The Shrewsbury and Telford Hospital NHS Trust
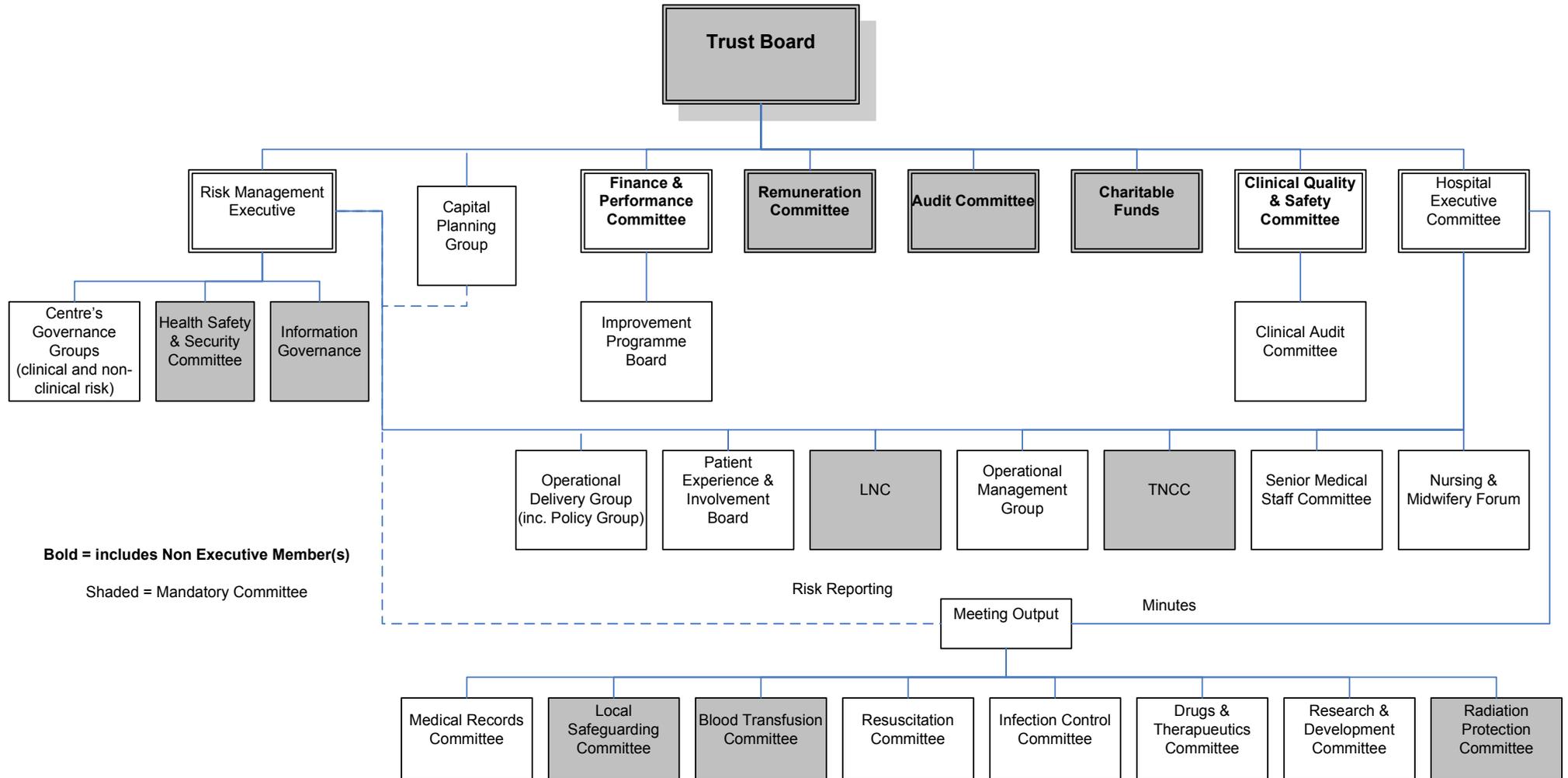
NHS

NHS Trust

RISK MANAGEMENT STRATEGY
Appendices

RM01

Version:	V10.1
Ratified by:	Trust Board
Date ratified:	
Approved by:	Risk Management Executive
Approval date:	
Name of originator/author:	Chief Compliance Officer
Lead Director	Director of Compliance and Risk Management
Date issued:	
Review date:	March 2013
Target:	Overarching Strategy for specific Trust Risk Management Policies

Contents

Appendix A   Trust Governance Structure

GOVERNANCE STRUCTURE

Bold = includes Non Executive Member(s)

Shaded = Mandatory Committee

Appendix B   Risk Management Executive Terms of Reference

Constitution
The Board hereby resolves to establish a Committee of the Board to be known as the Risk Management Executive (The Committee). The Committee is an Executive Committee of the Board and has delegated powers to review the most significant risks to the achievement of the Trust's objectives and ensure there are robust controls and mitigation actions in place. The Committee will be required to adhere to the Standing Orders of the Trust.

Membership
The Chief Executive will be the Chair of the Committee
Membership shall comprise:
Chief Executive (Chair)
Director of Compliance & Risk Management (Deputy Chair)
Director of Safety & Quality or nominated Deputy
Medical Director or nominated Deputy
Chief Operating Officer or nominated Deputy
Finance Director or nominated Deputy
Director of Strategy or nominated Deputy
Chief Compliance Officer or nominated Deputy
Centre Chief or nominated Deputy (eg governance Lead, senior manager)

To attend as required
Value Stream Leads
Workforce Director
Director of Communications
Head of Estates or nominated Deputy
Head of Patient Safety
Health and Safety Team Manager
Associate Medical Directors
Deputy Medical Director

Quorum
For the Committee to be quorate, it requires the presence of at least a third of members with at least 3 Centre Chiefs or their nominated deputy
Attendance
Members may appoint suitable deputies to represent them. Deputies must attend when members are not able to so that there is Centre representation at each meeting. It is expected that a member or their nominated deputy will attend for a minimum of 75% of meetings in a year. Attendance will be monitored by an attendance matrix
Frequency
The Committee shall meet monthly. Additional meetings may be held at the discretion of the Chair
Authority
Authority for all decisions relating to risk management lies with the Trust Board of the Shrewsbury and Telford Hospital NHS Trust. The Committee has delegated powers from the Trust Board to oversee and assess the effectiveness of risk management arrangements within the Trust. The Committee is authorised by the Board to investigate any activity within its terms of reference

Duties
The Committee will:
- Oversee the implementation and further development of the Trust's Risk Management Strategy ensuring it supports the achievement of the Trust's objectives and business plan
- Develop and manage the risk management system (including clinical risk) in line with the Trust's strategy, prevailing policies, standards, and guidance, and the changing environment in which the Trust operates
- Approve risk management policies and strategies and ratify relevant policies approved by sub-committees and groups which report to the Risk Management Executive.
- Assess and review the composition and ongoing development of the Board Assurance Framework ensuring it provides a robust tool through which the Board can monitor management of the organisation's key strategic risks, ensuring effective control and assurance mechanisms in place and that effective actions are being taken to address gaps in controls and assurance.
- Provide the Trust Board with assurance that a comprehensive Corporate Risk Register is maintained which will enable the Board to have a shared and clear understanding of the key risks in the Trust; what mitigations are in place to manage risks and which risks are being tolerated

