

Title: Risk Management Strategy

Purpose:

To outline the framework for risk management at The Christie NHS Foundation Trust.

Document Application:

The risk management responsibilities for all staff are outlined in the strategy.

Responsibilities for Implementation:

Board of directors; risk committee; divisional boards: all staff

Date Issued: September 2002

Date Revised: September 2003 September 2004 February 2005
June 2006 June 2007 December 2009

Review Date: December 2011

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References (if applicable):

Governance in the new NHS; Health Services Circular 1999/123
AS/NZS 4360: 1999 risk management standards
NHS Litigation Authority risk management standards

Consultation Process:

Divisional boards

Intranet Category for Location:

Trust documents

Associated Policies/Documents:

Adverse incident and near miss reporting policy; significant and serious untoward incident policy; major incident plan; public interest and disclosure policy; claims policy; complaints procedure; induction and mandatory training policy

Approved by: Risk committee

Date: March 2010

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1. Statement of intent

Risk management is a means of identifying, evaluating and controlling risks and is therefore an essential task for any organisation.

The Christie is committed to the implementation of a risk management strategy which minimises risks to patients, staff and other stakeholders through comprehensive systems of control. This is crucial to ensure the trust is able to fulfil its commitment to providing high quality treatment and care.

The focus of the strategy is the promotion of a risk conscious environment where safety is seen as paramount. All areas and activities of the trust on its main and satellite sites and at host organisations are encompassed by this document.

2. Introduction

The board of directors is responsible for ensuring The Christie consistently follows the principles of good governance applicable to all NHS organisations. This includes the development of systems and processes for risk management.

The trust recognises that every event or activity around the hospital involves risks which have the potential to actually compromise the safety of patients, staff and other stakeholders. However, if risks are appropriately identified and managed, the potential harm to people and property can be reduced or eliminated. This will enhance the quality of care provided for patients, improve safety and protect the reputation of the trust.

Risk management is integral to trust business and embedded in the culture of the trust. The trust uses Datix to support its risk management process. This database captures incidents, formal and informal complaints and litigation details.

All staff have a role to play in identifying risks and helping to reduce their impact, and these responsibilities are described in more detail in this strategy.

Individual and organisational learning from incidents, mistakes, accidents and near misses is a key component of the trust's risk management strategy to ensure continual improvement.

This document also sets out the processes for the implementation of the risk management strategy. It has, as appendices, the risk management structure and terms of reference for committees which have risk management responsibilities.

The risk management strategy has been prepared following consultation with staff and has been approved by the board of directors.

3. Aims and objectives

The aims and objectives of the strategy are to:

- Ensure the trust meets all NHS risk management requirements.
- Establish effective processes through which the board of directors can be assured that risks are recognised, understood and appropriately controlled.
- Facilitate an open and honest approach in all matters relating to risk management. The overall approach is one of help and support rather than recrimination and blame.

This is explained more fully in the trust's adverse incident/near miss reporting policy and the whistle blowing policy (public interest and disclosure policy).

- Embed risk management within the trust's overall performance management framework and link to business planning and investment.
- Embed risk management practices in the day to day running of the trust and within the role of every staff member.
- Promote a positive approach towards risk management whereby all staff feel they play an integral part in the risk management process.
- Provide risk management training for all staff appropriate to their levels of responsibility.

These aims are in line with the trust's vision and corporate objectives to enable as many patients as possible to benefit from the better clinical outcomes made possible by the combination of specialist care, research and education that the trust provides.

4. Definition of terms

What is risk?

AS/NZS 4360:2004 states that risk is "the chance of something happening that will have an impact on objectives. It is measured in terms of consequences and likelihood."

For a publicly accountable body such as the trust, risk can be defined as:

Anything that poses a threat to the achievement of the trust's objectives; this may include damage to the reputation of the trust which could undermine stakeholder confidence.

For the purposes of this strategy there are three types of risk: clinical, operational, and corporate. These may be defined as follows:

Clinical risk:

Any issue that may have an adverse impact on the achievement of high quality, safe and effective care for patients.

Operational risk:

Any issue that may have an adverse impact on the achievement of functions that ensure effective running of the day to day operation of the trust. These risks may include financial risks.

Corporate risk:

Any issue that may have an adverse impact on the achievement of the trust's objectives. These risks may include financial risks.

What is risk management?

Risk management can be defined as "the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects". (AS/NZ risk management standard 4360:2004).

Risk management is concerned with having in place an effective, systematic and robust process for evaluating and addressing the impact of risk in a cost effective way, having staff with the appropriate skills to identify and assess the potential for

risk to arise. The trust will ensure effective control and monitoring processes are in place to manage risk.

5. Responsibilities for risk management

5.1 Individual responsibilities

All members of staff have an individual responsibility for the management of risk and all levels of management have specific responsibilities for the implementation of the risk management strategy.

Chief executive

The chief executive has overall executive responsibility for governance within the trust, of which risk management is a key component. The chief executive is accountable to the board of directors for having in place an effective system of risk management and internal control.

The chief executive has appointed the director of nursing and governance as the accountable executive for risk management.

The director of nursing and governance

The director of nursing and governance is responsible for the overall management of risk throughout the trust and the implementation of the risk management strategy. To assist in this function, the director of nursing and governance will work in collaboration with her executive director colleagues who have responsibility for risk management within their divisions.

Executive directors

All executive directors have responsibility for risk management within their divisions. (See executive organisational chart – Appendix A). This includes ensuring all activities under their control comply with this strategy. In particular that their divisions carry out risk assessments and develop safe systems of work; develop risk registers; ensure managers and staff understand risk management processes and operate them effectively; and comply with external requirements for risk management – such as the NHSLA risk management standards and the care quality commission essential standards for quality and safety.

Chief Operating Officer

The chief operating officer is specifically responsible for the management of clinical, operational and corporate risks within the following clinical and corporate divisions:

- a) clinical cancer centre services
- b) clinical networked services
- c) clinical support services
- d) north western medical physics
- e) workforce
- f) facilities

Director of finance and business development

The director of finance and business development is specifically responsible for the management of operational and corporate risks that affect the financial security of the trust and business developments.

Medical director

The medical director is specifically responsible for the management of clinical, operational and corporate risks that affect the medical care received by patients.

Non executive directors

The non executive directors have the responsibility to ensure that the chief executive and her director colleagues are held to account for their governance and risk management responsibilities. As board members the non-executives share a broad responsibility to ensure the trust's affairs are managed efficiently and effectively through the implementation of internal controls to manage risk.

Deputy director of nursing and governance

The deputy director of nursing and governance has the responsibility to deliver and implement action plans relating to the Care Quality Commission essential standards, the NHS Litigation Authority risk management standards; risk assessments; the risk register and assurance framework; the clinical governance annual report; incident reporting; complaints; claims and policies /procedures relating to risk management.

To assist the fulfilment of these responsibilities the deputy director of nursing and governance manages and works closely with the risk management team, health and safety manager, manual handling adviser, infection prevention and control team, complaints and claims manager, patient advice and liaison service, clinical audit team, patient and public involvement manager and the patient information team.

The deputy director of nursing and governance also maintains close working relationships with the fire safety and security adviser, who is accountable to the chief operating officer, and the head of education, who reports to the director of nursing and governance.

