The Dudley Group NHS
NHS Foundation Trust

Trust Headquarters
Russells Hall Hospital
Dudley
West Midlands
DY1 2HQ

FREEDOM OF INFORMATION ACT 2000 - Ref: FOI/010909

With reference to your FOI request that was received on 27/06/2011 in connection with 'Medicines Management and Board Information'.

Your request for information has now been considered and the information requested is enclosed.

If you have any queries or concerns then please do not hesitate to contact me. Please remember to quote the reference number '**FOI/010909**' in any future communications related to this FOI request.

Further information about your rights is also available from the Information Commissioner at:

Information Commissioner
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
Tel: 0303 123 1113
Fax: 01625 524510
www.ico.gov.uk

Yours sincerely

Information Governance Manager
Room 34a, First Floor, Esk House, Russells Hall Hospital, Dudley, DY1 2HQ
Email: FOI@dgh.nhs.uk

The Dudley Group of Hospitals NHS
NHS Foundation Trust

Your request was for The Trust's:

1. Current Medicines Management Policy

Please find attached the Trust's current Medicines Management Policy

2. Risk Management policy/strategy or document which describes the Board Assurance Framework process covering the April 2010 - March 2011 period

Please find attached the Trust's Risk Management strategy and Policy

3. Board of Directors minutes from April 2010 - March 2011

Please follow the link below to the Trust's Publications on Annual Reports
http://www.dgoh.nhs.uk/about-us/publications

Please follow the link below for the Council of Governors Board Minutes from October 2008 to January 2011.
The April Minutes will be agreed at the next meeting in August. It has been agreed that going forward draft minutes will be published prior to the next meeting.

http://www.dgoh.nhs.uk/about-us/foundation-trust/our-council-of-governors/minutes-from-council-of-governors-meet
4. Board Assurance Framework covering April 2010 - March 2011

Integrated Governance Strategy which covers April 2010 to March 2011 (this has now been superseded by a Risk Management Strategy)

Please also see the Trust website publications page on the following link:
http://www.dgoh.nhs.uk/about-us/publications

THE DUDLEY GROUP OF HOSPITALS NHS FOUNDATION TRUST INTEGRATED GOVERNANCE STRATEGY

1. Background

The NHS and Community Care Act 1990 and subsequent regulations set out the legal framework within which the Trust operates. Since 1997 Chief Executives of Trusts have been required, as Accountable Officers, to sign an assurance statement, the Statement on Internal Control (SIC), on behalf of the Board to assure 'stakeholders' on the robustness of internal financial controls. Stakeholders include patients, relatives and carers, the public and partner NHS organisations. In 1999 this duty expanded beyond financial assurance to the production of a SIC covering wider organisational controls, including risk management.

Also, the 1999 Health Act placed a statutory duty of quality upon NHS Trusts. Clinical Governance is the framework by which the Trust fulfils this duty. Trust Boards are now encouraged to develop Integrated Governance to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical and information governance. Integrated Governance will better enable the Trust Board to take a holistic view of the organisation and to fulfil its capacity to meet its legal and statutory requirements and clinical, quality, financial and workforce objectives.

2. Introduction

Integrated Governance is defined as: Systems, processes and behaviours by which the Trust will lead, direct and control its functions in order to achieve organisational objectives, safety and quality of service in which it relates to patients and carers, the wider community and partner organisations.

Integrated Governance provides linkages between financial management, clinical governance, risk management, and information governance and enables the Board to work more corporately and deliver objectives in a coherent way and govern effectively.

The Trust has a statutory responsibility to:

- Produce Annual Business Plans for the Regulator of Foundation Trusts.
- Enter into contracts with PCTs for the provision of clinical services (Local Delivery Plans) Ensure that quality of care is delivered that meets standards laid out in statute – Standards for Better Health.
- Meet National Targets.
- Achieve financial balance and have annual financial plans with monthly monitoring arrangements.
- Have an Assurance Framework and ensure there are effective systems in place for governance, essential for the achievement of its strategic objectives and to underpin its SIC.

The purpose of this strategy is to:

- Describe the integrated governance arrangements and processes in the Trust and how these are evolving to meet the requirements of Monitor as a Foundation Trust.
- Define the roles and responsibilities of key officers/groups and the relationship between them.
- Ensure that the Trust complies with its statutory responsibilities.
- Develop an integrated approach to corporate and clinical governance, which embraces financial organisational and clinical risk management and which is linked to the Trust's cycle of business.
- Develop an open culture of learning and risk management across both corporate and clinical activity to ensure effective organisational and clinical performance.
- Ensure that all staff are aware of and contribute to the implementation of effective risk and governance processes.
- Provide a basis for performance measurement and management.

The Integrated Governance Strategy and arrangements are reviewed annually to ensure they reflect current NHS guidance and requirements and meet the local needs of the Trust and the population it serves.

This document is made available to all staff within the organisation, partner organisations and the public.

3. Operational and Strategic Accountability

3.1 The Role of the Board

The role of the Board of Directors is defined as: -

- *Foresight:* Looking ahead by setting the Trust's strategic aims, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and by reviewing management performance.
- *Planning:* Providing active leadership of the organisation within a framework of prudent and effective controls.
- *Management:* Directing and managing the Trust's resources and activities.
- *Accountability:* Setting standards and ensuring that its obligations to patients, the local community and Monitor are understood and met.

The Code of Accountability issued by the Secretary of State (1994) sets out the corporate role of the Board. The Board of Directors have explicitly subscribed to these Codes. In ensuring that the organisation consistently follows the principals of good governance applicable to NHS organisations, the Board of Directors has responsibility for:

- Providing active leadership of the NHS Foundation Trust within a framework of prudent and effective controls which enables risk to be assessed and managed

- Ensuring compliance by the NHS Foundation Trust with its Terms of Authorisation, its constitution, all relevant statutory requirements and contractual obligations.
- Setting the NHS Foundation Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place and that it meets its objectives and reviews performance.
- Ensuring the quality and safety of healthcare services, education, training and research it delivers and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission (CQC) and other relevant NHS bodies. It should also ensure that the NHS FT exercises its functions effectively, efficiently and economically
- Setting the Foundation Trust's values and standards of conduct and ensuring that its obligations to its members, patients and other stakeholders are understood and met.
- Reporting on its approach to the quality of care it provides and its plan for the improvement of clinical quality in accordance with guidelines set by the Department of Health, the CQC and Monitor.
- Confirming
    - For clinical quality – this it is satisfied that to the best of its knowledge and using its own processes it has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.
    - For service performance –to ensure compliance with all existing national core standards and targets and a commitment to comply with all known core standards and targets due to come into force within the following 12 months.
    - For other risk management processes that –
        - All issues and concerns raised by external audit and external assessment groups have been addressed and resolved or action plans are in place to address the issues in a timely manner
        - All recommendations made by the Audit committee are implemented in a timely and robust manner.
        - All necessary planning, performance and risk management processes are in place to deliver the annual plan
        - A Statement of Internal control is in place and the Trust is compliant with the risk management assurance framework requirements that support the SIC pursuant to most up to date guidance.
        - All key risks to compliance with the authorisation have been identified and addressed.
    - For other matters –
        - That it maintains its register of interests and can specifically confirm that there are not material conflicts of interest in the Board
        - That all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability.

