above specialist groups are co-ordinated by the Corporate Governance Committee which reports to the Executive Group.

4.3 Financial Risk

Financial controls assurance systems have been in place for a number of years and enable risk to be managed effectively.

There are no outstanding key tasks identified in terms of development, but systems are kept under continual review. This is facilitated by the Financial Management standard introduced in 2002, enabling an annual action plan to be produced.

SECTION 5: REPORTING ARRANGEMENTS

Section 2 sought to clarify roles and responsibilities of individuals, staff groups and the different committees. This section will describe how activities are reported.

5.1 Clinical Risk

Clinical Risk issues will be identified through clinical risk assessments undertaken at directorate level, complaints, claims and incident reports. Information accrued from these sources will feed the development of an annual action plan. (This plan will not, of course, preclude immediate remedial action which arises from in-year incidents, claims or complaints.)

Development of directorate/department plans will be co-ordinated by the Clinical Governance Committee (CGC). Directorates/departments will be required by the CGC to report on a number of issues including:

- Incidents
- Review implementation of protocols, guidelines and best practice recommendations
- Progress against action plans
- Outcome indicators
- Claims
- Complaints

The CGC will report progress at least twice yearly to the Executive Group which will in turn report annually to the Trust Board.

In these reports, the CGC will identify any issues it is referring to the Executive Group or Board for consideration.

Clinical Governance is a standing item at the Trust Board meetings each month.

Clinical Risk Management

Body	Reports to	Frequency	Month
Directorates/ Departments	Clinical Governance Committee	Monthly	Rolling programme of reports
Clinical Governance Committee	Executive Group	Twice yearly	June (Annual Report) November
Executive Group	Trust Board	Annual	July (Annual Report)

5.2 Corporate (Non-Clinical) and Financial Risk

Organisational non-clinical risk issues will be identified from the baseline and annual assessments against Controls Assurance standards, from incident reporting and from departmental risk assessments. Directorates/departments will undertake annual assessments and this will feed the production of an annual plan.

Directorates/departments will be required to produce regular reports to the Corporate Governance Committee which will in turn report at least twice yearly to the Executive Group. Likewise, the Trust Board will receive an annual report from the Executive Group. These reports will highlight issues for consideration by either the Executive Group or Board as indicated.

Corporate Governance is a standing item at Trust Board meetings each month.

Current financial Controls Assurance methods have been in place for many years and incorporate approved internal and external reporting frameworks. Financial governance will also form part of the corporate risk management framework.

Corporate (Non-Clinical) and Financial Risk Management

The finance function will also report into the corporate governance framework.

Body	Reports to	Frequency	Month
Directorate/ Department	Corporate Governance Committee	Alternate Months	Rolling Programme of reports
Corporate Governance Committee	Executive Group	Twice yearly	June (Annual Report) November
Executive Group	Trust Board	Annual	July (Annual Report)

An annual report will be produced, showing progress against annual and strategic objectives. The annual report will be reviewed by the Trust Board and will form the basis of the Annual Controls Assurance Statement of the Chief Executive.