In particular the deputy director of nursing and governance is responsible for:

- a) Supporting and managing the work of the governance team.
- b) Ensuring staff are aware of their responsibilities contained within the risk management strategy through appropriate training/induction.
- c) Ensuring the leads for the standards for better health are aware of the assessment process of the Care Quality Commission and supporting the implementation of action plans to ensure compliance with the standards.
- d) Developing and monitoring the implementation of action plans to ensure compliance with the NHS Litigation Authority risk management standards.
- e) Working closely with the risk and health and safety manager to facilitate training sessions so that staff understand the importance of risk assessments, how to undertake them, how to transfer them to their divisional/departmental risk registers, how to develop and implement action plans and subsequently re-evaluate the risks.
- f) Working closely with the director of nursing and governance to ensure the assurance framework is integrated into the risk register and updated appropriately.
- g) Producing a clinical governance annual report in conjunction with the clinical and research governance committee and ensuring that the report is widely disseminated.

- h) Ensuring that the adverse incidents/near miss reporting policy is fully implemented throughout the trust, that staff receive appropriate education regarding this process, that effective root cause analysis investigations are undertaken as necessary and appropriate feedback is provided for divisions and departments.
- i) Working closely with the risk and health and safety manager to ensure the major incident plan is up to date and that divisions/departments are fully aware of their responsibilities in the event of a major incident.
- j) Working closely with the complaints manager, general managers and lead nurses to ensure that complaints are investigated in a timely and effective manner and ensuring that reports are made available as required.
- k) Overseeing the management of claims which includes overseeing investigations and ensuring learning and changes in practice occur as required.
- l) Overseeing the development and management of relevant policies and procedures ensuring that they remain up to date and relevant, implemented and monitored as indicated within the documents.

Managers

All levels of management must understand the risk management strategy and facilitate its implementation.

Managers are responsible within their designated area and scope of responsibility for:

- a) Ensuring that appropriate and effective risk management processes are in place, and that all staff are made aware of the risks within their work environment and of their personal responsibilities.
- b) Preparing specific departmental policies and guidelines to ensure all necessary risk assessments are carried out in liaison with appropriate identified relevant advisors where necessary e.g. clinical risk, health and safety, infection control, security and environmental. These documents must also be updated, reviewed and monitored regularly as required.
- c) Identifying and quantifying risks which might affect their department's ability to deliver service objectives or which might impact on other areas of the trust.
- d) Implementing and monitoring any identified and appropriate risk management control measures. In situations where high level (i.e. scores of 15 or more) risks have been identified, managers are responsible for bringing these risks to the attention of their general manager/executive director and the risk committee together with effective action plans.
- e) Ensuring risk issues are included within the trust risk register.
- f) Managing risk factors within their sphere of influence/competency within allocated budgets and refer upward those elements that are not remedial locally or individually. Managers have authority to implement action to reduce risks in line with delegated financial, professional and human resource management and control within the scope of their role.
- g) Ensuring that all staff are given the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the trust's operations including contractors, members of the public, visitors etc.
- h) Ensuring relevant components within the standards for better health are understood and full compliance is achieved.
- i) Ensuring the relevant criteria within the NHS Litigation Authority risk management standards are understood and implemented
- j) Contributing to the annual clinical governance report when requested.

- k) Adhering to the adverse incident/near miss reporting policy ensuring all incidents are reported promptly and investigated effectively. Action plans and changes in practice must also be reported.
- l) Ensuring all complaints are investigated promptly and detailed responses are provided in a timely manner to the complaints manager. Action plans and changes in practice must also be reported.
- m) Learning from all incidents that lead to claims and ensuring all potential claims are thoroughly investigated and reported to the relevant committee.

To facilitate the implementation of this strategy, it is essential that managers, or their designated representatives, ensure they have:

- a) Adequate knowledge and/or access to all legislation relevant to their area and are advised by appropriate experts to ensure that compliance with such legislation is maintained.
- b) Adequate resources to provide safe systems of work. This will include making provision for risk assessments, appropriate control measures, raising outstanding concerns, ensuring safe working procedures/practices and continued monitoring and revision of same.
- c) Knowledge of the risk assessment process in partnership with appropriate risk leads and staff to develop a risk register to inform of the existence of all known risks.
- d) Access to a core of appropriate mandatory training for all employees to attend e.g. health and safety, fire, moving and handling, dealing with violence and aggression, food hygiene, resuscitation training etc and that appropriate mandatory updates are maintained. This will specifically involve the trust's head of education.
- e) Suitable staff to be released from training as risk assessors, first-aiders, moving and handling/health and safety co-ordinators etc.
- f) The ability to promote greater risk management and health and safety awareness amongst all staff by example, and by ensuring that only properly trained and competent staff are responsible for assessing risks and determining adequate control measures within the working environment.
- g) The ability to monitor clinical performance, health and safety standards including risk assessments, infection control measures, use of personal protective equipment and ensure that these are reviewed and updated regularly.
- h) Identified all employees who require health surveillance according to risk assessments, ensuring that where health surveillance is required, no individual carries out those specific duties until they have attended the occupational health department and have been passed as fit.
- i) Ensured that the arrangements for basic life support, first-aiders and first aid equipment required within the department are complied with: that the location of first aid facilities are known to employees, ensuring that proper care is taken of casualties and that employees know where to obtain appropriate assistance in the event of a serious injury.
- j) Made adequate provision to ensure that fire and other emergencies are appropriately dealt with.

All Employees

All employees have a responsibility to:

- a) Report incidents/accidents and near misses using the recognised reporting system. Every reported incident is a valuable learning opportunity. The trust recognises that this will require the development of a culture which accepts

- that the reporting of adverse events or near misses is based on the need to learn lessons rather than apportioning blame.
- b) Provide safe clinical practice in diagnosis and treatment. Maintain professional and technical competence in accordance with trust policy and professional guidelines.
 - c) Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the trust's business.
 - d) Comply with all trust rules, regulations and instructions to protect health, safety and welfare of anyone affected by the trust's business.
 - e) Be familiar with the trust's risk management strategy and divisional/departmental clinical risk and health and safety procedures and comply with these.
 - f) Neither intentionally, nor recklessly, interfere with or misuse any equipment provided for the protection of safety and health.
 - g) Be aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures appertaining to their particular directorate/department locations.
 - h) Ensure they work in accordance with all trust policies and procedures.
 - i) Ensure they attend induction and regular update training on risk management policies and procedures including mandatory training.
 - j) Participate in risk assessments within their area of work and identify any risks they feel exist.

5.2 Committee Responsibilities

In addition to the individual responsibilities outlined, there are a number of trust committees with responsibility for risk management.

Board of directors

The board of directors is responsible for ensuring the trust consistently follows the principles of good governance applicable to NHS organisations. This includes the development of systems and processes for risk management. The board of directors has approved the implementation of this risk management strategy and will receive assurances and updates relating to progress from a number of trust committees which have a responsibility for risk management.

These are highlighted in Appendix B which also demonstrates the reporting mechanism to the board.

Risk committee

The terms of reference for this committee are detailed in appendix C.

Governance committee

The terms of reference for this committee are detailed in appendix C. Its key function is to provide assurance to the board of directors.

Audit committee

The terms of reference for this committee are detailed in appendix C. Its key function is to provide assurance to the board of directors.

Clinical and research governance committee

The terms of reference for this committee are detailed in appendix C.

Health and safety committee

The terms of reference for this committee are detailed in appendix C.

6. Implementation of the risk management strategy

6.1 CQC Essential Standards of Quality and Safety

In December 2009 the Care Quality Commission published guidance for providers regarding their compliance with Section 20 Regulation of the Health and Safety Social Care Act 2008

Registration covers NHS and private health and social care providers.

The essential standards are outcome based and cover 6 key areas, each with a varying number of expected outcomes and prompts:

- Information and involvement
- Personalised care treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

Compliance needs to be demonstrated with outcomes and prompts relating to the three areas of registration that are applicable to The Christie.

