# RISK MANAGEMENT STRATEGY

<table>
<thead>
<tr>
<th>Post holder responsible for Policy:</th>
<th>Governance Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate / Department responsible for Policy:</td>
<td>Governance</td>
</tr>
<tr>
<td>Contact details:</td>
<td>Noy Scott House ext. 3933</td>
</tr>
<tr>
<td>Date written:</td>
<td>August 2003</td>
</tr>
<tr>
<td>Date revised:</td>
<td>October 2005</td>
</tr>
<tr>
<td>Approval route (names of committees):</td>
<td>Governance Committee Board of Directors</td>
</tr>
<tr>
<td>Date of final approval:</td>
<td>30th November 2005</td>
</tr>
<tr>
<td>Date due for revision:</td>
<td>November 2007</td>
</tr>
<tr>
<td>Date policy becomes live:</td>
<td>1st December 2005</td>
</tr>
<tr>
<td>This document replaces:</td>
<td>Risk Management Strategy 2004</td>
</tr>
</tbody>
</table>

---

**Controlled Document**

This document has been created following the Royal Devon & Exeter NHS Foundation Trust Policy on the creation of policies, procedures, protocols, guidelines and standards. It should not be altered in any way without the express permission of the author or their representative.
1 INTRODUCTION

1.1 Risk management is a proactive approach, which aims to identify, assess and prioritise risk on an ongoing basis, so as to minimise its negative consequences. Risk is defined as ‘the possibility of incurring misfortune or loss’ and may be associated with people (patients, visitors and staff), buildings and estate, equipment and consumables, systems and management. In its broadest sense, risk management applies to all risks and also covers the use of insurance to deal with potential losses.

1.2 The Trust manages risk in a holistic way and the risk management process deals with all risks, clinical, non-clinical, financial and organisational.

1.3 The Trust has established a Governance Committee. This committee is a sub-committee of the Board of Directors and deals with all aspects of Clinical / Corporate Governance and Risk Management.

1.4 All policies and procedures developed by The Royal Devon & Exeter NHS Foundation Trust are relevant to risk management. Following the appropriate standards, legal/statutory guidance and best practice identified in policies and procedures will minimise risk.

1.5 There are however, some policies that link directly to this strategy. These are risk assessment, incident reporting and investigation, health and safety, human resources and finance policies.

2 AIMS

2.1 The aims of effectively managing risk are to:

- ensure the management of risk is consistent with and supports the achievement of, the Trust’s strategic and corporate objectives.
- provide a safe high quality service to patients
- initiate action to prevent or reduce the adverse effects of risk
- minimise the human costs of risks i.e. to protect patients, visitors and staff from risks where reasonably practicable
- meet statutory and legal obligations
- link into the assurance framework of the Trust
- link into the Clinical Governance framework of the Trust
- improve compliance with the ongoing requirements of NHS Governance
- minimise the financial and other negative consequences of losses and
claims, for example, poor publicity, loss of reputation

- minimise the risks associated with new developments/activities

3 ACCEPTABLE RISK

3.1 The Board of Directors have defined ‘acceptable risk’ as any risk assessment that has a risk rating number of 7 or below when calculated using the Trust’s risk assessment matrix.

3.3 The Trust has a policy and procedure on how to undertake risk assessment and how risk should be treated depending on its level. Risk assessment is undertaken using the following matrix:

<table>
<thead>
<tr>
<th>LIKELIHOOD of hazard being realised</th>
<th>CONSEQUENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insignificant (1)</td>
</tr>
<tr>
<td>Rare (1)</td>
<td>1</td>
</tr>
<tr>
<td>Unlikely (2)</td>
<td>2</td>
</tr>
<tr>
<td>Possible (3)</td>
<td>3</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>4</td>
</tr>
<tr>
<td>Almost Certain (5)</td>
<td>5</td>
</tr>
</tbody>
</table>

\[ \text{LIKELIHOOD } \times \text{ CONSEQUENCE} = \text{ RISK RATING NUMBER (RRN)} \]

