



## Board Strategy

### NHS National Waiting Times Centre Board

#### Risk Management Strategy

<b>Name</b>	Risk Management Strategy
<b>Q-Pulse No</b>	Board-Strategy-8
<b>Summary</b>	Outlines the Board's approach to delivery of safe and effective care through the establishment of a robust risk management framework.
<b>Associated documents</b>	Clinical Governance Strategy. Incident Reporting Policy
<b>Target audience</b>	All staff of the National Waiting Times Centre Board
<b>Version number</b>	Version 4
<b>Date of this version</b>	March 2013
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<b>Date of full impact assessment</b>	N/A
<b>Name of Board</b>	National Waiting Times Centre Board
<b>Approving committee/group</b>	Clinical Governance Committee
<b>Document author</b>	Mark Swatton

Risk Management Strategy  
Date of Implementation: March 2013  
Date of Review: March 2016  
Responsible Officer: Head of Clinical Governance

Qpulse No: Board-Strategy-8

Strategy developer (Author): <b>Mark Swatton</b>
Strategy developer's designation: <b>Head of Clinical Governance</b>
Is this a new strategy? <b>No</b>
If 'Yes', why is it required? (e.g. new legislation necessitating Board compliance)
If 'No', reason for reviewing current strategy: (e.g. strategy review date expiring, change in legislation necessitating policy amendment): <b>Updated to reflect the Board's change to governance arrangements; reflect reporting changes; reduced in size the removal of unnecessary text; terms of reference for relevant groups/committees updated; updated organisational governance chart added; and to reflect changes to the Clinical Governance Department.</b>
Who has been involved or consulted with in order to develop this strategy? (i.e. Committees/Working groups, specific individuals, etc.) <b>Full consultation across Board including divisional clinical governance groups and Clinical Governance and Risk Management Group</b>
Has this document been assessed for relevance? <b>Yes</b>
Is this document relevant for Full Impact Assessment? <b>No</b>
Date of full impact assessment (please attach completed EQIA document on submission): <b>N/A</b>
How will this policy be implemented across the Board? (e.g. training programme, awareness raising, etc.) <b>See Section 4</b>

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## Glossary of Terms

**Acceptable Risk** An everyday risk, minor in nature, occurring on a routine basis.

**Assurance** Stakeholder confidence in our service gained from evidence showing that risk is well managed.

**Blame** Inappropriate attribution of responsibility to an individual for an adverse incident.

**Contingency** An action or arrangement that can be implemented to minimise impact and ensure continuity of service when things go wrong.

**Control Measure** Something done to minimise risk to an acceptable level either by reducing the likelihood of an adverse event or the severity of its consequences or both.

**Controls** An existing process, policy, device, practice or other action that acts to minimise negative risk or enhance positive opportunities.

**Governance** The system by which organisations are directed and controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all areas of governance.

**Adverse Incident** Any event or circumstance that led to **unintended or unexpected** harm, loss or damage.

**Serious Adverse Event (SAE)** Any **unintended or unexpected** adverse incident that could have or did lead to major permanent harm, loss or damage. A serious adverse event may seriously impact upon the delivery of objectives and which may attract adverse media attention and/or result in litigation or which may reflect a serious breach of standards for assuring the quality of the Boards services and its reputation.

**Likelihood** Used as a general description of probability or frequency which can be expressed quantitatively or qualitatively.

**Near Miss** An undesirable incident that by chance or design did not result in harm or loss.

**Risk** The chance of something happening that will have an impact on objectives.

**Risk Assessment** The overall process of risk identification, risk analysis, risk evaluation.

**Risk Register** A risk management portfolio, which allows the registering and active management of risks that face NWTC at any one time. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made.

**Risk Escalation** The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impossible or impractical to manage locally.

**Risk Management** The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.

**Risk Management Framework** Set of elements of an organisation's management system concerned with managing risk. These include strategic planning, decision making and other strategies, processes and practices for dealing with risk.

**Root Cause Analysis** Structured techniques to establish the true systematic causes of an event as opposed to its apparent causes.

**Severity** Most predictable consequence to the individual or organisation were the circumstances in question to occur.

**Stakeholder** Those people and organisations who may affect, be affected by, or perceive themselves to be affected by a decision, activity or risk.

**Statement of Internal Control** A statement by the accountable officer within the published Annual Report, required by HDL (2002)11, on the effectiveness of NWTC's systems of internal control, for which risk management is a key component.

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## National Waiting Times Board / Golden Jubilee National Hospital

### Risk Management Strategy 2013 - 2016

#### 1.0 Why is Risk Management so important to us?

The NHS National Waiting Times Centre Board (the Board) aims to provide high quality, safe services to the public it serves, in an environment, which is also safe for the staff it employs or contracts with to provide services.

In fulfilling this aim, the Board has established, implemented and will continuously review a robust and effective framework for the management of risk, one that is proactive in understanding risk and builds upon existing good practice.

