


<b>CORPORATE POLICY</b>		
Subject: <b>Governance and Risk Strategy and Policy</b>		
<b>Responsible Director:</b> Director of Nursing and Patient Services <b>Responsible Manager:</b> Deputy Director of Clinical Governance		Key References: Australian/ New Zealand Standard Risk management AS.NZS 4360:2004  NHS LA Risk Management Standards 2011/12
Date of Approval: September 2011		Review Date: August 2013
<b>Purpose</b>	This document sets out the Trust's structure for Governance and the aims for managing risks to patients, staff visitors, and contractors and to service quality. It outlines the organisational and individual responsibilities and arrangements for risk management and the systems and processes by which the aims will be achieved.	
<b>Objectives</b>	The Trust has a commitment to high quality of care which is free of unnecessary risks. This strategy and policy outlines a structured and systematic approach to the identification and management of risk across all the activities of the organisation.	
<b>For Use By</b>	All Directors, managers and staff.	
<b>Related Policies</b>	Incident / Accident Policy Policy and guidance on Risk assessment, RiskTrack/PRISM and the Risk Register Reporting and follow - up of Serious Incidents Complaints Policy Health and Safety Policy RIDDOR Reporting Policy Handling Concerns raised in the workplace Control of Infection Policies Claims Policy Maternity Risk Management Strategy Standing Financial instructions Standing orders Scheme of delegation	
<b>Definitions</b>	<b>Risk:</b> <i>The probability or likelihood that harm or untoward outcome may occur that results in undesirable outcomes for the Trust's patients, staff, stakeholders, finances or reputation. It is measured in terms of consequence and likelihood.</i>	

	<b>Risk management:</b> <i>The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.”</i> (Australian / New Zealand Risk Management Standard 4360/1999)
	<b>Hazard:</b> <i>the potential to cause harm</i>
	<b>Acronyms</b> - See Appendix 9
<b>Status / Version Control</b>	<b>Version 9 August 2011</b>
	Version 8: February 2010
	Version 7: January 2009
	Version 6: Revision January 2008
	Version 5: September 2007
	Version 4: July 2007
	Version 3: August 2006
	Version 2: March 2004
	Version 1: 10 February 2003
<b>Impact Assessment</b>	
<b>Equality and Diversity</b>	An Equality Impact Assessment has been undertaken in Appendix 10 below
<b>Business</b>	This governance strategy and policy sets out how the business risks are identified, monitored and controlled.
<b>Legal Implications</b>	Robust risk management structures and systems are required for good governance ,
<b>Quality</b>	Sets out how the risks to quality, safety, effectiveness and experience are to be identified, monitored and controlled.
<b>Resources</b>	Implementation requires risk management awareness training for all staff, risk leadership within the business units and resources to support the risk assessment and risk register process.
<b>Risk</b>	Sets out how risk are to be systematically identified, monitored and controlled
<b>Statutory Compliance</b>	Compliance with registration requirement under the Health and Social Care Act 2008; Health and Safety at work etc Act 1974.
<b>Sustainability</b>	None

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## **GOVERNANCE AND RISK MANAGEMENT STRATEGY AND POLICY**

### **1.0 INTRODUCTION**

- 1.1 This document sets out the aims of Bedford Hospital NHS Trust in managing risks to patients, staff, visitors and contractors and to service quality and describes a framework for the integration and development of the governance and risk management process.
- 1.2 This strategy and policy is approved by the Board and reviewed annually in accordance with the requirements of the NHSLA Risk Management Standards for Acute Trusts.
- 1.3 This strategy and policy is the high level document for the Trust and does not set out the detail of the management of specific risks. This more detailed information is set out in the relevant policies such as Infection Control, Serious incidents, Information Governance etc.

### **2.0 ORGANISATIONAL OBJECTIVES**

- 2.1 Bedford Hospital NHS has a four year Trust Strategy and business plan that commits to achieving an excellent service for patients and users.

The Trust Board has approved a set of Trust Objectives to meet these strategic aims:

1. Patient Experience improves.
2. Patient safety improves.
3. Clinical effectiveness improves.
4. Maintain or exceed external targets.
5. Maintain or Increase market share.
6. Teaching and research improvements.
7. Well governed and Financially viable organisation.
8. Improved workforce effectiveness.
9. Make best use of our estate.
10. Develop as a good corporate citizen.

- 2.2 This policy seeks to ensure that structures, systems and resources are in place to monitor and control the risks within the framework of the specific aims listed above. This strategy will continue to apply on achievement of Foundation Trust status.
- 2.3 The Trust has an integrated approach to the overall management of all risks – clinical, organisational or financial. As there are close links with corporate and clinical governance, risk management is embedded within the Trust's business unit organisational performance, business planning and service delivery processes.

### **2.4 RISK STRATEGY AIMS AND OBJECTIVES**

- 2.5 These are based on the underpinning principles of risk management and draw on the government's vision for quality and safety in the Health and Social Care Act 2008; the Care Quality Commission's Essential Standards for Quality and Safety and Equity and Excellence : Liberating the NHS July 2010
- 2.6 The Trust has a commitment to high quality of care which is free of unnecessary risks across the recognised dimensions of quality and throughout the organisation;

## ***SAFETY***

**The Trust has a positive safety culture and ensures Patient Safety is embedded into Trust processes.**

- Premises are suitable and safe.
- All staff are aware of risks and their responsibilities.
- The risks of untoward incidents are assessed and minimised.
- Investigate incidents and learn lessons.
- Implement the Trust Patient Safety Strategy and NPSA recommendations.
- Ensure the services delivered represent best practice.
- Meets NHS LA standards.
- Risks from equipment and medicines management are managed effectively.
- Staff are trained appropriately.

## ***PATIENT EXPERIENCE***

**Patients are respected and involved in their care**

- A patient-focused service.
- Quality of customer care meets expectations.
- Equality, diversity and human rights are respected.
- No unexpected deaths.
- No avoidable hospital-acquired infection.
- No harm or unnecessary pain.
- Appropriate nutritional standards.
- Patient and carer involvement
  - in care planning.
  - by actively seeking patient feedback and implementing improvements.

## ***STAFF EXPERIENCE***

**Staff are well-trained, empowered and accountable for their actions and know their responsibilities**

- The recruitment process is effectively managed.
- Staff are supported to deliver safe, effective care.
- Training programmes meet service needs and personal development.
- Meet NHS LA standards.
- Deliver a customer-focused service.

## ***CLINICAL EFFECTIVENESS***

**The care delivered to patients and outcomes achieved will be consistent with national standards.**

- Implements standards included in the Operating Framework.
- Implements national guidance from NICE, Professional bodies, National Enquiries.
- Maintains compliance with the NHS Constitution, regulations and CQC registration standards.
- Achieves compliance with NHSLA Risk Management Standards for Acute Trusts.
- Evidence-based practice implemented.
- Benchmarking used to monitor performance.
- Horizon-scanning to apply lessons learned to local situation.
- Learning organisation that implements change as a result of incidents and complaints.

## ***ORGANISATIONAL EXPERIENCE***

**All staff accept the responsibility for the management of risk as their fundamental duty. Effective risk management is delivered in an environment of honesty and openness**

- The Trust is well governed, with robust risk, performance and financial controls and assurances in place.
- Protect Trust assets and reputation.
- Risks to service planning and delivery identified.
- Financial risks identified and managed.
- Understand the organisation's risk management capability and maturity and develop risk management practices in their quality and effectiveness to achieve "mature" status.
- Well-informed about patient experiences and outcomes.
- Has effective arrangements for partnership working and meeting the needs of the local population.

### **3.0 RISK MANAGEMENT POLICY STATEMENT**

- 3.1 The Trust Board is committed to the provision of high standards of care and recognises that risk management is a key component of good management practice. The Board is, therefore, committed to ensuring that risk management is established as an integral part of its philosophy, practices and business plans. It is imperative that responsibility for understanding and mitigating risk is accepted at all levels of the organisation. The ongoing development of the Trust's approach to risk management will ensure that the Trust's organisational objectives are realised in an environment that is safe and secure for patients, staff and visitors alike.
- 3.2 The structured, systematic identification, analysis and control of risk will be afforded a high priority within the Trust. An educational process and the establishment of a supportive, open and learning culture that encourages all staff to report incidents or potential hazards through the appropriate channels will underpin this.
- 3.3 The Trust aims to take all reasonable steps in the management of risk with the overall objective of protecting patients, clients, visitors, staff, contractors and assets
- 3.4 The trust will review and monitor its governance arrangements to make sure that they represent best practice from industry and commerce as well as the public sector in order to deliver efficiency economy and openness in the Trust's stewardship of its resources. Key stakeholders, the local community and staff will be fully engaged in the governance arrangements

## 4.0 ORGANISATIONAL STRUCTURE AND ACCOUNTABILITIES FOR GOVERNANCE AND RISK MANAGEMENT

- 4.1. Trust Board
- 4.2. Assurance and Performance Committees
- 4.3. Executive-led Committees
- 4.4. Individual Executive, Non-Executive and Officer accountability
- 4.5. Clinical Business Unit Structure and accountabilities
- 4.6. General Risk management responsibilities
- 4.7. Partner Organisations

### 4.1 COMMITTEES

A Committee structure has been established to support integrated governance within the Trust. – see *Appendix 1 for Governance and Risk Committee Organisational Diagram*

#### 4.1.2 Trust Board

The Trust Board's role is to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. The Trust Board is corporately responsible for:

- Ensuring internal controls- clinical, organizational and financial are in place.
- Ensuring its financial viability, whilst providing the mandatory services;
- Achievement of financial surplus.
- Collective responsibility for adding value to the organization and promoting the success of the Trust by directing and supervising its affairs at a strategic level;
- Leadership and control within a framework of prudent and effective controls, enabling risk to be assessed and managed.
- Looking ahead; the Trust Board sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the organisation to meet its objectives.
- Setting and maintaining values; in setting the Trust's values and standards, the Trust Board ensures that its obligations to patients, the local community and the NHS are understood and met.
- Ensuring delivery of high quality care

#### 4.1.3 Responsibility of the Chairman

The Chairman is responsible for Leadership of the Trust Board ensuring their effectiveness on all aspects of their role and setting their agenda.

#### 4.1.4 Responsibility of the Non-Executive Directors

Non-executive directors have an overall responsibility to constructively challenge and contribute to the development of strategy, scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance.

Their responsibility for risk includes satisfying themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible. It is also a key responsibility for non-executives to be aware of their obligations around staff and patient safety and quality and the duty of the Trust Board regarding adverse incidents and occurrences. The non-executives, and in particular Audit Committee members, review and endorse the Statement on Internal Control (SIC) signed by the Chief Executive. To complete the Statement on Internal Control the Trust Board needs to ensure it is complying with the three core standards of Governance,

Financial Management and Risk Management.

*For responsibility of Executive Directors – see section 5.3*

## 4.2 Assurance and Performance Committees

### 4.2.1 Executive Management Board (EMB) (For Terms of Reference see Appendix 2)

The Executive Management Board is responsible for trust-wide performance and strategic decision making. It is the high level committee with overarching responsibility for risk.

The Executive Management Board is responsible for executing and communicating the decisions of the Trust Board. It has overall responsibility for the performance management of the delivery of quality, national and local targets and the management of risks within the Trust. The EMB is chaired by the Chief Executive.

It receives assurance on the effectiveness of Trust systems and processes from the Finance Committee, Audit Committee and from the structure of Executive-led sub committees and their feeder Committees which oversee specialist aspects of service.

