Health & Safety Strategy

Risk Management

DOCUMENT REF: SCGMRISK
(Version No: 5.0)

Name and designation of author(s)	Vicky Davies – Risk Management Facilitator
Approved by	Risk Management Committee
Date approved	5th December 2017
Review date	December 2019
Review type	Two yearly
Target audience	All staff
Links to other strategies, policies, procedures	Incident Reporting Policy Claims Policy Complaints Policy Raising Concerns Policy Board Assurance Framework Health and Safety Policy Major Incident Plan Safety Alerts Policy ICT Strategy Security Policy
This document replaces…	V4.3

Circulation/Dissemination:

Date added into Q-Pulse	28th December 2017
Date notice posted in the Team Brief	28th December 2017
Date document posted on the intranet	28th December 2017

Version History:

Date	Version	Author name and designation	Summary of main changes
January 2010	2.0	Vicky Davies – Risk Management Facilitator	Updated with new systems in place. Included detailed monitoring section.
June 2012	3.0	Vicky Davies – Risk Management Facilitator	Minor changes
August 2012	4.0	Vicky Davies – Risk Management Facilitator	Minor changes.
October 2013	4.1	Vicky Davies – Risk Management Facilitator	Added new Quality and Risk Management Standards
October 2014	4.2	Vicky Davies – Risk Management Facilitator	Updated changes to Patient Safety First Campaign and added Sign up to Safety Campaign
October 15	4.3	Vicky Davies – Risk Management Facilitator	Minor updates – updated TOR for Integrated Governance Committee
November 17	5.0	Vicky Davies – Risk Management Facilitator	Minor updates – change in committees, removal of out of date campaigns. Updated risk escalation process.

CONTENTS

THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

RISK MANAGEMENT POLICY STATEMENT

The Trust is committed to a strategy, which minimises risks through a comprehensive system of internal controls whilst maximising potential for innovation and best practice. The Trust acknowledges that the contribution of its staff is fundamental to achieving this.

The Trust will support and help its employees in providing services that are safe for patients. This will require all staff to recognise that Risk Management is everyone's business.

1.0 Introduction

The Clatterbridge Cancer Centre NHS Foundation Trust acknowledges that risks are present throughout the Trust on an everyday basis. The management of risk is an essential tool in ensuring a safe environment for patients, staff and visitors and to ensure the stability and reputation of the organisation. Failure to do so could result in harm, financial loss, complaints, litigation, adverse publicity or a poor reputation. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust. The Trust has adopted an integrated approach to the management of risk, irrespective of whether risks are clinical, financial or organisational.

This document sets out the Trust's approach to the management of risk and the implementation of a system that enables the assessment, treatment and monitoring of risk.

2.0 Purpose

Successive guidance documents from the Department of Health recommend that each NHS organisation develop a comprehensive risk management programme encompassing all activity within the organisation. This strategy provides the plan to ensure that the Trusts risk management capability is optimal and adheres to the current legislation and best practice.

The purpose of this strategy is to set out the strategic direction for risk management across the Trust.

3.0 Scope

The risk management strategy covers all types of risk, including clinical and non-clinical. It applies to all staff employed at the Trust and other non Trust staff working at the Trust or representing the Trust in anyway.

It is an overarching strategy, which needs to be read in conjunction with the other policies, procedure and strategies as listed on the front sheet.

4.0 Definitions

4.1 Risk

Risk is an event or uncertainty that may have the potential to impair or affect the Trust's ability to meet its current or future objectives. Risk may be strategic or operational. Risk is also exposure to danger with the chance of loss or harm. Losses may occur in terms of finance or reputation. Risk is present in all elements of the organisation: - the four key risk areas are

- Clinical
- Corporate
- Financial
- Reputation

4.2 Risk Management

Risk management is a systematic process whereby all the risks to which an organisation is exposed are identified, examined, assessed and evaluated. The purpose being to mitigate, manage or minimise the possibility of these risks occurring/ recurring and to agree the action required to alleviate or eliminate the risks.

Clinical Risk Management includes the protection of assets of the Trust from the potential harm of clinical malpractice. Clinical risk management aims to

reduce the risks to patients. Allegations of clinical negligence constitute a major risk to any hospital. Clinical Risk Management concentrates on identifying and correcting risks associated with direct patient care, whilst Non-Clinical Risk Management is associated with all other Trust activities.

4.3 Acceptable risk

It is accepted that it is not possible to totally eliminate all areas of risk. However, achieving the Trusts risk management objectives will minimise the possibility of incurring misfortune or loss. Levels of acceptable risk are determined by working within agreed Trust policies and procedures. Working outside Trust policies and procedures is unacceptable to the organisation.

An acceptable risk is one which has been accepted after proper evaluation, with all the possible controls in place. This risk must be entered on to the Trust's Risk Register and kept under review by the appropriate Department/ Committee.

5.0 Risk Management Duties/Responsibilities

The Trust Board expects all staff members to contribute to the management of risk throughout the organisation. Within the organisation key individuals / groups have specific defined responsibilities.

5.1 The Chairman and Chief Executive

The Chairman and Chief Executive of The Clatterbridge Cancer Centre NHS Foundation Trust, support the concepts of risk management within the broader clinical and corporate governance agenda. The Chief Executive has overall responsibility for having an effective governance system, including risk management.

5.2 The Director of Nursing and Quality

The Director of Nursing and Quality has executive responsibility for clinical governance and risk management and is the designated Risk Manager. They are the Executive lead with responsibility for the monitoring of risk and for the

delivery of reports to the Board and to ensure that mechanisms are in place for organisational learning.

5.3 The Director of Finance

The Director of Finance has responsibility for financial risk management.

5.4 The Medical Director

The Medical Director is the jointly responsible Executive for clinical governance.

5.5 Director of Operations and Performance

The Director of Operations and Performance is responsible for ensuring the Trust Operational departments adhere to all policies and procedures.

5.6 Non-Executive Directors

The Non Executives are responsible for scrutinising the work of the organisation and to hold the Executive Directors to account for their performance. They must also ensure that quality and safety remain a strategic priority. There is Non Executive representation on the Risk Management Committee.

5.7 Council of Governors

The Council of Governors are responsible for holding the Board of Directors to account for the performance of the Trust and ensuring the Board acts so that the Trust does not breach its terms of authorisation.

5.8 Trust Board

The Trust Board is responsible for ensuring that full support and commitment is provided and maintained for the implementation of risk management. They are responsible for reviewing and managing the top level risks.

5.9 The Quality Committee

The Quality Committee as a formal committee of the Board, has overarching responsibility for the Risk Management Agenda (see Appendix 8 for Terms of Reference).

5.10 The Quality and Safety Sub Committee

The Quality and Safety Sub Committee is a formal subcommittee of the Trust Board Quality Committee.

The role of the subcommittee is to provide the Trust Board Quality Committee with assurance on the effective management of quality and risk governance within the Trust.
This includes ensuring the delivery of associated strategies included but not limited to:

- Quality
- Patient Involvement
- Risk Management
- Infection Control
- Research and Research Governance

5.11 The Risk Management Committee

The Risk Management Committee leads risk management in the Trust (see Appendix 1 for Terms of Reference). The Risk Management Committee establishes controls assurance mechanisms to assure the Trust Board that risks are being managed adequately. Communication with related groups /committees (see Appendix 2) ensures that risks are managed, co-ordinated and prioritised on a holistic basis. Minutes or reports from these committees are submitted to the Risk Management Committee to ensure a holistic and co-ordinated approach to Risk management. The Risk Management Committee reports to the Board (Quality Committee) via the Director of Nursing and to the Quality and Safety Sub Committee.

5.12 The Audit Committee

The Audit Committee has an overarching responsibility for monitoring and reviewing the Trust's systems, processes and assurances to ensure that the Trust has an effective and robust framework of internal control. The Audit Committee's Terms of Reference can be found in the Trusts Corporate Governance Manual.

5.13 Heads of Department/ General and Senior Mangers

Heads of Department/General/Senior Managers have local responsibility for managing risk. Risk Management should be integral to their daily management responsibilities. Managers are authorised to mitigate risks locally wherever possible but to escalate these if appropriate.

The Risk Grading Matrix/Management Table details the authority of managers depending on the grade of the risk (see Appendix 4). Heads of Department are responsible for their department's risk register and are responsible for ensuring risk assessments are completed and reviewed regularly. They are also responsible for their departmental quality reports as part of their departmental reviews and for ensuring learning from this aggregated information in their departments.

5.14 Clinical Governance Support Team

The Clinical Governance Support Team (CGST) provides a cohesive team to further develop the Clinical Governance programme across the Trust and as such leads on aspects of risk management and patient safety to ensure an integrated approach (see Appendix 5 for membership, constitution and terms of reference).

5.15 Risk Management Facilitator, Clinical Governance Managers and Health &Safety Advisors

The Risk Management Facilitator, Clinical Governance Managers and Health and Safety Advisors have the responsibility of co-ordinating risk management across the Trust and for the provision of guidance, support and training to staff. The Risk Management Facilitator is the Datix lead for the Trust and manages the modules for incidents, claims, risks, complaints and PALS. The Risk Management Facilitator produces reports for the Risk Management Committee, Quality Committee, Quality and Safety Sub Committee and Health and Safety Committee relating to incidents, claims, risks, safety alerts;

including a Risk Management Annual report. The Clinical Governance Managers are responsible for producing the Directorate Performance Reports.