**Good risk management when oriented around performance improvement and focused on the delivery of high quality patient care can lead to:**

- **A minimisation of risks to the quality and delivery of patient care;**
- **Improved service delivery;**
- **Improved safety of patients, staff and visitors;**
- **Promotion and achievement of innovation;**
- **Optimised use of resources available for patient care by managing risk, thus reducing the financial implications associated with adverse incidents;**
- **The protection of services, reputation and finances of the organisation through a process of risk identification, assessment, control, elimination and transfer;**
- **Assurances that procedures, protocols and systems are robust and operating effectively; and**
- **The identification and control, by way of elimination or reduction to an acceptable level, of all risks which may adversely affect:**
  - **The health, safety and welfare of patients, visitors and staff;**
  - **The ability of the organisation to provide services;**
  - **The quality of care; and**
  - **The ability of the organisation to meet its contractual commitments.**

To achieve these aims we will:

1. Promote and maintain a culture, which secures the involvement and participation of all staff, and where appropriate patients and members of the public, in risk assessment and

incident reporting and which is open and transparent in line with the Board's Vision and Values.

2. Secure the commitment of management at all levels to promote risk management and provide the necessary leadership and direction.
3. Monitor and review risk management performance at a corporate and divisional level against agreed standards to ensure that corrective / improvement action is taken where necessary.
4. Ensure that there are processes to facilitate the systematic recording and reporting of incidents, including serious adverse events and near misses to minimise the risk of recurrence. The reporting mechanism will focus on systems more than individuals and cover clinical and non-clinical incidents.
5. Recognise the contribution of all staff to ensure their involvement and participation in the overall risk management process.
6. Have in place effective systems of communication to ensure the dissemination of information on risk management matters.
7. Ensure effective co-ordination between specialist groups particularly where there is a clinical / non-clinical dichotomy, in order to ensure that all aspects of care are considered and integrated throughout the patients' journey.
8. Ensure safe systems of work are in place to protect patients, visitors and staff.
9. Have continued development and implementation of emergency preparedness, response and contingency plans.
10. Secure the provision of resources, facilities, information, training, instruction and supervision to meet these objectives.

## **2.0 What is the purpose of the Risk Management Strategy?**

This strategy affirms our commitment to improving our capability to manage risk in a systematic way. Through this approach we can drive continuous improvement and have a positive impact on the quality of care, our staff and the efficiency of service delivery.

The following principles underpin our approach to risk management and are relevant to all Divisional Management Teams (DMTs), providing a common framework for the identification, assessment and management of risks:



### Guiding Principles

- **Incorporates clinical and non-clinical risks.**
- **Integral to achieving objectives and monitoring services and organisational performance.**
- **Supported by clear processes for escalation of risk.**
- **Integral to the business agenda and informs performance review.**

### 3.0 What will our strategy achieve?

The overall goal of risk management is to establish an appropriate infrastructure and culture to enable:

- **Continuous improvement in the quality of patient care by preventing or reducing harm or potential harm to patients and members of staff.**
- **Facilitation of continuous improvement in performance so we can manage risk effectively and efficiently and achieve our objectives at lower overall cost.**

### 3.1 Risk management objectives

In summary, our objectives will ensure:

- Risk management will be integral to all our business decision making, planning, performance reporting and delivery processes to achieve a confident and rigorous basis for decision-making.
- We aim to achieve a balance between realising opportunities for gains while minimising losses, in an environment where risk is recognised as a deviation from what is planned or expected rather than interpreted in terms of hazards or negative impacts.
- Risk will be managed by targeting underlying system weaknesses rather than blaming staff for error (providing they are not willful, criminal or evident of professional misconduct).
- Risk management will be devolved to divisions and corporate functions within a common risk management framework using a consistent approach to risk management and assessment with common criteria to inform decision making and support prioritisation of local risk registers and risk management arrangements.
- There is stakeholder involvement in our risk management arrangements and decision making, in order to bring different areas of expertise together and for ensuring different views are appropriately considered in evaluating risks and appropriate change management.

- We are committed to ensuring patients and their families are fully informed of how we manage risk through use of tools such as clinical dashboards. Specifically, we are committed to ensuring patients and their families are fully updated on the progress and outcomes of serious adverse events, which affected them.

We will review the effectiveness of this strategy, risk management policies, systems and processes across the organisation.

#### **4.0 Organisational arrangements**

##### **4.1 Risk management context**

There needs to be an appropriate committee infrastructure to support delivery of risk management objectives and to provide assurance to all stakeholders.

There needs to be clarity of '*who does what*' otherwise risks may remain unidentified, causing loss or harm that could otherwise be controlled or avoided.