5.3 Audit and Assurance Procedures

Clinical Audit

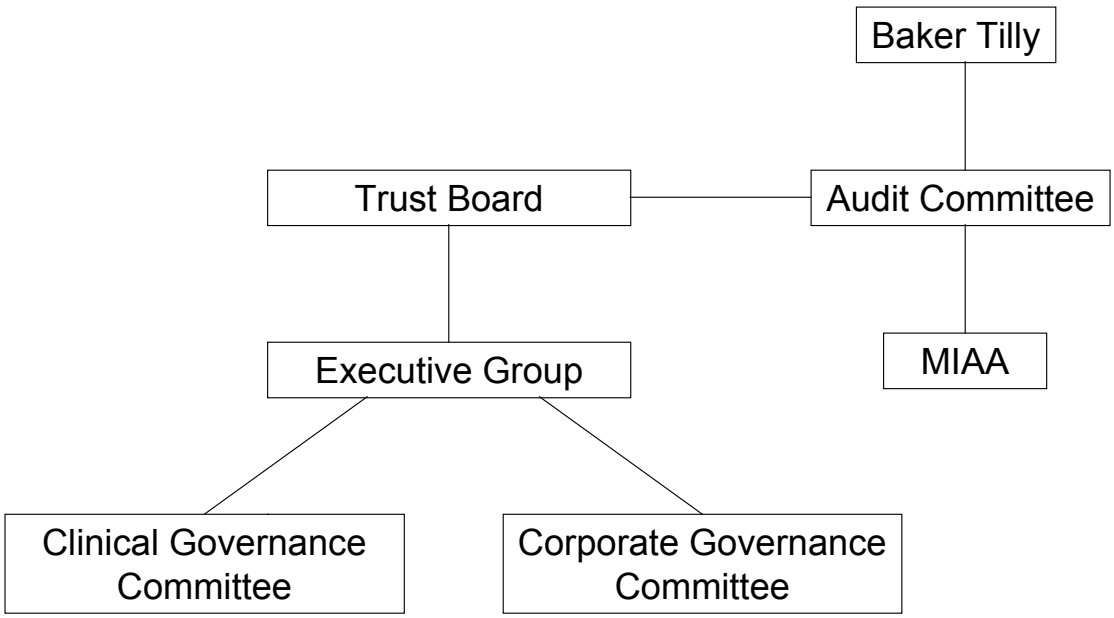
The annual programme of clinical audit is proposed by directorates and departments and co-ordinated and approved by the Clinical Governance Committee. Topics should reflect the internally driven needs of the specialty to audit its clinical practices, guidance from professional bodies, and demands of national annual reports eg CESDI, CEPOD.

Non-Clinical Audit

Mersey Internal Audit Agency are currently contracted by the Trust to audit and provide assurance to the Trust Board on progress against Controls Assurance standards. The audit programme is approved by the Audit Committee.

Financial

The Trust's financial activities are monitored by the Mersey Internal Audit Agency (MIAA) who provide regular reports to the Audit Committee of the Trust Board. Additionally, external auditors (Baker Tilly) provide an annual report on the accounting statements and financial activities to the Trust Board. The audit programme is approved by the Audit Committee.



Reporting

Body	Reports To	Frequency	Month
MIAA (Internal Audit)	Audit Committee	Annual	June (Controls Assurance Statement)
Audit Committee	Trust Board	Annual	
Baker Tilly (External Audit)	Audit Committee	Annual	November (Management Letter)
Audit Committee	Trust Board	Annual	

SECTION 6: PLANNING, RESOURCING AND PRIORITISATION

6.1 Planning & Resourcing

As previously described, directorates and departments are required to produce local risk management plans which reflect improvements required locally to treat risks. It is possible that local plans will require resource allocation which cannot be met from revenue budgets. It is therefore, essential to co-ordinate the planning timetable to enable requirements to be programmed in a timely manner for consideration.

Timetable

Annually	Conduct directorate/department risk assessments
July/August	Finalise action plans and prepare bids for the business planning cycle
30th September	Draft directorate business plans
December	Draft Trust Business Plan submitted to Executive Group Committee
January	Final draft Business Plan submitted to Trust Board

6.2 Prioritising

The Trust currently utilises a recognised frequency/outcome method of evaluation to enable prioritisation of action identified in the Controls Assurance System non-clinical assessment.

The planned clinical risk assessments incorporate a similarly approved method of prioritisation.

The grading of incidents is undertaken using a method approved by the NPSA.

SECTION 7: IMPLEMENTATION PLAN

7.1 Strategic Priorities

As previously stated in section 1, the purpose of this document is to provide the plan by which the organisation can further develop its capability to meet the demands of effective RM. Detailed action plans relating to the specialist fields associated with RM will be published in the Trust's annual clinical governance and controls assurance development plans.