5.16 Patient Experience Manager

The Patient Experience Manager is responsible for producing all reports relating to complaints, PALS and patient surveys.

5.17 All Staff

All staff are responsible for risk management and ensuring that any risks they have identified are reported to their manager/ Head of Department. Staff are also required to attend any training appropriate to their role, including the mandatory training sessions set down by the Trust. All staff must adhere to the Trust's policies and procedures and work within their own level of competence.

5.18 Key stakeholders

The Trust has recognised the importance of involving its stakeholders within the management of risk, and will involve them within its committee framework to agree and monitor areas of risk. Additionally through its strategy for patient and public involvement it will be able to demonstrate greater inclusion.

6.0 Aims of the Strategy

The Trust's key strategic risk management aims are:

- To protect service users, staff and others
- To create an environment that encourages and supports all staff to report risks so that learning and improvement can take place.
- To identify and assess risks (including near misses) that could cause harm, disrupt services, impact on health and safety or lead to loss or damage.
- To implement, monitor and evaluate risk control measures
- To encourage organisation and cross organisation wide learning

- To make the effective management of risk an integral part of everyday practice
- To use risk assessments to inform business planning
- To comply with national standards, e.g. Peer Review, ISO9001, Care Quality Commission, NICE
- To provide high quality service and to strive for continuous improvements in patient and staff safety
- To have clearly defined responsibilities for risk management

7.0 The Risk Management Process

The principles of risk identification, assessment, control and action planning is the same throughout all levels of the Trust. The management of risk is addressed through a number of different processes, some which are proactive and some, which are reactive.

7.1 Proactive Risk Identification

It is not possible to manage risks until they have been identified. This is the process of identifying what can happen or has happened and why. The Trust identifies risks through a number of mechanisms:

The Trust is legally obliged to carry out risk assessments. Their main purpose is to identify hazards and to determine whether planned or existing controls are adequate. The intention is that risks should be controlled before harm can occur, i.e. it is pro-active risk management.

Risk assessment is not a new concept and it is an implicit requirement of the Health and Safety at Work Act 1974, as well as a number of other regulations. However, risk assessments are not just concerned with health and safety but needs to be carried out on every activity we undertake in the Trust from clinical practices to financial and organisational issues.

7.1.1 The Process for the Management of Risk Locally- Risk Assessments and Risk Registers

- An ongoing risk assessment programme is carried out using the standard template for recording all risks (see Appendix 4). Risks are systematically identified during the annual environmental risk assessment programme which is carried out throughout the Trust
- All departments have a Risk Register which collates all risks identified from risk assessments, incidents, complaints, claims etc.
- Existing controls are recorded as well as any further action required.
- When it is not possible to eliminate the risk, it is important that all the necessary steps are taken to control the risk.
- All risks are scored using the Trust's Risk Matrix and managed in accordance with the risk grading procedure – see Appendix 4. These gradings can be altered after the initial grading according to the outcome of further risk assessments, the completion of action plans etc.
- The Trust Wide Risk Register is used to collate all risks. It is populated from a wide range of sources, including the assurance frameworks, risk assessments, incidents, complaints, safety alerts, claims, external visits etc.
- The Heads of Department are responsible for the completion of the assessments and the review their risk registers. Heads of Department and Directors review the risks within their remit and are responsible for the identification and documentation of new risks. All risks identified are then recorded into the risk register in Datix.
- In addition to the regular risk assessment/risk register reviews, any staff member can report a new risk identified using the Trust Risk Assessment Form (see Appendix 4 and found on the Trust intranet).
- This risk must be reported to the line manager in the first instance before the completion of the risk assessment form, which should then be included on the Trust Wide Risk Register if appropriate and managed in accordance with the risk grading procedure – see Appendix 4. Risks can't be added to the register without the following information:

- A description of the risk
- Source of the risk, e.g. risk assessment, incident, complaint etc
- Risk Score, i.e. the impact and probability scores
- Risk grading, i.e. residual risk rating
- Details of control measures
- Further actions required
- Review Date

- Once this information is added to the risk register in Datix, it is monitored by the relevant department/committee as appropriate as detailed below.

7.1.2 Risk Register

The Risk Register is the repository for all identified risks within the Trust and includes risk scoring for impact and probability together with controls and further actions required. The risk register is held within Datix and all managers have access to it to add new risks and review existing ones. Datix is able to compile reports in a variety of formats, e.g. committee reports, top risks report, departmental reports etc.

7.1.3 Board Assurance Framework

The Trust Board are committed to the maintenance of a robust Assurance Framework to identify key strategic risks that may prevent the organisation from achieving its corporate objectives.

The Assurance Framework is used to map key risks and controls of objectives, identify gaps and determine action plans to close these gaps. Systematic processes are designed to highlight significant risks which may prevent organisation/ directorate objectives being achieved. Every year, a new assurance framework is developed by the Board. All risks are then fed into the Trust Wide Risk Register and managed by the relevant Board Committee. In addition the Board of Directors review the entire Assurance Framework twice yearly.

The Corporate Objectives are cascaded down through the Trusts management structure which supports the performance management arrangements in the Trust.

7.1.4 Risk Assessment and Project Management

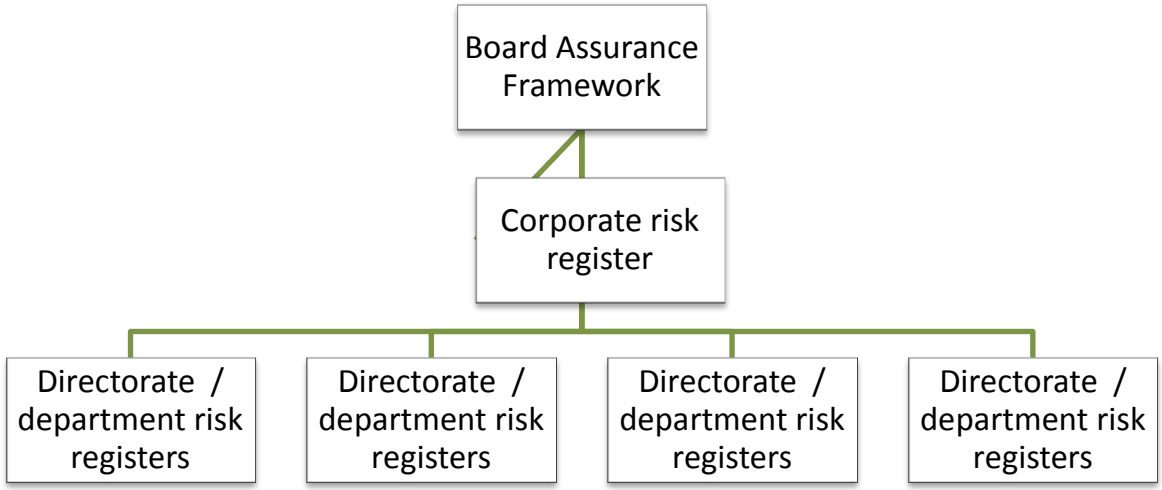
Risk management must be considered in any project. The aim is to manage risk to an acceptable level in a cost effective way.

Risk assessment is integral to this approach and the risk management process contained within the strategy are applicable to all projects.

Project managers are required to undertake risk assessments at the start of projects and throughout the stages of the project as appropriate. Risk assessments must be scored using the Trusts methodology and included in the Trust Wide Risk Register if required.

7.1.5 Risk Escalation

Risk Escalation.



Risk Statuses in DATIX:

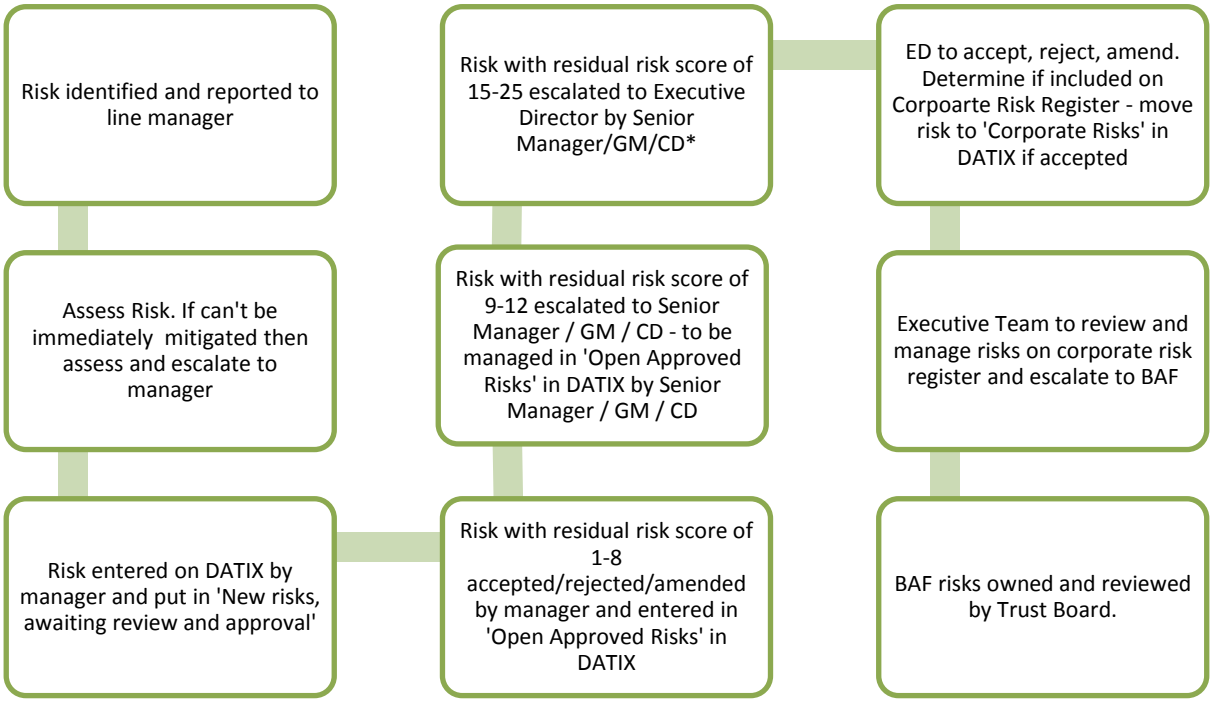
New risks, awaiting review and approval

Open approved risks: Dept/Directorate risks
Corporate risks (Executive approved risks only)
Board Assurance Framework
Closed risks

Risk escalation process:

Risk score	Responsibility	Risk register
Risk rated low/very low (1-8)	Responsibility of the risk owner (manager, head of department).	Directorate / dept risk register
Risk rated moderate (9-12)	Responsibility of the risk owner (head of department / GM / Clinical Director)	Directorate / dept risk register
Risk rated moderate (9-12) that require multi-department approach to manage the risk. Risk rated high (15-25)	Responsibility of the risk owner (Executive Director). Escalated to Executive Team.	Corporate risk register
Risks identified as strategic risks to the Trust and escalated by the executive to the Trust Board	Trust Board	Board assurance framework

Population of the risk register



*Escalation of risks to executive directors:

Senior manager/GM/CD to notify verbally and via email from Datix to the relevant executive director that a risk has scored 15 or over.
The risk will stay in the 'open approved risks' until the executive director moves it in to 'corporate risks'.
If the executive director does not accept the risk as a corporate risk the risk is either amended (risk score reduced) and managed by the Department/Directorate in the 'Open Approved Risks' status in Datix or rejected (rejected status in DATIX).

Responsibilities:

	Risk Level	Responsibility
	High risk (15 and over)	Reviewed by relevant Executive Director Reported to Trust Management Group monthly (corporate risk register) Executive director has authority to accept, reject, amend Executive Team determines inclusion in BAF if determined as a strategic risk
	Moderate risk (9-12)	Reviewed by Senior Manager / Clinical Director/General Manager Reviewed by departmental governance groups Senior Manager / CD has authority to accept,

		reject, amend
	Low risk (4-8)	Reviewed by local manager. Local manager has authority to accept, reject, amend
	Very low risk (less than 4)	Reviewed by local manager. Local manager has authority to accept, reject, amend

The Executive Team has the following responsibilities:

- Management of risks on the Corporate Risk Register
- Escalation of strategic risks to the BAF
- Undertake a monthly review of the Corporate Risk Register.
- Use the Corporate Risk Register to drive the meeting agenda.
- Escalate any risks to operational performance or quality relevant to contract performance to commissioners.

Corporate risk register:

For a risk to be included in the corporate risk register it must meet the following criteria:

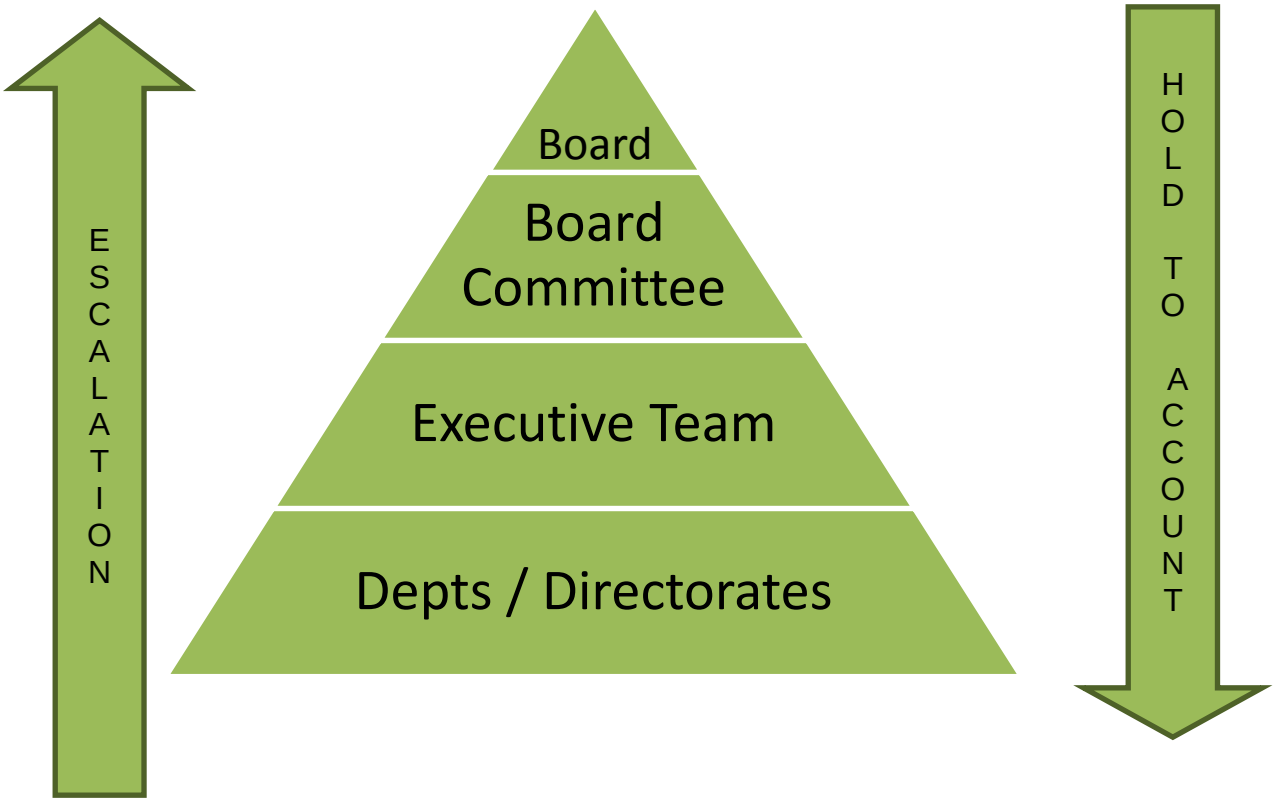
- Risk has the potential to affect the achievement of one or more corporate objectives
- The risk cannot be managed by the executive director in isolation
- It requires further controls to manage the risk which require considerable input to resolve the risk (finance, people, time).

Directorates/Departments:

Risk register to be reviewed at directorate/departmental governance meetings.

Risk Level	**Period of review**
Local / departmental / directorate (<=8)	At least 6 monthly
Local / departmental / directorate (9-12)	At least quarterly
Corporate risks (15-25)	At least monthly
BAF risks	

Risk Escalation Pyramid



7.2 Reactive Risk Identification

7.2.1 Incident Reporting

The reporting of incidents by staff is one of the most efficient and effective systems of identifying risk. It enables action to be taken and lessons to be learned with the aim of preventing recurrence. The Incident Reporting Policy sets out details of the systems in place, including the investigation, analysis and learning from incidents. Incidents and action taken are fed back monthly to staff via the Team Brief.

7.2.2 Complaints and Litigation

This information is recorded in Datix and reported to the Board via the Quality Committee. It is used to identify risks and trends throughout the Trust. Complaints and action taken are fed back to staff via the Team Brief.

7.2.3 Staff Concerns (Whistleblowing)

The Raising Concerns Policy (previously titled 'Whistelblowing Policy') which enables staff to voice any concerns they have. The Policy should be referred to for further details.

7.2.4 Internal and External reviews/assessments

Other risks can be identified from internal and external audit reports, assessments and other reviews, e.g. Peer Review, Quality and Risk Management Standards, BSI assessments, Care Quality Commission. Actions identified following these reviews are monitored via the External Visits Register and Monitoring report to Risk Management Committee (see External Visits Policy). Risks are added to the Trust Wide Risk Register if appropriate and actions monitored via the action tracker.

7.3 Risk Grading Process

All risks are scored using the Trust Risk Matrix and risk grading management system – see Appendix 4. This includes the assignment of responsibility for different levels of risk.

8.0 Other Risk Management Initiatives/Requirements

8.1. Quality and Risk Management Standards

The NHS Litigation Authority (now called NHS Resolution) ceased to assess organisations against the NHSLA standards from 2013/14. However, as the Trust valued the standards for providing a risk management framework, a decision was made by the Director of Nursing and Quality to continue to self-assess against the standards. The standards were reviewed to be more specific to CCC and an annual internal assessment is completed to monitor compliance with the standards. Please see Appendix 9 to view the Quality and Risk Management Standards.