- A robust selection process is in place and opportunities for development are available to ensure that the Non-Executive Directors have appropriate experience and skills.
- A process is in place to periodically review the overall skills and experience of individual members of the Board of Directors to ensure it has the necessary portfolio of expertise in place to deliver the Trust's agenda.
- The management structure is in place and the management team have the capability and experience necessary to deliver the annual plan.

3.2. Role of the Trust Chairman

The role of the Trust Chairman is to: -

- Lead the Board of Directors and the Council of Governors, ensuring its effectiveness on all aspects of its role and setting its agenda and ensuring the two work together effectively
- Ensure the Board of Directors and Council of Governors receive accurate, timely and clear information and that it is appropriate to their respective duties
- Ensure effective communication with staff, patients, the public and stakeholders
- Facilitate the effective contribution of non-executive directors and ensure constructive relationships between executive and non-executive directors and between the Board of Directors and the Council of Governors

3.2 Role of the Council of Governors

The Council of Governors of the Trust consists of 39 individuals either, elected as representatives of membership constituencies, elected as representatives of staff groups; or appointed by local stakeholder organisations.

The role of the Council is essentially to monitor the performance of the Trust in complying with the terms of its authorisation by Monitor to operate as a Foundation Trust. Specifically the Council monitors the extent to which the Trust achieves the requirements of Monitor's Compliance Framework. The Council is also responsible for the appointment of the Chairman and Non Executive members of the Board and the appointment of Auditors top the Trust.

3.3 Role of the Non-Executive Directors

The role of the Non Executive Directors responsibilities cover: -

- To contribute to developing the Trust's vision, values and standards and ensure that the Trust obligations to its stakeholders and the wider community are understood and fairly balanced at all times.

- Assist fellow Directors in setting the Trusts strategic aims; ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives, and that performance is effectively monitored and reviewed

- To provide independent judgement and advice on issues of strategy vision, performance, resources and standards of conduct and constructively challenge, influence and help the Executive board develop proposals on such strategies.

- To participate in the identification of strategic organisational risks and approve action plans to address those risks

- To receive and review performance measurement data & information and scrutinise progress against those plans to ensure that, where appropriate, action is taken to improve performance.

- To monitor the performance and conduct of management in meeting agreed goals and objectives and statutory responsibilities, including the preparation of annual reports and annual accounts and other statutory duties

- To seek assurance that processes and procedures are established to deliver high quality professional, clinical, governance, financial and personal standards and behaviours across the Trust.

- To act as an ambassador for the Trust in engaging with stakeholders, including the local community and dealing with the media when appropriate

3.4 Role of the Chief Executive

The Chief Executive's roles and responsibilities cover:

Setting Strategic Direction & Performance Monitoring & Management: Setting the strategic direction, vision, values & strategic goals of the organisation, balancing risk and entrepreneurship by ensuring that opportunities are exploited to the advantage of the Trust and the communities it serves.

Supporting the Board of Directors: Ensuring the Board of Directors discharges its duties in relation to the corporate governance of the organisation, acts in the interests of the population it serves and other stakeholders and is accountable for the services provided and the resources deployed.

Leadership: Lead the business of the trust, ensuring it operates as a commercially focussed organisation that provides high quality care and is focused on efficiency, productivity and value for money.

Corporate & Clinical Governance: To ensure that systems and processes are in place that enable the delivery and monitoring of a patient safety and high quality care service and culture. To ensure the Foundation Trust meets the requirements of its terms of authorisation, in accordance with regulations and provisions set down by

Monitor. As the Accounting Officer, discharge all general and specific responsibilities laid down by Monitor, as set out in the NHS Foundation Trust Accounting Officer Memorandum 2005 (or any revisions thereof).

Whilst this overall responsibility is maintained, responsibilities for some aspects of governance have been delegated to executive directors as follows:

- Integrated Governance (including Risk Management) to Nursing Director
- Financial Control to Finance Director
- Operational Performance to Operations Director
- Workforce & Health and Safety to Human Resources Director

In order to fulfil his/her responsibilities for governance, the Chief Executive has agreed the input for the relevant committees with the committee chair, and receives minutes of these committee meetings and, where not a member of the committee, has a process for meeting the committee chair on a regular basis. (See Appendix I for relevant committees).

3.5 Role of the Executive Team

The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively, the team is responsible for providing the systems, processes and evidence of governance.

The team are responsible for ensuring that the Board, as a whole, are kept appraised of progress, changes and any other issues affecting the Assurance Framework.

The key responsibilities of each executive director are outlined in the job description for the post. In terms of governance, the following are of particular relevance:

a. Director of Finance and Information

The Director of Finance is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. He/she is, with the Chief Executive, responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with extant accounting standards and Monitor and HM Treasury requirements.

The Director of Finance and Information ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meet its statutory and legal responsibilities relating to finance, financial management and financial controls. He/she ensures the Trust has in place Standing Orders and Standing Financial Instructions, including a Reservation of Powers and Scheme of Delegation, and takes responsibility for the financial management aspect of internal controls.

As part of the Trust's performance framework, the Director of Finance and Information, together with the Director of Operations, ensures that budgets are agreed between the Board and each Service function based upon the business

performance objectives and targets agreed by the Board and maintains the review/monitoring process. The outcome of the review/monitoring process will contribute to the Board's Assurance Framework.

The Director of Finance & Information is responsible for reporting on performance to Monitor.

In addition, the Director of Finance and Information takes responsibility for Information Governance.

The Director of Finance and Information ensures the Board of Directors receives the relevant information/annual reports according to the Board's information schedule. He/she will keep the Board appraised of any changes in requirements and draw to their attention shortfalls or omissions which will/may adversely impact on the Board's ability to fulfil its governance responsibilities.

b. Director of Nursing

The Director of Nursing is accountable to the Chief Executive for the Strategic development of:

- Risk management – clinical and non-clinical.
- Integrated Governance including organisational controls – to meet national clinical standards, for examples Standards for Better Health.
- Clinical Governance.
- Code of Practice for the Prevention and Control of Healthcare Associated Infections.

He/she ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structures to meet its statutory and legal responsibilities relating to his/her area of accountability and that these are based on good practice and guidance from the Department of Health and other external advisory bodies. He/she ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention shortfalls or omissions which will/may impact adversely on the Board's ability to fulfil its governance responsibilities.