### 4.2.2 Audit Committee

The Audit Committee comprises non-executive directors one of whom is its chair and reports directly to the Trust Board. The duties of the Audit Committee have been defined in accordance with the recommendations of the NHS Audit Committee handbook 2010 and the Integrated Governance Handbook 2006.

4.2.3 The Audit Committee has an overall remit to oversee the wider assurance agenda of financial, corporate, clinical, and research governance for the Trust. This involves the creation and monitoring of an assurance framework for the Trust. The primary role of the committee is to scrutinise the adequacy and effective operation of the organisation's overall internal control systems. That is, to be the scrutineer of all the risk management structures and processes and of the sub committees described within this strategy which are an integral part of such an assurance framework.

4.2.4 Other responsibilities are described fully in the Audit Committee's terms of reference and cover :

- Internal Audit
- External Audit
- Financial Reporting

(see Trust intranet for the terms of reference of sub committees under corporate information)

### 4.2.5 Finance Committee

The Finance Committee is responsible for the monitoring of the Trust's financial performance on a monthly basis including; performance against Service Level Agreements; delivery of cost improvement programmes and savings. Also for ensuring that the financial information reported to the Trust Board is accurate and acknowledges appropriate risks.

## 4.3 EXECUTIVE – LED COMMITTEES

The Trust has a structure of Executive-led Committees and sub committees which are responsible for the implementation of best practice in a number of Trust functions, for achieving healthcare standards and targets, and for assurance to the Trust Board that

the systems are working effectively and risks are controlled. Each committee has agreed terms of reference (which can be located on the trust intranet) and report upwards to the Executive Management Board

- 4.3.1 The sub committees submit a report upwards to their Executive-led Committee who in turn submits a report to the Executive Management Board. The report contains:
- **Description of areas that the Trust is not achieving/ complying with, barriers to implementation and action to address the issues**
  - **Items for the awareness and assurance of the EMB and Trust Board**
  - **Areas of concern**

See Appendix 3 for upward report template

#### 4.3.2 **Performance Committee**

The Performance Committee is chaired by the Chief Operating Officer and is responsible for overseeing the performance of the Clinical Business Units and the production of performance information to the Trust Board.

#### 4.3.3 **Quality Board**

The Quality Board is chaired by the Chief Executive and is responsible for the control of risks to the Quality agenda: Patient Safety, Patient Experience and Clinical Effectiveness. This committee has reporting sub committees that oversee Safeguarding; clinical safety including the management of medicines; research governance and emergency planning.

Specific areas of responsibility include: Patient Safety: implementing best practice from the NPSA and via the Trust strategy *Patient Safety Matters* (our contribution to the Patient Safety First campaign)

Patient Experience: reviewing trends in patient feedback, Complaints /PALS and action taken to improve services; Liaison with the LINKS (to become Healthwatch) and increasing and maintaining relationships with relevant external bodies in the local community

Clinical Effectiveness : monitoring progress with the action following clinical audit, compliance with national guidance and the priorities identified for improvement

The Quality Board receives reports from the following sub committees:

- Clinical Safety Committee: for aspects of risk around medicines management and medical technology including the areas formerly covered by:
  - Drug and Therapeutics Committee
  - Safer Medication Group
  - Medical Devices Group
  - Human Tissue Act Group
  - Resuscitation Committee
  - Radiation Protection Committee
  - Hospital Transfusion Committee
- Safeguarding Children and Vulnerable Adults Committee
- Hospital Infection Control Committee
- Emergency Planning / Major Incident Committee
- Clinical Business Units via a monthly Quality report
- Progress with achievement of CQUIN; Quality Account; PROMS;
- CQC Quality Risk Profile and compliance with Outcomes
- Registration with quality regulators.
- Network participation and performance e.g. Critical Care Delivery Group,

It reviews the quarterly Quality Contract Report prior to submission to the

commissioners.

It reports upwards to the EMB by exception , barriers to implementation, and recommends key policies for approval.

#### 4.3.4 **Organisational Development and Human Resources Board**

The OG and HR Board is responsible for assuring the Executive Management Board on all aspects of staffing; implementation of Trust HR policies, staffing and workforce, staff training and development, equality, staff representative involvement and advice and the health of staff.

The Joint Staff Management Committee (JSMC) has a consultative role in policies e.g. Health and Safety policies which relate to staff.

#### 4.3.5 **Information Management and Technology Board**

**The IM&T Board is** responsible for steering, governing and performance managing the IM&T programme in order to achieve targets, objectives and benefits set out in the national and local strategy. It is responsible for overseeing all IM&T projects and approving all projects involving IM&T systems or requiring IM&T input and Information Governance compliance.

The following sub- committees report to the IM&T Board:

- Information Governance Committee is responsible for overseeing the progress with attaining Information Governance standards including those assessed by the Information Governance Toolkit. It provides assurance that all information security risks are assessed with appropriate controls to mitigate events such as loss of data and breaches of confidentiality. The Trust has appointed a Senior Information Risk Owner (SIRO) a role which is currently taken by the Director of Finance and Performance who is responsible for any breaches of Information Security.
- Health Records Committee

#### 4.3.6 **Environment and Health and Safety Committee**

**The Environment and Health and Safety Committee** is responsible for assuring EMB that the trust premises are safe and there are robust Health and Safety management systems in place. Responsibilities including agreement of H&S related policies; compliance with requirement for local risk assessments; issues arising from incident / accident reporting; compliance with RIDDOR regulations ; ensuring adequate education and training programmes are delivered and to inform the Executive Management Board of any issues requiring urgent action. Sub committees include: Fire Safety Action Group, Security Group, Patient Environment Action Group, Smoking Group and the Estates Environment Committee.

#### 4.3.7 **Medical and Non – Medical Advisory Boards**

The Medical and Non-Medical Advisory Board are professional forums that provide advice and support on the control of risks around compliance with clinical education, supervision, leadership, professional regulation and performance. The Boards will also consider clinical developments, capital programmes, proposed business cases..

### 4.4 **INDIVIDUAL ACCOUNTABILITY**

*(For the Officer accountability see diagram Appendix 4 including specialist designated responsibilities)*

#### 4.4.1 **Responsibility of the Chief Executive**

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The Chief Executive has overall responsibility for the running of the Trust's business and for risk management within the Trust. The post holder is the Accountable Officer for the implementation of Corporate / Integrated Governance and the assurance to the Trust Board of compliance with the essential standards required by the regulations of the Health and Social Care Act 2008. He is the Accountable Officer for the financial resources controlled by the Trust and has a statutory responsibility for the quality of care and is required to sign the Statement of Internal Control.

#### **4.4.2 Responsibility of the Director of Finance and Performance**

The Director of Finance and Performance is accountable to the Chief Executive for the strategic development of Financial Management, for Financial risk, Financial Controls Assurance within the Trust, for Performance Management and risks identified in Trust Business Plans, and for risks associated with Procurement. The post holder is the Executive Director with professional responsibility for internal audit and is responsible for developing the Trust input into the Service Level Agreement (SLA) process using information from the Trust's Risk Register.

He receives reports from the Head of Estates who is responsible for the risks associated with the construction and maintenance of the buildings and the control of associated hazards. (including Electro Biomedical Medical Equipment EBME). This postholder is also the nominated officer for Fire Prevention and as the Trust's Senior Information Risk Owner (SIRO) is responsible for any breaches of Information Security.

#### **4.4.3 Responsibility of the Medical Director**

The Medical Director is responsible for the professional performance and standards of medical staff and is the Executive Director with joint responsibility for Clinical Governance and risk with the Director of Nursing and Patient Services. He is responsible for risks associated with research and for medical education. The current post holder is the Caldecott Guardian for the Trust and the Responsible Officer for medical revalidation.

#### **4.4.4 Responsibility of the Director of Nursing and Patient Services**

The Director of Nursing and Patient Services is responsible for the professional performance and standards of Nursing and Midwifery staff and Allied Healthcare Professions and advises the Executive Management Board on associated risks. She is the Executive Lead for risk management, non-clinical risk (health and safety) and processes for reporting compliance with Care Quality Commission "Essential Standards" and quality in contracts. The DN&PS is jointly responsible with the Medical Director for Clinical Governance, clinical quality and patient safety and the executive portfolio for risk management systems. She is the nominated lead for Safeguarding (Adults and Children).

#### **4.4.5 Responsibility of the Chief Operating Officer**

The Chief Operating Officer is responsible for the trust's clinical operations ensuring all performance indicators, targets and standards are delivered safely within allocated resources and for reporting risks against performance activity and targets to the Trust Board. The postholder is expected to lead the long term and short term planning of services to maintain capacity and capability year-on-year, ensuring service delivery is of the highest standard and associated risks mitigated.

#### **4.4.6 Responsibility of the Director of Organisational Development**

The Director of Organisational Development is responsible for the development of the organisation through delivery of organisational development strategies which meet the

NHS best practice requirements and meet the needs of business to deliver high quality patient care. The role includes the promotion of diversity, staff involvement, workforce development / engagement and new ways of working to ensure delivery of effective and efficient services. The postholder advises the board on the management of risks associated with Human Resources and employment legislation.

4.4.7 The Associate Director of Human Resources is responsible for the development of policies in order to mitigate against the risks associated with:

- the employment of staff (recruitment and selection),
- management of sickness and absence
- consultation with the Joint Staff Management Committee
- staff involvement
- Induction and training
- Occupational health
- Improving Working Lives.
- Equality Delivery System

and controls associated with standards to reduce employment risks linked to health and safety obligations.

#### 4.4.8 **Responsibility of the Director of Infection Prevention and Control**

The Director of Infection Prevention and Control is responsible for providing the Trust-wide leadership on Infection Control; assurance on compliance with the Health Act 2006 and the Hygiene Code; the development of the IC strategy; delivery of the annual programme and management of associated risks, development of Infection Control policies. An existing Executive Director takes on this role.

#### 4.4.9 **Responsibility of the Chief Information Officer**

The Chief Information Officer is responsible for the Trust IM&T Strategy and risks associated with information governance, Information Management and Technology systems including the integrity and security of Trust Patient Information Systems and databases. He is the lead for Information Governance.

#### 4.4.10 **Responsibility of the Trust Board Secretary**

The post holder has responsibility for

- Establishing procedures for the sound governance of the Trust and advising the Board on developments in governance issues.
- Ensuring the Trust operates in accordance with statutory and legal provisions and that there is appropriate stewardship and corporate governance of the business of the Trust
- Ensuring that the Standing Orders and Standing Financial Instructions of the Trust are maintained, communicated and up to date.
- Ensuring strong links between the Trust governance and risk management systems by facilitating the development of the Board Assurance Framework for submission to the Executive Management Board and Audit Committee.
- The management of claims within the Trust and the dissemination of information with regard to claims to relevant committees and staff within the Trust
- Leading on the requests for information under the Freedom of Information Act.
- Liaison with the Parliamentary and Health Service Ombudsman or the Local Government Ombudsman (LGO) on complaints.

#### 4.4.11 **Responsibilities of the Corporate Risk Team**

The corporate Clinical Governance and Risk management team within the Directorate of Nursing and Patient Services comprises the Deputy Director of Clinical Governance,

Clinical Risk and Health and Safety Managers, Assistant Risk Manager; Patient Safety Coordinator and Senior Information Analyst. Their responsibilities are to:

- Collate information on risk and governance activity including incident reporting, and feedback trends to the Quality Board and Environmental Health and Safety Committee.
- Assist with the investigation, review and analysis of incidents
- Prepare reports on risk management systems to the EMB, Executive and sub Committees.
- Support risk assessment and enable Clinical and Corporate Business Unit information to be fed into the Trust Risk Register.
- Support to the Clinical Business Unit and General Managers and Risk Leads in monitoring and reporting on progress with CBU action plans.
- Support risk management training and educational programmes.
- Liaise with external assessment and inspection bodies such as the NHSLA, MRHA and HSE and Fire Brigade.
- coordinate the implementation of the Patient Safety Strategy.