##### **4.2 Governance arrangements**

These are summarised as:

- **The Board** is corporately responsible for 'owning' the Risk Management Strategy and ensuring that significant risks are adequately controlled. Collectively and individually, Board members personally accept vicarious liability for the actions of the Board and criminal sanctions for breaches of statutory obligations to protect employees and the public from risks arising from the Board's activities or omissions.
- **The Clinical Governance Committee (CGC)** will provide assurances that clinical governance and risk management mechanisms are in place and effective through out the Board and will act as the Board's 'safe' committee. The CGC will scrutinise appropriate risk data including quarterly divisional risk and patient safety reports as well as quarterly corporate risk reports.
- **The Person Centred Committee (PCC)** has an important role in ensuring consistency of policy and equity of treatment of staff across the Board, including remuneration issues, where they are not already covered by existing arrangements at national level. The committee must be reassured that risk management systems are in place to deliver the objectives of the PCC.
- **The Audit Committee (AC)** through assurance processes, including internal and external audit, will provide an independent objective opinion to the Board on whether the risk management arrangements described in this strategy are in place and effective. The AC has overall responsibility for review of internal control / corporate governance.
- **Clinical Governance and Risk Management Group (CGRMG)** is a single point of co-ordination to integrate, oversee and direct the clinical governance and risk management

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agenda, sign off corporate risk policy and co-coordinating the implementation of risk control plans relating to clinical activity, including Infection Control. The group review trend analysis for incidents, claims and complaints and consolidate assurances for the governance committees that all significant risks are adequately managed; this will provide managerial assurances in line with HDL (2003)11 Statement of Internal Control. The CGRMG will also oversee the management of reviews related to serious adverse events (SAE) and associated root cause analyses (RCAs).

- **Divisional Clinical Governance Groups (DCGGs)** provide leadership, driving the agenda and setting the tone for risk management; review of aggregated risk data, review of divisional risk registers, ensuring integration of risk management and overview of local risk management performance.
- **Mortality and Morbidity (M&M) Management Group** is co chaired by the Medical and Nurse Directors. This group is charged with ensuring there are robust processes in place to ensure M&M arrangements are robust and relevant data is reviewed and reported to the Board to ensure mortality remains at acceptable levels.
- **Health and Safety Committee** supports the CGRMG by co-coordinating the implementation of risk control plans relating to health and safety activity.
- **Board Specialist Groups and Committees** provide reassurances to the CGRMG that specialty risks are being managed effectively and bring to their attention any significant risks.
- **Clinical Governance Department** staff are responsible for supporting and advising the Board and its staff on delivery of all elements of risk management.

#### **4.3 Staff accountabilities for delivery of this strategy**

All Executive Directors, members of the Senior Management Team (SMT) and Divisional Management Teams (DMTs) will have risk management responsibilities defined in their objectives. This will include the identification, assessment and analysis of risks and action plans to eliminate or minimise the impact of known risks.

All managers have a responsibility to ensure that their staff are familiar with the latest risk management guidance and controls and that risk registers are actively used.

Within each DMT, individuals may also be nominated to lead and co-ordinate particular elements of the risk management process and to work with colleagues and the local risk management advisors to develop and implement agreed actions.

Specifically:

- **Chief Executive** is responsible for maintaining a sound system of internal control that supports the achievement of the Board's policies, aims and objectives, whilst safeguarding the public funds and assets.
- **Medical Director** has lead responsibility for the ensuring implementation of the Risk Management Strategy and supporting processes.
- **Nurse Director** has lead responsibility for ensuring there are robust business continuity arrangements in place across the Board.
- **Head of Clinical Governance (HCG)** is responsible to the Medical Director and will ensure implementation, coordination and monitoring of risk management activity within the Board, ensuring that systems and processes are in place for the continuous and effective management of risk in line with this strategy. The HCG has responsibility for developing implementing and monitoring Key Performance Indicators (KPIs) ensuring a continual improvement in performance.

The HCG will be a Board wide point of resource for risk related issues and responsible for supporting the divisions in ensuring there are effective systems and processes in place to allow them to manage their risks locally. Additionally, the HCG will ensure smooth functioning of the incident reporting system and be responsible for the day-to-day management of operational risk management activity.

- **Divisional Heads of Operations** are accountable to the Operations Director and ultimately the Chief Executive for the implementation of this strategy within their respective divisions. Specifically they are responsible for:
  - Ensuring all functions across the division have an actively managed risk register so that all areas of risk (clinical and non-clinical) are assessed both proactively and reactively and action taken to implement improvements.
  - Ensuring all risk assessment processes are documented through the Board's incident reporting system, Datix.
  - Ensuring risks, where appropriate, are escalated to the appropriate group or committee.
  - Ensuring that staff under their management are aware of their risk management responsibilities and undertake these in a timely manner.
  - Incorporating risk management within the business planning process.
  - Developing mechanisms to enable feedback to staff on incident reporting and risk issues.
  - Ensuring divisional compliance with the various external assurance assessments, e.g. NHS Healthcare Improvement Scotland (NHS HIS) standards.