- Identify and validate new risks and consider whether they pose a principle risk to the Trust's strategic objectives and should be included on the Board Assurance Framework
- Oversee the maintenance and further development of the Centre's Risk Registers as key tools to support achievement of high levels of internal control, patient safety, and clinical quality to inform risk based decision making and specifically promote local level responsibilities and accountability for identifying and monitoring the organisations risks
- Assess all risks with a risk score of 15 and above and bring to the attention of the Board all serious risks (risk score to be decided) to consider whether to be added to the Board Assurance Framework.
- The Risk Management Executive will consider all risks with an consequence of 5.
- Ensuring Director risk owners and risk action owners have plans in place to control identified risks and to take necessary action to ensure remedial plans are put into place should mitigation fall behind plan
- Coordinate all risk management activities of the Trust using reports from Centres, specialist risk teams and operational groups with risk management responsibilities (eg Health & Safety, Information Governance) and agree actions to be taken to mitigate risk across the Trust, and where relevant monitor action/treatment plans.
- Ensure that standards for risk management and control are related legislation and regulations are brought to the attention of the responsible clinician/ manager and through the specialist risk teams and audit compliance with the standards
- Review and monitor compliance with the CQC standards using the trust's performance assurance framework
- Review progress against CQC Quality Risk Profile
- Review findings and ensure implementation of recommendations arising from internal audits of Trust risk and compliance processes

Reporting into the Committee
The Committee will receive minutes from the quarterly Health, Safety and Security Committee), Capital Planning Group, Information Governance, and Centre Governance reports. In addition, any risk (clinical and non clinical) issues from any of the current Trust subgroups will be submitted to the Committee. The Care Quality Commission Quality and Risk Profile will be reported to the Committee quarterly. Centres will report new risks to the Committee and provide updates on existing risks as required

Reporting from the Committee
The Committee will be directly accountable to the Board. The Chairman of the Committee will report on the proceedings of each meeting to the next meeting of the Trust Board and will draw to the attention of the Trust Board any matters of concern in relation to the effective management of the organisation's risks

The Chairman of the Committee will ensure that the Trust Board receives the Trust's Board Assurance framework and high level risk summary. The Committee will produce an annual risk management report for the Trust Board which will include monitoring compliance with these terms of reference.

Monitoring compliance with the Terms of Reference

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of action plan
Duties of the key individual(s) for risk management activities	*To be addressed through the monitoring below*			
Reporting arrangements from RME to the Board	Review of Board Agenda	Chief Compliance Officer	Annual	Risk Management Annual Report to RME, & Trust Board
Membership of RME	Review of Terms of Reference	Director of Compliance and Risk Management	Annual	
Attendance at RME	Attendance matrix	Chief Compliance Officer	Annual	
Reporting into RME	Review of agenda	Chief Compliance Officer	Annual	
Quoracy	Review of minutes	Chief Compliance Officer	Annual	
Frequency of meetings	Review of minutes	Chief Compliance Officer	Annual	

Review
The Terms of Reference will be reviewed by the Board of Directors annually.
October 2011

Appendix C   Hospital Executive Committee Terms of Reference

Constitution
The Board hereby resolves to establish a Committee of the Board to be known as the Hospital Executive Committee (The Committee). The Committee is an Executive Committee of the Board and has delegated powers to inform and implement the Trust's strategic decisions, policy and to reach decisions on, and monitor progress of, the Trust's business and organisational objectives on matters delegated to it by the Trust Board. The Committee will be required to adhere to the Standing Orders of the Trust.

Membership
The Chief Executive will be the Chair of the Committee, with the Chief Operating Officer acting as chair in their absence
Membership shall comprise:

Chief Executive (Chair)
Chief Operating Officer (Deputy Chair)
Medical Director
Quality and Safety Director
Finance Director
Director of Compliance and Risk Management
Director of Strategy
Director of Communications
Director of Human Resources
Centre Chiefs
Value Stream Leads
Head of Estates and Facilities
Associate Medical Director
Deputy Medical Director

Quorum
For the Committee to be quorate, it requires the presence of a minimum of three Directors together with two other members.

Attendance
Members may appoint suitable deputies to represent them. Deputies must attend when required. It is expected that a member of their nominated deputy will attend for a minimum of 75% of meetings in a year. Attendance will be monitored by an attendance matrix

Frequency
The Committee shall meet monthly.
Additional meetings may be held at the discretion of the Chair

Authority
Authority for all decisions relating to risk management lies with the Trust Board of the Shrewsbury and Telford Hospital NHS Trust. The Committee has delegated powers from the Trust Board to provide leadership, monitor performance and ensure necessary actions are taken to correct any deviations from plans

Duties
To interpret and apply local and national imperatives on health care and reflect such imperatives into the strategic and operational plans of the organisation.
To implement the strategic aims and objectives agreed by the Trust Board by establishing context and setting direction for the organisation,
To coordinate and monitor the significant programmes of work prioritised by the Trust Board and to provide progress reports to the Board on the status of the agreed programmes

- To consider and approve to the Board all business cases for capital investment, service development and new consultant appointments
- To receive risk management reports and high risk updates
- To be responsible for planning, organising, directing and controlling the organisation's systems and resources to achieve service objectives and quality development through implementation of the Trust's Business Plan.
- To approve significant operational decisions and monitor implementation
- To monitor the Trust financial position and all performance targets and monitor actions plans put in place to address any areas of failing performance
- To develop and manage the workforce requirements to ensure the Trust provides a quality service whilst achieving statutory and regulatory targets and requirements.
- To ensure that the organisation's objectives and standards for service, high level performance and quality set by the Trust Board, are managed and cascaded throughout the entire organisation.
- To ensure that the Trust responds to the requirements to provide independent verification of the Trust internal control mechanisms.
- To provide a forum for multi-disciplinary debate and the involvement of clinical staff with the management of the Trust.
- To approve and recommend to the Board, and monitor the implementation of relevant Trust Policies, guidelines and protocols.

Reporting from the Committee
- The Committee will be directly accountable to the Board.
- The Chairman of the Committee will report on the proceedings of each meeting to the next meeting of the Trust Board and will draw to the attention of the Trust Board any matters of concern
- The Committee is the key management meeting of the Trust which oversees the governance and operational framework of the Trust, ensuring that appropriate assurance is being provided against all key deliverables

Reporting arrangements to the Committee
- The Committee will be minuted and co-ordinated by the Trust's Committee Secretary. The Agenda will be approved by the Meeting's Chair.
- The Board will receive the outcome summary of each Hospital Executive Committee meeting.

Review
The Terms of Reference will be reviewed by the Board of Directors at least annually.

Appendix D   Audit Committee Terms of Reference

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

Membership
2. The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. A quorum shall be two members.
3. One of the members will be appointed Chair of the Committee by the Board. The Chairman of the Trust shall not be a member of the Committee.