As part of the Trust's performance framework, the Director of Nursing oversees the review/monitoring process covering directorates' performance in clinical governance and risk management.

Within the Foundation Trust, he/she will take on the development and responsibilities of Corporate Governance as identified in the Code of Corporate Governance for Foundation Trusts.

c. Board Secretary

The Board Secretary is responsible, with the Chief Executive and Director of Finance & Information, for making all formal returns to Monitor and other external bodies in accordance with statute and our terms of authorisation and for upholding the constitution and standing orders of the Trust in its corporate affairs.

d. Director of Operations

The Director of Operations is accountable to the Chief Executive for ensuring that the Trust operates sound systems of operational performance, working in conjunction with the Director of Finance and Information (see section a. above). He/she has a lead role in ensuring organisational progress against the Trust's Assurance Framework and risk register action plans in conjunction with the Executive Team.

e. Director of Human Resources

The Director of Human Resources is accountable to the Chief Executive for ensuring the Trust has in place systems and policies for staff management and health and safety and security management which meet legal and statutory requirements.

Working closely with other directors he/she maintains a system of monitoring the application of the Trust's Workforce Strategy, policies and procedures and, on behalf of the Board, ensures it receives the relevant information and reports to monitor performance and manage workforce risks. He/she is the Trust lead for education and development and as such is responsible for ensuring policies; systems and educational/training activities meet the needs of staff and the service and enable the Trust to discharge its obligations in relation to governance and risk management.

3.6 Specific Roles

a. Line Managers (see below) are supported and facilitated to meet their governance requirements by staff from the Corporate Directorates, with the following individuals providing specific support in advising on and co-ordinating risk management activities:

Health and Safety Adviser	-	All Aspects of health and Safety
Manual Handling Co-ordinator	-	Manual Handling
Fire Safety Officer	-	Fire Safety
Medical Devices Co-ordinator	-	Medical Devices use and maintenance
Resuscitation Training Co-ordinator	-	Resuscitation equipment/training and use
Security Management Specialist	-	Organisational Security; property & people
Clinical Governance Co-ordinator	-	Clinical Governance and Risk Management arrangements

b. Clinical Directors

Responsible for ensuring the effective implementation of Trust policies and procedures within their areas and monitoring performance and compliance against such.

As part of the Trust performance framework, they will agree with the Director of Operations the objectives and targets for their services based on those agreed by the Board. These will be cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and directorate performance reviews.

c. Risk & Patient Safety Director

Responsible for ensuring there is a robust comprehensive and co-ordinated approach to all areas of clinical risk management across the operations directorate and draw to the attention of the appropriate Board Director areas of shortfall or omissions which will/may adversely impact on the Board's ability to fulfil its governance responsibilities and which impact upon the assurance framework.

d. All Managers including Medical Service Heads/Matrons/Heads of Department

Responsible for ensuring that, within their area of responsibility, staff are aware of, and comply with, the processes for assuring sound governance. They will develop local systems and structures to support the various governance strategies, policies and procedures and ensure these are monitored and audited. They are responsible and have the authority for identifying and managing risks using the risk management systems that are in place.

The Heads of Service ensure their services provide the required information to support the assurance process and draw to the attention of the appropriate board director via the agreed reporting mechanisms, areas of shortfall or omissions which will/may adversely impact on the Board's ability to fulfil its governance responsibilities and which impact upon the Assurance Framework.

3.7 All Staff

This framework is aimed at achieving an integrated approach to governance, which engages all staff members.

All staff members employed by this Trust have a responsibility to perform their duties in accordance with the values, policies and procedures of the organisation, national good practice standards, and professional requirements and to contribute to the achievement of the Trust's objectives and targets. In the context of this framework all staff members are expected to fulfil their responsibilities as identified within the supporting strategies identified within this document.

Staff performance will be directed and monitored through the Trust's Performance and Development process.

4. Organisational Structure

4.1 Core Governance Committees Structure

The main Committees in the Integrated Governance Structure together with the terms of reference/duties are included in Appendix 1 with the two high level committees with overall responsibility for risk management being the Integrated Governance Committee and the Finance and Performance Committee. In addition, a summary of the remaining committees are included. A chart of the overall structure is provided in Appendix 2.

The Integrated Governance Committee has a structure and process in place to enable it to carry out its work and provide information and assurance to the Board of Directors.

The Chief Executive and relevant director, on behalf of the Board, will ensure each committee has complementary terms of reference which are reviewed regularly as part of the assurance process.

4.2 Supporting Policies and Strategies

This document provides the overarching framework for governance within the Trust. It is supported by the following policies and strategies:

- Trust Business Plan
- Assurance Framework
- Standing Orders and Standing Financial Instructions
- Reservation of Powers and Scheme of Delegation
- Health & Safety Policies
- Security Management Policies
- Manual Handling Policies
- Incident Reporting Policy
- Infection Control Strategy and Annual Programme
- Research and Development Strategy
- Learning and Development Associated Policies
- Patient and Public Involvement Strategy
- Clinical Audit Strategy and Plan
- Workforce Effectiveness Strategy & Associated HR Policies
- Information Strategy
- Operations Directorate Risk Management Team Strategies

5. Assurance Framework

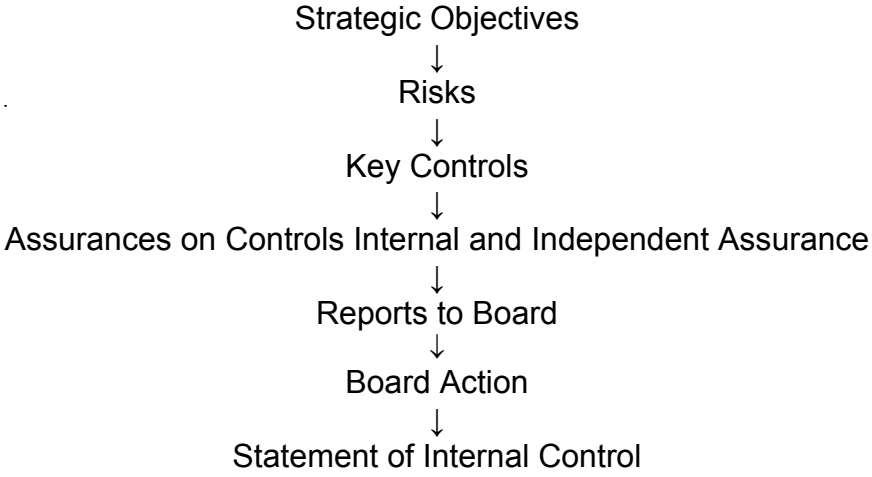
The Assurance Framework provides the structure by which the Board of Directors responsibilities are fulfilled. It encompasses the Trust's strategic objectives and the process for the identification of potential risks to their achievement and any gaps in assurance. The risks are outlined in the Trust's Risk Register, together with the action plans to address these. The Register is subject to at least six monthly reviews by the Integrated Governance Committee.