#### 4.4.12 **Responsibility of the Deputy Director of Clinical Governance**

The Deputy Director of Clinical Governance has overall responsibility for developing and co-ordinating the risk management programme, developing Trust risk management policies, procedures and methodologies and supporting staff in the implementation of the risk management strategy. The post holder coordinates the self assessment, of Trust compliance with the Essential Standards of the Regulations; production of the Quality Report on compliance with quality requirements within the contract with the commissioners; production of the patient experience report including results of patient feedback surveys and the co-ordination of the corporate system for maintenance, dissemination and archiving of Trust corporate policies and clinical procedures.

The post holder manages the Risk and Safety Managers and Patient Experience Officer, chairs the Risk / Policy Review meeting to ensure liaison between the Risk Management, Patient Experience, Complaints and Litigation functions and scrutiny of policies prior to approval.

#### 4.4.13 **Responsibility of the Risk Managers**

There are two Trust Risk Managers who report to the Deputy Director of Clinical Governance and whose responsibilities include:

- Provision of expert advice.
- Support to the risk assessment process and Risk Register.
- Supporting education and training.
- Monitoring of compliance with relevant policies and systems related to risk.
- Ensuring appropriate action in response to incidents.
- Provision of relevant reports on risk.

4.4.14 The Clinical Risk and Safety Manager promotes clinical risk management throughout the Trust and is responsible for co-ordinating Trust compliance with NHSLA Risk management standards and NPSA safety alerts.

The post holder also liaises with the Trust Board Secretary on issues and specific incidents where there is a risk of litigation.

4.4.15 The Risk Manager (Health and Safety) supports Health and Safety and Fire Safety activity throughout the Trust, including support to workplace risk assessments and advice to managers to ensure compliance with Health and Safety at Work etc 1974 Act, and other regulations and statutory requirements. The post holder is the competent

person for health and safety, fire safety and COSHH.

- 4.4.16 The Patient Experience Officer provides the Trust Board, Director of Nursing and Patient Services, the and Trust Senior management with specialist advice and support in complaints management ensuring that the Trust's service operates within the framework of the vision for "*Making Experiences Count*" and "*The principles of good administration*". This role also includes support for the implementation of the Trust's Patient Experience Strategy.

#### 4.4.17 **Responsibility of the Chair person of the Executive-led committees and Sub Committees**

The Chair person of the all Committees is responsible for:

- Identifying appropriate secretariat support for the collation and distribution of the agenda and papers for the committee meetings.
- Identifying a minute-taker for the meeting.
- Agreeing the work programme for the year aligned to the Trust Business Plan and activity to maintain compliance with Essential Standards and Outcomes and NHS LA standards.
- Agenda setting for the meetings.
- Review of the draft minutes prior to circulation.
- Identifying the key issues for reporting upwards to the Executive Committee or EMB and submitting the completed report template to the secretariat of the Executive committee as outlined in para 4.2.1 above.

#### 4.4.18 **Responsibility of the Secretariat to Committees**

- Collation of the papers for the meetings.
- Distribution of the agenda and papers prior to the meeting. Main committee papers should be circulated at least 5 working days prior to the committee meeting.
- Transcription and circulation of the draft minutes within 5 working days of the meeting.
- Distributing and archiving minutes in line with Trust standards.

### 4.5 **CLINICAL AND CORPORATE BUSINESS UNIT STRUCTURES AND SYSTEMS**

The heart of the Trust's Governance and Risk Strategy lies with the structures and systems at Clinical and Corporate Business Unit (CBU) levels that oversee the activity of frontline clinical and support services.

See Appendix 5 – Clinical and Corporate Business unit structure.

#### 4.5.1 **Business Unit Risk and Governance**

The CBU management group meetings oversee the "business" agenda, the service plans (including progress with Service Strategy, finance, capital, and meeting the Trust operational objectives). The Associate Medical Directors and the Associate Directors of Operations have joint responsibility for operational and financial risks.

- 4.5.2 The CBU Quality Committees or corporate business unit management meetings oversee the components embraced by the Essential Standards and expected outcomes relevant to the business unit for:

- Involvement and Information.
- Personalised care, treatment and support.
- Safeguarding and safety.
- Suitability of staffing.
- Quality and management.

- Suitability of management.
- And the quality requirements in the annual contract.

4.5.3 The CBUs exception report upwards to the Associate Directors of Operations or their Executive Directors for Clinical Operations; Nursing and Patient Services; Finance and Performance; Organisational Development

- Description of areas that the Trust is not achieving/ complying with, barriers to implementation and action to address the issues.
- Items for the awareness of the EMB and Board.
- Areas of concern

4.5.4 **Clinical Business Unit Accountabilities and Duties:**

4.5.5 **Responsibility of the Chief Operating Officer**

The COO will ensure that the Clinical Business Units implement the Governance and Risk Management strategy and policy.

4.5.6 **Responsibility of Associate Medical Directors and Associate Directors of Operations**

Associate Medical Directors and Associate Directors of Operations will ensure that:

- their CBU implements the Trust Governance and Risk Management Strategy and policy.
- This includes:
  - risk assessment, regular, timely review and update of the CBU Risk Register and associated action to treat risks
  - incident reporting and implementing the action from incident investigation
  - assessment of compliance with standards and policies
  - participation in cross trust sub committees

This will be achieved in conjunction with Clinical and Corporate Business Unit Managers and CBU Risk Leads (see below).

The Associate Medical Directors will identify a nominated person (Risk Lead) in each of their constituent departments who will co-ordinate risk management activity locally and liaise on a day to day basis with the corporate risk team and Risk Managers .

4.5.7 **Responsibility of Clinical and Corporate Business Unit Managers**

CBU Managers are responsible for ensuring that risk is managed within the CBU and that each work area within their CBU has a programme in place to implement the risk management processes as set out in the Strategy and reporting systems are implemented as described herein. They may discharge this responsibility through and in liaison with the Risk Leads (see below).

4.5.8 CBU Managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) and scope of responsibility. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, managers are responsible for bringing those risks to the attention of the Executive Management Board and Trust Board via the Risk Register if local resolution has not been satisfactorily achieved. All risks rated 15+ must have an Action Plan

4.5.9 The following Trust wide areas of responsibility are overseen by :

- Outpatients department, by the Chief Operating Officer
- Bed Management, by the Chief Operating Officer.

#### 4.5.10 **Responsibility of Clinical and Corporate Business Unit Governance and Risk Leads**

There should be a nominated Governance and Risk Lead in the Clinical Business Unit and the Corporate Business Unit (Nursing And Patient Services (Support Services)); Organisational Development ( Human Resources,); Finance and Performance (Including Procurement IT, and Estates)

Responsibilities include:-

- review of all the incidents and near misses reported by staff within their CBU; instigating the appropriate level of investigation and reporting upwards; production of monthly reports to the CBU Quality Committee and to the Trust Quality Board.
- implementation of risk management policies and initiatives disseminated by the Quality Board, Health and Safety Committee, Hospital Infection Prevention and Control Committee, and other groups where relevant.
- ensuring attendance of nominated staff at risk management training and education programmes organised by the Trust, and organising department/ward specific risk management training initiatives.
- Identification of key local risks and input into the RiskTrack/PRISM risk register system and implementation of the risk control measures.
- production of local Risk Action Plans.
- ensuring ward/department/service risk assessments are undertaken in accordance with the Trust's annual risk assessment programme.
- undertaking the risk assessment of "change" such as changes in service delivery, reduction in resources etc.

#### 4.5.11 **Responsibility of CQC Outcome Leads**

The nominated Outcome Lead for assessment of compliance with outcomes standards responsibilities include:

- Identification of the required monitoring process to gain assurance from and to provide assurance to the EMB of compliance with the outcomes standards and evidence of the expected outcomes for patients.
- Monthly reporting of achievements regarding compliance and outcomes and assessment of the risk to achieving ongoing compliance with the regulations via the Quality report.
- Collation of the evidence within trust systems

#### 4.5.12 **Information Governance Compliance**

All business units must nominate an IG / Data Quality Lead. This role will include responsibility for :

- Ensuring the accuracy of data held by the business unit.
- To undertake regular audits to assure the manager of data quality including
  - Accuracy of key data items.
  - Casenote audit.
  - Filing in healthcare records.

- Minutes of divisional meetings.
- To investigate data quality issues brought to the attention of business units by clinical teams, users of information and national benchmarking reports.
- To ensure that databases held in the business unit comply with the Information Governance standards and are recorded on the Trust Information Asset Register.

#### 4.6 **General Risk Management Responsibilities** (This applies to the all the Business Units)

##### 4.6.1 **Responsibility of All Managers**

All levels of management must understand and implement the Trust Risk Management Strategy. In particular, managers must:

- ensure that appropriate and effective risk management processes, including assessments of hazards and risk are in place within their designated area (s) and scope of responsibility; and that all staff are made aware of the risks within their work environment and of their personal responsibilities
- ensure that all staff are given the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trust's operations including sub-contractors, members of the public, visitors, volunteers etc.
- exercise their authority to manage risks, a responsibility which is included within their job description. The Trust expects managers to lead staff in identifying risks, assessing the controls necessary and implementation of a risk treatment plan. See the *Policy and guidance on risk assessment, Risk Track and Risk register* for the management action required in response to risk rating. If allocation of the required resources is outside of their delegated authority, approval by the Business Unit Manager or EMB should be sought.

##### 4.6.2 **Responsibility of all employees**

All employees should be aware of their personal responsibility in the management of risk and should:

- Identify all hazards in the workplace.
- Report all incidents/accidents and near misses using the recognised channels.
- Be aware that they have a duty under Health and Safety legislation to take reasonable care for their own safety and safety of others who may be affected by the Trust's business.
- Comply with all Trust policies, procedures, regulations and instructions to protect the health, safety and welfare of anyone affected by the Trust's business.
- Report any perceived hazards, risks or issues of concern regarding safety in their area of work.
- Attend risk management training.
- Neither intentionally, nor recklessly interfere with or misuse any equipment provided for the protection of safety and health.
- Be aware of all emergency procedures e.g. major incident procedures, resuscitation,

evacuation and fire precaution procedures appertaining to their particular Department / location/work environment.

- Comply with infection control policies and procedures.
- Observe the trust code of confidentiality.

#### **4.7 Partner Organisations (e.g. GSTS, Moorfields, SEPT)**

The trust is responsible for agreeing shared governance arrangements with partner organisations and for ensuring that governance and risk processes are clear in operational partnership working arrangements. With partner organisations, these will be set out in the formal legal agreements. As the implementation of the NHS Plan takes place, the trust will work with various health providers and social care organisations. Staff working across two or more providers must ensure they follow their employer's governance and risk arrangements and contribute to the partner's arrangements. It is the responsibility of general managers to ensure that the governance and risk arrangements are clear with any operational partners working within the trust.

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## 5.0 GOVERNANCE AND RISK MANAGEMENT PROCESSES

### Governance Framework

#### 5.1 Corporate Governance and the Assurance Framework.

#### 5.2 Statement of Internal control.

#### 5.3 Risk management.

#### 5.4 Strategic Risk Areas.

##### 5.4.1 Clinical Risk and Patient Safety.

Care Quality Commission review and Registration.

NHS Litigation Authority standards.