- Treatment of disease disorder or injury
- Surgical procedures
- Diagnostic and screening procedures

The prompts provide a guide to providers (and CQC inspectors) as to what needs to be demonstrated to evidence compliance. The outcomes and prompts are tracked to individual regulations within the act.

At The Christie, leads have been identified for each standard and will be supported by other colleagues as appropriate and where necessary by a representative from each of the three registered areas. The leads are responsible for ensuring that evidence is collated which demonstrates compliance with each standard.

The standards will be used as a means of measuring performance within the divisions and departments which have responsibility for the implementation of these standards.

Compliance with the essential standards of quality and safety will be discussed at relevant committees/meetings and areas of concern will be highlighted with the risk committee, governance committee and board of directors.

6.2 NHS Litigation Authority Risk Management Standards

The NHS Litigation Authority is a special health authority (part of the NHS) responsible for handling negligence claims made against NHS organisations in England.

The NHS Litigation Authority regularly assesses NHS organisations against a number of risk management standards which have been specifically developed to reflect issues which arise in the negligence claims made against NHS organisations. There are five standards which have ten criterion within each. The standards are:

1. Governance
2. Competent and capable workforce
3. Safe environment
4. Clinical care
5. Learning from experience

Each criterion has a nominated lead who is responsible for the development of policies and procedures in line with the requirements of the standards. They are also responsible for facilitating the implementation of the criterion and ensuring progress is monitored.

Areas of concern or non compliance will be highlighted with the risk committee, governance committee and board of directors.

6.3 Risk assessments (corporate, operational, clinical)

Risks may be identified from many sources including:

Proactive risk assessment

Reactive risk assessment following an incident, complaint or claim

Observation or reporting

Incidents in other organisations

Independent assessments, for example, Care Quality Commission, Auditors Local Evaluation (ALE), NHS Litigation Authority, Health and Safety Executive.

Articles in professional journals, newspapers or other areas of the media

The NHS has adopted the AS/NZS 4360:2004 Risk Management Standard which measures risk using a combination of **likelihood** (or probability/frequency) of an event occurring and its **consequence** (or impact). The specific measures are detailed in the following tables. Risk scores are determined by multiplying the score for likelihood by the score for consequence.

Risks will be ranked according to their risk score using the following formula.

15 – 25	High (Red)
8 – 14	Significant (Orange)
4 – 7	Moderate (Yellow)
1 – 3	Low (Green)

Risk assessments will only be undertaken by suitably trained managers. All assessed risks will be incorporated into the departmental/divisional risk register which will then be incorporated into the trust's risk register. There are clear processes for escalation of risk. The risk assessment process contains more detailed information on identifying controlling and monitoring risks. This is available via the trust intranet.

Qualitative measures of likelihood

Score	Descriptor	Description
5	Almost certain	Expected to occur in nearly all circumstances
4	Likely	Will occur in most circumstances
3	Possible	Reasonable chance of occurring at some time
2	Unlikely	Could occur at some time/at least annually
1	Rare	Only occur in exceptional circumstances/not expected to occur for years

Qualitative measures of consequence

Score	Descriptor	Description
5	Extreme	Death/multiple deaths, interruption to all Trust activities, financial loss of greater than £500,000, long term and / or repeated adverse national publicity that undermines patients' and/or referrer confidence.
4	Severe	Health and Safety Executive defined as serious injury or serious injuries to more than one person, suspension of operational activity for a sustained period, financial loss of between £100-500,000, widespread and sustained adverse publicity.
3	Moderate	Serious injury to one person or minor injuries to a number of people, suspension of operational activity for limited period, financial loss of £25-100,000, widespread or high profile adverse publicity.
2	Low	Minor injury to one person or irritation or discomfort to a number of people, significant inconvenience or cost in maintaining activity, financial loss of between £10-25,000, adverse publicity.
1	Negligible	Little or no harm, little or no disruption to activity, financial loss of less than £10,000, no publicity or loss of reputation.

6.4 Risk register

The risk register is the main database of information relating to risk within The Christie. All risks on the risk register will be reviewed quarterly by each department/division and these risk registers will be incorporated into the trust-wide risk register.

All high level risks will be reviewed monthly by each department/division and reported to the risk management team. A monthly report will be submitted to the risk committee and management board which will highlight the top risks within the organisation indicating mitigating action to be undertaken to reduce the score of the risk. This key risk report is also included within the board of directors' monthly performance report.

All reports made to the risk committee and management board relating to risk will also be reported to the governance committee. These reports will detail how risks are controlled and any additional remedial action that is required. They will also indicate where residual risk scores have been reached. These will include those risks that are deemed 'acceptable', where the cost of mitigation outweighs the benefit. The trust acknowledges that not all risks can be avoided or eliminated.

Summary reports on progress in reducing risk scores will be monitored by the relevant division/department and the risk committee.

6.5 Assurance framework

The assurance framework provides organisations with a comprehensive method for the effective management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the statement on internal control. The assurance framework is co-ordinated by the director of nursing and governance and is incorporated within the trust's risk register.

The lead managers with responsibility for achievement of the trust's objectives have been identified. This avoids confusion and clarifies responsibilities where the objectives may encompass a number of divisions or departments. The lead managers are responsible for ensuring that all high level potential risks are transferred appropriately to the risk register.

The assurance framework process and updating of progress is reported to the board of directors twice yearly. In addition, the assurance framework is an agenda item for the risk committee and governance committee.

6.6 Clinical governance annual report

The clinical governance report is prepared annually and submitted to the strategic health authority. The development of the clinical governance annual report is the responsibility of the clinical & research governance committee. It includes a summary of clinical governance activity within the trust during the previous year together with an account of significant achievements.

The report is presented to the clinical and research governance committee, risk committee, governance committee and board of directors. It is accessible to the public via the trust website under the publications scheme.

6.7 Adverse incident/near miss reporting

The routine reporting of clinical and non clinical incidents and near misses is an essential requirement of the trust's risk management strategy.

The Christie encourages the reporting of all such incidents through the development of its fair blame culture. This means that staff who make a prompt and honest report of an incident, near miss or error will be appropriately supported throughout the process, unless one of the following activities has been identified:

- The member of staff acted in a criminal, deliberate or malicious manner.
- The member of staff is guilty of gross carelessness with the potential for serious consequences and where the member of staff could reasonably be expected to appreciate the direct consequences of his/her behaviour.

- Where an incident follows other incidents of a similar nature and where the trust has provided all the necessary training, counselling and supervision to prevent a recurrence.

In the event of the above, appropriate investigations will take place and disciplinary action will probably be taken.

The trust has an electronic incident reporting process, accessible from all computers. The incident report form should be completed as soon as possible after an incident or near miss and reviewed by the manager (or their deputy) of the ward/department where the incident took place, within 48 hours. All incidents are assessed by the risk management team and forwarded to the relevant managers for investigation, action or information, as appropriate. It is expected that the investigation of an incident will be concluded within one month of the incident occurring. Further information regarding the incident reporting process is detailed within the adverse incident/near miss reporting policy.

All incidents are categorised using a 1 – 5 scoring system. The scoring system is made up as follows:

- 1 Near miss
- 2 Minor event – no injury sustained
- 3 Minor event – minor injury or harm sustained
- 4 Moderate event (significant incident)
- 5 Major event

A full explanation of the classification is found within the adverse incident/near miss reporting policy. In the event that an incident is classified as a major (5) event, the major incident plan must be considered and may require implementation.