In accordance with Monitor guidance, all NHS Trusts are required to submit an annual Statement on Internal Control signed by the Chief Executive underpinned by a supporting Assurance Framework. This should provide the Trust with confidence that systems are safe and subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the Trust.

The Board of Directors uses the Assurance Framework to manage risks as follows. It:

- Conducts an annual review of the strategic objectives which are agreed by the Board.
- Identifies and assesses the risks to achieving these strategic objectives through workshops and discussions involving all the Trust Board members.
- Uses the High Level Governance Framework challenge (see Appendix 3).
- Identifies the key controls intended to manage these risks, any gaps in controls and further action required with timescales and responsibilities agreed where gaps have been agreed. This work is led by the Executive directors and agreed by the Trust Board.
- Identifies external and internal assurances available relating to these objectives and risks, evaluates the efficacy of the modes of assurance and any gaps in assurance identified.
- Records these strategic risks on the Trust Risk Register together with any High risks from individual Directorates, using the agreed proforma (Appendix 5).

The following flowchart simplifies the process:



6. Risk Management

Principles

- The Trust has processes in place, which includes both top down and bottom up approaches to managing risks.

- Each Directorate will have a risk management arrangements based on the principles and processes outlined in this document. In particular, the Operations Directorate has three risk management teams: Medicine, Maternity & Children's and Surgery & Critical Care. The Operations Directorate and the small corporate directorates co-ordinate, identify, assess and manage risks and keep local risk registers,

- It is the Trust's policy to minimise levels of risk across the full range of its activities, thereby ensuring high quality services and protecting the interests of our patients, staff and visitors. This is achieved through a consistent and integrated approach to identifying risks and potential risks and making appropriate arrangements for dealing with them

- All levels of risk are identified, assessed and managed on a continual basis. This is done proactively by a review of previously identified risks and the documentation of new risks within each Directorate on at least an annual basis. The Operations Directorate will hold multidisciplinary workshops to undertake this. Risks will also be identified reactively from internal sources such as complaints, claims and incidents as well as the result of external sources such as national reports and issues.

- Risks identified as Low and Moderate will remain on local risk registers and be managed locally. All High risks will be placed on the Trust Risk Register which is reviewed at least twice a year by the Integrated Governance committee, which reports to the Trust Board.

- The focus of action is on those identified as High Risks. High Risks are those which threaten the achievement of the organisation's objectives. It is acknowledged that it is not possible to remove all risks from any organisation, and that ability to respond to risk is always constrained – for example by funding or staff time. Hence it is important to prioritise risks and actions. For instance, at the level of "very low" risk it would be realistic to take no action (unless this was easy to take), effectively "accepting" the risk; equally it is reasonable to expect that there will be action plans linked to all risks assessed as "High".

- Risk should always be seen in the context of the organisation's objectives – whether these are quantifiable (e.g. to achieve a measurable target) or less specific (e.g. to deliver high quality patient care).

- All staff has a duty to identify and minimise risk and either undertake risk assessments or bring the issue to the attention of their line manager.

- Any department/member of staff with a concern over an apparently unaddressed risk should raise such a concern initially with their Head of Service or if their concern remains unaddressed with their Director.

Process

This is set out in Appendix 4 with a summary below:

Risk Identification

- Risks will be identified in the following ways including:

- Actual risks (or near misses) already incurred – these can be extracted by reference to incident reports, claims and complaints

- Potential risks can be identified by such processes as Infection Control/Health and Safety audits, Trust wide multidisciplinary workshops, group self assessments etc.

  Given the complexities and interdependencies of many of our services and the possible diversity of action plans it is important to ensure that an appropriate mix of skills is involved.

Risk Assessment

- A review/reassessment of risks already on the risk register is undertaken at regular intervals and at least annually.

- Assessment (i.e. scoring) of risks to identify which are of greater/lesser concern, and hence which are most important to address will use the standard Trust approach (Appendix 4). This system developed by the National Patient Safety Agency uses a combination of likelihood and potential consequences to come to an overall assessment of impact – either to the individual or the organisation. It is important to note that the assessment of potential impact – and, indeed any consequent action plan – should be linked to an evaluation of the risk after taking account of how any existing controls are operating. All risks should therefore identify the likelihood, possible consequence and the overall risk assessment which will range from "very low" to "high".

Key Controls

- The key controls to be identified are those which, when taken together, support staff in the achievement of the organisation's objectives and reduce the threat of risk. These include:
  - Management structure and accountabilities
  - Policies, procedures and guidelines
  - Clinical Governance processes
  - Incident reporting and risk management processes

- Complaints and other patient and public feedback procedures
- Staff training, education and management
- Patient & Public Involvement Steering Group and Patient surveys.
- Statutory frameworks, for instance the Standing Orders, Standing Financial Instructions and associated Scheme of Delegation
- Communications processes
- Internal audit

- Gaps in controls

  This identifies areas where further action can be taken to reduce or minimise the risk further.

Action Plans

- Action plans are drawn up to reduce, manage or remove the risk. Action plans should be absolutely clear as to what the action is, who is responsible for taking the action, and the deadline for completion. It is important that all responsible parties agree to the action plan and its deadline especially when individuals with action items are from outside the area where the risk has been identified.

- All action plans must be agreed and subsequently monitored by directorate risk management teams, the Integrated Governance Committee or the Board of Directors. In addition, these groups and their chairs will ensure that the information gained from the risk management process links into business planning and service development.

- The Integrated Governance Committee requires to be notified of action plans against all risks assessed as 'High'.

- It is not feasible to centrally define "acceptable" risk and it is for those involved in the assessment process to determine the extent of action plans in the knowledge that no action plan = accepted risk. Directorate risk management teams are responsible for ensuring that action plans are appropriate and assesses the completeness of the action plans against both risk assessments and national requirements. The Integrated Governance Committee is responsible for monitoring that action plans to address high risks have been achieved and that further action is taking place when adverse exceptions are reported.

Assurances

For all High Risks, the way in which the Board gains assurance that the risk is being managed should be listed and any gaps in assurance should be identified.

Maintaining and Monitoring Risk Registers

Risk registers are kept at Trust and directorate levels. The risk registers contain the following:

- Source of risk
- Description of risk
- Risk Score
- Controls and Gaps in control
- Residual Risk score
- Mitigating actions
- Date of assessment and date for review.

Where a mitigating action is identified, the following information should be included:

  - Individuals responsible (name and title)
  - Timescales for completion

The Trust maintains an organisation wide risk register and action plan summary.

This includes:

- All High-level risks – identified at directorate level and at trust level through the Assurance Framework process. This is reported to the Integrated Governance Committee and Board of Directors at least six monthly.