<table>
<thead>
<tr>
<th>RRN RISK RATING</th>
<th>ACTION REQUIREMENT TO REDUCE RRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1-7)</td>
<td>ACCEPT RISK</td>
</tr>
<tr>
<td></td>
<td>Manage by routine procedures</td>
</tr>
<tr>
<td>(8-11)</td>
<td>MANAGEMENT ACTION REQUIRED</td>
</tr>
<tr>
<td></td>
<td>Costs to be funded within directorate</td>
</tr>
<tr>
<td>(12-15)</td>
<td>MANAGEMENT ACTION REQUIRED AS SOON AS REASONABLY PRACTICABLE</td>
</tr>
<tr>
<td></td>
<td>May necessitate bids for central funding</td>
</tr>
<tr>
<td>(16-25)</td>
<td>IMMEDIATE SENIOR MANAGEMENT ACTION REQUIRED</td>
</tr>
<tr>
<td></td>
<td>Directors to be informed. Priority for funding</td>
</tr>
</tbody>
</table>

3.5 Where a risk is acceptable, action will always be taken to ensure that it is minimised.

3.6 Details of all risks will form part of the Trust’s Risk Register and changes be reviewed by the Governance Committee as a standing agenda item.
RISK MANAGEMENT STRUCTURE - roles and responsibilities (see also Appendix 1 & 2)

4.1 The Chief Executive

4.1.1 The overall responsibility for effective risk management in the Trust lies with the Chief Executive. At an operational level, the Trust has designated a number of other executive Directors to manage the risk issues facing the Trust.

4.2 The Medical Director

4.2.1 The Medical Director is responsible for clinical risk management. The Medical Director will work closely with the Chief Executive and colleagues with particular responsibilities in risk management.

4.3 The Director of Finance and Information

4.3.1 The Director of Finance and Information will ensure that the Trust is appraised of external financial risks as soon as these become apparent. The Director of Finance and Information is also responsible for IM&T and will therefore develop systems that facilitate risk analysis in this area.

4.4 The Director of Human Resources

4.4.1 The Director of Human Resources will chair the Health & Safety Committee and will report to the Governance Committee and Trust Executive on all matters of non-clinical risk. He will have responsibility for co-ordination of all aspects of non-clinical risk management, excluding financial risk.

4.5 The Director of Operations

4.5.1 The Director of Operations will regularly update the Emergency Preparedness Procedure and ensure that all staff are aware of the procedure and understand their responsibilities.

4.6 Director of Facilities

4.6.1 The Director of Facilities Management has delegated responsibility for the management of the estate including security, although there are clear links with the Risk Management Department in relation to the management of security related risks.
4.7 Specialist roles

4.7.1 A number of staff are employed by the Trust to undertake specialist roles that are clearly within the risk management agenda. These are outlined below.

a. **Governance Manager** – responsible for coordinating all aspects of Governance / Risk Management across the Trust and providing a strategic direction.

b. **Risk Manager** – responsible for coordinating all risk management activities across the Trust including risk management training. The Risk Manager is also the competent health and safety advice for the organisation.

c. **PALS Manager** – responsible for leading and coordinating this service across the Trust.

d. **Complaints Manager** – acts as the focal point for the management of formal complaints and is responsible for coordinating the investigation of all formal complaints, ensuring that the Trust’s Complaints Procedure is adhered to and investigations are completed by Divisions/Directorates according to identified standards and that required follow-up action is taken in order to prevent recurrence.

e. **Trust Solicitor** – is responsible for managing claims against the Trust, liaising with other solicitors/insurers (where appropriate), to ensure timely and cost effective claims handling. Further, ensuring that any risk management issues/remedial action identified during the course of a claim, or during the review process on closure, is referred appropriately for action.

f. **Governance Support Unit Manager** – responsible for managing the clinical audit / ethics services for the Trust ensuring that the Trust meets its objectives against its Clinical Governance Development Plan and Commission for Healthcare Audit and Inspection action plans.