In order to deliver the strategic vision described in section 1.5, the Trust will need to focus on the following priorities:

Staff

- enable staff to be aware of RM thereby enabling them to fulfil their responsibilities of protecting others, themselves and the organisation from risks by;

  - providing effective clinical and non-clinical induction training
  - providing a rolling programme of training on clinical and non-clinical RM subjects
  - providing clear, up to date and accessible policies, procedures and guidance for staff

Lead Clinicians and Managers

- will minimise risk by utilising an assessment framework to identify and agree action as part of the planning process, and ensure that staff within their area of control understand and fulfil individual responsibility by;

  - ensuring that staff attend training and induction programmes to provide knowledge and skills enabling fulfilment of responsibilities, and maintain records to that effect.
  - undertaking annual risk assessments (or more frequently if there has been a change in practice or facilities), and producing action plans to treat identified risks.
  - monitoring and reviewing plans.
  - producing local policy, procedure and guidance which is clear and accessible to staff and complies with higher level documentation.
  - monitoring and reviewing policy, procedure and guidance.
  - complying with the Trust's reporting/planning timetable and requirements.
  - devising a system of feedback to inform staff of actions and outcomes of incident reporting as a means of learning and continual monitoring and improvement.

Corporate Management

- will provide advice on effective risk control
- will establish standards of responsible RM practice
- will audit compliance by:

  - co-ordinating the activities and reporting of specialist groups/committees responsible for overseeing the different aspects of RM via the Executive Group.
  - achieving compliance with the Clinical Negligence Scheme for Trusts Level 3 standard.
  - achieving compliance with the NHS Litigation Authority non-clinical risk standards for controls assurance.
  - maintaining an audit function to audit compliance with RM standards.

SECTION 8: APPENDIX

8.1 Audit Committee – Terms of Reference/Membership

Constitution The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee).

Membership The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Authority/Trust and shall consist of not less than 3 members. A quorum shall be 2 members.

Attendance The Trust Chairman, Chief Executive, Director of Finance, the Head of Internal Audit, and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any executive Board director present.

Frequency Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Authority The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Duties The duties of the Committee can be categorised as follows:

Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board;
- The structures, processes and responsibilities for implementing Clinical Governance and the management of clinical risk;

- The structures, processes and responsibilities for identifying and managing key non-clinical risks facing the organisation;

- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Controls Assurance Standards and other relevant guidance;

- The operational effectiveness of policies and procedures;

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Directorate of Counter Fraud Services.

Internal Audit

- To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal;

- To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure co-ordination between the Internal and External Auditors;

- To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

External Audit

- To consider the appointment of the External Auditor, as far as the Audit Commission's rules permit;

- To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;

- To review External Audit reports, including value for money reports and management letters, together with the management response.

Financial Reporting

To review the annual financial statements before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;
- major judgmental areas; and
- significant adjustments resulting from the audit.

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

8.2 Executive Group – Terms of Reference/Membership

1. Membership

The Executive Group of the Trust is an executive decision making forum whose membership includes:

- Chief Executive
- Director of Finance
- Medical Director
- Director of Human Resources
- Director of Nursing & Midwifery
- Director of Corporate Services

2. Role

The role of the Executive Group is:

- to provide advice to the Trust Board on strategic and operational issues
- to provide operational direction from corporate strategy
- to set operational policy
- to co-ordinate the planning, monitoring and performance management processes
- to prioritise investment requirements and advise on the allocation of resources
- to oversee the management and co-ordination of risk management issues and activities driven by the Corporate and Clinical Governance Committees

3. Frequency of Meeting

The Executive Group will meet on alternate weeks or as deemed appropriate by the prevailing agenda.

8.3 Key Individuals with RM Responsibility

8.3.1 Executive Team

The Chief Executive assumes overall management responsibility for devising and implementing an appropriate framework and system to support robust RM activities.

The 3 elements are operationally delegated to the following Directors:

- Clinical - Director of Nursing & Midwifery
- Corporate (non-clinical) - Director of Corporate Services
- Financial - Director of Finance & Information

8.3.2 Clinical Directors and Directorate/Department Managers

These staff have responsibility for ensuring that corporate policy and procedure are implemented locally and that staff are provided with appropriate training and information to fulfil their responsibilities.

8.3.3 Lead Managers for Controls Assurance (CA) Standards

All standards (with the exception of Transport) have allocated leads for assessing the organisation's position and identifying and delivering appropriate remedial action, achieving incremental annual improvement.