In producing the corporate summary, the Director of Nursing, in conjunction with others, takes a view of the sources of independent assurance that may be available and advises the Integrated Governance Committee and hence, the Board of Directors accordingly.

Each directorate maintains a risk register of all its risks with identified actions as appropriate. This includes:

- All high level risks – which are included on the Trust Risk Register and are reported to the Integrated Governance at least six monthly.
- All moderate, low and very low risks, which are maintained with the directorates, are reviewed at least annually.

Services Provided by Summit Healthcare

In order to ensure that the Trust's approach to risk management is comprehensive, links with risk management processes undertaken by Summit (and/or its sub-contractors) in respect of services provided to the Trust have been developed and will be maintained. These include the following: -

Incident recording	Summit has instituted an incident recording system in respect of all its services and provides summaries – including identified actions on a monthly basis. These are monitored by the Trust's Head of Estates and FM.
General Risk assessments	Summit has instituted appropriate arrangements to assess risk in its own services provided to the Trust, to develop and implement appropriate actions for significant risks, and to keep the Trust informed on progress. To the extent that Summit/Interserve/Siemens need to involve Trust staff in risk assessments/action planning/implementation, the Trust co-operates. The converse also applies (i.e. where a "Trust" risk involves staff from Summit).
Specific Areas of Risk	A number of these topics are in respect of functions provided by Summit. The Trust remains responsible for ensuring risk assessments are undertaken and requires the co-operation of Summit to ensure appropriate actions are implemented.

7. Awareness Training – Governance and Risk Management

All Staff

- All members of staff are required to attend induction training which includes basic awareness of governance and risk management and mandatory refresher training.
- Additional training for staff will be identified through the Performance and development process, based on mandatory training and other requirements and incorporated into Personal Development Plans.

Board Members, Executives and Senior Managers

- Training for Board Members, executives and Senior Managers (i.e. clinical Directors, Risk And Patient safety Director and Performance Director) will be undertaken annually, such training to include updates on Risk Management, the Integrated Governance Strategy and relevant policy changes, as appropriate. This will be organised and records maintained by the Director of Nursing, who will also follow up any non-attendance.

8. Monitoring of Integrated Governance

Organisational Framework

A periodic review of committee structures will be undertaken to determine fitness for purpose and will include:

1. Review against cycle of requirements for Integrated Governance Assurance Framework to check activities, reporting and monitoring has occurred.
2. Review of the work of Integrated Governance, Audit Committee and Finance and Performance Committee to determine if these are functioning as described in their terms of reference.
3. Review the attendance at Integrated Governance Committee, Audit Committee and Finance and Performance Committee against the details in the Terms of Reference.
4. Review the contributions of each Directorate, with risk assessments and identified actions.

Other monitoring

5. Review roles and responsibilities of key individuals. This will be undertaken through the Trust's Performance and Development process.
6. Review Partnership working between PFI partners and the Trust.
7. Review policies and strategies identified in this document to ensure they have been updated in line with any legislative or other requirements.
8. Review this Strategy and local Directorate risk management processes to ensure they are fit for purpose.
9. Consider the internal auditor's opinion statement to improve the robustness of the Assurance Framework.
10. The attendance of Board Members, Executives and Senior managers at the updating training for risk management and integrated governance will be monitored and checks made on the content against the strategy.
11. An annual report of Integrated Governance work will be produced incorporating key components of the work throughout the year.

9. Conclusion

Effective governance and assurance arrangements are critical in ensuring the confidence of the Board, staff, patients and the public and partner organisations in the Trust and for the effective delivery and execution of its functions. Developing a culture of openness and transparency is integral to assuring all of the effectiveness of these arrangements, together with an environment that fosters and develops personal and organisational growth as a key to success.

Approving Group : Integrated Governance Committee

Date of Approval : November 2009

Date of Review : November 2012

Policy Supercedes : This policy supercedes the policy of same name approved in 2008

Equality Screened : Y / N Date : November 09

Equality Impact Assessment : Y / N / NA

REFERENCES

Code of Practice on Openness in the NHS. DoH April 1994
Code of Conduct. Code of Accountability. In the NHS 2nd reved DoH 2004
Internal Control – Guidance for Directors on the Combined Code. The Institute of Chartered Accountants - England, Wales September 1999
NHS foundation Trust Code of Corporate Governance, Monitor 2005
Governance in the new NHS (HSC 1999/123) NHS Executive May 1999
Governance in the NHS (HSC 2001/005) NHS Executive February 2001
Governance in the NHS: Towards Convergence: Strategic Direction and Guidance for Boards Department of Health Draft May 2001
Governance in the NHS Statement on Internal Control 2001/2002 and Beyond (Including Controls Assurance – Supplementary Guidance) NHS Executive March 2002
Corporate Governance Framework Manual for NHS Trusts Department of Health
Draft Version I July 2002
The Intelligent Board – Monitor (no date)
Assurance: The Board Agenda Department of Health Governing the NHS – A Guide for NHS Boards Department of Health NHS Appointments Commission 2003

Appendix 1

Board Committees – Membership and Terms of Reference

1. Finance and Performance Committee

<table>
<tr><td>Members:</td><td>Chairing:</td></tr>
<tr><td>Chairman
Non-Executive Directors
Chief Executive
Executive Directors (or nominated deputy)</td><td>Trust Chair
When absent, chaired by Deputy Chair or, if not available, a Non-Executive Director</td></tr>
<tr><td>Quorum:</td><td></td></tr>
<tr><td colspan="2">Trust Chair or Deputy Chair plus two Non-Executive Directors and three Executive Directors</td></tr>
<tr><td colspan="2">Regularly receives:</td></tr>
<tr><td>• Strategic and Business Planning
<u>Annually</u>
o Annual Plan
o Income and Expenditure Plan
o Income and Expenditure Plan
<u>Quarterly</u>
o Exceptions Report on Annual Plan
<u>As required</u>
o Business Cases

• Performance Management
Monthly
o Operations Director Report
o Financial Performance Report
o Service Line Accounting Report
o Forecast outturn
o Cost Improvement Programme Performance
o Cash flow and balance sheet
o Other Working Capital
o Capital Programme
o Investment Performance
o Access and Other Target Performance Report, including HCC targets, Workforce Targets, Local Clinical Performance Indicators
o Benchmarking/efficiency reports, including NIII Indicators Scorecard
o Sign off Trust report to Monitor</td><td>• Legally Binding Contracts with Third Parties
<u>Monthly</u>
o Contract performance exception report

• Financial Accounting
<u>Annually</u>
o Annual Accounts
<u>Monthly</u>
o Current topics report
<u>As required</u>
o Changes in guidance and accounting policies

• Business Risks
<u>Monthly</u>
o Business risks report
o Market share/penetration review
<u>Quarterly</u>
o Review of risk reduction/mitigating actions
o Competitor analysis
<u>As required</u>
o Relevant external auditors reports (e.g. Acute Hospitals Portfolio)</td></tr>
<tr><td colspan="2">Co-opting:</td></tr>
<tr><td colspan="2">The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as necessary and to commission input from external advisors as agreed by the Chair</td></tr>
<tr><td colspan="2">Exclusions:</td></tr>
<tr><td colspan="2">None</td></tr>
</table>

Frequency:

Monthly scheduled meetings within 20 working days of month end
Ad hoc meetings can be called by the Trust Chair or as a result of a request from at least three members of the Committee, including at least one Non-Executive Director and one Executive Director. The request is to be made to the Trust Chair. Members should attend at least half the meetings in a year as a minimum.