- **Department Managers** are accountable for day-to-day implementation of risk management including responsibility for risk assessment; incident and near miss reporting; root cause analysis of adverse events; investigation of complaints and claims; dissemination of risk information and lessons; and promotion of learning.
- **All employees** have a general responsibility to protect patients, fellow employees and others by :
  - Taking reasonable care for the health, safety and welfare of themselves and any others who may be exposed to risk because of their acts or omissions.
  - Providing full co-operation to the organisation, enabling it to fulfil its duties to patients, employees and others.
  - Where equipment and substances are provided, they should be used safely, in the manner for which they were intended, and in accordance with any training provided; and
  - Reporting situations presenting danger to patients, employees or others, and any shortcoming in control measures employed by the organisation, supported through the arrangements laid out in the Board's Whistle Blowing Policy.

#### 4.4 Co-ordination and professional support

There is a number of staff who have specialist advisory roles. These can be viewed at Appendix C.

#### 5.0 Risk management framework

The risk management framework describes the practicalities of how risk management will be approached in the Board. The key elements of the framework are:

- **Risk identification.** The Board aims to minimise the likelihood and severity of risk events by the recording of all adverse incidents and near misses through the incident reporting system, Datix, implemented within each division. It is the responsibility of management within each division to encourage staff to report adverse incidents / near misses that could pose a hazard or threat to people or the provision of services and thus enable improvements to be identified, prioritised and implemented. Please refer to the Board's Incident Reporting Policy.

Recording and analysis processes will be made available to support local data entry, with the overall aim of shared learning across the Board. In addition to risks identified through the incident reporting system, the SMT will also be required to regularly 'horizon scan' to identify risks by looking forward to tomorrow's threats as part of the development of the Corporate and Local Risk Registers.

- **Risk assessment.** A universal approach will be defined for assessing the significance of risk to judge whether additional controls are required or whether the risk can be accepted. All departments will have arrangements in place for a regular programme of risk assessment using the NHS QIS Risk Matrix to rate risks.
- **Incident recording and sharing of learning.** Incidents, complaints and claims tend to fall into recurrent patterns regardless of the people involved, mainly due to system weaknesses. Incident recording of all types of adverse incidents and near misses will enable trends to be identified, system weaknesses to be captured and action taken.
- **Risk register and escalation.** The incident reporting system, Datix, will maintain the Board's Risk Register containing risk assessments and details of necessary control measures. Its purpose is to help every level of the organisation prioritise available resources to best effect and provide assurances that progress is being made. Significant risks deemed impossible or impractical to manage at a lower level will be escalated to a more senior level.
- **Business continuity arrangements.** As a category two responder the Board recognises its obligation to business continuity legislation. Fully risk assessed business continuity plans are in place supported by a Business Continuity Policy and Major Incident Policy.
- **Risk control and contingency.** For all significant risks, proportionate risk control and contingency measures will be introduced to reduce the risk to an acceptable level. To increase confidence of those deciding whether to accept or control a risk, the Board will retrospectively support all well judged risk assessments based on agreed risk criteria.
- **Monitoring progress.** The Board will monitor progress of risk management as a component of the overarching performance management arrangements to identify and prioritise areas requiring additional support.
- **Assurance of effectiveness of control.** An assurance framework will be developed to provide the Board with systematic assurance that local systems are capable of identifying their objectives and managing the risk to their achievement. The CGRMG will aggregate assurance data, to enable the Audit and Governance committees to provide evidence for the Chief Executive's annual Statement of Internal Control.

## **6.0 Risk management in partnership**

Our approach to risk management recognises the importance of working in partnership with all relevant stakeholders:

### **6.1 Patients and the public**

Risks relating to service availability and quality of service will be managed and communicated to the Involving People Group and where appropriate the Quality Patient Public Group. Guidance

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on dealing with such risks will be developed in conjunction with the CGRMG and DCGG. The Board seeks to inspire public trust, for all such risks, therefore, we commit to:

- Being open and transparent about our understanding of the nature of risks to the public.
- Seek patient and public involvement in the decision making process of those affected.
- Act proportionately and consistently in dealing with public risks.
- Base decisions on evidence.
- Publish assurance that we are doing our best to manage risk.

## **6.2 NHS Boards, partner agencies, contractors and the voluntary sector**

The delivery of the Board's objectives relies upon effective co-operation, partnerships and joint working with other NHS Boards, agencies such as Local Authorities, the Voluntary Sector and independent contractors. The Board commits to minimise risk associated with such partnerships by ensuring:

- Common objectives are agreed from the outset with all partners.
- Shared risks are identified and managed in partnership.
- An adequate risk management framework is incorporated as part of joint management and partnership governance arrangements.
- Monitoring arrangements exist to provide assurance that risk is managed adequately.