Attendance
4. The Finance Director, Medical Director, Director of Compliance & Risk Management and appropriate Internal and External Audit representatives shall normally attend meetings. At least once a year the Committee should meet privately with the External and Internal Auditors.
5. The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal control.
6. The Trust Secretary (Director of Compliance and Risk Management) shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

Frequency
7. Each Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting and audit cycle is proposed. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

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

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

9. a.   Governance, Risk Management
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Statement on Internal Control), together with any accompanying Head of Internal Audit statements, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

Review Schedules of losses and compensation (and the circumstances behind them), proposed changes to Standing Orders or Standing Financial Instructions, advising the Board of any significant issues arising.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from

directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

9. b.   Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal with ultimate recommendations to be made by the Committee to the Board.
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources. The Committee shall monitor the effective implementation of agreed actions arising from audit recommendations.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

9.c.   External Audit
The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

9.d.   Other Assurance Functions
The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

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

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the Quality and Safety Committee (with the remit for clinical governance) and the Risk Management Executive.

In reviewing the control processes underpinning the work of, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the nature of the assurance that can be gained from the clinical audit function.

9.e. Counter Fraud
The committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

9. f.   Management
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to enable the Committee to fulfil its duties or in response to any issues of concern that the Committee or Board may hold.

9. g. Financial Reporting

The Audit Committee shall monitor and review the integrity of the Financial Statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:
- The wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of representation
- Qualitative aspects of financial reporting.

Other Matters

10. The minutes of Audit Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Board. The Chair of the Committee shall, in summarising the recent work of the Committee, draw to the attention of the Board any material issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board annually on its work in support of the Statement of Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts.

11. The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:
- Agreement of agenda with Chairman and attendees and collation of papers.
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues / areas.

As well as an annual report, a self assessment of the Committee's effectiveness will take place annually.

Review: Annually

Appendix E   Health, Safety & Security Committee Terms of Reference

Membership [including nominated deputy]
The Committee is chaired by the Nominated Director for Health & Safety (or in exceptional circumstances by Nominated Deputy)

The general make up of the Committee is to reflect the following -
- A senior manager (or their nominated deputy) from each Centre
- Health and Safety Representatives from Trade Unions / Professional Organisations (or their nominated Deputy)
- Representatives for safety of non union employees (or their nominated deputies)
- Specialist Advisors
- Health and Safety Team Manager
- Security Manager

Responsibility
The health and safety aspects of the Committee is established under the Trust's Health & Safety Policy and in compliance with statutory requirements under Section 2, sub paragraph (7) of the Health and Safety at Work etc. Act 1974, and Safety Representations and Safety Committee [SRSC] Regulations 1977. The Committee shall undertake other such functions as may be prescribed by the Secretary of State, under and in accordance with the Act and appropriate Regulation. With agreement of the staff side aspects of security management are to be included within the meetings and the committee to be known as –

Trust – Health And Safety Committee, And Trust Security Committee

The purpose of the Trust Health and Safety Committee, and Trust Security Committee ["the Committee"] is to consult staff on all matters related to health, safety and security issues and to consider matters that have not been resolved by departments, Service Delivery Units and/or Divisional Health and Safety Committees. The Committee has the function of keeping under review the measures taken by the Trust to ensure, as far as is reasonably practicable, the health, safety and security at work of all staff, patients, contractors and visitors.

Remit
1. To receive reports and minutes of Health & Safety meetings from Centres, Service Lines and Departments.
2. To consider and action exception reports from meetings in 1 above where non-compliance with statutory duties is reported and to authorise or as appropriate refer items to the Trust's Risk Management Executive for consideration and appropriate action.
3. To be advised on reports from the Health and Safety Executive and confirm/advise on action to ensure compliance.
4. To review new legislation and guidance on health, safety and security issues, and advise the Trust Board, the Risk Management Executive, Centre and corporate services management and staff on action required to ensure compliance.
5. To review health, safety and security accidents and incident reports and trends in order that any adverse situations are investigated and that action is/has been taken in order to try and prevent repartition.
6. To review and update Trust Policies on health, safety and security before passing on to the Hospital Executive Committee for adoption.
7. To provide advice on matters associated with health, safety and security.
8. To help resolve cross Centre issues

Accountability
The Committee links with the Trust's Risk Management Executive to ensure health, safety and security risks are evaluated and managed in accordance with Trust Risk Management Strategy. It reports to the Trust's Risk Management and H&S assessments provide assurance to the Trust

Assurance Framework. Copies of the Committee's minutes shall also go to the TNCC and the Trust Executive Meetings.

Quorum

A **quorum** for The Committee will be –

- The Chair Person or nominated deputy from the management representatives; and
- 2 members of the management representatives; and
- 2 members from the staff representatives.

Reporting arrangements

Copies of the minutes of the Committee's meetings will be distributed to all members of the Committee. The outcome summary will be presented to the Risk Management Executive.

Copies of these minutes will also be posted on Trust's Intranet and retained on the Intranet for a period of three years.

Frequency of meetings

At least once every three months.

Date Terms of Reference Approved

June 2011

Date of Next Review

December 2011 (Unless any circumstance requires a review for the Trust to comply with its Statutory Duties and Obligations.)

Appendix F Clinical Quality & Safety Committee Terms of Reference

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

2. Membership
The membership of the Committee shall consist of three Non Executive Directors, Medical Director, Director of Quality and Safety, Chief Executive, Director of Compliance & Risk Management, Chief Operating Officer and others as appropriate. A quorum will be two Non Executive members and one Executive member.

3. Attendance
The Chief Executive, Medical Director and Director of Quality and Safety would be expected to attend each meeting. The Director of Quality & safety and Medical Director will also normally meet one hour before each meeting to conduct ad hoc patient safety walkabouts with the Chair of the Committee and other NED members of the committee.

Trust Board members who are not members of the committee attend at invitation and to support discussion and actions required on agenda items.

4. Frequency of meetings
Not less than six times a year and at alternate hospital sites

5. Authority
The Committee is authorised by the Board to investigate any activity within its terms of reference and is expected to make recommendations to the full board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Board is required.

6. Reporting
The Chairman of the Committee will report to the next meeting of the Board following the Committee, summarising the main issues of the discussion and drawing the Board's attention to any issues that require disclosure to the full Board or require Executive action. The approved or draft minutes will also be submitted to that meeting. The draft minutes will be issued to the Chairman within three working days of the meeting

7. Overriding Key responsibilities

o To provide assurance to the Board on Clinical Quality & Safety, (including Clinical Effectiveness, Patient Safety and Patient Experience) utilising best practice metrics that provide robust clinical governance processes to deliver safe, high quality and patient centred care.

o The Committee will drive an improvement culture to promote excellence in patient care across the domains of quality, safety and experience through the introduction, approval and implementation of a Clinical Quality & Safety Improvement Strategy

7.1 Key responsibilities for Patient Safety-
- Ensure the Trust is meeting all regulatory and mandated care standards, with robust response and tracking processes in place to meet national alert requirements, national guidelines and relevant external quality and safety standards with a focus on agreed patient sensitive indicators.
- To receive an agreed level of patient safety and outcomes data which provides trends and themes from care delivery, utilising clinical metrics to uniform and analyse the range of clinical services across the Trust.
- To ensure that the Committee has adequate information on which to advise the Board about the level of assurance or risks on the standards of care provided across the range of services, including actions in place to drive improvements and mitigate risks.
- To ensure that the Committee has adequate information on which to advise/assure the Board on the Care Quality Commission's essential standards of Quality and Safety and to develop a Quality Assurance Framework to support the governance arrangements required for FT.