Notification of meetings:

Agenda to be circulated with paper 3 days before the meeting
Ad hoc meetings to be arranged within 28 days of the Trust Chair's decision or the request from at least three members of the Committee, including at least one Non-Executive Director and one Executive Director

Terms of Reference/Duties

The Committee will:

Strategic and Business Planning

Consider processes for the preparation and the content of Strategic and Business Plans and Annual Revenue and Capital Budgets and test the key assumptions and risks underpinning such plans
Review the Trust Annual Plan and Annual Budgets before submission to the Board of Directors
Monitor performance compared with the Annual Plan and Budgets and to investigate variances from these
Consider financial aspects of Business Cases for significant revenue or capital expenditure, as defined in the Trust's Standing Financial Instructions and Scheme of Delegation, prior to submission to the Board of Directors
Review such Business Cases retrospectively for return on investment/benefits realisation
Review opportunities for increasing activity/income from market intelligence analyses

Performance Management

Monitor the financial performance of individual Clinical Units and Directorates
Consider regular performance management reports from individual Clinical Units and Directorates
Consider explanations of significant variances/deviations from Budget or Performance Plan by Clinical Units and Directorates on a regular basis and to consider proposals for remedial action
Develop a strategic approach to managing cost improvement programmes
Agree the annual cost improvement programme, monitor performance against it and take appropriate action
Consider performance against external performance targets set by the Healthcare Commission, Monitor and as agreed in legally binding contracts
Develop, implement and maintain an effective service line accountability framework

Legally Binding Contracts with Third Parties

Consider regular reports of Trust and Directorate performance in respect of contracts agreed with third party organisations and to take appropriate action
Ensure that Local Delivery Plans and contracts with Primary Care Trusts and other bodies are determined, managed and delivered

Financial Accounting

Consider the likely impact of technical changes to accounting policy or practices and agree significant changes to accounting practice in advance
Consider detailed expenditure, cash flow and working capital plans and forecasts
Consider regular financial performance reports and forecasts, focusing particularly on risks and assumptions
Commission and consider various financial reports and analyses, as appropriate

Consider other topics or matters, as directed by the Board of Directors **Business Risks** Consider the short to medium term impact on current performance of internal and external business risks Review Monitor's risk rating and instigate appropriate action Undertake detailed financial assessment of the Trust's strategic risks in conjunction with the Board of Directors and monitor trends and progress in reducing financial exposure
Reporting into the Committee
There are no groups/committees which report directly into this committee. The committee has reports on the following: Income/expenditure performance of the trust Balance sheet performance Performance against activity plans Performance against waiting list targets Performance against Standards for Better Health Performance against contracts with local PCTS Business risks
Reporting to Board
Matters are referred to the Board by exception.
Conflict of Interests
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders

2. Audit Committee

<table>
<tr><th>Members:</th><th>Regularly receives:</th></tr>
<tr><td>Three Non-Executive Directors
In attendance:
Finance and Information Director
Internal Auditors
External Auditors

NB
• Chair of Audit Committee is an ex-officio member of the Integrated Governance Committee
• All Non-Executive Directors are ex-officio members of the Finance and Performance Committee</td><td>• Internal Audit progress report
• External Audit VFM progress report
• Internal/External Audit joint meeting notes
• Information Governance Group (Dudley Health economy-wide group) reports relating to Dudley Group
• Internal Audit Opinion Statement
• LCFS Annual Report
• External Audit Management Letter
• Audit Plans
• Individual Audit reports
• Integrated Governance Strategy
• Assurance Framework
• SAS 610 report of External Auditors on the annual accounts</td></tr>
<tr><th>Quorum:</th><th>Chairing:</th></tr>
<tr><td>Two Non-Executive Directors</td><td>Non-Executive Director (CCAB qualified)
When absent, chaired by another Non-Executive Director</td></tr>
<tr><th colspan="2">Co-opting:</th></tr>
<tr><td colspan="2">The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary</td></tr>
<tr><th colspan="2">Exclusions:</th></tr>
<tr><td colspan="2">Trust Chairman
The Committee will exclude the Finance and Information Director and any other Trust employee from its meeting with Internal and External Auditors for a minimum of one meeting per year</td></tr>
<tr><th colspan="2">Frequency:</th></tr>
<tr><td colspan="2">Four scheduled meetings per year
Ad hoc meetings can be called by the Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Chair.</td></tr>
<tr><th colspan="2">Notification of meetings:</th></tr>
<tr><td colspan="2">Agenda to be circulated with papers 7 days before the meeting
Ad hoc meetings to be arranged at the latest within 28 days of the Chair's decision or the request from at least two members of the Committee</td></tr>
</table>

Terms of Reference/Duties

Internal Control, Risk Management and Governance

The Committee will review the establishment and maintenance of an effective system of internal control, risk management and governance. In particular, the Committee will review the adequacy of:

- all risk and control-related disclosure statements, including the Statement on Internal Control, together with an accompanying Head of Internal Audit statement, prior to endorsements by the Board of Directors
- policies for ensuring compliance with regulatory, legal and code of conduct requirements as set out in the Controls Assurance Standards and other relevant guidance
- operational effectiveness of internal controls and procedures
- policies and procedures relating to counter-fraud and corruption
- the Assurance Framework and the Integrated Governance Strategy (reviewed annually)
- the integrity of the financial statements, as required by Monitor's Code of Corporate Governance and Audit Code

Internal Audit

The Committee will:

- consider all matters in connection with the appointment of, or changes in, the Trust's Internal Audit service
- determine the role of Internal Audit with regards to consultancy related work and the impact on independence
- review the Internal Audit Strategy and plan its implementation
- consider the findings of internal audit reports
- ensure co-ordination between Internal and External Audit
- recommend to the Board of Directors the appointment of, and review the performance of, Internal Auditors
- ensure that adequate relationships exist between the Head of Internal Audit and the Accountable Officer (or designated officer)

External Audit

The Committee will:

- review the External Auditor's Audit Strategy Memorandum, including the level of reliance to be placed on work undertaken by Internal audit
- review external audit reports, including in particular:
  - Report on Examination for the Annual Accounts (SAS 610)
  - The Management Letter (including any management response)
- review the performance of External Audit and report to the Council of Governors