An analysis of incidents and investigations will be submitted to departments and divisions as required. The most relevant committee will review incidents dependent upon their category. For example, all medication related incidents are reviewed by the safe medicines practice committee. All incidents relating to blood products are reviewed by the hospital transfusion committee. Further detail is provided in the adverse incident/near miss reporting policy.

All significant incidents are reported to the director of nursing and governance and the relevant general manager by email as soon as received by the risk management team. The director of nursing and governance and medical director will determine whether an executive review is indicated, depending on the nature of the significant incident and actual harm or potential for harm that did or could have occurred. A significant incident may become a serious untoward incident (SUI) leading to review by a SUI panel following evaluation of each incident by the director of nursing and governance and the general manager. Further information on the management of significant and SUIs is detailed in the significant and serious untoward incident policy.

A monthly report detailing significant incidents is submitted to the clinical and research governance committee.

The trust also shares its patient harm incidents with the National Patient Safety Agency through their National Reporting and Learning System (NRLS).

6.8 Major incident plan

The trust has a major incident plan which has been developed by heads of department and divisional managers and has been circulated to all wards and departments.

A major incident refers to an incident or accident which requires extraordinary measures to be taken within the hospital in order to cope with a situation. The major incident plan will be reviewed annually or as required following implementation of the plan.

6.9 Complaints

Patient complaints may be the indicators of risk or adverse outcomes in the delivery of care. It is therefore essential that the complaint management system is integrated with the trust's other risk management systems.

The Christie has a procedure for devolving the everyday management of complaints to the divisions. The management of complaints will be facilitated by the complaints and claims manager.

A quarterly complaints report will be made to the clinical and research governance committee, board of directors and governance committee. The board of directors receives monthly reports on complaints trends and themes. An annual complaints report is also published.

All complaints are recorded, reported and managed in accordance with the requirements of the NHS complaints procedure.

The Christie complaints procedure is well publicised to ensure that all staff know how to deal with comments, informal complaints and formal complaints. In addition, there is a designated Patient Advice Liaison Service (PALS) which co-ordinates any immediate concerns and enquiries that may affect patient care.

6.10 Claims

The effective management of clinical and non-clinical claims, including public and employer liability, will lead to lessons to be learned within the Trust which in turn will reduce risk. The divisions and board of directors will be informed of all claims as they are made. All claims will be analysed and appropriate quality improvement information will be disseminated throughout the trust. A bi-annual claims report will be submitted to the risk committee. Further information relating to claims may be found in the claims policy.

6.11 Policies and procedures

The trust will ensure that all risk management policies and procedures are in place to meet national and local requirements. These will be made available on the trust intranet. All areas in the Trust will have free access to this information. The policies will be kept up to date and reviewed as necessary.

A full list of policies held on the intranet is available via the web team.

6.12 Job descriptions

All job descriptions will specifically include mention of the responsibilities of the postholder for risk management. These responsibilities are detailed in full in this risk management strategy.

7. Education and training

The trust recognises the importance of training staff so that they are fully aware of the trust's risk management procedures and their risk management responsibilities within the organisation.

Risk training, which includes the incident reporting procedure, will form part of the induction training received by all staff.

Training will also be available for risk assessment and the risk register, investigating incidents, complaints and claims, the standards for better health, the NHS Litigation Authority risk management standards and the major incident plan for those staff identified as requiring such training. It is expected that all staff in a managerial role will require this training.

There will also be training arranged relating to the control of infection, health and safety, fire, security, moving and handling and resuscitation which are all key components of risk management.

These training sessions are described in more detail in the training needs analysis which is contained as an appendix of the induction and mandatory training policy.

Details of all education and training provided within The Christie is available via the intranet. Further information may also be obtained from the education and training department.

8. Communication of the strategy to stakeholders

The trust will communicate this strategy to a wide audience of stakeholders through existing communication mechanisms. This includes staff training/induction programmes, internal/external newsletters, publication on the internet and intranet sites.

Departmental managers will ensure that their staff are aware of the strategy and its impact within their work area.

9. Review Mechanism

In the context of this strategy, the trust will use a variety of internal and external mechanisms to monitor, audit and review its risk management arrangements. These will include:

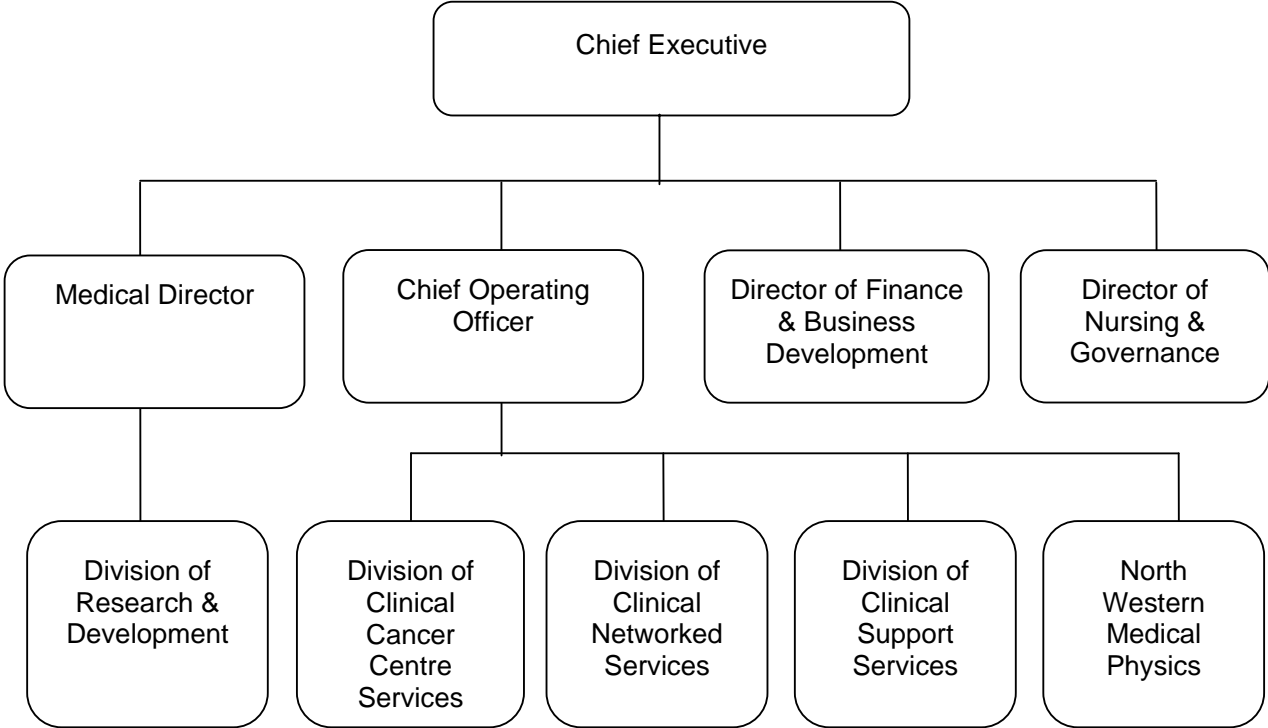
- The use of external assessment reports from bodies such as the Care Quality Commission, the Health and Safety Executive, the NHS Litigation Authority, internal audit reports, Improving Working Lives, Strategic Health Authority.
- Regular review of the divisional/departmental risks on the risk register via the divisional boards, risk committee, management board and governance committee.
- The production of an annual clinical governance report

- A quarterly complaints reports.
- A six-monthly claims report.
- A quarterly review of incidents, trends and analyses.
- A monthly review of significant incidents.
- A monthly review of SUI panel action plans.
- A review of attendance at training sessions relating to risk management.