8.2 Trust Wide Registration ISO 9001:2008 Quality Management Standard

CCC achieved trust wide registration to the ISO 9001: 2000 Quality Management Standard in March 2007 through our certification body, the British Standards Institute (BSI). The Radiotherapy Directorate has been accredited since 1998 and it was felt that the Quality Management System used in Radiotherapy had contributed significantly to the successful and safe development of the department during the past few years. Trust wide accreditation aims to provide similar assurance of quality and safety across the Trust as a whole.

Twice yearly assessments are undertaken by the certification body, the British Standards Institute (BSI) in order to ensure that the high standards required for compliance are maintained. Assessments undertaken, combined with our own internal monitoring mechanisms, have ensured that practice and processes have been reviewed regularly, opportunities for improvement identified and changes made promptly and safely to ensure the highest standards of quality of care.

Action plans are developed following each assessment to ensure ongoing compliance. They are monitored by the Risk Management Committee. The Trust was assessed as being compliant with the latest version (ISO 9001:2008) in March 2008 and has since maintained this compliance.

The Trust is aiming to achieve compliance with the latest version of the standard, ISO 9001: 2015, by March 2018.

8.3 Global Trigger Tool

The IHI Global Trigger Tool for Measuring Adverse Events provides an easy-to-use method for accurately identifying adverse events (harm) and measuring the rate of adverse events over time. Tracking adverse events over time is a useful way to tell if changes being made are improving the safety of the care processes. The Trigger Tool methodology is a retrospective review of a random sample of inpatient hospital records using “triggers” (or clues) to

identify possible adverse events. It is important to note, however, that the IHI Global Trigger Tool is not meant to identify every single adverse event in an inpatient record. The methodology, recommended time limit for review, and random selection of records are designed to produce a sampling approach that is sufficient to determine harm rates and observe improvement over time.

Monitoring of progress of the above is reported to the Risk Management Committee at each meeting.

8.4 Care Quality Commission (CQC) Standards of Quality and Safety

All health and adult social care providers who provide regulated activities are required by law to register with the Care Quality Commission.

The Care Quality Commission (Registration) and (Additional Functions) and Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012 details how the Care Quality Commission will regulate healthcare in England.

Inspection and regulation of care services will ask the following questions about services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

The CQC implemented new fundamental standards from April 2015 and processes are in place to ensure the trust maintains registration and meets the requirements set out in the Act.

8.5 Quality Surveillance Programme

The Quality Surveillance Team (QST), formerly National Peer Review Programme, lead an Integrated Quality Assurance Programme for the NHS

and is part of the National Specialised Commissioning Directorates, Quality Assurance and Improvement Framework (QAIF).

The QST regional teams will be involved in the surveillance and review visits of all specialised and cancer services.

The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all cancer services and specialised commissioned services within NHS England.

The QST will measure performance against quality standards for cancer and specialised services.

The programme is an integrated process for quality assurance which covers all aspects of quality in particular; patient safety, patient experience, clinical effectiveness and outcomes.

Each service will need to provide an annual self-declaration to comply with the indicators. This is monitored by the QST and any non-conformances are actioned accordingly.

8.6 Sign up to Safety Campaign

The Clatterbridge Cancer Centre NHS Foundation Trust has signed up to a three-year national campaign that aims to make the NHS the safest healthcare system in the world.

Sign up to Safety requires NHS organisations to:

- Listen to patients, carers and staff
- Learn from what they say when things go wrong
- Take action to improve patients' safety

We have developed our plan that describes what we will do to reduce harm and save lives by working to reduce the causes of harm and take a preventative approach.

The plan is built around five core pledges:

1. Put Safety First – commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally
2. Continually learn – make organisations more resilient to risk, by acting on feedback from patients and by constantly measuring and monitoring how safe services are
3. Honesty – be transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. Collaborate – take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. Support – help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress

Our action plan builds on our existing work and actions in our Quality Strategy. Progress against this action plan will be published on the website.

9.0 Analysis and Monitoring of Aggregated Data

The monitoring of risk is an ongoing process to ensure that risks are identified, assessed and minimised as much as possible. There are a number of different monitoring processes within the Trust, from Department to Board Level. All staff need to be involved in the risk management process either through the identification of risk, monitoring of risk, audits, consultation and communication of risk to ensure an holistic approach to risk management.

9.1 Analysis of Incidents, Complaints and Claims

The Trust ensures a systematic approach to the analyses of incidents, complaints and claims on an aggregated basis.

Co-ordinated approach to the aggregation of incidents, complaints and claims

Incidents, complaints and claims are aggregated into a quarterly risk management report by the Risk Management Facilitator, which is monitored by the Risk Management Committee at every meeting. These reports act as a single point of co-ordination for the analysis of incidents, complaints/PALS and claims and include both quantitative and qualitative analysis for review at each Risk Management meeting.

Minimum content of analysis report for the Risk Management Committee

The minimum content of the reports include:

- Risk Register Review, including risks by grade
- Incident reporting:
    - total reported per month over the previous 12 months,
    - incident type per month over the previous 12 months,
    - monitoring of trends table over previous 12 months,
    - details of serious incidents and incident reviews including action plans,
    - details of trends and areas of concern,
    - externally reported incidents
    - Levels of harm
- Claims:
    - New claims
    - monitoring of all outstanding claims, including any identified actions
- Complaints/PALS
    - New complaints and PALS issues raised,
    - details of previous complaints and PALS to identify trends over time
    - Actions taken/planned
    - Monitoring of complaints process table
- Inquest details, including conclusion and any actions identified
- All safety alerts received, including actions taken and all outstanding alerts for monitoring of progress

This information is communicated to departments via the Departmental Reviews and to all staff by the monthly Team Brief.

9.2 Learning from incidents, complaints and claims

A key aspect of the Risk Management Strategy is to ensure learning has taken place following incidents, complaints/PALS and claims. Improvements in practice take place following the analysis of the information on an individual and aggregated level. Action plans are developed and monitored by the appropriate committee which will identify any learning requirements, e.g. further staff training, changes to policies, new equipment requirements etc. The actions plans are then monitored on a regular basis to ensure the actions have been completed to minimise any further risk.

The Risk Management Committee, Quality and Safety Sub Committee and the directorates/departments identify new risks from this information which will then be added to the Trust wide and Departmental Risk Register to ensure further on-going monitoring and risk reduction measures have been taken.

9.2.1 The Process of Implementing Risk Reduction Measures from the analysis of incidents, complaints and claims

- Actions identified from incidents, complaints and claims analyses are reported as part of the risk reports at each Risk Management meeting
- The outstanding actions for each department are included in the departmental/directorate quality reports for further monitoring and review at departmental/directorate level

9.2.2 Local and Organisational Learning – lessons learnt

Local and organisational learning from incidents, complaints and claims takes place through:

- Local ownership via Departmental quality reports, which includes details of both departmental and trust wide issues

- Team Brief – a monthly team brief is held by the Chief Executive to the Heads of Department which is then cascaded down to all staff. This contains a clinical governance section with sections on incidents/complaints/claims/policies/safety alerts/audits at every meeting.
- Monitoring of action plans by Risk Management
- Risk Management Annual Report and Clinical Governance Annual Report
- Working groups, e.g. Manual Handling/Falls Prevention
- Serious incident panels and the on-going monitoring of action plans by the relevant committees
- Incidents, complaints or claims involving other organisations are investigated jointly where possible and lessons learnt are shared across the other organisations, either by holding joint reviews or sharing the investigation reports

10.0 Training

Details of the training requirements for all staff groups are detailed in the training needs analysis and monitored centrally by Learning and Development via the training database (see Training Needs Analysis in Learning and Development Policy).

11.0 Risk Funding

Financial planning to deal with risks is determined as part of the annual budget setting round, with the financial plans being approved by the Trust Board. The budgeting round identifies investment required in revenue and capital, priorities being judged in terms of developments and risks. More specifically the financial consequences of managing risk include the following key elements:

- The Trust participates in the Clinical Negligence Scheme for Trusts and the non-clinical risks scheme. The cost of premia are fully budgeted for.
- Budget holders are expected to manage financial risks within their revenue resources, however where this is not possible, corporate

reserves may be accessed with a bid which is subject to Executive Director approval.

- Capital resources are also set aside to deal with generic estates issues

12.0 Monitoring and Review

The Strategy is reviewed on a biannual basis by the Risk Management Committee and the Trust Board if changes are made. A number of review mechanisms are used to measure performance:

- Risk management indicators (see Appendix 4) have been developed and are monitored at least annually by the Risk Management Committee.
- An annual Risk Management report is completed which will assess the Trust's position against the key sections of strategy. This report will be reviewed by the Risk Management Committee and any deficiencies identified will be monitored via the annual report action plan (monitored at each meeting until completion).

See Appendix 9 for detailed monitoring of the policy.