Incident reporting and investigation
- To monitor the effectiveness of the Trust's systems for reporting and investigating Serious Untoward Incidents (SUIs), near misses and other incidents;
- To review the outcomes of investigations and external inspections, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified;
- To receive and comment on action plans and progress reports proposed by management in response to SUIs, near misses and other incidents.

7.2 Key responsibilities for Patient Experience
The Committee will ensure that the patient experience is a core focus of its remit and agenda and will seek a patient representative as a formal Committee Member to provide challenge and assurances that the Committee is addressing the required improvement areas.

- To receive the assurances in that all Cauldicott principles are being met in relation to patient confidentiality and data.
- Be able to provide assurances to the Board on the tracking and completion of all agreed actions/improvements required to improve the patient experience.
- To monitor the effectiveness of the Trust's systems for complaints handling, and reviewing complaints for trends and themes monitoring the effectiveness of the Trusts system for advocacy and the encouragement of feedback from patients and relatives;
- To monitor patient complaints.
- To oversee and monitor action plans resulting from patient surveys
- To receive the Complaints Annual report
- Ensure that the Committee receives triangulation on the patient experience data using patient stories/diaries and includes the experience of both the patient and their relative/carer
- Patient survey and action plan to come to the Committee. A patient experience report to be presented quarterly.
- To receive the Complaints Policy once a year
- At least 6 times a year a verbal patient story or diary to be presented at the beginning of the meeting.

7.3 Key responsibilities for Clinical Effectiveness
- To receive assurances regarding the workforce including education and learning plans, appraisal and overall staff performance.
- To review assurances received on clinical practice e.g. national audits and other external clinical reviews.
- To be updated on outcomes being improved at the Trust including the productive ward and Leading Improvements in Patient Safety (LIPS) programme
- To review the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes;
- To receive and comment on action plans and progress reports proposed by clinical leads in response to monitoring data on patient outcomes.
- To review clinical audit findings and the action plans proposed by management in response to these;
- To receive the Research and Development Annual Report

8 Committee Governance Arrangements
- Terms of Reference to be reviewed once a year.
- The Committee will review its effectiveness against these terms of reference on at least an annual basis.
- Provide the Audit Committee with an overview of the scope and effectiveness of the Trusts Quality Improvement and risk management systems.
- Provide assurances to the Board (within the scope of the TOR) on a monthly basis.
- The Committee will agree an annual workplan which will be reviewed quarterly.

Peter Vernon
Chairman
January 2011

RISK CONSEQUENCE SCORE

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Severe	5 Catastrophic
Safety	None or minimal harm – no intervention required H&S – Little chance of injury or illness due to lack of maintenance or process.	Minor avoidable injury or illness, requiring minor intervention H&S – small chance of injury or illness	Moderate avoidable injury requiring professional intervention (RIDDOR reportable) H&S – moderate chance of injury or illness due to lack of maintenance or failure in process	Major avoidable injury leading to long term incapacity / disability H&S – Probable serious injury due to lack of maintenance or failure in practice.	Incident leading to avoidable death or serious permanent harm (for example e.g. wrong site surgery or loss of vision.) H&S – Probable fatality due to lack of maintenance or failure in practice.
Quality	Peripheral element of treatment or service sub optimal Informal complaint	Clinical outcome not affected OR increase in length of stay 3 – 10 days (department level) Overall treatment or service suboptimal Minor implications for patient safety if unresolved	Individual consultant clinical outcome in lower 25% for up to a month OR increase in length of stay for large number of patients <15 days (Centre level) Repeated failure to meet internal standards Patient safety implications if findings are not acted on	Individual consultant clinical outcome in lower 10% for up to a month OR speciality clinical outcomes in lower 25% for up to one month OR increase in length of stay for large number of patients >10 days (Trust level) Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent critical report	Individual consultant clinical outcome in lower 10% for in-excess of 3 months OR speciality clinical outcomes in lower 25% for over one month OR increase in length of stay for significant number of patients >10 days (Trust level) Gross failure of patient safety if findings are not acted on Inquest Rule 43 potential/ ombudsmen inquiry Gross failure to meet national standards
Finance	Costs within the remit of individual employees as set by the Scheme of delegation	0.5% of budget OR Major impact on budget holder's financial position	Earnings volatility of <250k OR Major impact on Centre's financial position	Earnings volatility of >250k OR Significant impact on financial position of Trust	Earnings volatility of £1m OR Serious impact on financial position of Trust
Inspection / Audit	Minor recommendations. Minor non-compliance with standards. No breach of guidance	Single breach of statutory duty.	Challenging external recommendations / improvement notice issued	Multiple breach and prosecution notice issued Enforcement Action Prohibition notice.	Multiple breach and prosecution Severely critical report
Service / Business Interruption Environmental impact	Loss / interruption > 1 hour OR Minimal / no impact on environment OR Little damage to machinery / equipment	Loss / interruption > 1 day (department level) OR Minor impact on environment OR Moderate damage to machinery, easily repairable	Loss / interruption > 1 day (Centre level) OR Moderate impact on environment OR Machinery shut down immediately and restarted in less than half a day	Loss / interruption > 1 week OR Major impact on environment OR Machinery will be out of action less than a week to repair	Permanent loss of service or facility (Trust level) OR Catastrophic impact on environment OR Damage will spread beyond one item of machinery and take over one week to repair
Service Delivery / business management	Failure to meet individual objectives set out in KSF process or minimal impact	Failure to meet internal standards with some impact on overall performance of business unit	Failure to meet internal standards with some impact on overall performance of Trust	Major impact on overall performance which puts achievement of standards or ability to meet Monitor risk rating and national requirements at risk	Sustained failure to meet standards or failure to meet Monitor risk rating and national requirements. Serious impact on overall performance and possible intervention
Adverse Publicity / Reputation	Minimal impact	Short term local interest and impact from an issue	Local impact and interest in specific issue	National and local interest and impact on reputation specific to an issue – prolonged interest	Serious long term impact (nationally and locally) on reputation, prolonged interest and DH/Select Committee overview
Human Resources / Organisational Development	Nil	Low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). OR OR Unsafe staffing level or competence (>1 day).OR OR Low staff morale OR Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff OR Unsafe staffing level or competence >5 days) OR Loss of key staff. Very low staff morale. OR No staff attendance for mandatory / key training. OR Serious error due to insufficient training	Non delivery of key objective / service due to lack of staff OR Ongoing unsafe staffing levels or competence OR Loss of several key staff OR No staff attending mandatory / key training on an ongoing basis