g. **Occupational Health Physician and Advisors** – provide an occupational health service to the Trust and wider health economy.

h. **Fire, Infection Control & Radiation Advisors** – are responsible for advising the Trust on the standards arising from statutory requirements and which minimise risks to patients and staff within the Trust.

i. **Security Manager** – responsible for developing systems to manage the security risks that face the Trust.
4.8 The Governance Committee

4.8.1 The Governance Committee is a sub committee of the Board of Directors.

4.8.2 Its purpose is to scrutinise and review the systems in place to ensure, monitor and improve the quality of healthcare provided for or delivered to patients and

To ensure that the Trust has a strategy which allows for:

- the continuing identification and prioritisation of risks
- a description of action taken to manage each key risk
- the identification of how risk is measured

4.8.3 The Governance Committee is appointed by the Board of Directors. The membership shall be:

- A Non-Executive Chairman – appointed by the Board of Directors
- At least two non-Executive members
- The Chief Executive
- Joint Medical Director
- The Director of Finance and IM&T
- The Director of Nursing & Service Improvement
- The Director of Human Resources
- The Director of Operations
- The Director of Facilities
- Consultant in Occupational Health
- The Clinical Director of the Professional Services Directorate
- The Chairman of the Trust Clinical Audit Committee
- A Clinical Director from a medical or surgical Directorate
- Joint Director of Infection Prevention and Control
- A Medical Consultant
- A Surgical Consultant
- Chairman: Drugs & Therapeutics Committee
- Chairman: Hospital Transfusion Committee
- Chairman: Resuscitation Committee
- Chairman: Radiation Safety Committee
- A Senior Nurse
- Governance Manager

4.8.4 A quorum will consist of not less than five members of the Committee, one of whom shall have substantial clinical expertise and three of who will be as follows:

- Two non executive directors, one of whom should chair the meetings
- The Medical Director or a Clinical Director.
4.8.5 Meetings will be held no less than five times in each accounting year.

4.8.6 The Governance Committee will have the following duties and responsibilities

- Consider any matters relating to Clinical Governance and Risk Management within the Trust that it determines to be desirable.

- Examine any matters referred to it by the Board of Directors.

- The Committee shall have the following specific duties and responsibilities:

  a) The implementation, development and ongoing management of Clinical Governance within the Trust

  b) The establishment and maintenance of procedures and systems of internal control designed to give reasonable assurance that all aspects of Clinical Governance are in place

  c) To review and implement the Trust’s Risk Management strategy

  d) To coordinate and prioritise all areas of risk in the Trust

  e) To monitor the Trust’s risk register

  f) To review and analyse trends arising from incidents, complaints and claims

  g) To oversee the work of committees considering Governance / Risk Management issues and to receive action notes from such committees

  h) To review the Assurance Framework before presentation to the Board of Directors

  i) To oversee external reviews of the Trust’s Governance arrangements

  j) To review the draft Governance Annual Report before presentation to the Board of Directors.

  k) To consider the content of any report on Governance issues involving the Trust and review the proposed response before making a recommendation to the Board of Directors.

  l) To satisfy itself that the requirements of Governance Best Practice are being met by the Royal Devon & Exeter NHS Foundation Trust.

4.9 The Audit Committee

4.9.1 The audit committee is a sub-committee of the Board of Directors. In the risk management capacity, its remit is to offer independent assurance to the Board of Directors that the actions detailed in this strategy are adhered to. A summary of the terms of reference of this committee can be seen in Appendix 2.
4.10 Quarterly Reviews

4.10.1 Directorate quarterly reviews are the Trust’s formal mechanism for managing performance. Executive Directors receive written reports from Directorates on a number of Risk Management issues including a review of items included on the Trust’s Risk Register and the numbers and management of incidents and complaints. In addition, the Directorates will report on compliance with standards for risk training e.g. Fire, Manual Handling, and Resuscitation.