A list of managers and delegates area of responsibility for CA can be found in appendix 8.5.

8.3.4 Other Areas

Control of Infection

This specialist field is addressed by the Control of Infection Midwife working collaboratively with a Consultant Microbiologist. Activities and progress are reported via the Control of Infection Committee and the two governance sub-committees of the Trust Board. The Control of Infection Midwife is managerially and professionally accountable to the Director of Nursing & Midwifery.

Health & Safety

The Health and Safety/Risk Manager is managerially accountable to the Director of Corporate Services and is responsible for ensuring that the organisation complies with relevant legislation, devising policy and procedure and ensuring a robust programme of risk assessment. This role also ensures a system for the recording and monitoring of non-clinical incident reporting.

Clinical Governance Facilitator

Managerially accountable to the Director of Nursing & Midwifery the facilitator supports organisational development of objectives relating to clinical governance.

Estates Manager

Fire Safety is regulated by legislation. It is the responsibility of the Estates Manager (the nominated officer for fire safety) to ensure that the organisation is kept aware of and complies with current legislation. Managerially accountable to the Director of Corporate Services, the Estates Manager must ensure that

- policy and procedures exist and are widely distributed and available
- regular risk assessments are done
- training is provided
- a programme of fire drills is undertaken

8.4 Clinical Governance Committee – Terms of Reference/Membership & Accountability

1. The Clinical Governance Committee of the Trust is a sub-committee of the Trust Board, and is multi-disciplinary, representative and inclusive.

2. The role of the Clinical Governance Committee is to monitor the quality of all aspects of clinical practice within the Trust, to include clinical effectiveness, professional development, continuous quality improvement and risk management.

3. Regular reports will be made on clinical quality to the Trust Board which will include information on:

   a) progress in achieving agreed objectives for clinical governance (action plan from baseline assessment)
   b) local and national audits
   c) complaints received and action taken
   d) clinical negligence claims received and action taken
   e) adverse clinical incidents reported and action taken
   f) medication and transfusion errors reported
   g) hospital infection reports
   h) staff development programs, participation in training programs and CPD
   i) staff appraisal
   j) progress with IT development

4. The Clinical Governance Committee will also, through directorate team representatives, ensure that each directorate team regularly reviews its clinical protocols, clinical incident reports, and new developments and clinical guidelines, and reports progress to the Committee.

5. The Clinical Governance Committee will prepare and submit an annual report on clinical governance activity to the Trust Board.

6. Action resulting from decisions taken at the Committee will be implemented via the clinical directorate management structure.

Membership

- Clinical lead for Clinical Governance – Chair
- Directorate Representatives
  - Neonatal
  - Obstetrics
  - Gynaecology
  - Theatres & Anaesthesia
  - Clinical Support Services
  - Genetics
- Control of Infection
- Supervisor of Midwives
- Public Representation - Member of Community Health Council
- Board Representatives
  - Executive Directors
    - Chief Executive
    - Medical Director
    - Director of Nursing & Midwifery
    - Director of Human Resources
  - Non-Executive Director

8.5 Corporate Governance Committee – Terms of Reference/Membership & Accountability

The Corporate Governance Committee of the Trust is a sub-committee of the Trust Board, and is multi-disciplinary and representative.

1. Role

The role of this group is; to monitor activity, and to facilitate the development and associated compliance with controls assurance risk management system standards.

- Monitor compliance against standards
- Agree action plans
- To report progress to the Trust Board
- To co-ordinate activities and produce an annual plan
- To produce an annual report
- To co-ordinate a programme of audit

2. Frequency of Meeting

The Corporate Governance Committee will meet monthly or more frequently as determined by the prevailing agenda.

3. Reporting

The Group will provide reports to the Executive Group twice a year and will produce an annual report to the Trust Board.

4. Action

In most circumstances, the accountable manager will have responsibility for formulating policies and procedures, and the Directorate/Departmental Manager will be responsible for their implementation.

5. Membership

Membership is configured to provide representation of the specialist controls assurance systems areas, directorates and departments, Trust Board representation by a non-executive director and a public representative.