## **7.0 Communicating this strategy**

We realise that to be effective this strategy must be communicated widely. To achieve this we will utilise:

- Awareness sessions relating to all facets of risk management through corporate and mandatory training days.
- Communication through structures highlighted in the Clinical Governance Strategy including learning facilitated through the DCGGs.
- Progress on delivery of this strategy including associated action plans communicated to the CGC through quarterly monitoring reports.
- Where appropriate periodic reports and bulletins provided to all stakeholders with the support of the communications department.

- Provide access to the Risk Management Strategy and associated policies via the Q pulse document management system, Golden Jubilee National Hospital website and local intranet site.

**This strategy is linked to the following policy documents:**

- Clinical Governance Strategy
- Incident Reporting Policy
- Claims Management Policy
- Complaints Policy
- Guidance on Risk Matrix and Risk Register
- Training Strategy
- Health and Safety Policies
- Infection Control Policy
- Whistle Blowing Policy
- Radiation Protection Policy

**8.0 Monitoring effectiveness**

This strategy provides a framework through which risk can be managed effectively and efficiently across the Board. The ongoing implementing of this strategy will be monitored by the CGRMG on an ongoing basis by the following processes:

- Approval of this strategy will be by formal ratification with final publication on the Q pulse document management system, Golden Jubilee National Hospital website and local intranet site.
- Publish an annual risk report, which will be approved by the Audit Committee, which will show evidence that we have implemented this strategy.
- Conduct periodic reviews (audits) of the component parts of this strategy and its supporting policy and procedure to provide reassurance that it is being implemented in an effective and systematic way.
- The duties of key individuals for risk management activities will be monitored through the Board's appraisal process.
- With regard to authority of all managers with regard to managing risk, the Health and Safety Department will undertake regular audit of ward and departments and accordingly their managers' compliance with statutory responsibilities under the Health and Safety at Work Act (1974).
- Implementation of Audit Report recommendations as conducted by internal audit.
- Review of the Board's submissions to external agency inspections and accreditations.



- Completeness of corporate risk register which will be presented to the Board quarterly and updated at least annually and more frequently as risks are escalated.
- All specialist groups and committees will present an annual report and work plan to the CGC which will outline management of key risks.

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## Appendix A

### Terms of reference

#### Clinical Governance and Risk Management Group (CGRMG)

##### 1.0 Introduction

The primary responsibility for the delivery of clinical governance and quality initiatives sits within Divisional Management Teams (DMT), Divisional Clinical Governance Groups (DCGGs) and ultimately with staff. The following groups provide the support structure for clinical governance:

- The daily 'operational' business of clinical governance is supported by the Clinical Governance Department (CGD).
- The coordination and leadership for development of clinical governance at divisional level is through the DCGGs with support and advice provided through specialist groups and committees.<sup>1</sup>
- The CGRMG provides oversight of clinical governance across the Golden Jubilee National Hospital (GJNH) providing assurance to the Board's Clinical Governance Committee (CGC) that safe and effective care and services be delivered across all areas of the Board including the Beardmore Centre for Health Science and the Beardmore Hotel and Conference Centre.
- The Involving People Group (IPG) has specific focus on implementing the Involving People Strategy and provides reassurance of this to the Person Centred Committee.

##### 2.0 Remit of the CGRMG

The overarching objective of the CGRMG is to ensure that care and services are safe and effective and that risks from all areas of the Board are managed and escalated appropriately. The CGRMG will:

1. Oversee the delivery of the Board's clinical governance and risk management strategies and appropriate action plans. In doing so, it will ensure that there are fit for purpose reporting structures which are reviewed for effectiveness on an annual basis. Progress action plans at all meetings.
2. Ensure there is a Risk Management Strategy in place, which clearly defines responsibilities, and risk management objectives for the Board and that these are delivered.
3. Be generally aware of the Board's risk profile through scrutiny of the corporate risks. Specifically, to assist and advise the Senior Management Team (SMT) to maintain a

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<sup>1</sup> See Governance Structure at Appendix B

corporate risk register, which will ensure the Board focus on key prioritised risks and the action implemented to address such risks.