4.11 The Risk Management Department

4.11.1 The role of the Risk Management Department is to communicate and co-ordinate the process of risk management throughout the Trust. Specifically, this involves the following responsibilities:

- supporting the development of Directorate Governance Groups to identify and manage risks at local level. This is consistent with the development of clinical governance and build on the structures in place for the management of non clinical risk

- coordinating the management of clinical risk activities throughout the Trust

- educating and stimulating Trust staff to take an active role in the identification and reduction of risk and in particular training and supporting staff

- ensuring full and prompt reporting of all actual and near miss incidents and ensuring that the necessary action is taken; this involves ensuring that immediate health and safety needs are met (for example, that defective equipment is taken out of use), notifying the statutory authorities, and feeding back statistics about incident trends to Directorate Governance Groups, Executive Directors, Governance Committee and to the Health & Safety committee

- liaising with statutory and other official bodies, for example the Health and Safety Executive

- acting as a central source of information on risk issues and distributing this information as necessary

- ensuring that the Trust has policies, procedures and plans in place that reflect the latest guidance, comply with legal and statutory requirements and are formally audited where reasonably practicable. In addition, ensuring that these policies are reviewed and ratified on a planned basis
• developing links with professional organisations concerned with risk management in the Health Service to ensure that the Trust is kept at the forefront of developments in the field

• the investigation of incidents

4.11.2 In undertaking the functions listed, the Risk Management Department works closely with other departments (notably Occupational Health, Human Resources, Finance, Complaints, Legal, Patient Advice & Liaison and Facilities).

4.12 Directorate Governance Groups

4.12.1 Directorate Governance Groups exist within each Directorate and will usually be chaired by the Clinical Director or the Directorate lead clinician for clinical governance (senior manager in non-clinical areas).

4.12.2 Membership of the group will comprise staff able to consider a broad range of risks, i.e. clinical, organisational, health and safety etc. Typically there will be representation from medical and nursing staff, Allied Professionals, managers and others as appropriate.

4.12.3 The role of the groups are to ensure that

• risks within the directorate are identified through a process of risk assessment, prioritised, minimised and where possible eliminated

• the importance of managing risk is communicated to all staff within the directorate

• development of Directorate risk register

• the Governance Committee is made aware of any unacceptable risks that cannot be managed within the directorate via the risk register

• risk treatment plans are implemented as required by the Governance Committee

• data from incidents and complaints is reviewed to identify any trends or areas for retrospective action

• patient information is reviewed to ensure that it is accurate, appropriate and contains information regarding risks and benefits of treatment.

4.13 Managers

4.13.1 All managers are responsible for effective risk management measures within their own area. Staff will be trained in all areas to undertake risk management processes within their departments. Managers must ensure
that appropriate staff are trained in sufficient numbers to successfully complete this duty.

4.14 All staff

4.14.1 The Trust's Health and Safety policy outlines the duties of all staff under the Health and Safety at Work etc. Act 1974. In addition to their responsibility for health and safety, staff have a general responsibility for wider risk management issues and should follow Trust procedures in their work. These include reporting incidents, be familiar with this strategy, be aware of emergency procedures and attend training as required.

4.15 The Health & Safety Committee

4.15.1 Details of the Committee's membership and terms of reference are to be found in the Royal Devon & Exeter NHS Foundation Trust Safety Representatives: Consultation with Employees Policy Statement.

5. Forums for Managing risk

5.1 Appendix 2 illustrates the principle forums for managing risk.

6. Assurance Framework

6.1 The Trust has developed an assurance framework to ensure that all strategic objectives are assessed for risk and gaps in controls and assurance are identified.