Risk Likelihood : Frequency or Probability Score

Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency *How often might it/does it happen?*	Highly unlikely but it may occur in exceptional circumstances. It could happen but probably never will.	Not expected but there's a slight possibility it may occur at some time	The event might occur at some time as there is a history of casual occurrence at the Trust or within the NHS	There is a strong possibility the event will occur as there is a history of frequent occurrence at the Trust or within the NHS	Very likely. The event is expected to occur in most circumstances as there is a history of regular occurrence at the Trust or within the NHS
Probability *ie will it happen or not within given time frame?*	<0.1 percent	0.1 – 1 percent	1 – 10 percent	10 – 50 percent	> 50 percent

Risk Rating   Consequence v Likelihood

Insert Consequence and likelihood scores on the risk assessment form and consult matrix below
High - Prompt action is required, so far as is reasonably practicable. NOTIFY RISK MANAGEMENT EXECUTIVE for Corp. Risk Register. PROACTIVE REVIEW BY TRUST BOARD AND RME. Strategic Risks included on BAF.
Medium - Risk reduction is required, so far as is reasonably practicable (amber / red). PROACTIVE REVIEW BY RME and consideration of inclusion on BAF.
Low - Risk within tolerance. Risk reduction is required, so far as is reasonably practicable (amber / green). PROACTIVE REVIEW BY CENTRE and assurance through local governance.
Very Low - Risk within tolerance and further risk reduction may not be feasible or cost effective. ONGOING REVIEW & MANAGEMENT AT OPERATIONAL LEVEL.

Risk Quantification Matrix

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

NB Any risks that score a 5 for consequence ie 'catastrophic' will also be notified to the Risk Management Executive and Trust Board for information.

Appendix H   Risk Management Process

Risk identification using:
Strategy and key objectives
Business plans
National and local standards
Known hazards and risks
Newly identified hazards

Risk Assessments
Identify and assess hazards
Identify and grade controls in place
Identify and grade likelihood of risk
Identify and grate harm, severity
Identify further controls required

Monitor using key indicators
Feedback from staff
Incidents
Complaints
Claims
Performance Reports

Develop and implement a prioritised action plan
Validate proposed controls
Assign lead
Set implementation dates
Set review dates
Escalate uncontrolled risks
Identify resources

Review completed actions
Re-assess re-grade residual risk
Accept sign off residual risk
Escalate uncontrolled risks
Set review date

Submit to risk register
Risk acknowledged by manager
Level of risk accepted by manager
Need for further controls agreed by manager

Communicate risks to stakeholders

Internally:
Local staff, managers, contractors, committees

Externally:
Regulating bodies – e.g. NPSA, MDA, MCA, NHSE, NHSLA, HSE, SHOT, IRMER etc.
Public and patients groups, GPs
Commissioners, SHA, DH, emergency services
Professional bodies

Appendix I   Risk Register Template

Risk Title

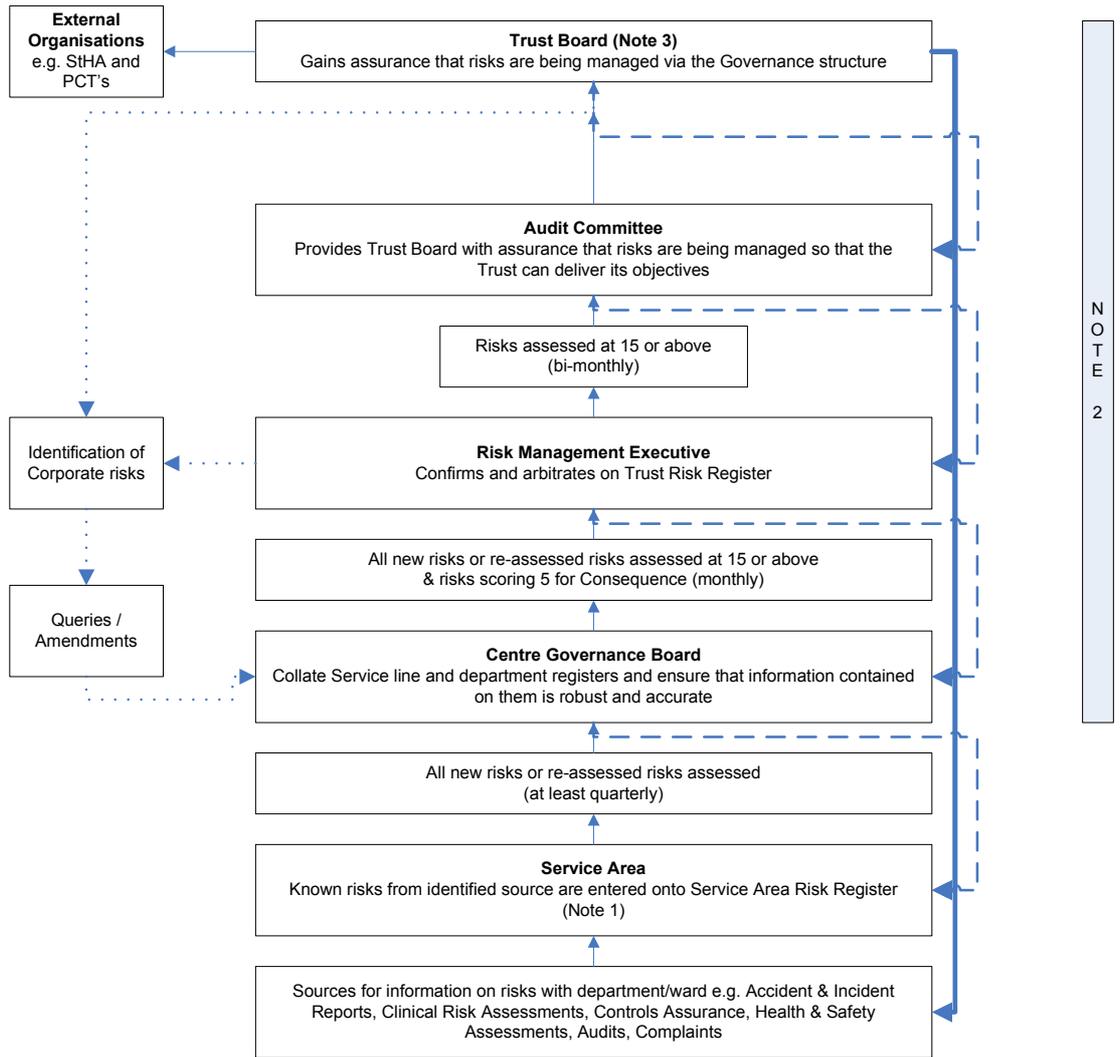|	
Risk Owner	Who owns the risk? Identify a named person, who will be responsible for ensuring action is taken to mitigate the risk.
Risk	Contains a high level statement of the risk and some detail about how that risk might identify itself and impact - Describe the risk including the cause and potential effects
Source of Risk Notification	State where the risk originates eg CQC standards, HSE inspection, local risk assessment, national guidance etc, patient safety incidents etc.
Impact On Objectives	State how the risk will impact on the corporate objectives
Personnel Involved in Risk Assessment	List the members of staff involved in the risk assessment
Risk Score (Uncontrolled)	Score the risk as if there were no controls in place (needed for 4risk system)
What Risk Control Measures are in Place Now?	Briefly list any controls which are currently in place to manage the risk and explain how these controls operate to control the risk
Risk Score	Score the risk taking account of the controls listed above
Method of checking, audit or verification (Assurances that risk is being controlled)	Assurances: identify any internal or external reviews /reports etc that will enable you to understand whether the identified risk is being controlled
Further Action Required with responsibility and Timescales	Describe what additional actions need to be taken to control the risk and identify an action owner and timescales for each action identified NB: The action owner may not be the risk owner and may be in a different area of the Trust.
Target Risk Score	Score the target risk score once the identified actions has been taken. If you have more than one action identified you should indicate the target risk score for each action identified. This will enable prioritisation of the actions
Cost (Including Capital Equipment, Other Capital, Recurring Costs and Non-recurring Costs	Cost of resolving the risk per action identified (if any)
Entered on to Centre / Service Register	Date that the risk was identified and placed on local register
Signature Centre Chief / Director Confirming Details	
Date of Review	When will you review the risk and progress of action plan? (should be at least quarterly)