4. Oversee the development, implementation, monitoring and review of the Board's Business Continuity cycle.
5. Review and provide final approval for all Incident Reviews (IR) (*see the Board's Incident Reporting Policy for full details*).
6. Review on a quarterly basis, risk and patient safety reports from both divisions.
7. Review all major incidents which have been subject to root cause analysis (RCA) prior to their submission to the Board and ensure action plans are in place for such events and that these are delivered against agreed timescales (*see the Board's Incident Reporting Policy for full details*).
8. Monitor health & safety action plans and addressing of risks and risk alerts.
9. Ensure that DCGGs are leading clinical governance activity across divisions. Outputs will be monitored through scrutiny of agreed reports, principally the risk and patient safety report.
10. Ensure there is a Clinical Improvement Policy in place, which clearly defines responsibilities and clinical effectiveness and improvement objectives. The CGRMG will ensure there is an annual clinical audit and improvement plan in place, informed by activity from both divisions, as well as corporate functions, and monitor its delivery.
11. Ensure there is active participation of group members in NHS Healthcare Improvement Scotland (NHS HIS) reviews. This includes completion of self-assessment of NHS HIS standards or providing information for other peer reviews. In addition, ensuring appropriate remedial plans in place to meet shortcomings from peer reviews and / or national reports (recommendations from fatal accident enquiries etc.) and monitor the delivery of these plans by appropriate clinical leads and associated groups and committees.
12. Liaise with the SMT and Performance and Planning Committee to ensure relevant information and ideas are exchanged between these forums to enhance the delivery of safe and effective care and services.
13. Provide leadership and direction to resolve issues which directly or indirectly affect the delivery of safe and effective care and which cannot be resolved at divisional level.
14. Monitor activity and outputs of all specialist groups and committees to ensure work plans are being delivered. Minutes of meetings are required to be sent to the Head of Clinical Governance and chairs of such groups and committees will be required to provide exception reporting on a quarterly basis related to annual work plans.

15. Ensure wide communication of clinical governance and risk management strategies through training/ media /communication etc. to develop an evaluation process and staff involvement.
16. Provide the CGC with appropriate reports as guided by the committee's schedule of reports.
17. Support and champion the Board's approach to a fair and open culture and reviewing the progress of embedding this.
18. Agree and coordinate a scheme of delegation annually.
19. Approve all Board wide policies and strategies linked to clinical governance and risk management activity.
20. Whilst the IPG will oversee implementation of the Involving People Strategy and associated actions the CGRMG will liaise appropriately with the IPG to ensure risk and effectiveness activity is appropriately informed by its agenda.

### **3.0 Membership**

The membership of the group is highlighted below.

#### **Members**

Chief Executive (Chair)  
Nurse Director (Vice Chair) (Executive lead for CG&RM)  
Medical Director (Executive lead for CG&RM)  
Director of HR  
Head of eHealth  
Director of Finance  
Director of Business Services  
Head of Operations for Surgical Services  
Head of Operations for Regional and National Medicine  
Co Chairs from Divisional Clinical Governance Groups  
Chair of Local Clinical Forum  
General Manager for Beardmore Hotel and Conference Centre  
Infection Control Manager  
Head of Clinical Governance (Professional Secretary)  
Clinical Governance Leads from Clinical Governance Department  
Health and Safety Advisor  
Clinical Education and Improvement Nurse

#### **In attendance as required**

Head of Learning and Development  
Chairs of Specialist Groups and Committees

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Research and Development Manager

#### 4.0 Responsibilities of Specific Members

**(a) Chief Executive.** Acts as the chair of the CGRMG and as such is responsible for providing leadership and direction.

**(b) Vice Chair.** Will be the Nurse Director (or Medical Director in their absence) and will support the chair in their duties. Where the chair is absent from meetings the vice chair will act as their deputy.

**(c) Head of Clinical Governance.** As professional secretary to the group, is responsible for coordination of all its activity. This individual will be required to:

- Ensure meetings are arranged to maximise attendance;
- Along with Chair / Vice Chair, set agendas for meetings;
- Ensure reports for the CGC, as directed by its schedule of reports, are completed.

**(d) All members.** All those who are members of the CGRMG are expected to attend meetings regularly and prepare appropriately for meetings.

#### 5.0 Meetings

The CGRMG will meet approximately six weekly. Dates will be planned annually by the CGD. To ensure appropriate feedback to members who are unable to attend a list of action points will be circulated no less than one week after a meeting. Queries will be addressed by the Head of Clinical Governance or by an appropriate member of the group who attended.

**Quorum.** For a meeting to be quorate the following must be present:

- Chair or Vice Chair; and
- Seven other members of the group.

Administration for meetings will be provided through the CGD.

#### 6.0 Agenda

A fixed agenda will be used however, given the potential size of the agenda there should be flexibility around prioritising items. Production of the final agenda will rest with the Chair / Vice chair. Decisions around prioritisation will be influenced by:

- Local or national issues, which have an immediate impact on clinical care and / or staff or patient safety.
- Local or national issues, which have an immediate impact on external peer, review updates as relates to the preparations for such reviews.

- Scrutiny of outputs from Steering Groups and Specialist Groups and Committees.
- Policy, procedure and guideline reviews.
- Updated reports for DCGGs / Health & Safety / Corporate.

Agenda items will be called for two weeks prior to meeting with agenda and papers issued seven days prior to meeting.

### **7.0 Disseminating Information to Staff**

The CGRMG recognises the importance of ensuring staff are fully apprised of its activities and milestones in the development and embedding of clinical governance throughout the Board. Therefore, all staff will:

- Be able to attend meetings as observers. This will be through agreement and support of the Chair / Vice Chair/ Head of Clinical Governance.
- Be able to raise issues relating to clinical governance (and represent them as appropriate) either:
  - Through DCGGs
  - Through the Head of Clinical Governance, as appropriate.
- Be able to view minutes of meetings and action plans on the local intranet.
- Papers are available on request.