6.2 When strategic directions are reviewed, the assurance framework will be mapped onto these directions to ensure that that any foreseeable gaps in control or assurance are highlighted and dealt with accordingly.
Royal Devon & Exeter NHS Foundation Trust

Governance Structure

Management Assurance

Independent Assurance

Board of Directors

Governance Committee

Management Assurance

Appendix 1

Risk Management Strategy
Approved by the Governance Committee: 9th November 2005
Approved by the Board of Directors: 30th December 2005
Review Date: November 2007 Author: Governance Manager
Appendix 2

Principal forums for Managing Risk

A Governance Committee Structure is in place to drive the Trust’s risk management agenda. These arrangements ensure that there is full involvement across all Directorates and that the management of risk issues involve the most appropriate personnel and that staff feel both supported and involved in the process. The following committees report directly to the Governance Committee.

Health & Safety Committee

study accident/incident statistics and consider the circumstances and causes of accidents, dangerous occurrences, incidents and occupational illnesses (as specified by the Health and Safety Executive) and make recommendations and monitor action taken in order to prevent the recurrence of accidents, etc;

make inspections of specific hazards in circumstances where the general interests of employees may be affected, to make appropriate recommendations for improvement in respect of health and safety welfare, and to monitor these improvements;

cconcern itself with the arrangements for the effectiveness of safety training, instruction and guidance of all new and existing employees;

consider regulations, codes of practice, reports and any other guidance information produced by the Health and Safety Executive or other government bodies, and to consider means whereby these can be introduced;

secure the co-operation of all employees in the promotion of health and safety through the provision of adequate publicity in the workplace;

consider and make recommendations as appropriate on any reports submitted by safety representatives. It should be noted that such reports will only be considered by the Committee in circumstances where the content of the report has been discussed with the appropriate line manager.

Infection Control Committee

Agree and monitor an annual programme of activity including surveillance, audit and education programmes.

Advise and support the Infection Control Team on the most effective use of available resources in delivering an annual programme to include audit surveillance and education.
Draw the attention of the Chief Executive and the Board to any serious problems or hazards relating to infection control.

Review reports on hospital acquired infection and infection control problems.

Commission, approve and review policies for all aspects of infection control and monitor their implementation.

Draw up plans for management of outbreaks both in the hospital and the hospital’s response to major outbreaks in the community.

Ensure that all relevant legislation, Health Service Guidelines etc is reviewed and that appropriate amendments/additions are made to local policies and procedures.

Review the funding and resource implications of other infection control issues such as provision of adequate hospital facilities and accommodation and make appropriate recommendations to the Trust Board.

**Hospital Transfusion Committee**

Promote best practice through local protocols based on national guidelines.

Lead multi-professional audit of the use of blood components within the NHS Trust, focusing on specialties where demand is high e.g. certain surgical specialties and haemato-oncology.

Audit the practice of blood transfusion against the hospital policy and national guidelines, focussing on critical points.

Provide feedback on audit of transfusion practice and the use of blood to all hospital staff involved in blood transfusion.

Promote the education and training of all clinical, laboratory and support staff involved in blood transfusion, including the collection of specimens.

Have the authority to modify and improve existing blood transfusion protocols and to introduce appropriate changes to practice.

Be a focus for local contingency planning for and management of blood shortages.

Report regularly to Regional Transfusion Committees, and through them, to the National Blood Transfusion Committee.

Participate in the activities of the Regional Transfusion Committee.
Consult with local patient representative groups where appropriate.

Contribute to the development of clinical governance.

**Clinical Audit Committee**

To monitor multi-disciplinary clinical audit activity throughout the Trust through reports from each directorate.

To ensure that the findings of completed audits are implemented and, where appropriate, subject to re-audit.

To ensure that the educational aspects of audit activity are implemented by the Directors of Medical and Non-medical Education.

To co-ordinate the Trusts’ clinical audit activity with PCT, Health Authority, Regional and National audits including the work of NICE and the NHS R&D and HTA Programmes.

To oversee the development of systems for recording clinical audit activity that link with other systems within the Trust and within the Health Community.

To provide an Annual Report to the Board of Directors.

To develop an Annual Audit Programme for the Trust.