##### 5.4.2 Clinical effectiveness and audit.

##### 5.4.3 Safe Environment.

##### 5.4.4 Financial risk.

##### 5.4.5 IM&T risk and Information Governance.

#### 5.5 Internal auditor and outside assessors / accreditation.

### 5.1 Introduction: Corporate Governance and Internal control

Corporate Governance is the ongoing activity of maintaining a sound system of internal control by which directors and officers of an organisation ensure that effective management system, including financial and performance monitoring and control systems have been put in place to protect assets, earning capacity and the reputation of the organisation.

As a public organisation, the Trust is required to include in each annual report a report on the adequacy of internal control structures and the effectiveness of the processes. Risk management is one aspect of the internal control systems.

#### 5.1.1 The Assurance Framework : process for identification and evaluation of Board level risks

5.1.2 The Trust Board is responsible for achievement of the organisational objectives which are in the Integrated Business Plan. The Chief Executive is responsible for agreeing the objectives of the Executive Directors. The Trust Board is responsible for ensuring that internal controls – financial, clinical, organisational are in place and the effectiveness of these controls are regularly reviewed. The EMB ensures that action is taken to implement controls and address any shortcomings.

5.1.3 Business planning for the Trust is predicated on the achievement of the Trust objectives and the successful management of the risks to them. These objectives form the framework for the corporate risk register and assessment of the “Principal risks” associated with achieving these objectives. These form the basis of the *Assurance Framework* document for the Board. This is reviewed four times a year in line with the review of the Risk Register and reported to the Executive Management Board, Audit Committee and the Board of Directors.

5.1.4 The purpose of the *Assurance Framework* is to confirm the adequacy of controls in place to manage the principal risks that arise in meeting the Trust objectives. The *Assurance Framework* also provides a structure for the evidence to support the Statement of Internal control (SIC).

5.1.5 The Board regularly reviews its objectives and risks to ensure that its *Assurance Framework* is appropriate, adequate and up-to-date. Progress with achieving the Objectives is reviewed by the Executive Directors and reported to the Executive

Management Board. This review generates the principal risks against the objectives and the relevant responsible Executive Director will update these in the Risk Register (RiskTrack/ PRISM). (*For Risk Register review process see para 5.3 below*)

- 5.1.6 The Executive Management Board ensures that local operational risks are inputted into the risk management database, (RiskTrack / PRISM). These are mapped to relevant key objectives. All risks are reviewed four times a year and reports are reviewed by the Clinical and Corporate Business Units and the EMB .(*cross refer to para 5.3.7 to 5.3.21 on Risk Register process below*) The EMB reviews the Action Plans for risks rated 15+.

## 5.2 **Statement of Internal Control**

The Chief Executive is required to sign a Statement of Internal Control annually on behalf of the Trust Board. The statement is based on assessment against the Assurance Framework and includes currently ; Financial management; Risk management; (National, targets, Service reviews, national studies, Essential Standards Quality Risk Profile ), information risks and climate change .

## 5.3 **Risk Management**

The Trust is committed to establishing, implementing and monitoring a risk management programme based on the principles of the AUS/NZ Risk management standards 4360. It has established structures and systems to allow the key parts of the risk management process to take place:

- Risk identification
- Risk Analysis and Evaluation
- Risk Control

### 5.3.1 **Risk identification**

There is a single Trust Risk Assessment process. (*See the Trust Policy and Guidance on Risk Assessment, RiskTrack/PRISM and Risk Register*)

The Trust Policy : *Policy and Guidance on Risk Assessment, Risk Track and the Risk Register* sets out the process for assessing risks and recording them into the Trust risk database. The “RiskTrack/ PRISM” database will be used for recording all risk assessments: organisational, financial, clinical and non-clinical. Reports from RiskTrack/PRISM comprise the Trust Risk Register.

- 5.3.2 The range of risks to be identified is broad and depends on the area or service to be assessed but it is important that staff identifying risks are aware of a full range of potential risks, including:

- risks affecting patients and the quality of care
- risks affecting staff, their safety, competence and ability to function
- risks affecting equipment, buildings, the environment of care etc
- risks arising from the organisation itself e.g. IT; human resources systems, financial planning, communications systems etc and its environment e.g. pandemics
- risks arising from the implementation of change
- risks arising from business and service development
- risks arising from information security risk assessment

### 5.3.3 **Incident and Near- Miss reporting**

The Trust has an incident reporting procedure described in the *Incident/Accident Reporting Policy*.

All trust staff are responsible for logging incidents on the Datix incident database. Clinical Business Units (CBUs) and Corporate Business units are responsible for:

- Investigating incidents
- Implementing action to prevent recurrence
- Disseminating lessons learned

Trends in Clinical incidents are reported to the CBU's Quality Committee, the Quality Board and Non-clinical incidents to the Health and Safety Committee.

#### 5.3.4 **Risk Awareness Training**

Some staff may not fully appreciate or understand the importance of reporting incidents centrally. The Trust will address those cultural and educational issues which influence the effectiveness of incident and 'near miss' reporting.

Arrangements for training and supporting staff are set out in Section 6.

#### 5.3.5 **Risk Register – see Appendix 6 Risk Register process flow chart**

The Risk Register is a database (RiskTrack/ PRISM) of all identified risks, with the results of their analysis (risk rating) current controls and Action plan to treat the risk.

#### 5.3.6 **Board level Risk**

Risks to the Trust Objectives (“Principal risks” ) will be assessed and reviewed four times a year by the Executive Directors and reviewed by the Trust Board .

#### 5.3.7 **Local risks - Business Units**

Each Business Unit must have a process for identifying risks from all sources:

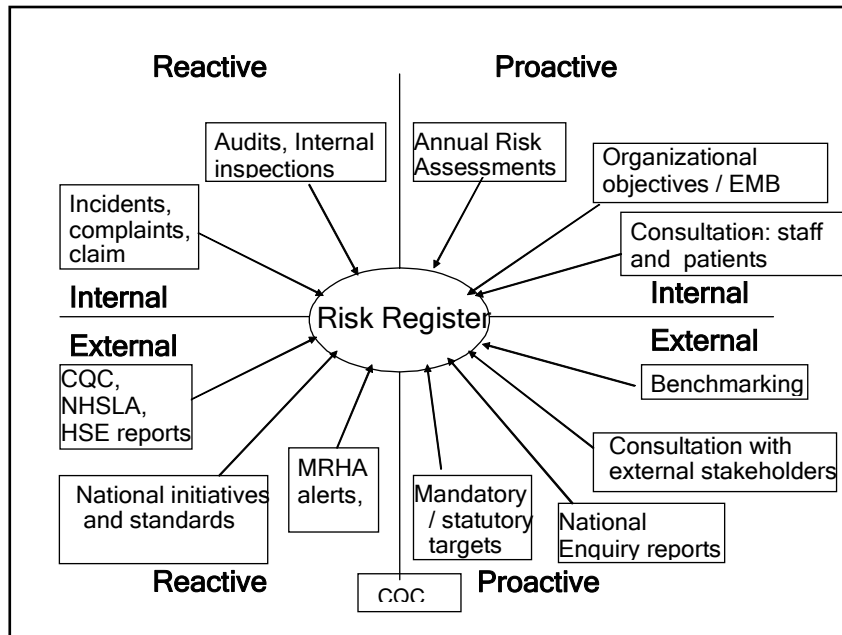
- Ensuring that workplace risk assessments for their services are undertaken comprehensively as a baseline and then reviewed and updated regularly and at a minimum annually.
- The identification of risks associated with service activity and the introduction of new procedures undertaken by Clinical Business Unit management
- Risks identified in response to incidents and hazards reporting and identified in. Serious Incident Investigation Reports
- Risks as a result of external agency visits, inspections and accreditations
- Risks to trust non compliance with NICE and national guidance
- Risks associated with equipment

Local management structures must provide:

- Support for the input of risks into the RiskTrack/ PRISM database
- Leadership for risk management within the business unit
- Nominated RiskTrack/ PRISM users who are trained in its use.
- A regular risk register business cycle
- A regular meeting at which the Risks are discussed and generated giving consideration to all above sources
- A meeting at which the Risk Register is reviewed four times a year (in January, April, July and October)

*See Diagram 1 below: Sources of Risk*

**Diagram: Sources of information feeding into the Risk Register**



### 5.3.8 Risk Assessment

Risks are assessed at all levels of the organisation:

- Ward managers and department heads assess risks associated with the workplace and work activities.
- Matrons and senior managers assess clinical risks and those associated with new developments in service.
- Directors assess strategic risks associated with their Business Unit and for their areas of Trust wide responsibility
- Trust-wide groups responsible for cross trust activities such as Resuscitation, Blood Transfusion, Drugs and Therapeutics assess the risks associated with this activity and log them on the relevant Business Unit register.
- The Board identifies strategic risks as part of the annual strategy review.

5.3.9 Risk assessment should take place whenever there is a change to service delivery.

5.3.10 All members of staff can contribute to the Risk Register. Business Units must agree locally the process for how risks that are identified on a daily basis are alerted to the Business Unit management teams.

It is the responsibility of the Clinical and Corporate Business Units to review their risks and update the risk ratings prior to the extraction of the report from the RiskTrack/ PRISM database in January, April, July and October.

See Appendix 6 for flow chart showing the **Risk Assessment Process for the review of the Risk Register and Assurance Framework**

### 5.3.11 Risk Analysis

Risk analysis is primarily concerned with quantifying risk in terms of frequency and severity. The Trust Risk Assessment tool uses a 5x5 matrix for describing levels of frequency and severity. (see the *Policy and Guidance on Risk Assessment, Risk Track and the Risk Register*)

5.3.12 The risk rating “scores” achieved by applying the Trust process enable risks to be

prioritised against each other and for a decision on risk mitigation (see below) .

- 5.3.13 The Trust Board has approved a definition of “significant” and “acceptable risk” (See Appendix 3 of *Policy and Guidance on Risk Assessment, Risk Track and the Risk Register*) which applies to the Risk Assessment Process as well as the Incident Reporting Procedures.
- 5.3.14 The “acceptable risk” guidance also provides the necessary authority for Senior Managers and other staff to take appropriate action to control risks/hazards identified through the assessment and incident reporting process
- 5.3.15 All risks assessed as high (Risk Rating 15-25 ) will be reported to the Executive Management Board immediately for management review. The EMB will review the Risk Register/ Assurance Framework four times a year to ensure sufficient and appropriate management action is being taken to address these high-risk issues and draw to the attention of the Trust Board the current key risks that threaten the Trust Objectives and any resource implications.
- 5.3.16 **“Risk Appetite”**
- The given nature of business, safety, finance and reputation leads to a low appetite for avoidable risk.
- 5.3.17 **Risk Control**
- Risk control measures will include both those measures which prevent risk materialising and those which minimise loss when risk does occur. The Trust’s risk control strategies will therefore aim to:
- prevent losses from occurring
  - protect patients, staff, visitors and property from harm
  - detect and limit the extent and impact of any loss
  - maximise the potential for recovery once it has occurred
  - risk transfer (via insurance);
  - risk avoidance (by ceasing to do something).
- 5.3.18 **Risk mitigation** is undertaken by four types of response which needs to be assessed by the Clinical Business Unit and Corporate management team and entered into the appropriate field in RiskTrack/ PRISM:
- Tolerate**  
The exposure of risk may be tolerable without any further action being taken. In risks that are not tolerable, ability to do anything about them may be limited, or the cost of action may be disproportionate to the potential benefit gained. This option is supported by contingency planning for handling the impacts that may arise if the risk materialises.
- Treat**  
Most risks will be treated by action taken to control the risk to an acceptable level.
- Transfer**  
For some risks the best response is to transfer them. This may be done either by conventional insurance or by paying a third party to take the risk in another way.
- Terminate**  
Some risks will be only treatable or containable to acceptable levels by the termination of the activity.
- 5.3.19 The risks rated 15+ from the Risk Register will be reviewed by the Executive Management Board who will agree what risk mitigation and actions recommended to manage identified risk, where responsibility for implementation rests and what the expected timescales for achievement are. Action plans for risks rated 15+ will give

more detail for the full range of risks identified locally.