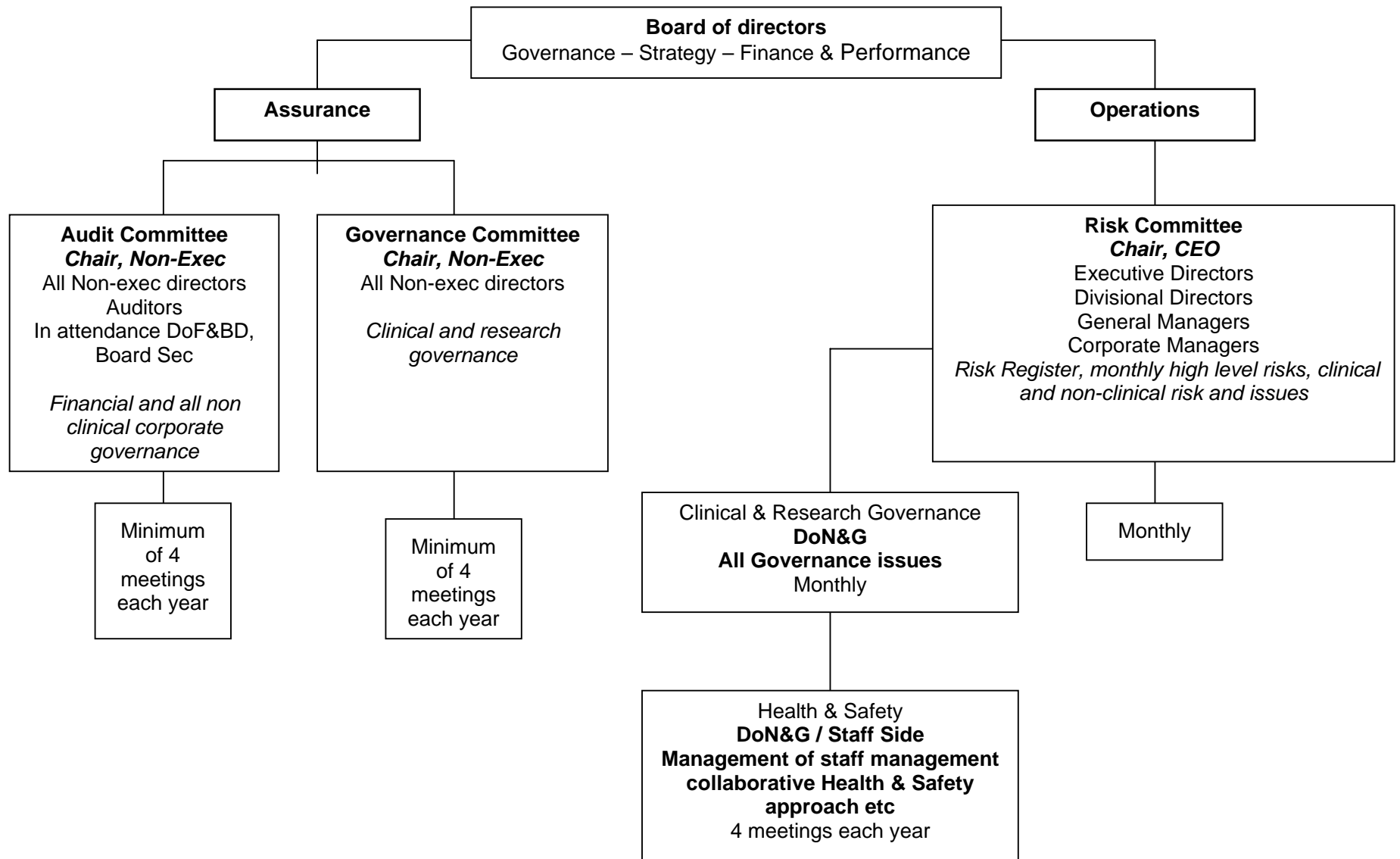
Minutes of the appropriate committee(s) will provide evidence of monitoring and identify any required action.

Appendix A

Executive Organisational Chart



Appendix B – Risk Management Committee Structure



RISK COMMITTEE TERMS OF REFERENCE

1. Formation of this committee

The board has established a committee, known as the risk committee (the committee) reporting to the board, in accordance with standing order 6 for the practice and procedure of the board of directors (annex 8 of the constitution).

The committee shall have terms of reference and powers and be subject to such conditions, such as reporting back to the board, as the board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator.

The committee shall be an executive committee of the board and has executive powers specifically delegated in these terms of reference.

2. Role

The committee is responsible for providing information and assurances to the board of directors that The Christie is safely managing all issues relating to risk.

3. Membership of the committee

The committee shall be comprised of all the executive directors of the board, the associate medical director and:

a manager and divisional/clinical director from the following clinical divisions:

- Cancer Centre Services
- Clinical Support Services
- Networked Services
- North West Medical Physics
- Research and Development
- or their deputies

a manager from the corporate divisions:

- Corporate Development
- Facilities
- Finance and Business Development
- North West Cancer Intelligence Service
- Nursing & Governance (representing Education)
- Workforce

Formal written notification of named attendees must be submitted to and agreed by the director of nursing & governance. Attendees must have the authority to make decisions and speak to all papers relating to their division. It is expected that all members will attend at least 75% of meetings of the risk committee. An annual attendance report will be submitted to the committee for information and action as required.

- 4. Chair of the committee**

The chair of the committee shall be the chief executive and the vice chair shall be the director of nursing and governance.
- 5. Quorum**

The quorum shall be six members of the committee, including two executive directors and at least one divisional/clinical director.
- 6. Meetings**

The committee shall meet twelve times per year. The chair may at any time convene additional meetings of the committee to consider business that requires urgent attention.
- 7. Attendance at meetings**

Other senior employees may be invited to attend by the chair, particularly when the committee is discussing an issue that is the responsibility of that employee.
- 8. Notice of meetings**

Meetings of the committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the committee not less than five working days before the date of the meeting.
- 9. Reporting arrangements**

The proceedings of each meeting of the committee shall be reported to the next meeting of the board of directors and the management board. The chair shall draw to the attention of the board of directors any issues that require disclosure to the board or requires executive action.
- 10. Responsibilities of the committee**

The committee is responsible for providing information and assurances to the board of directors that The Christie is safely managing all issues relating to risk. In particular, the duties include the following tasks:

 - 10.1** To monitor the strategic and operational systems and processes which ensure the competent risk management of the organisation.
 - 10.2** To instigate any required action and sign off action plans.
 - 10.3** To receive regular reports on the risk challenges faced by the divisions and corporate departments, and the mitigating action taken.
 - 10.4** To advise the board of directors of any significant risk issues.
 - 10.5** To ratify non clinical Christie-wide policies.
 - 10.6** To review and update annually these terms of reference, recommending any changes to the board of directors;
 - 10.7** To evaluate its own membership and performance on a regular basis.
- 11. Authority**

The committee is authorised by the board of directors to investigate any activity within its terms of reference. It is authorised to seek any information it

requires from any employee, and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the board of directors to obtain independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

12. Relationships with other committees

The committee receives information and assurances about The Christie business and activities from the clinical and research governance sub-committee, the health and safety committee and the divisional boards. These relationships will be a regular agenda item to ensure reports are routinely received by the committee.

13. Administration

The committee shall be supported administratively by the risk and health and safety manager, who will agree the agenda with the chair, produce all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the chair and members of the committee.