Appendix 1

Risk Management Committee Terms of Reference

1. Constitution

The Risk Management Committee will include the following members of CCC staff:

- The Director of Nursing and Quality - Chair
- The Director of Finance
- Medical Representative
- Workforce and Organisational Development Manager
- Risk Management Facilitator
- Clinical Governance Managers
- Non-executive Director
- Health and Safety Advisors

Other staff members will be co-opted to the RMT as required.

2. Arrangements for meetings

a) Frequency of Meetings
The Committee shall meet quarterly. Additional meetings may be convened, at the discretion of the Chairman in the event of important matters arising, at the request of any member of the Committee. A schedule of meetings will be agreed at the beginning of each year.

b) Quorum
A quorum of the Committee shall consist of not less than five of those members (or their deputies) entitled to be present. This must include a member of CGST (Clinical Governance Support Team) and at least 2 Executive/Non Executive members.

c) Deputies
The nominating of deputies and their attendance in the absence of regular members is encouraged in order to ensure active involvement and to minimise the deferring of agenda items.

d) Attendance
All members are required to attend at least 2 of the 4 meetings held each year. This will be monitored as part of the Risk Management Indicators.

e) Reporting arrangements

Quality Committee:
Receive a bi-annual report on the analysis and trends identified in the serious incident report, highlighting any emerging risks
Review any significant serious incident investigation reports or thematic reviews from the last quarter as determined by the Chair to ensure learning and quality improvement

Quality and Safety Committee:
Receive an annual report on compliance with the Quality and Risk Management Standards

Review the outcomes of relevant investigations, audits and reports, including those that highlight good practice, and ensure that appropriate action plans

are in place to implement the learning from such reports to improve systems, processes and practice. Monitor the implementation of relevant plans and report outcomes to the Board by exception.

Receive the six monthly Serious Incident Report and identify or escalate risks. Including Coroners findings, complex complaints, learning from adverse incidents

Reports from the subcommittees (detailed in the organisational chart – see Appendix II) to the Risk Management Committee will take place via reports from the relevant committee members on an exception basis at each meeting.

3. Terms of Reference

The scope of risk addressed by the Risk Management Committee (RMC) can be categorised into patient related risks, organisation related risks and Health and Safety issues. A programme developed by the RMT will address all parts of CCC activity from clinical services to the maintenance of equipment and the education of staff.

Meetings will be held every four months (4 in total per annum)

1. The RMC will formulate (or ensure the existence of) the policies and procedures necessary to fulfil the requirements of the CCC strategy for managing risk.

2. The RMC will ensure that monitoring mechanisms are in place to assure compliance with agreed policies and protocols.

3. The RMC will review the collated results of incident reports, claims, complaints and safety alerts at each meeting, identify trends and make recommendations for changes to policy or activity.

4. The RMC will recommend a programme of education on risk management for CCC staff.

5. The RMC will regularly review the mechanism for reporting untoward incidents/accidents and make any necessary recommendations for change.

6. The RMC will report to the Board via the Quality Committee quarterly or as necessary in the case of major incidents.

7. The RMC will receive from managers or staff information (in confidence if necessary) about any potential risk identified within the Centre.

8. The RMC will oversee a centre-wide programme of action and audit to meet the objectives of the Risk Management Strategy.

9. The RMC will receive exception reports/updates from other specialist risk groups (H&S Committee, Infection Control Committee, RPA/RPS, Manual Handling/Falls).

10. The RMC will monitor the management process of the Risk Register.

11. The RMC will monitor and review key performance indicators capable of showing improvements in risk management.

12. The RMC will review all safety alerts received via CAS (Central Alerting System), claims and inquests.

13. The RMC will review policy audits and ensure any actions identified are monitored until completion.

14. The RMC will monitor actions plans from incidents, claims, safety alerts, external visits/assessments, complaints and inquests to ensure completion.

15. The RMC will review the Risk Management Annual Report and monitor any actions identified until completion

Appendix 2

Risk Management Organisational Structure

Appendix 3

Risk Assessment Guidance

Introduction

The Trust is legally obliged to carry out risk assessments. Their main purpose is to identify hazards and to determine whether planned or existing controls are adequate. The intention is that risks should be controlled before harm can occur, i.e. it is pro-active risk management.

Risk assessment is not a new concept and it is an implicit requirement of the Health and Safety at Work Act 1974, as well as a number of other regulations. However, risk assessment is not just concerned with health and safety but needs to be carried out on every activity we undertake in the Trust from clinical practices to financial and organisational issues.

The Risk Assessment Process
All departments will be issued with a generic form to assist with the risk assessment process. This form is available on CCO comms in the Risk Management Folder. The risk assessments should provide an inventory for action and form the basis for implementing control measures. The assessments should be carried out by staff with practical knowledge of the work activities. Ideally they should be carried out by small teams and every effort made to consult with all staff in that department.

The following steps should be followed:

1. Think about all the work activities carried out in the department. You may find it helpful to divide your department into distinct areas such as sluice etc and then consider elements related to direct patient care risks, health and safety risks, organisational risks etc
2. Identify any hazards that exist - a hazard can be described as anything with the potential to cause injury, damage or loss. Hazards that clearly possess negligible potential for harm should not be considered further.
3. Decide who may be harmed
4. Determine if there are any risks associated with this hazard
5. Identify if there are any control measures already in place
6. Identify whether further controls need to be introduced
7. Record your findings, including a target date for action and a review date. Please sign and date the assessment. Copies should be kept within the department and staff should be made aware of them.
8. The action plans need to be monitored
9. Please forward copies of your assessments to Risk Management/Health and Safety

Assessments should be reviewed/updated:

- At least annually/in accordance with the risk grading management process
- When any new practice/procedure is introduced
- When any change is made to existing practice
- In the light of changes to legislation
- On staff reporting pregnant
- On the employment of persons under the age of 18

- Following any incident to ensure there is no recurrence

Examples of risks affecting direct patient care:
Standards of record keeping
Standards of service and care delivered
Adequacy of policies, protocols and guidelines
Informed consent arrangements
Training and supervision of staff
Medication errors/issues
Equipment issues (are staff trained in its use?)
Control of infection
Falls

Examples of health and safety risks:
Needles and other sharps (storage, use and disposal)
Manual Handling
Slip trip fall hazards
Work equipment (mechanical/electrical/tools/ladders/handling aids)
Exposure to hazardous substances (COSHH)
Access to height (high shelves)
Lack of storage space
Computer equipment use (DSE)
Access to sharps/drugs by visitors especially children
Personal security, especially at night
Poor lighting
Electrical equipment (fire and electrocution)
Fire hazards
Vehicles (on and off site)
Stress
Medical gases
Radiation
Verbal or physical abuse

N.B. Some risks are subject to regulations which demand their own specific risk assessments. These include: COSHH, DSE (Display screen equipment), Manual Handling and Radiation.
Where assessments relating to these topics are already in place, it is sufficient during general risk assessment simply to make reference to them.

Control Measures
Examples of control measures:
Written procedures, rules and protocols (and are these readily available for reference?)
Physical protection (machinery guards, fencing)
Electromechanical protection (proximity switches, interlocks)
Permit to work systems
Professional training (initial)
Regular staff update training, e.g. manual handling. (records available?)
Regular maintenance of equipment. (evidence available?)
Personal protective equipment (e.g. gloves, safety glasses)
Warning signs and notices

RISK ASSESSMENT FORM

Dept:	**Assessment date:**
Lead Assessor/s:	**Who/What is at risk:**

RISK INFORMATION

Summary of risk (brief description to populate the Trust Risk Register):

Description of risk (background information / detail to give risk context):

Existent control measures: (i.e. what is currently in place to reduce the risks)

Risk Scoring- see risk matrix attached

Impact score = ☐

Likelihood score = ☐

Risk Score (impact x likelihood) ☐

Impact descriptor used (e.g. finance, radiation etc) = ☐

Action Plan

Action	Responsibility	Due Date	Progress	Completed date

Please send a copy to your manager for review and inclusion on the risk register if required.

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix 4

Risk Grading

Risk scoring methodology, risk reporting and action

Risk Grading:

1. **Impact: Use table 1 to determine the Impact score. In the case of incidents, complaints and claims, this is the actual consequence (what actually happened). In the case of proactive risk assessments, it is the potential consequence (i.e. what could potentially happen). All events may have one or several types of impact (e.g. patient injury, financial etc). The score used as the overall impact score is the highest one.**
2. **Likelihood: Use Table 2 to determine the Likelihood score. This is the chance of the impact score described above will occur or recur.**
3. **Risk Score: Use Table 3 to calculate the Risk Score. Multiply the Impact score with the Likelihood score. This will give a value between 1-25.**
4. **Detail actions in the action plan to mitigate or eliminate the risk.**
5. **Table 4 details the management of the risk depending on the risk score.**

TABLE 1: The descriptors and levels of Impact.