Appendix J   Action plan Template

Risk Ref	Risk Title	Residual Risk Score	Further Actions Required	Target risk score	Action Owner	Action Cost	Implem- entation Date	Update on position

Appendix K   Information Flows for Risk

External Organisations e.g. StHA and PCT's

Trust Board (Note 3)
Gains assurance that risks are being managed via the Governance structure

Audit Committee
Provides Trust Board with assurance that risks are being managed so that the Trust can deliver its objectives

Risks assessed at 15 or above (bi-monthly)

Identification of Corporate risks

Risk Management Executive
Confirms and arbitrates on Trust Risk Register

All new risks or re-assessed risks assessed at 15 or above & risks scoring 5 for Consequence (monthly)

Queries / Amendments

Centre Governance Board
Collate Service line and department registers and ensure that information contained on them is robust and accurate

All new risks or re-assessed risks assessed (at least quarterly)

Service Area
Known risks from identified source are entered onto Service Area Risk Register (Note 1)

Sources for information on risks with department/ward e.g. Accident & Incident Reports, Clinical Risk Assessments, Controls Assurance, Health & Safety Assessments, Audits, Complaints

NOTE 2

Key:

→ Document Flow

┄┄► Information Flow

‑ ‑ ‑► Feedback

━━► Exceptional items

Note 1: To prioritise risk, risks scoring 8 or below are considered to be operational risks that need to be mitigated by Service Governance Teams
Note 2: Exceptional items reported directly to Trust Board (i.e. risks scoring 25)
Note 3: Whilst the flow of information is up through the structure, communication of risk analysis flows up and down

Appendix L   Improvement Programme Quality Framework 2010/11

Quality Risk Assessment of Improvement Programme schemes
In assessing the impact of proposed Improvement Programme schemes on our ability to deliver our commitments to quality as defined within our Annual Corporate Plan the Quality KPIs and the Monitor requirements of Clinical outcomes; Patient experience and Patient safety, each scheme will need to be risk scored for its potential to have an adverse impact on these three dimensions of quality. The Trust Risk Management Strategy sets out how risks are to be quantified, Section 6 of the Programme Management Office Guidance for Project Managers also describes how the PMO will monitor and quantify risks in accordance with the Trust Policy.

Risk Register (a Risk is something that may impact project delivery but has not yet occurred)

Defining the difference between a Risk and an Issue:
o A *Risk* is an event which has not occurred, but may do so in the foreseeable future. The Trust need to understand the impact, cause and likelihood of it occurring, before deciding to Transfer, Mitigate, Accept, Exploit, Ignore.
o An *Issue* is an event which has occurred and is impacting the project deliverables.
The purpose of this tab is to record the risks associated with project delivery, to understand how much of a concern these risks are and identify what can be done to mitigate these risks.

Each risk must have an owner responsible for ensuring that any mitigating actions are completed and that the risk is monitored.

Any risks rated as high should be reported to your line manager / Director or immediately (a score of 15 or over).

Risk Register (Extract from Trust Risk Management Policy)
▪ All project risks identified will be rated by the project manager on a 1 – 5 basis (1 = low and 5 = high) for likelihood of risk happening and then consequences should the risk occur.
▪ These two scores are automatically multiplied together to give the risk a rating out of 25.
▪ If you identify a new risk to your project that is rated as 'high' or 'very high' (15 or above), you should notify the Project Lead/ Exec Sponsor and the PMO of the risk immediately.
▪ If you are unsure how to rate your risk, please contact the PMO to discuss, or refer to the trust's risk assessment guidance that can be provided by the Compliance and Risk Management directorate.

This current guidance is being adapted to ensure that all elements of the national guidance for Monitor the NHS Foundation Trust Regulator Quality Impact Assessment are completed as part of all cost improvement schemes. The process as described by Monitor is set out below for information.

Monitor issued guidance to existing and aspirant Foundation Trusts earlier this year, below is a summary of this guidance.	
a)	**Identify CIP Scheme;**
	o The majority of CIPs should be based on changes to current processes, rather than top-slicing current budgets
	o Where possible ,CIPs should be expected to have a neutral or positive impact on quality as well as reducing costs
	o At a minimum, CIPS should not put registration at risk by bringing quality below essential common standards
b)	**Assess potential impact on quality and cost;**
	o CIPs should be categorised by potential impact on quality
	o CIPs with significant potential impact on quality should be subject to an assessment of their impact covering safety, clinical outcomes and patient experience, which could include analysis of current processes, KPI Benchmarking and historical evidence
	o All CIPS should be subject to a detailed assessment of their financial impact, in line with current practice
c)	**Approve plans**
	o Clinicians understand and accept CIPs and approved plans have appropriate clinical ownership (e.g. relevant clinical director)
	o Board assurance is required that CIPs have been assessed for quality (potentially via direct

		approval for highest potential impact CIPs)
	o	There must be appropriate mechanism in place for capturing front-line staff concerns
d)		**Assess actual impact on quality;**
	o	All CIPs should be subject to an ongoing assessment of their impact on quality; post roll-out:
		i. Identify key measures of quality covering safety, clinical outcomes and patient experience
		ii. Monitor each measure before and after implementation
		iii. take action as necessary to mitigate any negative impact on quality
SHA assurance process - 6 basic tests:		
a)	QIA will need to be completed for schemes with a potential impact on quality. This will assess schemes in terms of patient experience, safety and clinical outcomes	
b)	Have organisations used the monitor Quality Assessment Framework to 'quality assure' their CIPs?	
c)	Has each CIP been risk assessed and RAG rated?	
d)	Are there mitigating actions clearly expressed for the risks identified risks?	
e)	Have Trust Medical and Nurse Directors explicitly signed off the organisations CIPs?	

3   Ongoing Monitoring

At the proposal stage, each scheme will be risk assessed for impact on quality. They will be monitored on an ongoing basis against an agreed KPI through the Programme Management Office. Any adverse quality performance will be escalated at the Risk Management Executive and further mitigating action and / or enhanced monitoring requested where appropriate.