**Drugs & Therapeutics Committee**

To advise the local health community on all matters, related to prescribing, within the strategic framework and policy guidance agreed between NEDHA and local Trusts.

To ensure that systems are in place to promote evidence based, safe and cost effective prescribing both within and across the boundaries of primary and secondary care.

To publish a joint local formulary and monitor and evaluate its impact.

To identify priority areas for action and to recommend and implement change.

To ensure the adequate provision of advice and information, to medical practitioners, on prescribing issues, within primary and secondary care.

To advise on the shift of funds between primary and secondary care prescribing budgets or vice versa.

To encourage and promote the development of good practice and treatment guidelines. This in the context of an annual programme of selected national and local priority areas in primary and secondary care.
To implement prescribing incentive schemes for both primary and secondary care in partnership with the Health Authority

To evaluate the impact of local and national initiatives

To work in partnership with other local prescribing groups, avoiding duplication of effort

**Radiation Safety Committee**

Advise on safe working practices for the use of ionising and non-ionising radiation throughout participating Trusts.

Review the operation of radiation safety procedures and monitor staff doses.

Assess compliance with legislation and Trusts’ policies on all aspects of the safe use of ionising and non-ionising radiation.

Review new and forthcoming legislation in order to advise on effective implementation.

Provide a forum for RPSs/LPSs to discuss radiation safety issues.

Evaluate and advise on training needs of RPSs/LPSs.

Advise the relevant Health & Safety Personnel and where appropriate the Chief Executives of any shortcomings in the safe use of radiation.

**Evidence Based Practice Committee**

It should seriously include the interests of users and carers of the Trust and consider having lay representation to comment on these terms of reference and work plan, where appropriate.

The group will provide a mechanism for the sifting of new national and international evidence, which will then be appraised and put forward for Trust adoption if appropriate.

The group will establish a framework to support the development of new and existing EBP guidelines and policies within the Trust where they are not available or adaptable nationally.

This framework will include:

- Corporate development and presentation of guidelines and policies
• A collaborative health community approach will be used sharing guidelines, with the eventual expectation of unifying best practice where appropriate

• Guidelines on dissemination, including educational considerations with access via the info-web and from paper versions in each clinical area

• A library / archive of policies and guidelines

• Systems for reviewing guidelines and policies on a regular basis

• Systems for audit of guidelines and policies as part of a rolling programme in each clinical area/ directorate or as part of Trustwide audit in the case of Trustwide policies and guidelines

• The group will report to the Governance Committee through the Evidence Based Practice Chair

All current guidelines and policies should be identified by the directorate leads on the Clinical Audit Committee, and by Senior Nurses on the Nursing and Midwifery Governance Committee.

The policies should be re-drafted in the corporate style

Input of service users to comment on relevant policies

Areas with no agreed policies would be identified in order to gain some consensus on best practice where appropriate

Areas where more than one policy or guideline exists for the same condition or procedure should also be targeted to gain agreement on the best way that these differences can be accommodated

When considering the implementation of broad based policies and guidelines, the group will involve key stakeholders

A database of all existing policies, new policies and policies under development containing date, person responsible and the review and audit dates

Definitions of ‘guidelines’, ‘policies’ ‘protocols’ should be agreed and their usage within the Trust clearly defined

A lead person will be identified for each set of policies and guidelines who will be responsible for their review and if necessary updating.
Nursing and Midwifery Governance Committee

Each meeting will be structured with a pre-determined agenda. Apologies will be required from those members who are unable to attend and minutes will be sent.

The N&MGC will consider any governance matters relating to nursing which will include:

a) The implementation, development and ongoing management of clinical governance related to Nursing within the Trust
b) The establishment and maintenance of procedures and systems designed to underpin the safe and effective delivery of nursing care
c) To review and implement and risk management strategies relating to nursing
d) To identify and monitor all; areas of risk related to nursing in the Trust

To oversee the work of committees, forums etc considering issues relating to nursing and nursing care

To review trends and/or issues arising from directorate governance meetings that relate to nursing

To oversee external reviews of nursing matters within the Trust

Members can task the Nursing & Midwifery Strategy Implementation Group to initiate and/or review professional issues that require a programmed piece of work.