	1	2	3	4	5
	None	**Minor**	**Moderate**	**Major**	**Catastrophic**
Patient injury (emotional, physical, psychological, loss of function)	No injury or identifiable damage	Mild injury. Extra observation or minor treatment. Minimal harm.	Significant but not permanent harm. Moderate increase in treatment.	Serious injury with prolonged disability-permanent harm	Unexpected death or significant permanent disability
Staff / visitor injury	No injury or minor injury not requiring first aid	Mild injury requiring first aid	Injuries that last for more than 3 days	Major injuries reportable under RIDDOR	Unexpected death or significant permanent disability
Control of infection	Minor microbiological contamination not coming into contact with patients, staff or public	Contamination or hospital acquired colonisation affecting one or more individuals	Contamination causing hospital acquired infection of one or more individuals	Contamination or hospital acquired infection causing clinical impact to patient / staff or closure of the ward	Contamination or hospital acquired infection causing unexpected death or significant permanent disability or multiple ward or hospital

					closure
Possibility of complaint or litigation	No possibility of complaint or litigation	Slight possibility of complaint or litigation	Likely complaint or litigation	Claim above excess level. Justified multiple complaints	Multiple claims or single major claim
Objectives / project slipping	Insignificant project slippage, cost increase. Barely noticeable reduction in scope or quality	Minor project slippage. Minor reduction in scope or quality. <5% over budget	Serious over run on project Reduction in scope or quality 5-10% over budget	Project in danger of not being delivered. Failure to meet secondary objectives 10-25% over budget	Unable to deliver project Failure to meet primary objectives >25% over budget.
Service / business interruption	Loss / interruption up to 1 hour	Loss / interruption up to 4 hours	Loss / interruption up to 8 hours	Loss / interruption up to 2 days	Loss / interruption more than 2 days
Workforce capacity / capability	Service delivery not compromised	Service delivery compromised at a minimum short term level (1 day) Unsatisfactory staffing level (below minimum level and skill mix)	Service delivery compromised / reduced. Ongoing unsafe for 2-5 days	Service delivery compromised / reduced. Ongoing unsafe for 5-10 days	Major service disruption / inability to provide service due to significant lack of staff
Financial	No obvious / small impact.	Financial impact less than (£50K)	Financial impact (£50-<250k)	Financial impact : Capital schemes: (£250k - <£3m) Revenue: (£250K - <£1m)	Financial impact : Capital schemes: (£>3m) Revenue: (£>1m)
External inspections	No adverse comments / non compliances	Recommendations given	Challenging recommendations	Enforcement action / critical report	Severely critical report / improvement notices / removal of licence
Adverse publicity / reputation	Rumours (internal / external) no impact on reputation	Local media attention – short term and retrievable	Local media attention – ling term – impact on reputation resulting in detrimental impact upon perception of stakeholders	National adverse publicity or significant negative publicity relating to Trust practice which has impact on business continuity	National adverse publicity resulting in significant detrimental impact on business. Full public enquiry.
Estates infrastructure	Minor service inconvenience. Able to be resolved in 1 day.	Temporary loss of service in single area. Safety breach that could	Prolonged loss of service to single areas that would result in area closure. Safety breach that	Prolonged loss of service to single or multiple areas that would result in area closure.	Hospital wide disruption to clinical services.

	Effects small part of hospital	lead to injury but risks able to be controlled.	could lead to serious injury and able to be controlled.	Safety breach that could lead to serious injury and risks not able to be controlled	External safety warning of major danger to staff / patients.
Compliance	No or minimal breach of guidance / regulatory or statutory duty.	Breach of guidance / regulatory or statutory duty. Reduced performance but able to resolve. Unresolved.	Breach of guidance / regulatory or statutory duty. Reduced performance rating if unresolved.	Breach of guidance / regulatory or statutory duty. Improvement notices. Low performance rating	Breach of guidance / regulatory or statutory duty. Prosecution. Complete systems change required. Severely critical report.
Information governance	Less than 5 people affected or risk assessed as low e.g. files encrypted	Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people effected	Serious breach of confidentiality e.g. up to 100 people effected	Serious breach with either particular sensitivity or up to 1000 people effected	Serious breach with potential theft.
Radiation	None or minimally increased dose to staff or patients	Some increase in dose to one or more individual(s) (non-patient) Some increase in patient dose (for <30% of treatment fractions)	Dose Investigation Levels exceeded for one or more individual(s) (non-patient) Impact on dose for many treatment fractions or for several patients Significant increase in patient dose (non-treatment) (>50%)	Annual Dose Limit exceeded for one or more individual(s) (Reportable) >5% impact on treatment dose (full course) Impact on treatment dose for many patients (>5%) Major increase in patient dose (non-treatment) (>3x)	Critical dose to one or more individual(s) >20% impact on treatment dose (single fraction) or 10% (full course) (Reportable) Impact on treatment dose for very many patients (>15%) Reportable increase in patient dose (non-treatment)
Patient experience / outcome	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience readily resolved	Mismanagement of patient care, short term effects (less than a week)	Serious mismanagement of patients care, long term effects (more than 1	Totally unsatisfactory patient outcome or experience.

				week)	
Chemotherapy Prescribing	Insufficient information, treatment not prescribed, calculation errors within 10% . Intervention did not affect standard of patient care	Minimal harm/disruption to patient, legal requirements for prescriptions not met, missing signatures, non protocol forms, incorrect number of cycles, Incorrect interval/date/schedule, supportive meds not prescribed, dose calculation error between 10-20%. Late prescriptions.	Moderate toxicity, illegible prescription, Dose calculation error >20%, chemotherapy drugs omitted from protocol	Incorrect route. Major/permanent toxicity. Dose calculation error >30%, wrong drug prescribed	Death or significant permanent disability. Dose calculation error>50%
Omitted Medicines	No omitted doses	Omission of any medicines without a valid reason (minor harm)	Omission of any medicines without a valid reason (moderate harm)	Omission of any medicines without a valid reason (major harm)	Omission of any medicines that leads to patients unexpected death or significant permanent disability

TABLE 2: Likelihood.

	Descriptor	Proposed description
1	Rare	May occur in exceptional circumstances, not expected to occur.
2	Unlikely	Unlikely to occur, could occur on an infrequent basis
3	Possible	Reasonable chance of occurring. Expected to occur a few times.
4	Likely	Will occur in most circumstances, expected to occur in most circumstances. However, not a persistent issue.
5	Certain	Most likely to occur than not, expected to occur frequently / expected to occur in most circumstances. Is a constant threat, is custom and practice.

TABLE 3: Risk grading matrix:

Impact→ **↓ Likelihood**	None	Minor	Moderate	Major	Catastrophic
Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

TABLE 4 : Management of Risk:

	Risk Level	Responsibility
	High risk (15 and over)	Reviewed by relevant Executive Director Reported to Trust Management Group monthly (corporate risk register) Executive director has authority to accept, reject, amend Executive Team determines inclusion in BAF if determined as a strategic risk. Managed by an executive director Immediate action to remove or reduce the risk Highlight action plan contained in risk register with defined timescales and target reduction to reduce or remove the risk with full risk mitigation plan developed by risk owner. Risk reviewed at least monthly. Risks included in departmental reviews.
	Moderate risk (9-12)	Reviewed by Senior Manager / Clinical Director/General Manager Reviewed by departmental governance groups Senior Manager / CD has authority to accept, reject, amend Managed by Senior Manager / Clinical Director/General

		Manager Action plan contained in risk register with defined timescales to reduce or remove the risk Risk reviewed at least quarterly.
	Low risk (4-8)	Reviewed and managed by department manager. Manager has authority to accept, reject, amend Action cost effective in reducing risk Actions contained within risk register, reviewed minimum of 6 monthly
	Very low risk (less than 4)	Reviewed and managed by department manager. Local manager has authority to accept, reject, amend Actions contained within risk register, reviewed minimum of annually

Appendix 5

Terms of Reference for Clinical Governance Support Team (CGST)

Membership

Associate Director of Quality
CGST secretary/PA to AD Quality
Quality Manager/Clinical Governance Manager-Radiotherapy
Clinical Governance Manager-Regulation
Clinical Governance Manager-Patient Safety
Clinical Governance Manager-Medicines Safety
Quality Manager/Clinical Governance Manager-Audit & Statistics
Document Control Manager /FOI Lead
Health and Safety Advisor/LSMS
Health and Safety Advisor/EPO
Patient Experience Manager
Risk Management Facilitator
Information Governance Manager
Volunteer Coordinator
Manual Handling Advisor
Co-opt other Trust staff as appropriate

Background

The Clinical Governance Support Team has been established to improve the experience of patients and to offer practical support to staff in ensuring care and services provided across all Trust sites are consistently of the highest quality and in line with regulatory, locally agreed and national standards.