Appendix 1: Improvement Programme Quality Impact Assessment summary

Scheme Ref	Scheme description	Type of quality risk Patient Experience Patient Safety Clinical Outcomes	Risk assessment Score	Mitigating Action required	Post mitigation score

The Shrewsbury and Telford Hospital **NHS**

NHS Trust

Statement of Internal Control 2009 / 2010

Subcertification Process

I certify that the Centre Risk Register:

- is up-to-date,
- reflects all risks rated at 8 or above in my areas of responsibility
- identifies all the controls currently in place for the identified risks
- Identifies the assurances (received or planned) that will enable the Centre to demonstrate that the risk is adequately managed.

For any lapses please provide details of action taken:

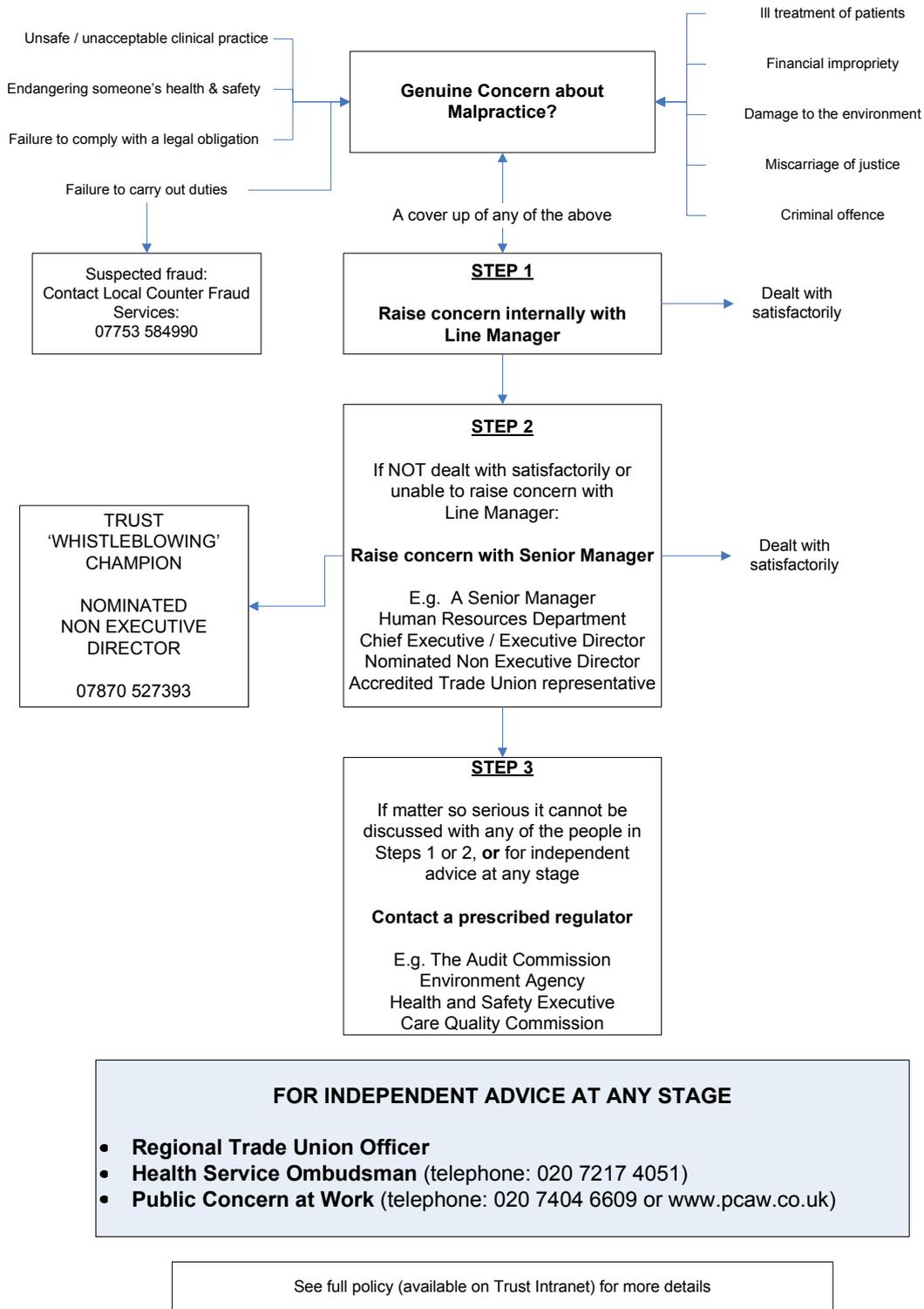Signature   Date

Position

Appendix N   Additional Definitions

Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved. Assurances can be positive or negative.
Assurance Framework	A structure within which boards identify the principal risks to the organisation meeting its principal objectives and map out both the key controls in place to manage them and also how they have gained sufficient assurance about their effectiveness.
Business Continuity	Strategic and tactical capability of the Trust to plan for and respond to incidents and business interruptions in order to continue business operations at an acceptable pre-defined level
Business Risk	Risk that arises from the infrastructure supporting the delivery of healthcare.
Clinical Governance	A framework within which local organisations can work to improve and assurance the quality of services through an ongoing cycle of assessing, monitoring and improving.
Clinical Risk	Risk that arises from the delivery of healthcare, directly impacting on patients.
Consequence	Outcome or impact of an event. • There can be more than one consequence from one event; • Consequences can range from positive to negative; • Consequences can be expressed qualitatively or quantitatively; and, • Consequences are considered in relation to the achievement of objectives.
Corporate Governance	System, structures, tone and behaviours by which the organisation is directed and controlled, and accountabilities clearly assigned so that decisions can be effectively made, objectives set and performance monitored to ensure the efficient and effective use of resources and safeguard assets.
Corporate Risk	A risk that could cause the Trust to fail to meets its published objectives or those objectives requiring strategic leadership Such risks will normally be identified (or approved) by Directors and members of the NHS Board, (either Executive or Non Executive members)
Effective Control	A control that is properly designed, and delivers the intended objective.
Error	The failure of a planned action to be completed as intended (i.e. error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning). Errors may be errors of commission or omission, and usually reflect deficiencies in the systems of care
Event	Occurrence of a particular set of circumstances. • The event can be certain or uncertain; • The event can be a single occurrence or a series of occurrences; and, • The likelihood of occurrence can be estimated for a given period of time – usually the time period of the objectives
External Assurance	Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as external audit, accreditation or inspection reports, Care Quality Commission, NHSLA or Royal Colleges.
External Risk	Forces that could either put an organisation out of business or significantly change the assumptions that drive its overall objectives and strategies.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is place are operating effectively.
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives.
Inherent Risk	Exposure arising from a specific risk before any action has been taken to manage it.
Hazard	A source of potential harm (e.g. unsafe practices, unsafe conduct, faulty equipment, incorrect labelling, incorrect names, etc).
Head of Internal Audit Opinion	An annual opinion provided to inform the Board in completing their Statement on Internal Control. This provides opinions on (a) the overall assurance framework and (b) the effectiveness of that part of the system of internal control reviewed by Internal Audit during the year.