Revised: May 2007, May 2008, July 2008, February 2009,
June 2009
Revision approved: September 2009
Review date: February 2010

**GOVERNANCE COMMITTEE
TERMS OF REFERENCE**

1. Formation of this committee

The board has established a committee, known as the governance committee, (the committee) reporting to the board, in accordance with standing order 6 for the practice and procedure of the board of directors (annex 8 of the constitution).

The committee shall have terms of reference and powers and be subject to such conditions, such as reporting back to the board, as the board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator.

The committee shall be a non-executive committee of the board comprised of independent non-executive directors and has no executive powers, other than those specifically delegated in these terms of reference.

2. Role

The role of the committee is to provide assurance to the board, along with the audit committee, that The Christie and The Christie Charitable Fund are properly governed and well managed across the full range of activities and to provide internal and external assurance by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control.

3. Membership of the Committee

The committee shall be comprised exclusively of the independent non-executive directors of the board. The chairman of The Christie may be a member of the committee.

4. Chair of the Committee

The chair of the committee shall be one of the independent non-executive directors selected by the board. In their absence their place shall normally be taken by the chair of the audit committee, or in their absence by another independent non-executive director.

5. Quorum

The quorum shall be any three members of the committee.

6. Meetings

The governance committee shall meet at least four times per year. The chair may at any time convene additional meetings of the committee to consider business that requires urgent attention.

Members may participate in meetings by telephone, video or computer link and participation in this manner shall be deemed to constitute presence in person at the meeting.

7. Attendance at meetings

The following individuals shall normally be in attendance:

- executive secretary to the board
- director of nursing & governance
- medical director
- deputy director of nursing & governance

The chief executive, other directors and other officers may be invited to attend by the chair, particularly when the committee is discussing an issue that is the responsibility of that director or officer.

8. Notice of meetings

Meetings of the governance committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the governance committee not less than five working days before the date of the meeting.

9. Minutes

Minutes of all meetings of the committee shall be taken and kept by the executive secretary to the board.

10. Reporting arrangements

The proceedings of each meeting of the governance committee shall be reported to the next meeting of the board of directors. The chair shall draw to the attention of the board of directors any issues that require disclosure to the board or require executive action, together with reports of particular interest or importance.

11. Responsibilities

The committee has a shared responsibility with the audit committee, to provide assurances to the board of directors that The Christie and the The Christie Charitable Fund are properly governed and well managed across the full range of their activities.

In broad terms, the audit committee is responsible for all matters relating to corporate, financial and investment governance and risk management, whilst the governance committee is responsible for clinical and research governance and risk management, informing the audit committee of any significant clinical or research risks.

11.1 Governance, risk management and internal control

The committee will provide internal assurance by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control, particularly in relation to the clinical & research governance and risk management activities that support the achievement of the objectives of The Christie. In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the statement on internal control, and the relevant elements of the standards for better health), together with any accompanying head of internal audit statement or other appropriate independent assurances, prior to endorsement by the board of directors.
- The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- The policies for ensuring compliance with regulatory, legal and code of conduct requirements, as they relate to clinical and research governance and risk management
- Review arrangements by which staff of The Christie may raise, in confidence, concerns about possible improprieties in matters of clinical quality, patient safety or other matters.
- Annual reports and development plans relating to research governance, clinical governance, clinical audit, infection control, patient experience, fire safety, water systems, etc.
- Internal risk management arrangements incorporating the risk register and assurance framework.
- Compliance with the standards for better health and other requirements of the Care Quality Commission or its predecessor.
- Infection control arrangements and compliance with the Hygiene Code
- Serious untoward incident reports and investigations.
- Compliance with HR policies.
- Compliance with Equality and diversity policies
- Learning and development reports including attendance on induction programmes, uptake of professional education and development, provision of supervision and support.

In carrying out this function, the committee will primarily utilise the work of internal audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The committee may request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The committee may also request specific reports from individual functions within the organisation, as they may be appropriate to the overall arrangements.

In addition, the committee will review the work of other committees within The Christie, whose work can provide relevant assurance to the committee's own scope of work. This will particularly include the risk committee, the management board, the clinical and research governance committee and the health & safety committee.

This will be evidenced through the committee's use of the assurance framework to guide its work and that of the audit and assurance functions that report to it.

11.2 Internal Audit

The committee will also obtain internal assurance from the Internal Audit function, which meets mandatory NHS internal audit standards and provides independent assurances to this committee, the chief executive and the board. This will be achieved by:

Ensuring that adequate internal audit capacity consistent with the governance needs of the organisation is purchased by the audit committee

Consideration of the major findings of governance related internal audit reports, and management's response, ensuring co-ordination between the audit and governance committees.

Contributing to the annual review of the performance and effectiveness of the internal audit service conducted by the audit committee.

11.3 External assurance

The committee will review the findings of other significant assurance functions, both internal and external to the organisation, and consider the governance implications for The Christie. These will include, but not be limited to:

- Assessment reports from external accreditation agencies or regulators such as the NHS litigation authority, health and safety executive, medicines and healthcare products regulatory agency, professional bodies with responsibility for the performance of staff or functions (e.g. royal colleges, accreditation bodies etc.), strategic health authority, improving working lives standard, JACIE accreditation, ISO 9002, etc.
- Declarations of compliance with the standards for better health and compliance with the Hygiene Code and other requirements of the Care Quality Commission or its predecessor.
- Statements from internal or external audit opinion relating to clinical and research governance and risk management.
- Compliance with national quality imperatives including National Institute of Clinical Excellence guidance, National Service Framework requirements and National Patient Safety Agency reporting.
- Compliance with relevant regulatory legal and code of conduct requirements relating to clinical and research activity and employment legislation.

11.4 Reporting to the board

The committee will report annually to the board of directors on its work in support of the statement of internal control, specifically commenting on the fitness for purpose of the assurance framework, the completeness and the effectiveness of risk management in the organisation..

11.5 Annual report and financial statements

The committee shall review the annual report and financial statements for The Christie and for the The Christie Charitable Fund, before submission to the board of directors, focusing particularly on the wording in the statement on internal control and other disclosures relevant to the terms of reference of the committee.

11.6 The committee must review and update annually these terms of reference, recommending any changes to the board of directors.

11.7 The committee must evaluate its own membership and performance on a regular basis.

12. Authority

The committee is authorised by the board of directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the board of directors to obtain reasonable external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

13. Relationships with other Committees

This committee and the audit committee have a shared responsibility to provide assurances to the board of directors. As such, both committees need to work collaboratively, to ensure that all aspects of governance are covered and that the board receives comprehensive assurances on The Christie's and the The Christie Charitable Fund's business and activities.

14. Administration

The committee shall be supported administratively by the executive secretary to the board, who will agree the agenda with the chair, produce all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the chair and members of the committee.

Date issued: May 2006
Date revised: May 2007, February 2008, July 2008
Revision presented: February 2009
Review date: February 2010

**AUDIT COMMITTEE
TERMS OF REFERENCE**

1. Formation of this committee

The board has established a committee, known as the audit committee, (the committee) reporting to the board, in accordance with standing order 6 for the practice and procedure of the board of directors (annex 8 of the constitution).

The committee shall have terms of reference and powers and be subject to such conditions, such as reporting back to the board, as the board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator.

The committee shall be a non-executive committee of the board comprised of independent non-executive directors and has no executive powers, other than those specifically delegated in these terms of reference.

2. Role

The role of the committee is to provide assurance to the board, along with the governance committee, that The Christie and The Christie Charitable Fund are properly governed and well managed across the full range of activities, including investment, and to provide internal and external assurance by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control.