Accountable to:

Director of Nursing and Quality
Associate Director of Quality

Responsibilities of the group;

- Manage Health, Safety and local security arrangements and Information governance
- Manage the incident reporting system
- Manage Claims, Inquests and Complaints Handling on behalf of the Trust
- Manage the Clinical Effectiveness Team to ensure the delivery of an effective and accurate clinical coding, clinical information and clinical audit service and medical statistics.
- Chair the Clinical Audit Sub-Committee
- Lead/manage the Trust's mortality and NICE guidance compliance programme
- Provide a PALS service
- Lead the implementation of the Patient and Public Involvement Strategy

- Develop and manage a Trust Wide Quality System to BSI standards and ensure it functions effectively. NB Protection of the current BSI standards in the Radiotherapy Directorate is essential
- Manage Clinical Governance projects effectively
- Lead and co-ordinate delivery of Trust wide regulatory compliance
- Ensure that mandatory training is delivered effectively and that appropriate records are maintained
- Manage the document control system (e.g. policies, procedures)
- Ensure that any relevant external reviews are co-ordinated and managed effectively e.g. Care Quality Commission, BSI, Quality Surveillance Team, MIAA
- Identify and monitor appropriate Clinical Bench Marks
- Provide advice on all aspects of the Quality Agenda
- Assist in the achievement of the Trusts corporate business plans
- Assist in the achievement of Trusts, and Quality Departments, quality business plans / quality strategy
- Promote Quality throughout the Trust
- Lead / manage workload management systems
- Manage and provide advice/guidance for staff in order to continually improve and expand the Trust's Patient Information series
- Develop an annual Quality Report and Annual Risk Management Report
- Manage Freedom of Information Requests
- Manage Patient Safety Campaign
- Collate comprehensive evidence for regulatory requirements, e.g. CQC
- Manage Safety Alert System (CAS)
- Lead/manage Non- Medical Prescribing and Patient Group Directions programmes

Relationships between Committees

The team will provide regular and appropriate reports for the

- Trust Board
- Quality Committee
- Quality and Safety Sub Committee
- Risk Management Committee
- Health and safety committee
- Governance & Compliance Committee

Authority to Act

This group will act on recommendations from the Trust's Quality Board Lead

Monitoring the work of the Committee

The Director of Nursing and Quality, the Associate Director of Quality and the Quality and Safety Sub Committee will regularly review the activity of the CGST

Appendix 6

Risk Management Key Performance Indicators

INDICATOR	AUDIT / EVALUATION
Number of incidents reported	• Reported at each Risk Management meeting • Risk management annual report
Incident reporting by staff groups	• Reported at each Risk Management meeting • Risk management annual report
Top five incident type reported	• Trend analysis reported at each Risk Management meeting • Annual summary report
Number of serious incidents panels and incident reviews	• Reported at each Risk Management meeting • Risk management annual report
Number of harm incidents	• Risk management annual report • Incident reports to Risk Management Committee
Number of incidents reported externally (e.g. STEISS, DoH, SHOT, HSE)	• Report to risk management committee • Risk Management annual report
Number and type of staff incidents	• Annual report to risk management committee
Number of claims received	• Monitored at each Risk Management meeting • Annual report to risk management committee
Claims status – settled, discontinued, open	• Claims status and updates reported at each Risk Management meeting • Annual summary report to risk management committee
Number and outcome of Inquests	• Update report to each risk management committee meeting • Annual report to risk management committee
Number of complaints and referrals to Ombudsman	• Monitored at each Risk Management meeting • Annual report to risk management committee
Adherence to reporting times for complaints	• Monitored at each Risk Management meeting • Annual report to risk management committee
Board and senior manager risk/H&S training	• Annual report to risk management committee
Percentage of CAS alerts actioned within required timeframe.	• Annual report to risk management committee
Review of Risk Register	• Report at each risk management committee • Annual summary report to Risk Management Committee
Attendance at risk management committee	• Annual report to risk management committee
Reporting arrangements from sub-committees to Risk Management	• Annual report to risk management committee

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix 7

Quality Committee Terms of Reference

Committee Terms of Reference

Quality Committee

Purpose

The role of the Quality Committee is to provide the Trust Board with assurance on the effective management of quality and risk governance for the Trust to ensure the safety and quality of the services provided by the Trust. This includes ensuring the delivery of associated strategies included but not limited to:

- Quality
- Patient Involvement
- Risk Management
- Infection Control
- Workforce & Organisational Development
- Research Governance

Date Adopted	6th September 2017
Review Frequency	Annual

Core Accountabilities	
Terms of reference drafting	
Review and approval	Quality Committee
Adoption and ratification	Trust Board

1. Authority

1.1 The Trust Board hereby resolves to establish a Committee of the Board to be known as the Quality Committee ("the Committee").

1.2 The Committee is a standing committee of the Trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be set out below and will be subject to amendments approved by the Board.

1.3 The Committee is authorised by the Board to act and investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 The Committee is authorised to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

2. Membership and attendance at meetings

Membership

2.1 The Committee shall be appointed by the Board and shall consist of:

- Three Non-Executive Directors
- Two Executive Directors
  - Director of Nursing and Quality
  - Medical Director
- Director of Workforce and OD

2.2 A Non-Executive Director shall be appointed Chair of the Committee.

Quorum

2.3 The quorum necessary for the transaction of business will be:

- Two Non-Executive Directors
- One Executive Director

Attendance

2.4 Meetings of the Committee shall normally be attended by:

- A Public Governor
- Chief Executive

2.5 The Committee may invite other persons to attend a meeting so as to assist in deliberations (other Executive and Non-Executive Directors can attend meetings as desired but will not form part of the permanent membership of this committee). The Chair shall be notified of any additional attendees prior to the meeting.

2.6 Members will attend at least 75% of meetings.

2.7 If needed, meetings by conference telephone call are acceptable with the approval of the Committee Chair.

3. Roles and responsibilities

3.1 The Board will delegate delivery of Strategic Plan actions to the appropriate Committee in conjunction with any relevant sections of the Board Assurance Framework.

3.2 The Committee will act on any delegated responsibilities allocated by the Board.

3.3 The Committee will delegate actions to appropriate sub-groups as and when required.

Governance

3.4 The Committee will ensure that there are appropriate arrangements in place to deliver the highest standards of quality and risk management including clear responsibilities from 'Board to Ward'.

3.5 The Committee will review the Trusts Quality Accounts prior to its submission to the Trust Board. Undertake any other responsibilities as delegated by the Board.

3.6 Review benchmarked performance against other providers.

3.7 Promote visible leadership with regard to quality and risk management.

Quality Assurance

3.8 The Committee will ensure that the Board is assured in relation to quality (patient experience, safety and outcomes) and workforce.

3.9 This will include but not limited to:

- Infection control
- Appraisal and revalidation
- Clinical outcomes and mortality
- Safeguarding
- Quality Impact Assessment of CIP and service developments. The Committee will scrutinise and challenge relevant Trust plans and developments in respect to the impact on quality.
- Medicines safety
- CQUINS delivery
- Workforce indicators
- Staff engagement
- Clinical and process audit
- CCC Quality and Risk Standards
- Patient harms
- Safety Climate Survey
- Unwarranted variations in clinical practice

Regulatory and other Compliance

3.10 The Committee will ensure that all regulatory and other requirements are complied with proven and demonstrable assurance.

3.11 This will include but not limited to:

- CQC regulatory requirements
- Health and safety legislation
- NHS Constitution
- Equality legislation
- IR(ME)R and IRR
- Contractual quality requirements
- ISO 9001:2008
- NICE guidance
- National audits and NCEPOD enquiries

Risk Management

3.12 The Committee will ensure that there are robust risk management systems in place.

3.13 This will include but not limited to:

- Ensuring that there is an up to date risk register in place
- Monitor progress against actions to mitigate risks to quality and ensure appropriate controls and assurances are in place
- Ensuring a culture of openness and transparency with regard to reporting risk
- Providing a forum for reviewing risk, incidents and concerns (including whistleblowing) and ensure a culture of continuous learning from incidents, claims and complaints
- Ensure that the Trust meets its obligations with regard to the Duty of Candour

Involving and Learning from Patients and Public

3.14 The Committee will ensure there are systems and processes in place to elicit feedback from patients and stakeholders on the quality of services provides by the Trust.

3.15 The Committee will review information on trends and themes from patient experience measures including complaints and PALS.

4. Conduct of business

4.1 A nominated individual from the Executive Secretariat 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.

4.2 The Committee Secretary will:

- Provide timely notice of meetings
- Liaise with the Chair and Director of Nursing and Quality to agree meeting agendas and attendees

- Collect and forward agendas and supporting documents to members and attendees in advance of the meetings
- Attend to take minutes of the meeting
- Maintain a record of matters arising and issues to be carried forward

Frequency

4.3 The Committee will meet bi-monthly.

4.4 Meetings will normally last no longer than two and a half hours.

Notice of meetings

4.4 An agenda of items to be discussed will be forwarded to each member of the Committee and other attendees as appropriate no later than four working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

5. Reporting

Reporting Arrangements from Quality Committee

5.1 Formal minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.2 The Chair of the Committee will present a report to the next meeting of the Board, summarising the decisions of the Committee.

5.3 The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to any regulatory authority eg CQC, NHS Improvement, the Council of Governors, or require executive action and raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.4 On an annual basis the Committee will complete and report to the Board on:

- the performance of its duties as reflected within its Terms of Reference
- an annual work plan of activity
- output of the Committee's self assessment
- attendance of Committee members
- make a recommendation as to whether the Committee continues.

5.5 Provide assurance as required on its activities to the Board.

5.6 The Trust's annual report will include a section describing the work of the Quality Committee in discharging its responsibilities and attendance of members.

Reporting Arrangements into Quality Committee

5.7 The Committee will receive information in a variety of formats. These will include:

- A Quality Committee Performance Report
- Reports from sub committees
- Annual Reports
- Subject reports
- Ad hoc reports.