Recommendations arising from the work of the Nursing & Midwifery Strategy Implementation Group will be considered at the Nursing and Midwifery Governance Committee for debate and approval.

Resuscitation Committee

The development, implementation and on-going management of resuscitation issues within the Trust.

Develop resuscitation guidelines and policies for adults and children, including ‘Do not Attempt Resuscitation’ (DNAR) guidelines and ensure they are appropriate and up to date.

Ensure public, patient and staff involvement in the development of these polices.

Advise on the production of easily understandable information for patients,
relatives, parents and staff.

With the resuscitation training officer, develop appropriate resuscitation training programmes for all relevant hospital staff.

Provide advice and clinical supervision through the Chairman of the Committee to the resuscitation training officer.

Monitor compliance with these policies and guidelines through audit and clinical reporting.

Identify risk management issues around resuscitation and report to the Governance Committee.

Advise members of staff on specific resuscitation issues including the ethical aspects of resuscitation.

Provide advice to PCTs where proper contractual arrangements have been put in place.

**Security Forum**

Responsible for both strategic planning and operational security issues.

Review current practice and make recommendations for improvement, in particular the need for crime reduction and the maintenance of a safe environment.

Ensure that both costs and risks are included in any security review process and to forward information and results, as appropriate, to the Governance Committee.

To ensure that monitoring systems are in place in relation to crime incidents and to report these to the Trust Board on an annual basis.

Review security issues and consult with key individuals on appropriate actions.

Review incidents and adherence to the Exclusion Policy.

To monitor the effectiveness of Access Control, CCTV and other security systems.

To produce an annual action plan and review progress annually.
To liaise with the Learning and Development Service over the development of staff training programmes required to support safe practice and risk reduction.

To maximise the effectiveness of the Policing in Partnership Agreement.

**Decontamination Task Group**

To be responsible for both the strategic and operational issues concerning the decontamination of surgical instruments and medical devices.

To review current practice and make recommendations for improvement, in particular the need for central re-processing of surgical instruments.

To ensure that both costs and risks are included in the review process and to forward information and results, as appropriate, to the Risk Management Committee.

To annually review the Statement of Intent concerning decontamination.

To act as the Trusts decision making group for decontamination issues.

To act as the Trusts advisory group for all risk issues relating to decontamination processes and procedures and to liaise with other working groups as necessary.

To develop key indicators and ensure that monitoring systems are in place.

To liaise with clinicians and other appropriate staff as necessary.

To produce an annual report detailing key achievements and an action plan for the year ahead.

The group is authorised to set up ad hoc groups when detailed work is required in specific areas.

**National Standards Local Strategy (NSLS) Committee**

To ensure that the Trust scoring system for both the Healthcare Standards and locally agreed priorities is robust

To ensure that action plans are in place for both core and developmental national standards and locally agreed priorities

To cross-reference any financial implications to the planning process in order that future funding arrangements are in place to achieve objectives
To ensure that any significant risks associated with achieving the action plans are highlighted on the Trust Risk Register.

To recommend innovative ways of storing evidence required by external bodies with the goal of reducing the burden on operational management.

To promote the national standards and locally agreed priorities across the Trust.

To ensure that the above work is reflected in the Assurance Framework.

**Environmental & Waste Management Group**

To be responsible for both strategic and operational issues concerning the environment and waste management so as to ensure compliance and rectification of any areas of non-compliance.

To review current practice and make recommendations for improvement of compliance in line with any changes in statutory regulations.

To ensure that both costs and risks are included in the review process and to forward information and results, as appropriate, to the Governance Committee.

To act as the Trusts decision making group for environmental and waste management issues.

To develop key indicators and ensure that monitoring systems are in place.