3. Membership of the committee

The committee shall be comprised of non-executive directors and should include at least three independent non-executive directors. The chairman of The Christie shall not be a member.

The board should satisfy itself that at least one member of the audit committee has recent or relevant financial experience. (Monitor Code F 3.1)

4. Chair of the committee

The chair of the committee shall be one of the non-executive directors selected by the board. In their absence their place shall normally be taken by chair of the governance committee, or in their absence by another non-executive director.

5. Quorum

The quorum shall be any three members of the committee.

6. Meetings

The audit committee shall meet at least four times per year. The chair may at any time convene additional meetings of the committee to consider business that requires urgent attention. At least once a year the committee shall meet privately with the external audit internal audit and counter fraud service providers and the senior representatives of these organisations may request a meeting if they consider that one is necessary.

Members may participate in meetings by telephone, video or computer link and participation in this manner shall be deemed to constitute presence in person at the meeting.

7. Attendance at meetings

The following individuals shall normally be in attendance:

- Director of finance and business development
- Executive secretary to the board
- An appointed representative of the DoF&BD, normally the financial services manager
- Representative(s) of the external audit service provider
- Representative(s) of internal audit service provider
- Representative(s) of counter fraud service provider

The chairman, chief executive and other directors may be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director.

The chief executive should be invited to attend at least annually, to discuss the process of assurance that supports the statement of internal control.

8. Notice of meetings

Meetings of the audit committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the audit committee not less than five working days before the date of the meeting.

9. Minutes

Minutes of all meetings of the committee shall be taken and kept by the executive secretary to the board or an appropriate alternative.

10. Reporting arrangements

The proceedings of each meeting of the audit committee shall be reported to the next meeting of the board of directors. The chair shall draw to the attention of the board of directors any issues that require disclosure to the board or require executive action.

11. Responsibilities

The Committee has a shared responsibility with the governance committee, to provide assurances to the board of directors that The Christie and The Christie Charitable Fund are properly governed and well managed across the full range of their activities.

In broad terms, the audit committee is responsible for all matters relating to corporate, financial and investment governance and risk management, whilst the governance committee is responsible for clinical and research governance and risk management, with the audit committee reviewing any significant clinical or research risks, as identified by the governance committee.

11.1 Governance, risk management and internal control

The committee will provide internal assurance by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control, particularly in relation to the corporate, financial and investment activities that support the achievement of the objectives of The Christie and The Christie Charitable Fund. In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the statement on internal control, and the relevant elements of the standards for better health and disclosure statements required under charity legislation), together with any accompanying head of internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board of directors.
- The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with regulatory, legal and code of conduct requirements, as they relate to corporate, financial and investment issues and, for The Christie Charitable Fund, with the terms of its declaration of trust and appropriate legislation
- the policies and procedures for all work related to fraud and corruption, as set out in the secretary of state directions and as required by the counter fraud and security management service. This will include receipt of the counter fraud annual report and counter fraud work plan , to ensure that the committee is satisfied with action taken under the annual report and that significant losses have been properly investigated and reported to the internal and external auditors and relevant external bodies.
- Review arrangements by which staff of The Christie may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

In carrying out this function, the committee will primarily utilise the work of internal audit, external audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The committee may request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The committee may also request specific reports from individual functions within the organisation, as they may be appropriate to the overall arrangements.

In addition, the committee will review the work of other committees within The Christie, whose work can provide relevant assurance to the committee's own scope of work. This will particularly include the risk committee, the management board and the charitable funds committee.

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

11.2 Internal Audit

The committee will provide internal assurance by ensuring that there is an effective Internal Audit function, which meets mandatory NHS internal audit standards and provides appropriate independent assurances to this committee, the governance committee, the chief executive and the board. This will be achieved by:

- Leading the consideration of any questions regarding the appointment of the internal audit service or revisions to/termination of the internal audit service contract.
- Ensuring that adequate internal audit capacity is identified and purchased, and that the function has appropriate standing within The Christie.
- Reviewing and approving the internal audit strategy, operational plan and more detailed programme of work, ensuring that these are consistent with the audit and governance needs of The Christie, as identified in the assurance framework.
- Consideration of the major findings of internal audit reports, and management's response, ensuring co-ordination between internal and external audit in order to optimise audit resources and between the audit and governance committees.
- Leading an annual review of the performance and effectiveness of the internal audit service.

11.3 External Audit

The committee will review the work and findings of the external auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment, effectiveness and performance of the external auditor, as far as any applicable rules permit,
- the provision and cost of the external audit service.
- Discussion and agreement with the external auditor, before an audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of The Christie, and the associated impact on the audit fee.
- Review of all external audit reports, including agreement of the annual audit letter before submission to the board, and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

The committee will make recommendations to the council of governors, in relation to the appointment and removal of the external auditor of The Christie and approve the remuneration and terms of engagement of the external auditor of The Christie. For the avoidance of doubt the council of governors has no responsibility in relation to the external auditor of The Christie Charitable Fund.

The committee will develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm.

11.4 Reporting to the board

The committee will report annually to the board of directors on its work in support of the statement on internal control, specifically commenting on the fitness for purpose of the assurance framework, and the completeness and the effectiveness of risk management in the organisation, together with the adequacy and effectiveness of The Christie's arrangements for economy and efficiency.

11.5 Annual report and financial statements

The committee shall review the annual report and financial statements for The Christie and for The Christie Charitable Fund, before submission to the board of directors, focusing particularly on:

- The wording in the statement on internal control and other disclosures relevant to the terms of reference of the committee.
- Changes in, and compliance with, accounting policies and practices.
- Unadjusted mis-statements in the financial statements.
- Major judgmental areas.
- Significant adjustments resulting from the audit.

The committee should also ensure that

- the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the board of directors, and
- they monitor the integrity of the financial statements of The Christie and the The Christie Charitable Fund, and any formal announcements relating to the financial performance, reviewing significant financial reporting judgements contained in them.

11.6 The committee must review and update annually these terms of reference, recommending any changes to the board of directors;

11.7 The committee must evaluate its own membership and performance on a regular basis.

12. Authority

The committee is authorised by the board of directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the board of directors to obtain reasonable external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

13. Relationships with other committees

This committee and the governance committee have a shared responsibility to provide assurances to the board of directors. As such, both committees need to work collaboratively, to ensure that all aspects of governance are covered and that the board receives comprehensive assurances on The Christie's and The Christie Charitable Fund's business and activities.

14. Administration

The committee shall be supported administratively by the executive secretary to the board of directors, who will agree the agenda with the chair, produce all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the chair and members of the committee.

Date issued:	May 2006
Date revised:	April 2007, February 2008, July 2008
Revision presented:	February 2009
Review date:	February 2010

**CLINICAL AND RESEARCH GOVERNANCE COMMITTEE
TERMS OF REFERENCE**

1. Constitution

The board hereby resolves to establish a committee to provide clinical and research governance information to the risk committee which is a committee of the board. This committee is known as the clinical and research governance committee (the committee).

2. Membership of the Committee

Chair: Executive Director of Nursing and Governance
Vice Chair: Executive Medical Director
Secretary: Assistant Risk Manager

Members: Chief operating officer (for information purposes)
deputy director of nursing and governance
research and development manager and lead nurse
risk and health and safety manager
general manager and lead nurse for the division of clinical networked services or governance co-ordinator
general manager and lead nurse for the division of clinical cancer centre services or governance co-ordinator
general manager and lead nurse for the division of clinical support services or governance co-ordinator
director of pharmacy
radiotherapy manager
complaints and claims manager
representative from the junior medical staff
clinical audit medical representative or facilitator
infection control team representative
NW medical physics representative
chair (or nominee) resuscitation committee
pathology department representative
chair (or nominee) hospital transfusion committee
patient and public involvement representative
clinical project manager of the wolfson molecular imaging centre (alternate meetings)
chair (or nominee) thrombosis committee

Quorum: Eight members of the committee.