### **8.0 Reporting Arrangements**

The CGRMG reports to the CGC and will ensure that all relevant reports as outlined in its schedule of reports are complete and submitted by agreed timescales.

An annual report will be prepared for the Board on all clinical governance activity and outcomes of external monitoring visits.

### **9.0 Review**

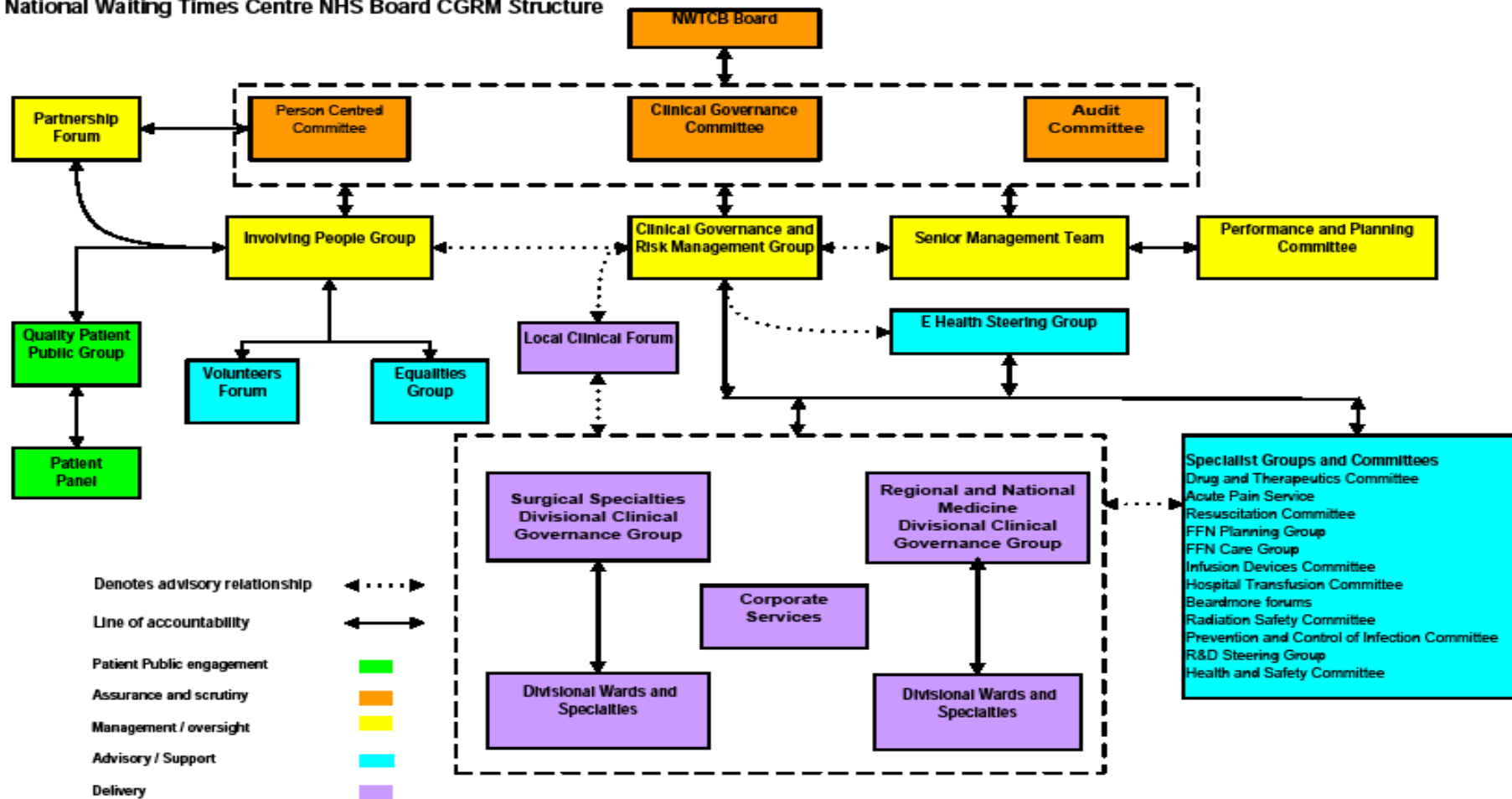
These terms of reference will be reviewed as part of the review of this strategy.