To maintain an overview of the interface issues between the Trust's Environmental Policy and cost effective waste management.

To monitor the work of the Environmental Action Team (EAT) via their action plans at each meeting.

The group is authorised to set up ad hoc groups when detailed work is required in specific areas.

**Medical Devices Group**

To be responsible for developing and maintaining a Medical Devices strategy in line with Medicines & Healthcare products Regulatory Agency (MHRA) guidance.

To ensure that policies and procedures are in place to minimise risk in relation to Medical Devices.
To maintain an overview of significant incidents relating to the use of medical devices and ensure that training needs and system reviews are addressed as a consequence.

To ensure that clear lines of accountability are established in the procurement and subsequent maintenance of medical devices in conjunction with the sub groups, the Budgetary Control (BCG) and the Capital Control Groups (CCG).

To monitor the work undertaken by the 3 sub-groups that report to this group, to review their recommendations and take proposals and decisions to the Governance Committee and CCG as appropriate.

To seek continual improvement in relation to Medical Devices Management across the organisation.

**Patient & Public Involvement Steering Group**

Trust Members

- Represent issues from their own constituency/peer group which impacts on the PPI agenda
- Represent issues from the Trust perspective
- Acknowledge issues raised as a result of users’ views and act as appropriate
- Act as a champion for PPI across the Trust
- Use and act on as appropriate information from the Steering Group within their own sphere of responsibility in the Trust

User Members

- Represent issues from their own constituency/peer group which impact on the PPI agenda
- Cascade back to their representative group information from the steering group
- Act as champions in the development of PPI in the Trust and the wider community
- Report regularly to the steering group on PPI activity and issues as raised within their own representative groups

Other responsibilities of the group include:

- To develop and update as appropriate the Organisational PPI Strategy
- To develop and agree a yearly PPI action plan to deliver the organisational PPI objectives and monitor its progress
• To work in partnership with Trust-wide user groups
• To work in partnership with the wider Health & Social Care community
• To assess and monitor levels and effectiveness of PPI activity at all levels of the Trust
• To identify any training needs relating to PPI
• To promote the sharing of good practice
• To meet the PPI requirements as identified by the Health Care Commission

The Audit Committee

The Audit committee reports to the Board of Directors. However, its terms of reference are summarised here.

7.1 The minutes of the Audit Committee shall be considered by the Trust Board at its next meeting.

7.2 The Audit Committee shall consider any matters relating to the financial affairs of the Trust and to the Trust’s internal and external audit, that it determines to be desirable.

7.3 The Audit Committee shall examine any matters referred to it by the Trust Board.

7.4 The Audit Committee shall have the following specific duties and responsibilities:

(a) reviewing the Internal Audit strategy and plan;

(b) receiving a report at each meeting from the Head of Internal Audit on audit reports completed and management’s response to them. Unless there are significant issues this will not normally include full copies of audit reports, but these must be available for any member on request;

(c) reviewing the annual report of the Head of Internal Audit before presentation to the Trust Board;

(d) reviewing the annual report of the Head of Internal Audit on the Statement of Internal Control;

(e) discussing the external audit plan with the External Auditor before the external audit commences and the extent of the reliance to be placed on Internal Audit;
(f) discussing problems and reservations arising from the work of the External Auditor and any other matters the External Auditor may wish to discuss (in the absence of executive Directors and other management where necessary);

(g) reviewing the External Auditor’s management letter and management’s response to it;

(h) considering the content of any report involving the Trust issued by the Public Accounts Committee or the Comptroller and Auditor General and reviewing management’s proposed response before presentation to the Trust Board for agreement.

7.5 The Audit Committee will also carry out the following functions:

(a) review proposed changes to Standing Orders and Standing Financial Instructions;

(b) examine the circumstances associated with each occasion when Standing Orders are waived, or reported to the Audit Committee as being contravened;

(c) approve accounting policies;

(d) monitor the implementation of policy on standards of business conduct for members and staff (the Codes of Conduct and Accountability).