3. Administration

The committee shall be supported administratively by the assistant risk manager. He/she will agree the agenda with the chair, produce all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward, and generally provide support to the chair and members of the committee.

4. Frequency of Meetings

The committee will meet monthly (12 times a year). The chair may at any time convene additional meetings of the committee to consider business that requires urgent attention.

5. Authority

The committee is authorised by the risk committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the risk committee to obtain independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

6. Responsibilities of the Committee

The committee is responsible for providing information and assurances to the risk committee that the trust is safely managing all issues relating to clinical and research governance. In particular, the duties include the following tasks:

- To maintain a comprehensive incident reporting system, acting on trends and matters of urgency.
- To ensure a comprehensive incident report detailing adverse incidents, trends and action taken/recommended is produced for the risk committee.
- To review the patients' experience, focussing on complaints, comments and surveys.
- Review national clinical guidelines and ensure implementation as appropriate within the trust.
- Receive minutes, exception reports and set the agenda for action (as appropriate) for the following :
 - clinical audit committee
 - drugs and therapeutics committee
 - falls prevention group
 - health records committee
 - hospital transfusion committee
 - infection prevention and control committee
 - medical devices and procurement committee
 - national chemotherapy advisory group implementation group
 - nutrition steering group
 - patient information committee
 - radiation protection committee
 - resuscitation committee
 - safe medicines practice committee
 - thrombosis committee
- Work closely with heads of service/professional leads in ensuring the continuing professional development of clinical practitioners within the organisation.
- To be involved as required with ensuring compliance with the standards for better health.

- To be involved as required for ensuring compliance with the NHSLA risk management standards
- To ensure compliance as required with the strategic and annual objectives of the trust
- To approve trust policies relating to clinical and research governance
- To produce an annual clinical governance report
- To produce an annual research governance report

7. Management

The committee may request and review reports and positive assurances from directors and managers on their arrangements for clinical and research governance. The committee may also request specific reports from individual functions within the organisation

8. Reporting Arrangements

The committee is accountable directly to the risk committee. The minutes of the committee shall be formally recorded and submitted to the risk committee. The chair of the committee shall draw to the attention of the risk committee any issues that require disclosure to the board or require executive action.

9. Relationships with other Committees

This committee, the health and safety committee and divisional boards have shared responsibility to provide information and assurances to the risk committee. As such, all boards/committees need to work collaboratively, to ensure that all aspects of risk management and governance are covered and that the risk committee receives comprehensive assurances on the trust's business and activities.

10. Review

The terms of reference will be reviewed annually by the committee and approved by the risk committee.

Written: January 2002
 Revised: December 2003; December 2005; May 2006; May 2007; May 2008, May 2009
 Next Review: May 2010

**HEALTH AND SAFETY COMMITTEE
TERMS OF REFERENCE**

1. Constitution

The Management Board hereby resolves to establish a committee to provide health and safety information to the Risk Committee which is a committee of the Board. This committee is known as the Health and Safety Committee (the committee).

2. Membership of the Committee

Chairs: Executive Director of Nursing & Governance
Staff side representative
(to alternate after every third meeting)

Members: *Management (representative from each division)*
Risk and Health and Safety Manager
Assistant Risk Manager
Manager from Cancer Centre Services
Manager from Clinical Support Services
Manager from Corporate Development
Manager from Facilities
Manager from Finance & Business Development
Manager from Networked Services
Manager from North West Cancer Intelligence Service
Manager from NW Medical Physics
Manager from Research & Development
Manager from Workforce & Corporate Development

Advisers

Infection Control Nurse
Moving and Handling Adviser
Fire Safety Adviser
Occupational Health nurse or physician
Radiation Protection Adviser
Estates Officer – Planning and Environment (Waste Management)

Staff side

Statutory health and safety representatives who are members of recognised trade unions and staff organisations and non-union representatives who may attend on behalf of their department, if nominated. Names should be forwarded to the secretary.

Other employers

University of Manchester, represented by Paterson Institute Health & Safety Manager

Where a significant number of employees of other organisations are based on the The Christie site, they may be represented

Quorum: 8 Managers/Advisers
3 staff side representatives

3. Administration

The committee shall be supported administratively by the Assistant Risk Manager. He/she will agree the agenda with the Chair, produce all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward, and generally provide support to the Chair and members of the committee.

4. Frequency of Meetings

The committee will meet 4 times each year. The Joint Chairs may at any time convene additional meetings of the committee to consider business that requires urgent attention.

5. Authority

The committee is authorised by the Risk Committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the Risk Committee to obtain independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

6. Responsibilities of the Committee

The committee is responsible for providing information and assurances to the Risk Committee that the Trust is safely managing all issues relating to health and safety. In particular, the duties include the following tasks:

- to monitor progress/implementation of the Trust's health and safety strategy
- to ensure a comprehensive incident report detailing accidents, incidents of violence, ill health, trends and action taken/recommended is produced quarterly
- to keep under review the measures taken to ensure health and safety at work
- to review information on health and safety legislation and make recommendations on the appropriate mechanisms for its implementation
- to work to promote co-operation between employers and employees in instigating, developing and carrying out measures to ensure health and safety at work
- to continually review the effectiveness and relevance of policies to ensure good and consistent standards are being maintained
- to monitor the effectiveness of health and safety arrangements through the study of accident and incident reports, including those which are notifiable to the HSE, notifiable disease statistics and the examination of departmental safety reports and audits
- to identify unsafe and unhealthy conditions and practices and make recommendations for action
- to consider reports and information provided by HSE inspectors and other enforcing authorities
- to consider the communications on health and safety information and make recommendations for improvements as necessary
- to participate in the implementation of training/educational programmes to help meet identified training needs
- receive minutes, reports and set the agenda for action (as appropriate) for the following:

- Medical Physics Safety Committee
 - Genetic Modification Committee
 - Pathology Health and Safety Committee
 - Radiation Protection Committee
 - Laser Protection Committee
 - PICR Safety Committee
 - Radiology Safety Committee
 - Waste Management Working Group
- to be involved as required with ensuring compliance with the Standards for Better Health
 - to be involved as required for ensuring compliance with the NHSLA Risk Management Standards
 - to ensure compliance as required with the strategic and annual objectives of the Trust
 - to produce an annual health and safety report

7. Assurance

The committee may request and review reports and positive assurances from directors and managers on their arrangements for health and safety. The committee may also request specific reports from individual functions within the organisation.

8. Reporting Arrangements

The committee is accountable directly to the Risk Committee. The minutes of the committee shall be formally recorded and submitted to the Risk Committee. The Chair of the committee shall draw to the attention of the Risk Committee any issues that require disclosure to the Board or require executive action.

9. Relationships with other Committees

This committee and the Clinical and Research Governance Committee have shared responsibility to provide information and assurances to the Risk Committee. As such, these committees need to work collaboratively, to ensure that all aspects of risk management and governance are covered and that the Risk Committee receives comprehensive assurances on the Trust's business and activities.

10. Review

The terms of reference will be reviewed annually by the committee and approved by the Risk Committee.

Written: January 2004

Revised: May 2006, March 2007, March 2008, March 2009

Next Review: March 2010