**This version: May 2013**

# Appendix B

## Governance Structure

National Waiting Times Centre NHS Board CGRM Structure



## Appendix C

### Roles of Specialist Staff

- **Occupational Health Nurses** roles relates primarily to maintenance of employee health, and responsibilities include:
  - Evaluate features of work related ill health
  - Record and evaluate sharp's injuries
  - Provide professional assistance to management in DS, COSHH, general risk assessment and Pregnant Worker programmes
  - Advise management of any uncontrolled risk
  - Recommend control solutions
  - Ensure (ongoing) fitness / suitability for employment
  - Develop policies and procedures for Board-wide implementation
  - Manage immunisation programmes
  - Deliver training programmes
- **Health & Safety Advisor's** responsibilities include:
  - Advising Management on all Health & Safety Legislation, Codes of Practice and EC Directives
  - Assisting with Health and Safety issues in connection with major new build and refurbishment projects
  - Undertaking Risk Assessments and Safety Audits and contributing to the Risk Register
  - Liaison with key departments to facilitate accident/incident investigations where clinical and non-clinical issues overlap
  - Assisting with training
  - Assisting in the drafting, reviewing and implementation of the Board Health & Safety policies
- **Fire Officer's** role is to ensure the Board is complying with all Fire related legislation, including:



- Monitoring all buildings
- Deliver training to all staff on Fire Prevention
- Develop policies and procedures for Board wide implementation
- Advising Management on any areas of concern
- Ensuring action is taken to rectify any works needed
- **Manual Handling Coordinator** is responsible for:
  - Supporting staff to carry out clinical risk assessments
  - Advising on patient risk assessments
  - Advising on formulation of manual handling care plans
  - Problem solving in challenging situations
  - Providing support training on the ward/department on a one-to-one basis and classroom practical workshops
  - Providing local manual handling induction and refresher training
  - Carrying out internal audit and provide statistical information on compliance
  - Develop policies and procedures for Board wide implementation
  - Develop manual handling e - learning materials for all staff and up-date when required
  - Providing advice and coordination of mechanical equipment for patient and inanimate load handling, including trial, purchase, repair and servicing.
  - Coordinating the Boards implementation and compliance with the Scottish Manual Handling Passport Scheme (CEL 14 2012)
  - Compile a risk register of manual handling tasks that require a risk assessment (All MH task with a risk require a RA and each department is responsible for their own RAs, currently there is not a central register of MH RAs).
  - Carry out inanimate load risk assessments and write a remedial action plan and safe system of work

(All MH tasks involving inanimate loads that have a recognised risk must have a RA completed prior to the task being carried out. It is the manager's responsibility to have the RA completed but any member of the team involved in the task can complete the RA. The MH Coordinator can assist and advise but not carry out the RA. RAs can be generic for certain tasks but if a task does not fall into the generic category an individual RA must be completed).

- **Radiation Protection Advisor** has responsibility for:
  - Advising the Board on appropriate radiation safety matters
  - Audit, inspect and perform such tests as necessary and issue an annual report
  - Ensuring radiation risk assessments are performed and reviewed and implemented
  - The Chairman of the Radiation Safety Committee is the author of the Employer's Level 1 Procedures.
  - The IRMER Lead is responsible for the authorisation, control and issue of the Employer's Level 1 Procedures (EPs).
  - The Lead Clinicians are responsible for the authorisation, control and issue of Employer's Level 2 Procedures.
- **Prevention and Control of Infection Team (PCIT)** role is to make medical and nursing decisions, on a 24-hour basis, about the prevention and control of infection, providing advice to all grades of staff on the management of infected patients and other infection control problems including:
  - Identification and control of outbreaks – in keeping with CNO letter 2010 on the new support frameworks in relation to outbreaks, incidents, surveillance exceedence and HEI inspectorate reports. This advises on risk assessment and also when Health Protection Scotland, Public Health and Scottish Government should be alerted to provide support.
  - Education of hospital staff in Prevention and Control of infection procedures
  - To produce, review and update Infection Control Policies and Guidelines
  - Formulation of an annual programme of work and ensuring appropriate support for its implementation
  - Liaison with the Occupational Health Service on relevant staff health issues
  - Liaison with clinical teams on the development of standards, audit and research.

- Liaison with relevant outside agencies including HPS, HFS, HEI, Scottish Government Health Department etc
- To act as a resource for, and provide specialist advice to, both clinical and non-clinical health care staff, managers, clinicians, contract workers, patients and their carers/visitors, e.g. advice regarding direct patient care practices, food hygiene practices, waste disposal, environmental hygiene, purchase of new equipment, commissioning of new buildings, laundry management, health and safety, decontamination processes, isolation procedures, transportation of specimens, health screening of staff.
- Lead on the NHS QIS Standards relating to Prevention and Control of Infection
- **Estates & Engineer Services Manager** has overall responsibility for management of Security to include the following:
  - Responsibility for interrogation of incident data for security related events, identifying themes and influencing specific action plans.
  - Production of security reports for the Board Health and Safety Committee.
  - Conducting security related risk assessments, prioritises expenditure, and formulates bids to mitigate risks identified.
  - Ensure compliance against external performance assessment specifically relating to security.