5.3.20 Decisions on risk control measures will be taken at local level and monitored through the structures described in the strategy. Where the priority rating indicates that a risk must be managed or reduced and it has not proved possible to identify and / or implement the required risk control measure, this will be referred through the management line to the Executive Management Board.

5.3.21 The Executive Management Board will make recommendations to the Trust Board on the management of significant risks to the Trust.

#### 5.4 **Strategic Risk Areas:**

1. **Clinical Risk.**
  - Patient Safety
  - Infection Control risk
  - Compliance with CQC registration regulations
  - NHS LA Risk management standards
2. **Clinical effectiveness and clinical audit.**
  - Policies and Guidelines
3. **Safe environment.**
4. **Financial Risk.**
5. **IM&T risk**

#### 5.4.1 **Clinical Risk:**

##### 5.4.1.1 **Patient Safety**

The Trust recognises the risks to patients during their episode of care and controls this risk through an active Patient Safety Strategy focusing on priority areas for improvement.

##### 5.4.1.2 **Infection Control Risks**

Control of Infection is a Trust priority for the safety of patients and well - being of staff and aims to ensure that the principles of infection prevention and control are embedded in practice throughout the Trust. There is Director of Infection Prevention and Control (DIPC) who leads the infection control team who work to an approved Infection Control Plan. Infection Control risks are reviewed by the DIPC and the Hospital Infection Prevention and Control Committee (HIPCC).

##### 5.4.1.3 **Registration with the CQC (Health and Social Care Act 2008)**

The risks to non compliance with the CQC Outcomes are logged on the Risk Register.

Providers of health and social care must comply with the legislation contained in Health and Social Care Act 2008 (Regulated Activities) and Care Quality Commission (registration) Regulations 2009. The regulations describe the essential standards of quality and safety that people who use health and social care services have a right to expect.

As a provider of regulated activities, to operate legally the trust was registered with the Care Quality Commission in January 2010 without conditions. The CQC will require

evidence of “Ongoing Compliance” and may make further enquiries including inspections and make judgement (according to their Judgement Framework) on the ongoing compliance with the standards and regulations.

The trust must also monitor services for continued compliance with the essential standards. These will be referred to by the CQC for monitoring compliance with regulations, bringing about improvements via enforcement or preventing the trust carrying out regulated activities.

The assurance of compliance with the essential standards has strong links with the Trust Assurance Framework. Compliance will be managed through the trust’s routine processes for assurance.

The Executive Management Board must be able to assure the Trust Board of assurance on targets and compliance with the standards based on evidence that there is reasonable assurance of compliance and there are no significant concerning areas. It discharges the latter responsibility by Compliance reports and assurances it receives from the sub committees .

#### 5.4.1.4 **NHS Litigation Authority Standards**

Compliance with the NHSLA risk management standards at Levels 1,2 and eventually 3 will demonstrate that significant progress has been made on establishing, implementing and evaluating the effectiveness of the approved organisation-wide risk management strategy. Compliance at Level 2 will give substantial assurance against the compliance with regulations, as well as affording discounts on the Trust’s contribution to the Scheme.

The Clinical Risk and Safety Manager is responsible for preparing the trust for the NHSLA assessment in liaison with the appropriate staff in the Business Units and in the Organisational Development and Human Resources department.

There are many cross links between compliance with the NHSLA standards and the Essential Standards of the regulations.

#### 5.4.2 **Clinical Effectiveness and Clinical Audit**

The Trust will ensure that there are close links between clinical audit systems and risk management systems. In particular, information from risk assessments, incident reporting, claims and complaints inform the trust clinical audit programme. This process will work in two ways within the trust.

- Firstly, the Medical Director and Clinical Business Unit Clinical Governance Leads will identify the emerging trends in the clinical risk management from benchmarking information to enable prioritising of key topics for audit. The CBU Clinical Governance team and Clinical Audit Leads will use this information to ensure that the Trust’s clinical audit programme incorporates topics which address the priority issues.
- Secondly, on receiving the results of the audits the Clinical Business Units will assess the assurance value of the findings and the level of concerns that they raise with regard to ongoing compliance with essential standards. The risks identified by audit activity will be logged in the CBU Risk Registers. Progress with this action will be included in the CBU Quality report to the Quality Board.

##### 5.4.2.1 **Policies and Guidelines**

The Trust system for the production and review of policies clinical guidelines and  
\\bedford\data\CMC\Trust Board Papers\2011 Trust Board\Agendas\8 Sept 2011 part 1\8.2.1  
Governance and Risk Strategy and Policy draft 5 EJ 08\_09\_2011.docx

procedural documents has been approved as part of the *Policy for Policies* which will ensure the following:

- Clear roles and responsibilities
- Guidelines are developed with due regard to evidence-base
- There has been an adequate and appropriate level of consultation
- Clear style and format
- Guidelines are accessible to staff
- Guidelines are maintained, reviewed and updated appropriately and archived.
- Approval takes place at the appropriate level
- Clear processes are in place for the monitoring and reporting compliance with key policies

#### 5.4.2.2 **Policies and Guidelines Review Group**

It is the responsibility of the Policies and Guidelines review group to ensure that the requirements of the Trust's *Policy for Policies* have been met and that the relevant policies comply with the NHS LA criteria. The group will review the documents and recommend them for agreement by the relevant committee e.g. Quality Board or Health and Safety Committee and final approval by the EMB .

#### 5.4.3 **Safe Environment**

The Board needs to ensure that it is kept informed of, and alerted to relevant Health and Safety risk management issues. Health and Safety risks can result in costs to the trust in terms of staff absence, low staff morale, financial loss, civil and criminal legal action resulting in fines and compensation payments or damage to trust public reputation as an employer or service provider.

The Trust will maintain Health and Safety systems that:

- facilitate compliance with current Health and Safety legislation.
- improve Health and Safety performance throughout the organisation and thus reduce the personal and financial costs associated with adverse incidents.
- develop a positive Health and Safety culture amongst all staff throughout all aspects of their activity.
- identify, analyse and manage Health and Safety risks.
- execute action plans to eliminate or reduce all identified risks.
- ensure the ongoing Health and Safety of patients, staff, visitors and the organisation.

These aims will be achieved through the Health and Safety Policy.

#### 5.4.4 **Financial risks**

The trust financial risks are identified and mitigated via the monthly meetings of the Finance Committee who have principal responsibility approving the financial and activity assumptions, approving budgets and reviewing the risks presented by adverse variances and for responding to the Independent Financial Review of Financial management in the trust.

Operational financial risks are the responsibility of the Clinical and Corporate Business

Units and these are managed via the trust performance management processes.

## 5.5 **IM&T and Information Governance**

Information risk is managed by the Information Security Owner (SIRO) who has access to appropriate expertise to ensure that information systems are managed affectively in line with the trust Information Governance Policy

Information risk assessment is the responsibility of all CBUs who must assign an Information Asset Owner for all key information assets. These must be risk-assessed and recorded on the trust Risk Register (Risk Track/ PRISM)

Assurance on the control of risks is achieved via assessment against the criteria in the Information Governance (IG) toolkit which is submitted quarterly to Connecting for Health via the Information Governance Committee.

## 5.6 **Internal auditor and outside assessors/ accreditation**

The purpose of internal audit is to provide the Trust Board, through the Audit Committee, with an independent and objective opinion on risk management, control and governance and their effectiveness in achieving the organisation's agreed objectives. This opinion forms part of the framework of assurances that the Board receives and should be used to help inform the annual Statement on Internal Control. Internal Audit also has an independent and objective consultancy role to help line managers improve risk management, governance and control.

The Internal Audit Strategy will include projects to meet external audit/ regulatory requirements, and review key risks based on the assurance framework.

## 6.0 TRAINING AND EDUCATION

6.1 The Trust Board recognises that training and education is central to the successful implementation of its Governance and Risk Strategy. Investment has been made in running the 3 IOSH accredited Directing, Managing and Working Safely courses which are expected to continue and also the delivery of the Risk Management Awareness module monthly at the All New Staff induction programme.

6.2 The Trust Training Programme outlines the risk management training available and the annual updates. According to the role and responsibilities of staff, (linked to KSF) training will be provided in the following areas:

- Risk awareness
- Risk assessment
- Risk management
- Incident reporting and investigation
- Root cause analysis of incidents
- Health and safety awareness
- Handling patient concerns
- Mandatory training:
  - Hand hygiene
  - Moving and handling
  - Consent
  - Slips trips and falls (staff and patients)
  - Inoculation incident
  - Harassment and bullying
  - Violence and aggression
  - Health record keeping
  - Medicines management
  - Transfusion process
  - Resuscitation
  - Venous thrombo-embolism
  - Investigation of incidents
  - Fire safety
  - Infection Control
  - Patient confidentiality and Data Protection issues
  - Medical Equipment / Devices
  - Safeguarding

### 6.3 **Process for ensuring that Board members and senior managers receive relevant training**

An ongoing training and education programme will be developed and implemented to ensure that all staff, including Non-Executives, receive training appropriate to their role. (See Appendix 7 and 8) This is set out in the Trust's Training Needs Analysis.

6.4 Under the terms of the Trust Induction policy all new staff will receive Risk Awareness Training and an assessment of their level of needs for risk training in relation to their job role. This is identified in the Trust Training Needs Analysis (TNA).

6.5 The Risk Managers will co-ordinate risk awareness training programmes in liaison with the Learning and Education Department, CBU Managers and Risk Leads.

Delivery will be through:

- Monthly induction training
- Locally tailored training sessions
- Clinical yearly updates

- Fire updates
- H&S updates etc (see Monthly training programme)
- Facilitating root cause analysis sessions

6.6 Business unit management need to ensure that:

- Staff training needs are identified
- The risk management needs of business units can be met (i.e. risk assessment and incident reporting and investigation)

#### 6.7 Process for recording attendance

Attendance records are maintained centrally in the Trust HR database. Regular reports on attendance are forwarded from the Education and Training department to the appropriate managers. Training attendance is reported to the staff's management team, CBU risk and governance meetings and exceptions / concerns reported onward to relevant overseeing committee and the EMB by the Training Manager.

#### 6.8 Process for following up non-attendance

Notification of non- attendance is forwarded by the Learning and Education Manager to the relevant line manager requesting a reason for non attendance and re-booking. The summary of reasons for non attendance is included in the summary reports to committees.

6.9 The effectiveness of the training events and programme is evaluated by completion of feedback forms submitted to the training manager. This feedback is reviewed by the risk management team annually with the aim of improving the content or delivery.