Controls Assurance System		Representative
1. Risk Management	}	
2. Medicines Management	}	Director of Corporate Services
3. Medical Devices	}	
4. Security	}	
5. Catering & Food Hygiene	}	Operational Services Manager
6. Waste Management	}	
7. Health & Safety	-	Health & Safety/Risk Manager
8. Human Resources	-	Director of Human Resources
9. Fire Safety	}	
10. Environment Management	}	Estates Manager
11. Buildings, plant and equipment	}	
12. Emergency Preparedness	-	Director of Nursing & Midwifery
13. Records	}	
14. Information Management & Technology	}	Head of IM&T
15. Infection Control	-	Infection Control Manager
16. Professional & Product Liability	}	
17. Financial Management	}	
18. Management of Purchasing & Supply	}	Director of Finance & Information
19. Corporate Governance	}	
20. Decontamination	-	Directorate Manager – Theatres
21. Transport	-	Not applicable to this Trust

Others		Representative
• Directorates	-	Directorate Managers
• Trust Board	-	Non Executive Director
• Public representation	-	Community Health Council Rep
• Mersey Internal Audit Agency		

8.6 External/Statutory Bodies (reportable agencies) – contact list

8.6.1 Health & Safety

(See Health & Safety File Annex C)

• Incidents reportable under RIDDOR	The Health & Safety Executive The Triad, Bootle Tel: 0151 479 2200
• Environmental issues	Environmental Protection Agency Warrington Tel: 01925 653999
• Food related issues	Environmental Health Officer Graham Slee Tel: 0151 225 4938
• Police	Admiral Street Police Station Tel: 0151 709 6010
• Medical Device incidents	National Reporting & Investigation Centre Medical Devices Directorate Department of Health Tel: 0171 636 6811 x 3030 (office hrs) Fax: 0171 436 6764

8.6.2 Medicine/Drug defects

(See Health & Safety File Annex C)

Contact via the Trust's Pharmacy Dept
Defect Medicines Report Centre
Department of Health
Tel: 0171 273 0574 (office hrs)
On call Duty Officer: 0171 210 5371

8.6.3 Control of Infection

• Notifiable diseases	Consultant in Communicable Disease C/o Environmental Health Control Service Tel: 0151 225 6043/4922 Fax: 0151 225 4912

See Infection Control File – Policy No 1

8.6.4 Estates

• Legionellae (HTM 2040)	Consultant in Communicable Disease C/o Environmental Health Service Tel: 0151 225 6043/4922 Fax: 0151 225 4912

• High Voltage (HTM 2021)	Injuries & Fatalities Health & Safety Executive Tel: 0151 479 2200 Faults – NHS Estates Tel: 0151 479 2200
• Low Voltage (HTM 2020)	Injuries & Fatalities Health & Safety Executive Tel: 0151 479 2200 Faults – NHS Estates Tel: 0151 479 2200
• Fire	Health & Safety Executive Tel: 0151 479 2200 NHS Estates (Director of Policy) Tel: 0113 254 7000
• Lifts (HTM 2024)	Health & Safety Executive Tel: 0151 479 2200 NHS Estates (Director of Policy) Tel: 0113 254 7000 Trust's Insurance Company: Griffiths & Armour Tel: 0151 236 5656
• Ventilation in Healthcare Premises (HTM 2025)	Consultant Microbiologist at Royal Liverpool & Broadgreen University Hospital Trust Tel: 0151 706 2000 Trust Infection Control Committee
• Hot and Cold Water Supply (HTM 2027)	Health & Safety Executive Tel: 0151 479 2200 Trust Infection Control Committee
• Sterilisation (HTM 2010)	Consultant Microbiologist at Royal Liverpool & Broadgreen University Hospital Trust Tel: 0151 706 2000 Trust Infection Control Committee

• Washer Disinfectors (HTM 2030)	Consultant Microbiologist at Royal Liverpool & Broadgreen University Hospital Trust Tel: 0151 706 2000 Trust Infection Control Committee
• Medical Gases	Quality Control Officer Tel: 0151 794 8118 Trust's Insurance Company: Griffiths & Armour Tel: 0151 236 5656