Other

The Committee will:

- receive proposed amendments to the Trust's Standing Orders, Standing Financial Instruction and Scheme of Delegation; and to make recommendations to the Board of Directors on such proposed amendments
- publish an annual report on the work of the Audit Committee (June each year) to the Board of Directors and the Council of Governors, to include an assessment to the Council of Governors of the performance of the external Auditors
- consider the impact of any changes in accounting policy, advising the Board of Directors as appropriate
- consider other topics, and initiate any investigation or review, as it deems fit, and on behalf of the Board of Directors

Conflict of Interests

These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders

3. Remuneration Committee (for Executive Directors and Senior Posts)

Members:	**Normally receives:**
Chairman Non-Executive Directors By invitation: Chief Executive Director of Human Resources	• Salary information and details of Trust Chief Executive and Executive Directors' remuneration packages • Reports and guidance on pay levels and non pay benefits in the NHS and private sector for comparable roles
Quorum:	**Chairing:**
Three Non-Executives	Trust Chair When absent, chaired by Deputy Chair
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff or appropriate advisor, as felt necessary	
Exclusions:	
No Executive Directors will be in attendance for decisions on their remuneration	
Frequency:	
One scheduled meeting per year Ad hoc meetings can be called by the Trust Chair or as a result of a request from at least two members of the Committee or the Chief Executive. The request is to be made to the Trust Chair	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged within 28 days of the Trust Chair's decision or the request from at least two members of the Committee or the Chief Executive	
Terms of Reference/Duties	
The Committee will: • Determine the terms and conditions and pay levels and non pay benefits for the Trust Chief Executive and Executive Directors • Determine any monetary severance arrangements for the Trust Chief Executive and Executive Directors • Determine the implementation of the agreed policy for any performance-related pay scheme applicable to the Trust Chief Executive and Executive Directors • Review pay levels annually in line with inflation and relevant labour markets • Review and determine expenses payable to Governors • The scope of the Committee's remit is: o The Chief Executive o The Executive Directors employed by the Trust o In respect of the Medical Director, to consider the non-consultant contract element of remuneration of the role. Regard will be given to the specific nature of his/her clinical and non-clinical responsibilities and the structure of his/her overall remuneration package o Governors' expenses	
Conflict of Interests	
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders	

4. Nomination Committee

Members:	**Regularly receives:**
Chairman Non-Executive Directors Chief Executive Directors of Human Resources and Board Secretary – advisory roles	• Information on current skills, knowledge and experience of the Board of Directors • Updates on the challenges and opportunities facing the Foundation Trust • Guidance from Monitor on relevant corporate governance issues
Quorum:	**Chairing:**
Three Non-Executives	Trust Chair When absent, chaired by Deputy Chair or a Non-Executive Director
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, or external advisor, as felt necessary	
Exclusions:	
The Committee will exclude the Chief Executive from discussions relating to his/her post	
Frequency:	
Two scheduled meetings per year Ad hoc meetings can be called by the Trust Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Trust Chair.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting As hoc meetings to be arranged within 14 to 28 days of the Trust Chair's decision or the request from at least two members of the Committee	
Terms of Reference/Duties	
• To operate as a formal Committee of the Board of Directors • To review regularly the size, structure and composition of the Board of Directors and make recommendations • To evaluate the balance of skills, knowledge and experience on the Board of Directors and to identify those required for appointments of the Trust Chair, Non-Executive Directors, Chief Executive and Executive Directors • To review the skills and expertise needed on the Board, taking account of current and future challenges and opportunities • For the appointment of the Chief Executive and Executive Directors, to agree a job description and person specification for the role and capabilities required • To identify and nominate suitable candidates for Chief Executive and Executive Director vacancies • To agree and manage the nominations, appointments and re-appointments processes for: o Chief Executive o Executive Directors • To agree the size and composition of the selection panel for these appointments • To recommend its proposed appointment for the Chief Executive post to the Council of Governors for approval • To meet, without the Chair, Chief Executive and Director of Human Resources, to review the performance of the Chair on a regular basis	
Conflict of Interests	
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders	

5. Integrated Governance Committee

Members:	**Regularly receives reports:**
Chief Executive Executive Directors : Nursing, Finance and Information, Human Resources, Medical Three Non-Executive Directors, including Chair of Audit Committee Risk and Patient Safety Director Deputy Medical Director Director of Research and Development Clinical Governance Co-ordinator Clinical Audit Lead Lead Cancer Clinician Head of Customer Relations and Communications (All members can nominate deputies.)	• Reports from the corporate and operations Directorates • Reports from Patient Safety Group, Clinical Audit, NICE, Mortality, Infection Control, Research and Cancer Services • Reports and action plans from external visits, and reviews as specified by the committee • Reports and action plans from high level enquiries (unless requested directly by the Board) • Trust Risk register • Serious incidents and aggregated incident, complaints, claims reports • Reports (by exception) on Standards for Better Health • NHS and local patient and staff survey results
Quorum:	**Chairing:**
6 members, three of which must be clinical staff	Chief Executive When absent, chaired by the Nursing Director
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary	
Exclusions:	
See conflict of interest below	
Frequency:	
Minimum 9 meetings per year Ad hoc meetings can be called by the Chief Executive or Governance Lead (Nursing Director) if there are urgent issues of clinical governance or risks to the Trust identified. Members should attend at least half the meetings in a year as a minimum.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged as necessary to ensure a quorum is achieved	
Terms of Reference/Duties	

• To oversee the development and implementation of an integrated governance strategy and action plan and ensure this reflects the Trust's objectives.
• To coordinate the development of related strategies and action plans e.g. audit, clinical effectiveness, patient and public involvement, education and training, information use, research and development and risk management, to ensure they fit with the overarching strategy and to monitor implementation.
• To establish an annual cycle of requirements for governance, monitor progress, be informed of adverse performance and ensure action is taken in relation to:
  • Assurance Framework and Statement of Internal Control
  • Risk Management
  • Clinical Governance
  • Standards for Better Health
  • Healthcare Commission Annual Healthcheck
  • Patient Safety Group
  • PPI agenda
  • Workforce and HR risk issues	

• Research Governance • Information Governance • Health and Safety • Infection Control • External visits and reviews • To ensure information about Governance in the Trust is communicated internally and externally. • To ensure there is a link with the Audit Committee and Finance and Performance Committee through common membership.
Reporting to Board
The Nursing Director will report by exception issues from the committee to the Trust Board.
Conflict of Interests
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders.