Impact	Result or effect of an event.
	• There might be a range of possible impacts associated with an event; and,
	• The impact of an event can be positive or negative relative to the Trust's objectives.
Incident	Situation that might be, or could lead to, personal injury, a business interruption, near miss, disruption of service, loss, harm, emergency, disaster or crisis.
Internal Assurance	Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as clinical audit or management peer review.
Internal control	Mechanisms, including policies, procedures and processes, used for governing an organisation.
Likelihood	Used as a general description of how often and probable an event might occur.
	NOTE 'Likelihood' is often used as a synonym for probability and frequency, especially in a qualitative context where a precise analytical calculation cannot be obtained.
Mapping of Assurance	A process, providing a clear management trail, that links:
	• Principal objectives to principal risks
	• Principal risks to key controls
	• Key controls to assurances
Near-miss	Serious error or mishap that has the potential to cause an incident or adverse event to occur but fails to do so because of chance or because it is intercepted. Also called potential adverse event.
Residual Risk	Exposure remaining from a specific risk after action has been taken to manage it, assuming the action is effective.
Operational Risk	Any issue that may have an impact on the operational running of the organisation, for example staffing issues, capacity issues.
Positive Assurance	Evidence that shows risks are being reasonably managed and objectives are being achieved.
Prioritisation of Risk	A process by which risks are graded in order based on the likelihood of their occurrence and the impact of their consequences.
Risk	The chance of something happening that will have an impact on objectives.
	NOTE 1 A risk is often specified in terms of an event or circumstance and the consequences that may flow from it.
	NOTE 2 Risk is measured in terms of a combination of the consequences (or impact) of an event and the likelihood (or probability) of it occurring.
	NOTE 3 Risk may have a positive or negative impact.
Risk Analysis	Systematic process used to estimate / understand the risk in terms of its consequence and likelihood.
	NOTE 1 Risk analysis provides a basis for risk evaluation and risk response / treatment.
	NOTE 2 Information can include, but is not limited to, historical data, theoretical analysis, informed opinions, and the views of stakeholders.
Risk Appetite	The amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time.
Risk Assessment	The identification and analysis of relevant risks to the achievement of objectives.
Risk Avoidance	Decision not to be involved in, or to withdraw from, an activity or opportunity because of the risk involved.
Risk Evaluation	Process of comparing the level of risk against risk criteria to determine the significance of the risk and whether it is tolerable and whether action is to be taken.
Risk Identification	Process of determining what, where, when, why and how something could happen.
Risk Management	The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.
Risk Management Framework	Series of components which provide the foundations and a common infrastructure for delivering, maintaining and governing risk management throughout the organisation.
Risk	Systematic identification, evaluation and treatment of risk. A continuous process

Management Process	with the aim of reducing risk to organisations and individuals alike.
Risk Manager	The person who is responsible for the management of a particular risk.
Risk Owner	Director(s) or nominated manager who is ultimately accountable for the management of all aspects of specific risk(s) within their area.
Risk Profile	Overall picture of risk within an organisational unit or across an organisation, demonstrating the nature and level of risks, the impact of risk incidents and losses on stakeholders, and the effectiveness of the risk management framework and controls.
Risk Reduction	Proactive measures taken to reduce risk, either through minimising likelihood or mitigating the consequences.
Risk Register	A register of all the identified risks and the results of their analysis and evaluation. Risks can be broken down into a Corporate Risk Register (owned and monitored by the Board), and Operational Risk Registers for each Centre (owned by the responsible Centre Chief). Information on the status of the risk is also included. The risk register should be continuously updated and reviewed throughout the existence of the risk.
Risk Response	Actions taken to bring the situation to a level where the exposure to risk is acceptable, either through avoidance, modification, transfer or acceptance.
Risk Transfer	Process of moving the responsibility for risk or a specific component of risk to another party. This might be achieved through legislation, contract, insurance or other means.
Sources of assurance	The various reviewers, auditors and inspectors, both internal and external, who carry out work at NHS organisations. Boards will have to determine which sources of assurance are relevant to the principal risks and to what extent they are sufficient.
Stakeholders	Those with an interest in (either directly or indirectly) and / or are affected by the Trust and its activities.
Statement on Internal Control (SIC)	An annual statement signed by the Accountable Officer on behalf of the board that forms part of the Annual Financial Statements for the year. The SIC provides public assurances about the effectiveness of the organisations system of internal control.
Strategic Objective	An overall goal of the organisation.
Strategic Risk	Internal and external risks that may compromise the ability of the Trust to achieve its medium to long term objectives and strategies. They can be affected by such areas as capital availability, reputation, regulatory changes, policy decisions and demographics. Such risks will normally be identified by members of the NHS Board, (either Executive or Non Executive members).
System	A set of inter-dependent elements (people, processes, equipment) that interact to achieve a common aim.
System of Internal Control	A system, maintained by the Board, that supports the achievement of the organisations objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organisations objectives, to evaluate the nature and extent of those risks and to manage them efficiently, effectively and economically.

Appendix O   Whistleblowing flowchart

Unsafe / unacceptable clinical practice

Endangering someone's health & safety

Failure to comply with a legal obligation

Failure to carry out duties

Ill treatment of patients

Financial impropriety

Damage to the environment

Miscarriage of justice

Criminal offence

Genuine Concern about Malpractice?

A cover up of any of the above

Suspected fraud:
Contact Local Counter Fraud Services:
07753 584990

STEP 1

Raise concern internally with Line Manager

Dealt with satisfactorily

STEP 2

If NOT dealt with satisfactorily or unable to raise concern with Line Manager:

Raise concern with Senior Manager

E.g. A Senior Manager
Human Resources Department
Chief Executive / Executive Director
Nominated Non Executive Director
Accredited Trade Union representative

Dealt with satisfactorily

TRUST 'WHISTLEBLOWING' CHAMPION

NOMINATED NON EXECUTIVE DIRECTOR

07870 527393

STEP 3

If matter so serious it cannot be discussed with any of the people in Steps 1 or 2, **or** for independent advice at any stage

Contact a prescribed regulator

E.g. The Audit Commission
Environment Agency
Health and Safety Executive
Care Quality Commission

FOR INDEPENDENT ADVICE AT ANY STAGE

- **Regional Trade Union Officer**
- **Health Service Ombudsman** (telephone: 020 7217 4051)
- **Public Concern at Work** (telephone: 020 7404 6609 or www.pcaw.co.uk)

See full policy (available on Trust Intranet) for more details

Appendix P   Related Policies and Procedures

Reservation of Powers to the Board and Delegation of Authority
Standing Financial Instructions and Standing Orders

Corporate Risk Register
Board Assurance Framework
Women's Risk Management Strategy

An Organisation-wide Policy for the Development and Management of Procedural Documents (Gov 01)

Procedure for the reporting and Investigation of incidents, complaints and claims
Serious Incident policy
Learning from adverse events policy

Health and Safety Policy
Health and Safety Risk Assessment Templates
Claims Handling policy
Complaints policy
Guidance for Risk Assessment
Fire Policy
Security Policy
Major Incident Plan

Induction Policy
Whistleblowing policy HR05
Maintaining high standards of performance
Maintaining high professional standards for Doctors and Dentists
Knowledge and Skills Framework
Training and Development Support

Infection Control Policies
Resuscitation Policy
Medical Devices Policy
Medical Equipment Training Policy

Appendix Q   References