#### 6.10 Process for monitoring compliance with Risk Awareness training

<i>Aspect of the Policy</i>	<i>Monitoring method</i>	<i>Responsibility for monitoring</i>	<i>Date</i>	<i>Reported to:</i>	<i>Action to be taken to address shortfalls in performance</i>	<i>Documentation of this process and where located</i>
Board members receive risk management awareness training	Annual review of development and training	CEO and Chairman	Annual	Trust Board	Schedule training	TB minutes
Senior managers receive risk management training	Annual review at PDP appraisal	Line manager	Annual	OD and HR Committee	Schedule training	KSF Appraisal documentation
Training records	Extract of reports	Learning and Education manager	Monthly	Relevant committee and OD&HR Committee	Refresh database records	OD &HR committee minutes
Non attendance	Attendance follow up	Learning and Education manager	Monthly	OD&HR Committee	Managers to ensure staff attendance	Minutes OD &HR Comm

## 7.0 **IMPLEMENTATION PLAN**

The aim of the implementation plan is to ensure that the Governance and Risk Management Strategy is understood, implemented and maintained throughout all levels of the Trust. The Executive Management Board will monitor the delivery of the Implementation Plan and will report progress to the Audit Committee

*See table 7.1 below*

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Table 7.1 . Key Objectives and milestones

Key stage	Responsibility	Date
<b>1. Committee Structure</b>	Trust Board / Executive Management Board	Ongoing
1.1 Establish the New Committee structure: <ul style="list-style-type: none"> <li>Quality Board; Performance Committee; HR and OD Board; IM&amp;T Board; Clinical Safety Committee and Environment Health and Safety Committee</li> <li>Nominated chairpersons and secretariat support</li> </ul>	Executive Directors	October 2011
1.2 Confirm Terms of reference and objectives of board sub committees and place on Trust intranet site	Executive Directors	December 2011
1.3 Committee objectives and work programme set	Chief Executive	October 2011
1.4 Executive committees and sub committees are confident of role and responsibilities	Executive Directors	November 2011
•		
<b>2.0 Board Reporting</b>		
2.1 Continued development of system for reporting upwards from sub groups <ul style="list-style-type: none"> <li>Synopsis of issues not minutes</li> <li>Scorecard style</li> </ul>	Executive Directors	March 2012
2.2 Quality reports include compliance with Essential Standards of the regulations and attainment of outcomes reported to the Quality Board		October 2011
2.3 Confirm nominated responsibility for Business unit's Governance and Risk Lead role and Compliance Lead role.	All Executives and Associate Medical Directors	November 2011
<b>3.0 Development of the Assurance Framework</b>		
3.1 Executives to identify the principal risks against the Trust objectives	Executive Directors and DD of Clinical Governance	Quarterly and year end March 2012
3.2 Effectiveness of Risk Register process: <ul style="list-style-type: none"> <li>CBU's to ensure operational risk identified at top level of their Risk register and complete risk assessment for workplace areas.</li> <li>Timely sign off of risk register every quarter</li> </ul>	EDs and Associate Medical Directors	
3.3 Deliver update training in use of RiskTrack to relevant staff	Dep. Director of Clinical Governance / Risk managers	Ongoing
3.4 Refresher training for Risk Leads	Dep. Director of Clinical Governance / Risk managers	Ongoing
<b>4.0 Development of risk maturity</b>		
<b>4.1 Conduct a Risk maturity assessment</b>	<b>Trust Board Secretary / Internal Audit report</b>	See Internal audit plan
<b>5.0 Dissemination of strategy to all staff</b>	Divisional Management Teams	Ongoing to Sept 2010 (survey)
<b>5.1 Feedback to staff on progress made with risk management</b>	Divisional Management teams	Ongoing to Sept 2010 (survey)
<b>6.0 Training in risk awareness</b> <ul style="list-style-type: none"> <li>Executives</li> <li>Non-Executives</li> </ul>	Chief Executive	Ongoing to April 2013
<b>7.0 Scrutiny of effectiveness of systems</b>	Audit Committee	TBC

## **8.0 PROCESS FOR MONITORING COMPLIANCE WITH STRATEGY AND POLICY**

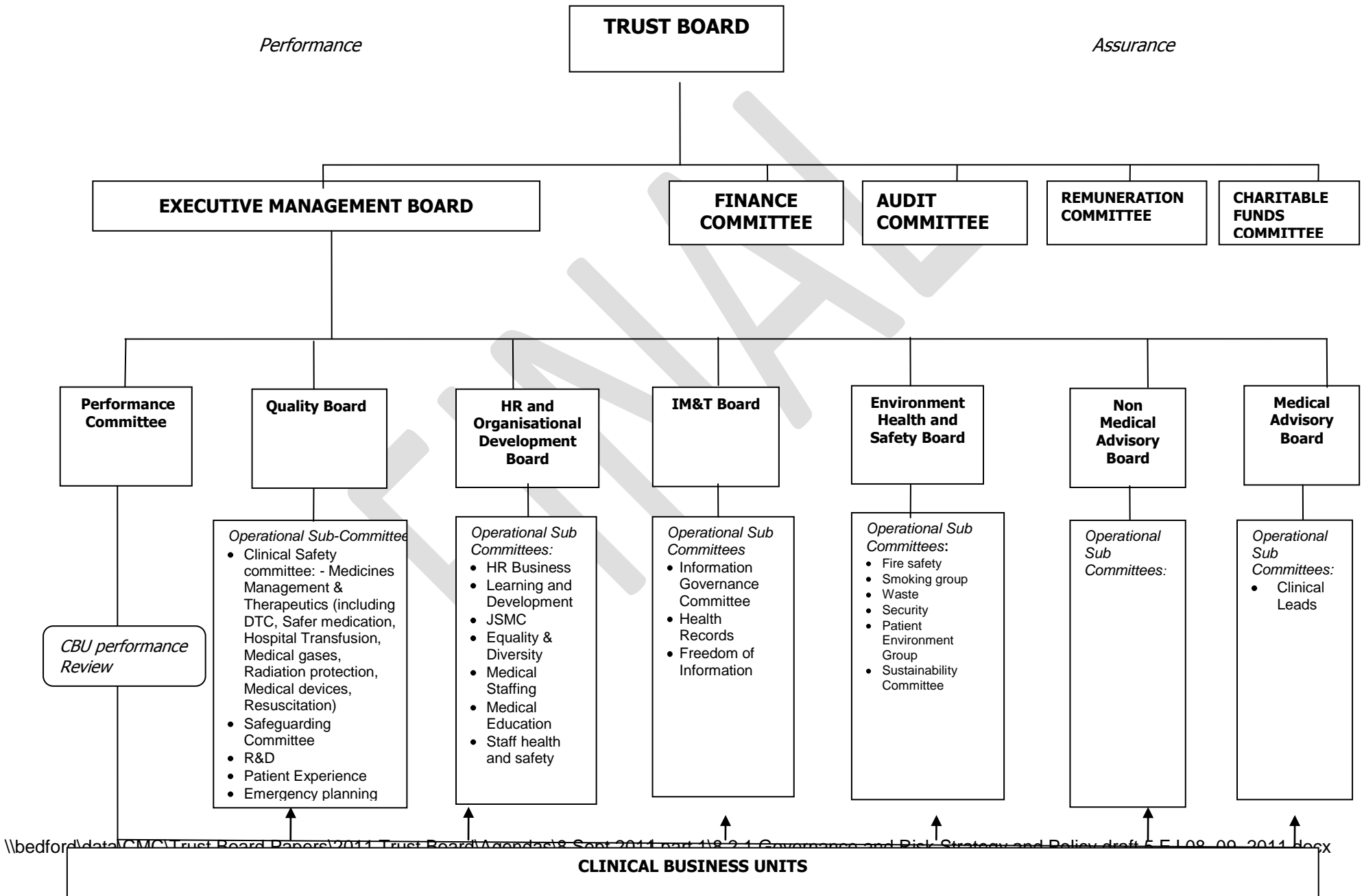
- 8.1** The Implementation Plan set out in Section 7 of this document describes the actions necessary to implement the Governance and Risk Management Strategy within the framework of Integrated Governance. This plan will be implemented by the relevant managers and monitored by the EMB as the overarching committee with responsibility for risk. Updating of this Plan is a critical part of the annual review of the Governance and Risk Management Strategy.
- 8.2** The Trust Board develops a set of key objectives including milestones and performance indicators to enable the Board to highlight key concerns and commission extraordinary reports or remedial activity accordingly.
- 8.3** The review of compliance with the Trust Governance and Risk Management Strategy and Policy and the effectiveness of the risk management processes and implementation of action plans is part of the Trust's performance review system and included in the annual review of effectiveness of sub committees. The Trust Board has assurance via regular reports which can be viewed in the context of the Trust's overall objectives.
- 8.4** Review of the risk management processes described above is a key responsibility of the Executive management Board with support from the organisation as a whole.
- 8.5** **Process for monitoring compliance**  
The processes for monitoring compliance are summarised in the table below

## 8.6 Monitoring compliance

<b>Aspect of the Policy</b>	<b>Monitoring method</b>	<b>Responsibility for monitoring</b>	<b>Date</b>	<b>Reported to:</b>	<b>Action to be taken to address shortfalls in performance</b>	<b>Documentation of this process and where located</b>
Committee Structures	Survey of the nominated chairs of the Executive committees to confirm: <ul style="list-style-type: none"> <li>• Is established</li> <li>• meeting frequency</li> <li>• TOR</li> <li>• formal minutes recorded</li> <li>• formal upward report</li> <li>• annual review of effectiveness</li> </ul>	DD of Clinical Governance	Annually December	Executive Management Board	Gaps identified and specific action to be addressed required by the Chief Executive	<ul style="list-style-type: none"> <li>• Report of the survey findings to the Executive Management Board</li> <li>• Minutes</li> <li>•</li> </ul>
Review of risk register	Review of completeness of risk assessments within RiskTrack  Evidence that report from risk register has been reviewed by management	Executives and Business unit managers  Submission of report to QB	Quarterly	Executive Management Board	Registers not updated to be completed and signed off	<ul style="list-style-type: none"> <li>• Risk Track database</li> <li>• Reports</li> <li>• Minutes</li> </ul>
Process for management of risk locally	% of areas that have completed risk assessments	Managers	Quarterly	H&S committee	Exception report to EMB	<ul style="list-style-type: none"> <li>• Minutes of H&amp;SC</li> </ul>
Accountabilities / Duties	Audit to confirm that the risk management responsibilities included in the named officers' Job Descriptions have been implemented.	Business unit managers	Annually March	EMB	Action Plan agreed to rectify omissions	<ul style="list-style-type: none"> <li>• Report of audit findings reported to EMB Minutes</li> <li>• Standards shared drive</li> </ul>
Authority of managers for managing risk	Review of the Risk Register to ensure all risks have named risk owners	Corporate Risk management team	quarterly	EMB	Managers requested to update Risk Register entries	<ul style="list-style-type: none"> <li>• Minutes of EMB</li> </ul>

FINAL

**APPENDIX ONE: Committee Structure**



## APPENDIX TWO: Executive Management Board: Terms of Reference

### 1. Purpose

The Executive Management Board (EMB) is responsible for trust-wide performance and strategic decision making. The EMB will:

- ensure adequate understanding of all current and expected performance issues
- agree service and capital developments
- receive all strategic plans prior to presentation to Trust Board
- approve Trust Policy development as appropriate

The EMB is responsible for all matters relating to the delivery of the Trust's objectives, managing the Trust's operational performance, including patient safety, quality, human resources and workforce and for controlling the associate risks to the Trust. The EMB is the principal mechanism for executing and communicating the decisions of the Trust Board. The Executive Management Board is chaired by the Chief Executive.

### 2. Membership

Chief Executive (CHAIR)  
Chief Operating Officer (VICE CHAIR)  
Director of Finance and Performance  
Medical Director  
Director of Nursing and Patient Services  
Director of Organisational Development  
Director of Strategy and Service Development  
Trust Board Secretary  
Associate Medical Director, Surgery  
Associate Medical Director, Acute Medicine  
Associate Medical Director, Specialty Medicine  
Associate Medical Director, Women and Children's services  
Associate Medical Director, Clinical Support  
Associate Director of Operations: Elective CBUs  
Associate Director of Operations: Non Elective CBUs  
Deputy Chief Operating Officer  
Head of Communications  
Chief Information Officer  
Head of Estates

#### 2.1 Required frequency of attendance:

Members are required to attend each meeting. A representative (deputy) should attend on behalf of a member of the EMB when they are unavailable to attend.