These topics will be included in the annual programme for the Committee.

6. Review

6.1 These Terms of Reference will be subject to an annual review. This review will include a self-assessment on performance of its duties as set out within the Terms of Reference and delivering against the needs of the Trust. Any conclusions and recommendations for change are to be reported to the Board.

6.2 As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

Appendix 8

Quality and Risk Management Standards

Standard ⇨ Criterion ⇩	1 Safe	2 Effective	3 Caring	4 Responsive to people's needs	5 Well led
1	Identifying and managing risks to quality of care (QIPP)	VTE	Sickness absence	Concerns and complaints	Risk Management Strategy (including Risk Register)
2	Maintenance of Medical Devices	Medicines Management	Fluid Balance – new for 2017/18	Being Open / Duty of Candour	Claims management
3	Transfusion	Sepsis	Violence and aggression	Screening procedures	Root cause Analysis
4	Safe Surgery Checklist	Deteriorating Patient	Stress	Diagnosis (source documentation)	Dealing with external recommendations
5	Slips, trips and falls	PDR	Supporting staff (incidents, claims, inquests, complaints, whistle blowing)	Secure environment	Professional registration (clinical and non clinical)
6	Moving and handling	Imaging Reporting – new for 2017/18	Harassment and bullying	Incident reporting	Clinical audit
7	Inoculation risk	NICE (including quality standards) and NCEPOD	Intentional rounding	Consent and Information Giving Consent training	Procedural documentation
8	Medical devices training	Pressure ulcers	Dementia / additional needs	Patient ID checks	Training needs analysis
9	Employment checks	Health records management	Discharge	Mental Capacity	Mandatory training (including Communication skills training and risk management training for senior managers)
10	Checking pregnancy status	Health record keeping standards	Clinical handover of care	Nutrition	Induction

Appendix 9

Monitoring and Review

The lead person responsible for monitoring compliance and developing and implementing action plans to rectify non compliance with this strategy is the Risk Management Facilitator.

Where non compliance is identified action plans will be developed by the lead assigned to each section and progress against the action plan will be presented to the identified monitoring committee at each meeting until the issue is resolved.

The Strategy is reviewed on an annual basis by the Risk Management Committee and the Trust Board if changes are made. A number of review mechanisms are used to measure performance: Risk management indicators (see Appendix IV) have been developed and are monitored at least annually by the Risk Management Committee.

An annual Risk Management report is completed which will assess the Trust's position against the key sections of strategy. This report will be reviewed by the Risk Management Committee and any deficiencies identified will be monitored via action plans.

1. Monitoring of the Risk Management Strategy

1A. The organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- The Strategy details the risk management structure in Appendix II and a biannual review of the strategy by the Risk Management Committee ensures this is kept up to date
- As part of the Key Performance Indicators, monitored on an annual basis as part of the Risk Management Annual Report, a review of the reports received from the various committees at each risk management meeting takes place.

1B. The process for board or high level committee review of the organisation-wide risk register

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- Review of the Risk Register is monitored at each Risk Management meeting via the Risk Register Monitoring Report
- The Annual Risk Management Report reviews when and where the risk register has been reviewed in the previous year

1C. The process for the management of risk locally, which reflects the organisation-wide risk management strategy

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee/H&S Committee

- The Risk Management Annual Report reviews the process for the management of risk locally in the previous 12 months. This includes a review of the monitoring of risk registers by departments, board committees (Integrated Governance and IM&T) and the Board to ensure the process has been followed as required (see section 7.1.1.1 risk register)
- Any actions identified are included in the action plan produced as part of the annual report, which is monitored by the Risk Management Committee to ensure actions are completed. This is a standing agenda item at each meeting.

1D. *Duties* of the key individual(s) for risk management activities

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- Responsibilities for risk management activities are monitored in the Risk Management Annual Report
- Key Performance Indicators reported in the Risk Management Annual Report monitor attendance at Risk Management meetings and reporting arrangements to the Risk Management Committee

1E. Authority of all managers with regard to managing risk

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- This will be monitored in conjunction with responsibilities as above, via the Risk Management Annual Report
- Managers responsibilities are also monitored via the incident reporting audit completed on an annual basis

2. Monitoring of Terms of Reference of Risk Management Committee

2A. Duties

Lead: Risk Management Facilitator

Monitoring committee: Risk Management Committee

- Responsibilities are monitored as part of the Risk Management Annual Report and Key Performance Indicators (attendance at Risk Management meetings)

2B. Reporting arrangements to the board and 2E. Reporting arrangements into the high level committees

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- A review of the Terms of Reference for the Risk Management Committee, including the reporting arrangements into the Board and reporting into each committee from the other committees is undertaken as part of the Risk Management Annual Report. This involves a review of the minutes and reports from the Risk Management Committee, in the previous year to ensure the reporting requirements as stated in the Terms of Reference and in section 5 (5.10 and 5.11) of the strategy have been completed.
- Any actions identified will be reported in the Risk Management Annual Report action plan which is monitored by the Risk Management Committee at each meeting until completion. This is a standing agenda item.

2C, 2D, 2F, 2G . Membership, including nominated deputy, required frequency of attendance by members, requirements for quorum and frequency of meetings

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- The membership of the Risk Management Committee, frequency of meetings, attendance of meetings and quorum requirements are all monitored via the Risk Management Annual Report via the Key Performance Indicators – see Appendix, which is reviewed on an annual basis via the Risk Management Committee

3. Monitoring of the Risk Register

3A Source of the risk (including, but not limited to, incident reports, risk assessment and directorate risk registers)

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- The Risk Management Annual Report monitors the source of the risks on the risk register to determine how risks have been identified in the previous 12 months

- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion.

3B Description of the risk, risk scores, summary risk treatment plan, date of review.
Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- A random sample of risks on the register are reviewed on an annual basis as part of the Risk Management Annual Report to ensure each risk contains a description of the risk, risk grade, action plan and review date.
- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion

4. Monitoring of the Analysis of incidents, complaints and claims

A. Duties/Responsibilities

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- Aggregated reports are reviewed at each Risk Management meeting by the Risk Management Committee. They are a standing agenda item.
- Actions are monitored at each meeting by the Risk Management Committee
- A review of the minutes/papers of the meetings in the previous 12 months are undertaken as part of the Risk Management Annual Report
- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion

B. Coordinated approach to the <u>aggregation</u> of incidents, complaints and claims

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- Aggregated reports are reviewed at each Risk Management meeting by the Risk Management Committee. They are a standing agenda item.
- Actions are monitored at each meeting by the Risk Management Committee
- A review of the minutes/papers of the meetings in the previous 12 months are undertaken as part of the Risk Management Annual Report
- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion

C. frequency with which an aggregated analysis of incidents, complaints and claims is to be completed

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- The reports in B above are standing agenda items, reported and reviewed at every meeting
- A review of the minutes/papers of the meetings in the previous 12 months are undertaken as part of the Risk Management Annual Report to ensure they were completed as required
- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion

D. minimum content required within the analysis report, including qualitative and quantitative analysis

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- The content of the reports is monitored by the Risk Management Committee at each meeting (quarterly) to ensure it includes both qualitative and quantitative analysis. The reports have a standard format to ensure the content is the same at each meeting.
- A review of the content of the reports in the previous 12 months is undertaken as part of the Risk Management Annual Report to ensure the reports meet the minimum content as detailed in the Strategy (section 9.1).
- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion.

E. process for communicating this information to relevant individuals or groups

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- Information is communicated to the relevant committees as detailed and monitored as in section B above.
- Reports are produced for every Team Brief (monthly) to cascade information to all staff
- A review of all Team Briefs in the previous 12 months is undertaken as part of the Risk Management Annual Report to ensure this information was communicated to all staff
- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion

5. Monitoring of Improvement – encouraging learning and promoting improvements in practice

A. process by which the organisation ensures both local and organisational learning from incidents, complaints and claims

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- Monthly reports, including trends and actions from complaints, claims and incidents are included in Team Brief to be cascaded to all staff. A review of the all Team Briefs in the previous 12 months is undertaken as part of the Risk Management Annual Report.
- All outstanding actions are monitored at each Risk Management Committee .A review of the minutes and reports of the Risk Management Committee in the previous 12 months is undertaken as part of the Risk Management Annual Report to ensure it was submitted at each meeting.
- The Risk Management Annual Report is produced and reviewed by the Risk Management Committee
- Any actions identified are included in the Risk Management Annual Report action plan and monitored at the Risk Management Committee until completion

B. opportunities for sharing lessons learnt from incidents, complaints and claims across the local health community

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- An annual review of all incidents, complaints and claims involving other local health providers will be undertaken to ensure lessons learnt have been shared and appropriate actions taken. Any actions identified will be monitored by the Risk Management Committee until completion.
- Monthly reports, including trends and actions from complaints, claims and incidents are included in Team Brief to be cascaded to all staff. They are reviewed as in section A above.

C. process by which the organisation ensures that lessons learnt from analysis result in a change in organisational culture and practice

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- See A above

D. process for implementing risk reduction measures

Lead: Risk Management Facilitator
Monitoring committee: Risk Management Committee

- See A above