### 3. Frequency of meetings

The EMB meets as a body monthly on third Monday afternoon each month.

#### 3.2 A quorum is achieved by 3 Executive members and Associate Medical Director.

### 4. Accountability

The Executive Management Board reports via the Chief Executive to the Trust Board.

### 5. Organisational Relationships

#### 5.1 Items for EMB agendas will be generated through Executive Directors, Associate Medical Directors or their Business Unit Managers. Agendas and papers will be circulated by the Chief

Executive's PA, who will also be responsible for recording and communicating decisions agreed at the meeting. All items other than confidential ones will be made available to staff on the Trust Intranet.

- 5.2** The EMB receives reports from the following executive-led committees and meetings:
- Quality Board for assurance on the control of risks to the delivery of the whole Quality agenda: - Patient Safety, Patient Experience and Clinical Effectiveness and to ensure progress against the key Trust objectives associated with patient safety, quality and experience.
  - HR and Organizational Development Board for assurance on risks related to workforce
  - IM&T Board for assurance on the control of risks related to the trust IT strategy and information governance and security
  - Environment Health and Safety Committee for assurance on the control of risks relating the safe systems of work and premises.
  - Medical and Non Medical Advisory Boards for advice and support on the control of risks around compliance with clinical education, supervision and leadership and to ensure there are procedures in place to remedy poor clinical performance.
  - Financial and performance information relating to Trust and Clinical Business Unit (CBU) issues

## **6. Duties / Responsibilities**

- 6.1** Monitors the performance of the hospital through monthly monitoring of Business Unit financial, activity, staffing, quality and risk issues.
- 6.2** Considers and signs off key decision papers and reports for the Board
- 6.3** Debates critical issues, and decides on issues which are Trust wide.
- 6.4** Decides on major projects within the Trust, e.g. proposals for major services or capital development for recommendation to the Board.
- 6.5** Develops position papers, strategy and policy for Board endorsement.
- 6.6** Communicates Board decisions to wider staff groups
- 6.7** Identifies and reviews service changes / plans on an ongoing basis.
- 6.8** Acts as a forum for information exchange, learning and support.
- 6.9** Meets the responsibilities for risk management as outlined in the Trust Risk Strategy and policy including upward reporting to Trust Board of risks rated 15 and above on a quarterly basis.

## **7. Reporting Arrangements:**

- 7.1** The minutes of the Executive Management Board will be formally recorded.
- 7.2** The following reports are reported to the Trust Board:
- An Executive Management Board Report incorporating all key performance indicators and variances across main areas of the Trust.
  - Chief Executive's report incorporating key strategic highlights in the month, updates on national and local policy developments.
  - The Board Assurance Framework identifying the risks to the trust objectives and the key current risks.
  - The Annual Quality Account summarising progress with quality improvement and priorities.

## **8.0 Process for monitoring the effectiveness of the above arrangements:**

The process for monitoring the effectiveness of the committee is via an annual self analysis that includes evaluation of: Terms of Reference; the purpose of the committee; delivery of objectives; committee inputs and outputs; meeting stakeholders' needs and action for delivery of improved performance.

**Prepared by: Chief Executive**

**Date: August 2011**

**Version1: 2011**

**Review date: February 2012**

**FINAL**

## APPENDIX THREE : Upward Reporting Template

Upward reporting from the .....Committee to the Executive Management Board

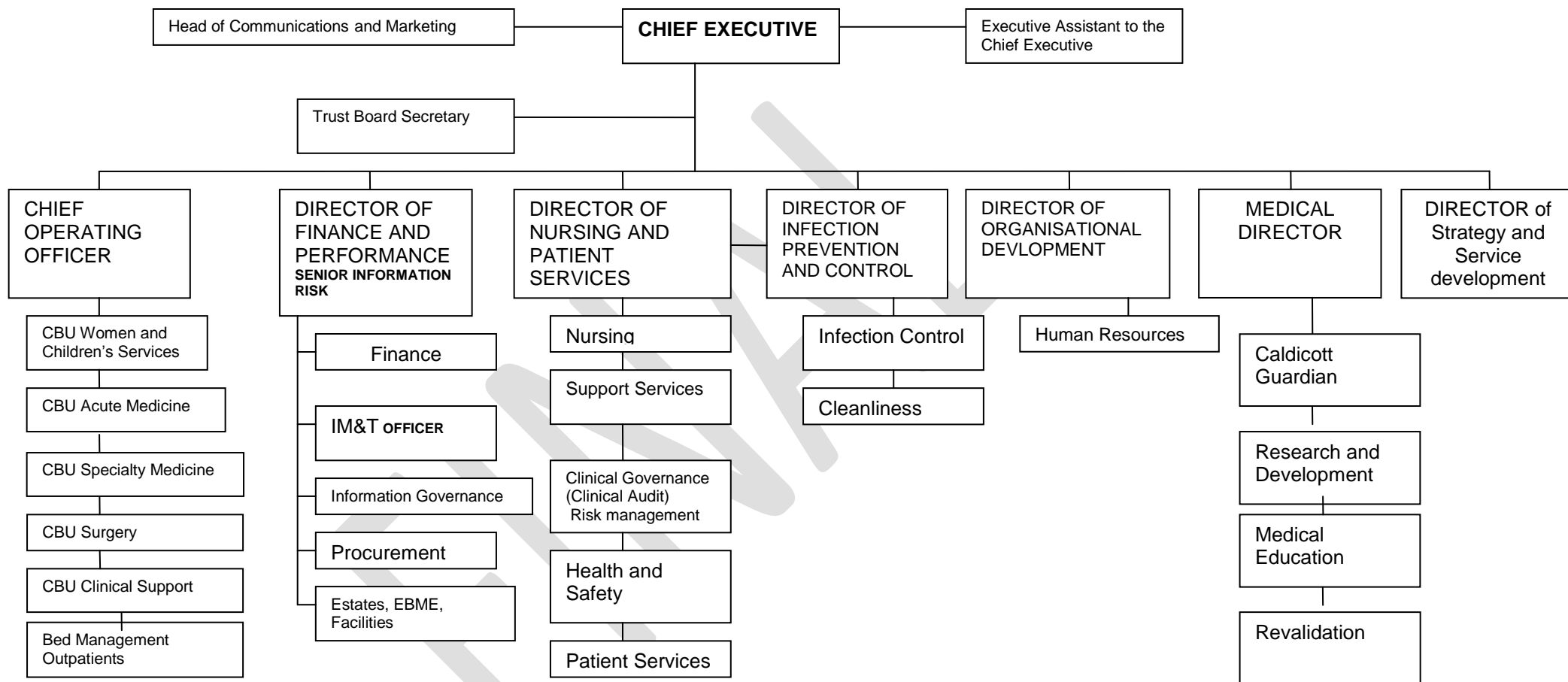
*This report should include the following sections:*

- *Items for the awareness and assurance to the EMB and Board with reference to the relevant Essential Standard*
- *Description of areas that the Trust is not achieving/ complying with, barriers to implementation and action to address the issues.*
- *Areas of concern*

Issues identified by the .....held on .....			
	Topic	Issue	Action Taken
<b><i>Items with issues not achieved/ compliant</i></b>			
<b><i>Areas of Concern/ Risk</i></b>			
<b><i>Items for awareness / assurance</i></b>			

**APPENDIX FOUR:**

**Trust Management Structure**



**Designated Roles:**

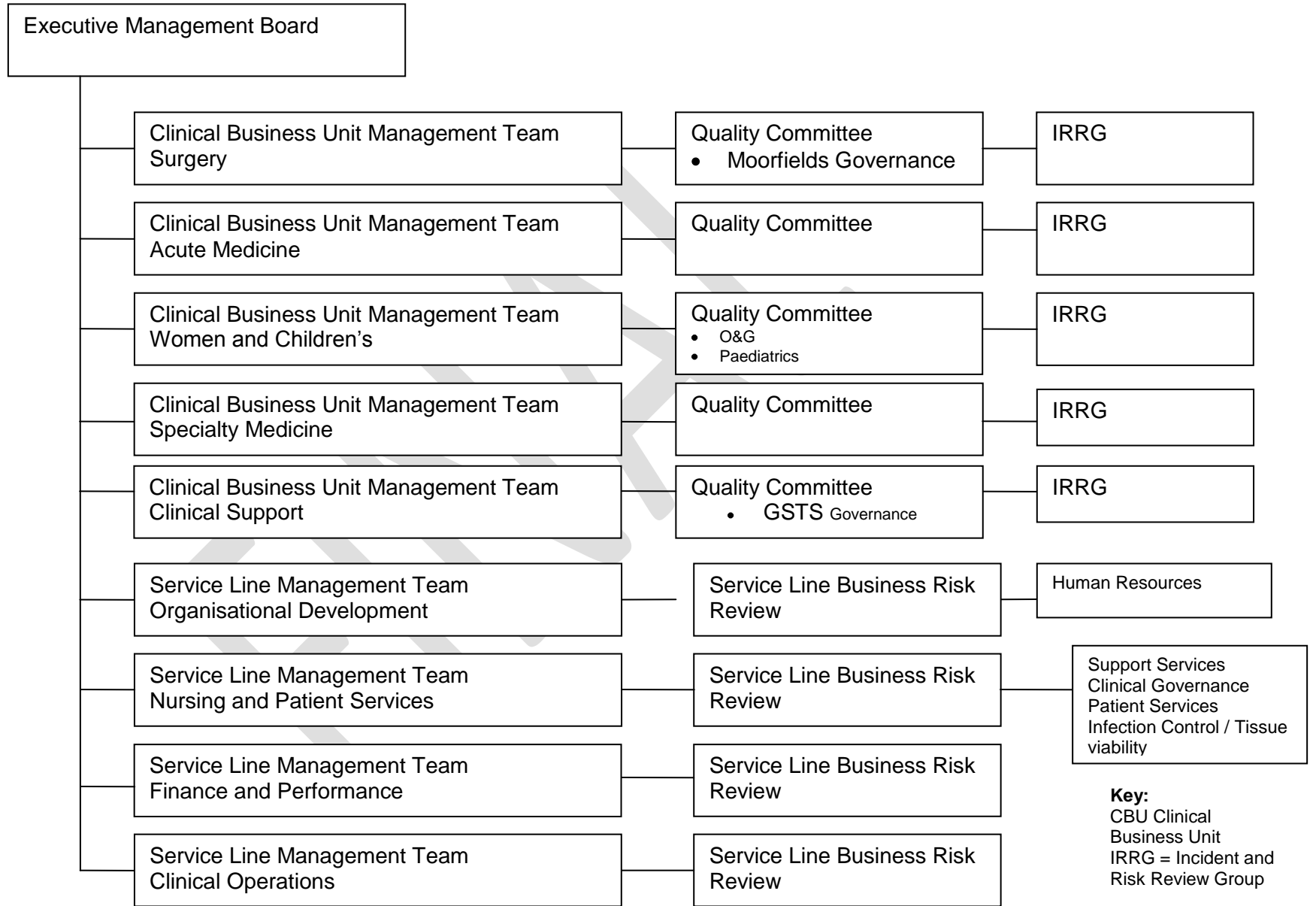
- **Designated individual under the Human Tissue Act:** The Trust has identified and trained a designated individual responsible for the application of the terms of the Human Tissue Act licences throughout the Trust.
- **Safeguarding Children and Adults:** The Board Executive with responsibility for Safeguarding (Children and Adults) is the Director of Nursing and Patient Services
- **Clinical Governance:** the Director of Nursing and Patient Services manages the clinical governance team and is jointly accountable with the Medical Director for clinical governance across the Trust .

- **Revalidation for Doctors:** The Medical Director is the Responsible officer for the Revalidation / GMC.

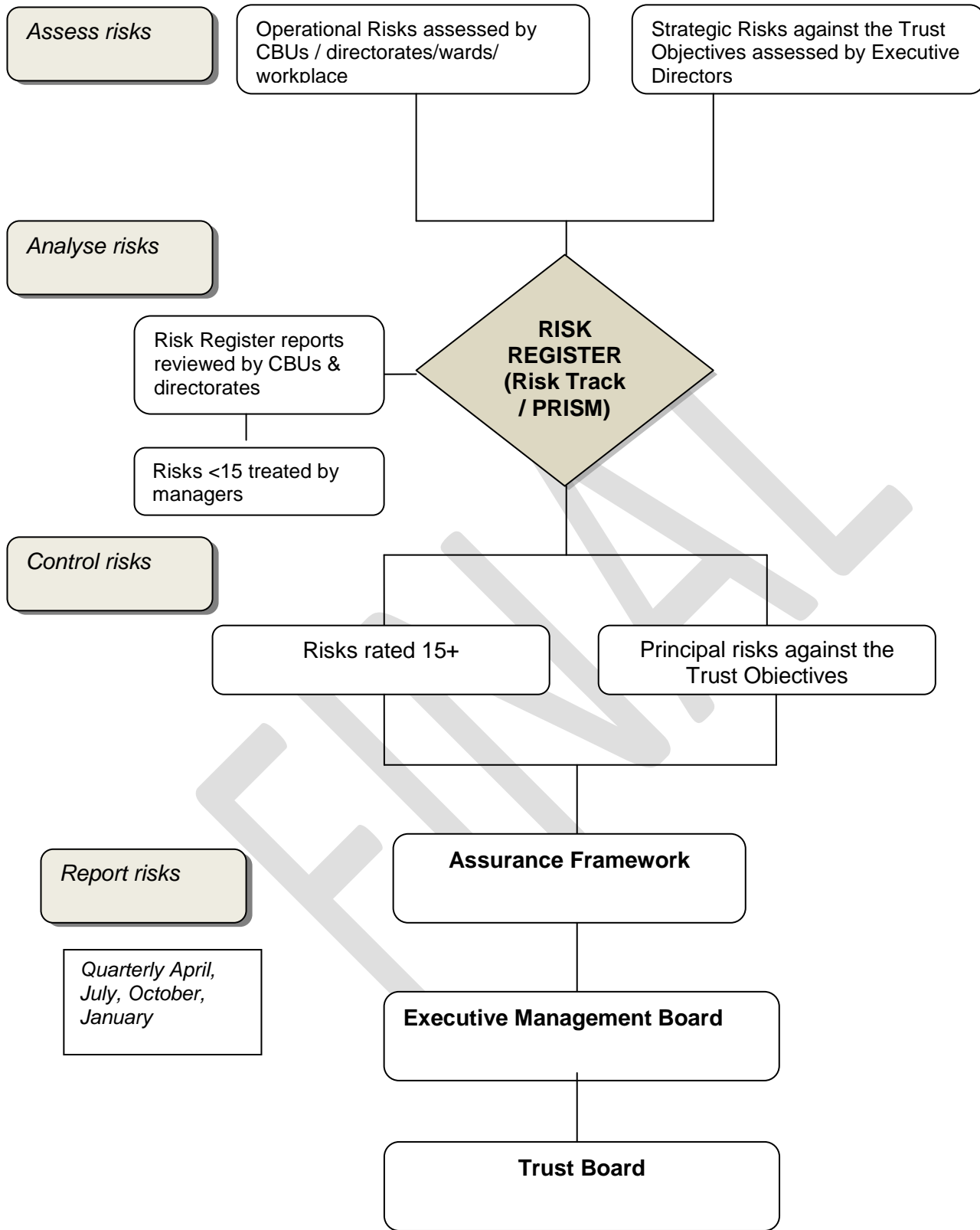
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**APPENDIX FIVE: CLINICAL and CORPORATE BUSINESS UNITS Risk and Governance Structure**

**DRAFT**



**APPENDIX SIX; Risk Register Process Flow chart**



## APPENDIX SEVEN

### a.) Extract from Trust Training programme – Risk Management Awareness Training programme



#### TRAINING PROGRAMME

#### RISK MANAGEMENT AWARENESS

<b>For:</b>	All Staff including: <ul style="list-style-type: none"> <li>• All New starters at Induction</li> <li>• New consultants</li> <li>• Trust Board members, Executives and Non- executives</li> <li>• Senior managers</li> <li>• Matrons and Ward managers / sisters</li> </ul>
<b>Objectives:</b>	To introduce staff to the concepts of risk management.
	To be introduced to risk management methodology
	To be aware of the Trust Risk Strategy and understand how risk is managed within the Trust
	To understand own accountability for risk – to know what the individual's job role is responsible for
<b>Learning outcomes:</b>	By the end of the session the participant will know: <ul style="list-style-type: none"> <li>• Where to find the Trust Risk Strategy and the key items of content</li> <li>• The levels of responsibility for risk within the organisation</li> <li>• The basics of risk identification</li> <li>• Risk assessment</li> <li>• What we mean by a hazard</li> <li>• How to describe a risk</li> <li>• Risk Analysis – how to use the Trust Risk matrix</li> <li>• Incident and accident reporting</li> <li>• An introduction to the risk reporting process to the Board</li> <li>• The Trust's Risk Register – RiskTrack</li> <li>• Risk control</li> <li>• Responsibilities under Health and Safety Act</li> <li>• Introduction to Incident Reporting: NPSA</li> <li>• Awareness of the NHS Litigation Authority standards</li> </ul>
<b>Duration:</b>	75 minutes
<b>Tutor:</b>	A member of the Risk Management team: <ul style="list-style-type: none"> <li>• Deputy Director of Clinical Governance</li> <li>• Risk Manager – Clinical</li> <li>• Risk Manager – Health and Safety</li> </ul>

**APPENDIX EIGHT; Bedford Hospital NHS Trust : Risk Management / Awareness Training by Staff Groups**

	<b>Executives and NEDs</b>	<b>Senior Managers (Bands 7/8)</b>	<b>Div/ Dept Risk leads and Matrons</b>	<b>Ward / dept managers (Bands 5/6)</b>	<b>Consultant Medical staff</b>	<b>Junior medical staff</b>	<b>H&amp;S dept reps</b>	<b>All staff Clinical</b>	<b>All staff Non-clinical</b>	<b>All new staff –</b>	<b>Volunteers</b>
<b>Level1 Risk Awareness</b>	✓ (on induction)	✓ (on induction)	✓ (on induction)	✓ (on induction)	✓ (on induction)	✓		✓	✓	✓	✓
<b>Risk Update (annually)</b>	✓ Review of strategy		✓	✓	✓		✓	✓			
<b>Working Safely</b>							✓				
<b>Level 2 Risk Management:</b> • Incident Investigation • Root cause analysis • Risk Register • Risk management processes (part of Bedford Manager module)		✓	✓	✓							
<b>Level 3 Managing Safely</b>		✓	✓	✓							
<b>Directing Safely</b>	✓										

## APPENDIX NINE : Acronyms

CMO	Chief Medical Officer
<b>CBU:</b>	<b>Clinical / Corporate Business Unit</b>
CRAG	Clinical Risk and Governance
EMB	Executive Management Board
H&S	Health and Safety
HR	Human Resources
HSC	Health Service Circular
HSE	Health and Safety Executive
IC	Infection Control
IRRG	Incident and Risk Review Group
MRHA	Medicines and Healthcare products Regulatory Agency
NHS LA	NHS Litigation Authority
NPSA	National Patient Safety Agency
PCT	Primary Care Trust
PPI	Public and Patient Involvement
PSC	Patient Safety Committee
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SPC	Summary of Product Characteristics
TNA	Training Needs Analysis

**Consultation and Circulation List**  
(A completed list should accompany **every** guideline/policy)



Name	Department	Comments
<b>Executive Directors</b>		
Joe Harrison		✓
Eiri Jones		✓ comments included
Ed Neale		✓ I am jointly accountable for Clinical Governance and risk, solely responsible for research and medical education I am the Responsible Officer for medical revalidation
Don Richards		
Nigel Benjamin		
Steve Collins	Acting Chief Operating Officer	
Stephen Conroy		
Alan Dickinson		Comments included re roles and responsibilities
Hilary Jones		✓ no additional comments
Ranjini Beverage		No comments
Paul Tisi		Comments on MAB , 4.6.1 and responsibilities of the AMDs and ADOs included
Nick Morrish		
Stuart Lloyd		
Rosemary Wallace		
Jonathan Wilson		
Ian Pridding		
Viv Kilgour		
Caroline Roberts		
Lynda Fitzgerald	CNST maternity lead	
Karen Radley		
Cheryll Bethell		
Sue Blackley		Comments included
Nina Richardson		
Caroline Kinglake		Comments included
Ann Buck		
Sally Quinn		

Rosa Lombardi			
Steve Morgan			
Phil Eagles			✓
Mark Austin			✓ comments included

**Approved by the Executive Management Board**

**Date:**

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**Signature:**

---

**Name:**

---

**(Chairperson for the Executive Management Board)**

**Approved by the Trust Board**

**Date:**

---

**Signature:**

---

**Name:**

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**(Chairperson for the Trust Board)**

<b>References</b>	NHS LA risk management standard 1
<b>Staff Involved In Development</b>	Deputy Director of Clinical Governance Trust Board Secretary Director of Nursing and Patient Services Medical Director
<b>Monitoring /Audit Criteria</b>	See section 8



Name of Sub-Committee / Business Unit: \_\_\_\_\_

Date:	Date:
Signature:	Signature:
(Chairperson of Board or Committee indicated above)	(Chairperson of Board or Committee indicated above)

- (✓)
- Approved by**
- Trust Board
  - IM&T Strategy Group
  - Information Governance Committee
  - Audit Committee
  - Human Resources and Organisational Development Committee
  - Quality Board
  - Executive Management Board
  - Health and Safety Committee
  - Safeguarding Committee
  - Other – Please Specify [ ]**

Date:	Date:
Signature:	Signature:
(Chairperson of Board or Committee indicated above)	(Chairperson of Board or Committee indicated above)

**Responsible Executive Director Signature**

Signature:	Date:
Print Name	Job Title

## Consultation List

A completed list should accompany **every** guideline/policy  
(This gives evidence on who has seen this policy and any comments made)

Name of Person	Department or Committee	Comments
Joe Harrison;		
Eiri Jones		
Ed Neale		
Don Richards;		
Nigel Benjamin;		
Steve Collins;		
Stephen Conroy		
Alan Dickinson;		Comments included
Hilary Jones;		
Ranjini Beveridge		
Paul Tisi;		Comments re role of MAB included
Nick Morrish;		
Stuart Lloyd;		
Rosemary Wallace;		
Jonathan Wilson;		
Ian Pridding		
Vivien Kilgour		
Caroline Roberts;		
Lynda Fitzgerald		
Karen Radley		
Cheryll Bethell;		
Terry Edwards		
Steve Morgan		
Phil Eagles		Comments on 4.4 2 included

<b>Mark Austin</b>		
<b>Anne Buck (HR)</b>		
<b>Caroline Kinglake;</b>		
<b>Rosa Lombardi;</b>		
<b>Sally Quinn</b>		