6. Investment Panel Terms of Reference

Members:	**Regularly receives:**
Three Non-Executive Directors Finance and Information Director In attendance Associate Director of Finance	• Performance report on key benchmarks, incl return on investments • Analysis of investments (performance, liquidity and security) • Medium & long term forecasts on liquidity
Quorum:	**Chairing:**
Two Non Executive Directors Director of Finance	Non Executive Director (CCAB qualified/ Investment decision-making experience) When absent, chaired by another Non Executive Director
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary	
Exclusions:	
None	
Frequency:	
Four scheduled meetings per year Ad hoc meetings can be called by the Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Chair.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged at the latest within 28 days of the Chair's decision or the request from at least two members of the Committee	
Terms of Reference	
• Establish the overall methodology, process and controls that govern investments • Ensure robust processes are followed • Evaluate, scrutinise and monitor investments • Oversee the performance of the Treasury function in meeting its key objectives • Approve the relevant benchmarks for measuring performance. Review and monitor against these benchmarks • Identify and agree a risk profile for investments • Receive regular reports from the Treasury function • Receive proposed amendments to the Trust's Operating Cash Management Policy and to make recommendations to the Board of Directors on such proposed amendments • Consider the impact of any changes in accounting policy, advising the Board of Directors as appropriate • Consider other topics, and initiate any investigation or review, as it deems fit, and on behalf of the Board of Directors • Consider audit reports • Establish and monitor best practice	
Conflict of Interests	
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders. Please see note below.	

7. Patient Safety Group

This group brings together the activities from the operational groups and address all aspects of patient safety. The terms of reference/duties are:

- To identify common risks and trends across the organisation that impact on patient safety, ensure that identified actions are developed to minimise the risk and monitor implementation.
- To monitor serious untoward incidents and trends in incidents across the organisation, ensure root cause analysis are undertaken and where appropriate and actions identified and implemented.
- To track action plans on a regular basis.
- To monitor complaints and trends in complaints across the organisation and ensure action is taken to make improvements.
- To share good practice and ensure there is learning across the organisation from incidents, complaints and health and safety issues.
- To identify NPSA patient safety alerts and other national patient safety reports of relevance to the Trust and ensure actions are taken to meet the requirements.
- To review and agree clinical policies, guidelines and Patient Group Directions and ensure these are updated according to Trust policy.
- To ensure the organisation is prepared for external reviews e.g. NHSLA, Care Quality Commission reviews, StHA reviews.
- To act as a conduit for patient safety information from the Operations Directorate Risk Management Teams to and from the Integrated Governance Committee
- Consider, agree and monitor action from the following leads/groups:

Cleanliness	Blood Transfusion
Resuscitation	Medical Devices
Medicines Management (inc. Drugs and Therapeutics)	Decontamination
	Thrombosis/VTE
Medical Records	Patient Falls
Tissue Viability	Nutrition
Health and Safety	Adult Safeguarding

- Provide the monthly minutes and report to the Integrated Governance Committee through the Clinical Governance Co-ordinator.

Membership of the Patient Safety Group: (Deputies may attend)

- Patient Safety & Risk Director
- Deputy Medical Director
- Clinical Governance Co-ordinator
- Assistant Clinical Governance Co-ordinator
- Quality Manager
- Matron Lead for Patient Safety
- Radiology Manager
- Medical Consultant Representatives
- Consultant Microbiologist
- Head of Pharmacy
- PALS Manager
- Specific topic leads (see table above) (attendance as per agreed schedule)

The Chair of this group is the Patient Safety & Risk Director. The Nursing Directorate will undertake the administration of the Committee.

8. Other Committee/Groups (see chart in Appendix 2)

Operations Directorate Risk Management Teams – there are three groups:

- Medicine
- Maternity and Children's service
- Surgery and Critical Care

These groups develop a local specialty specific risk management strategy, identify, assess and manage risks and keep local risk registers, address and take action on medical devices and patient safety alerts, identify, assess and monitor health and safety, review complaints and take action to make improvements, investigate incidents and take action to minimise risks of recurrence, provide a route for sharing information ensuring that individual members of staff and the Board of Directors have access to risk management information, ensure feedback is provided to individuals and/or groups on matters relating to governance and report to the Patients Safety Group.
Contacts Yvonne O'Connor, Risk and Patient Safety Director
Medical Devices Steering Group – is responsible for leading and coordinating the purchase and maintenance of medical devices and for ensuring there are training programmes for staff to operate them. The group is also responsible for the progress towards achieving the Controls Assurance Standard for Medical Devices.
Contact Mark Tindall, Consultant Anaesthetist or Bal Kainth, Medical Devices Coordinator
Resuscitation Committee – is a Trust wide Committee with responsibility for developing resuscitation policy and recommending good practice in resuscitation and the equipment used. It also ensures training programmes at different levels are developed and provided for staff and audits the outcome of resuscitation events.
Contact Paul Innes, Consultant Anaesthetist or Ros Clarke, Senior Resuscitation Training Officer
Medicines Management/Drugs and Therapeutics Committees – have a role to promote a rational and cost effective approach to drug use and policies effecting drug use throughout the Trust and the local health economy. A key component of its activity is to encourage the safe and economic use of drugs.
Contact Richard Cattell, Head of Pharmacy Services
Medical Records Committee – a multidisciplinary, representative group comprising of Trust and Interserve staff which agrees and monitors the structure, composition and availability of clinical records.
Contact John Macgowan, Outpatients Services Manager
Cleanliness Group – a liaison group between Trust and Interserve staff which ensures and monitors environmental cleanliness.
Contact Andrew Rigby Facilities Services & Development Manager
Decontamination Group – a co-ordinating group to ensure that all areas of the Trust comply with all relevant legislation and maintains good practice in decontamination of equipment.
Contact Bal Kainth, Medical Devices Coordinator or Yvonne O'Connor, Risk and Patient Safety Director
Blood Transfusion Group – a co-ordinating group ensuring the Trust complies with national blood transfusion directives and implements and monitors good practice.
Contact Craig Taylor, Consultant Haematologist or Caroline Stone, Transfusion Practitioner
Thrombosis Committee – a multidisciplinary group set up following the recommendations of the House of Commons Select Committee report to raise best practice by adapting

accepted risk assessment, treatment and monitoring guidelines and be a source of education and training for all staff dealing with patients at risk of venous thromboembolism.
Contact Paul Harrison, Consultant Haematologist
Nutrition Steering Committee – a multidisciplinary group to co-ordinate a systematic approach to the nutritional screening, treatment and monitoring of all patients.
Contact Barry Jones/Sheldon Cooper, Consultant Gastroenterologists

Health and Safety Committee – this monitors the performance of the Trust against health and safety requirements, and requires departments/directorates to undertake annual risk assessments and to develop action plans to address health and safety issues. It reports into the Integrated Governance Committee by exception through the Director of Human Resources.
Contact Graham Dunn, Health and Safety Advisor
Fire Safety Committee (sub-committee of the H&S Committee) – reviews the Trust's fire precaution policy and operational arrangements, reviews risk assessments and assesses fire safety training.
Contact Graham Dunn, Health and Safety Advisor

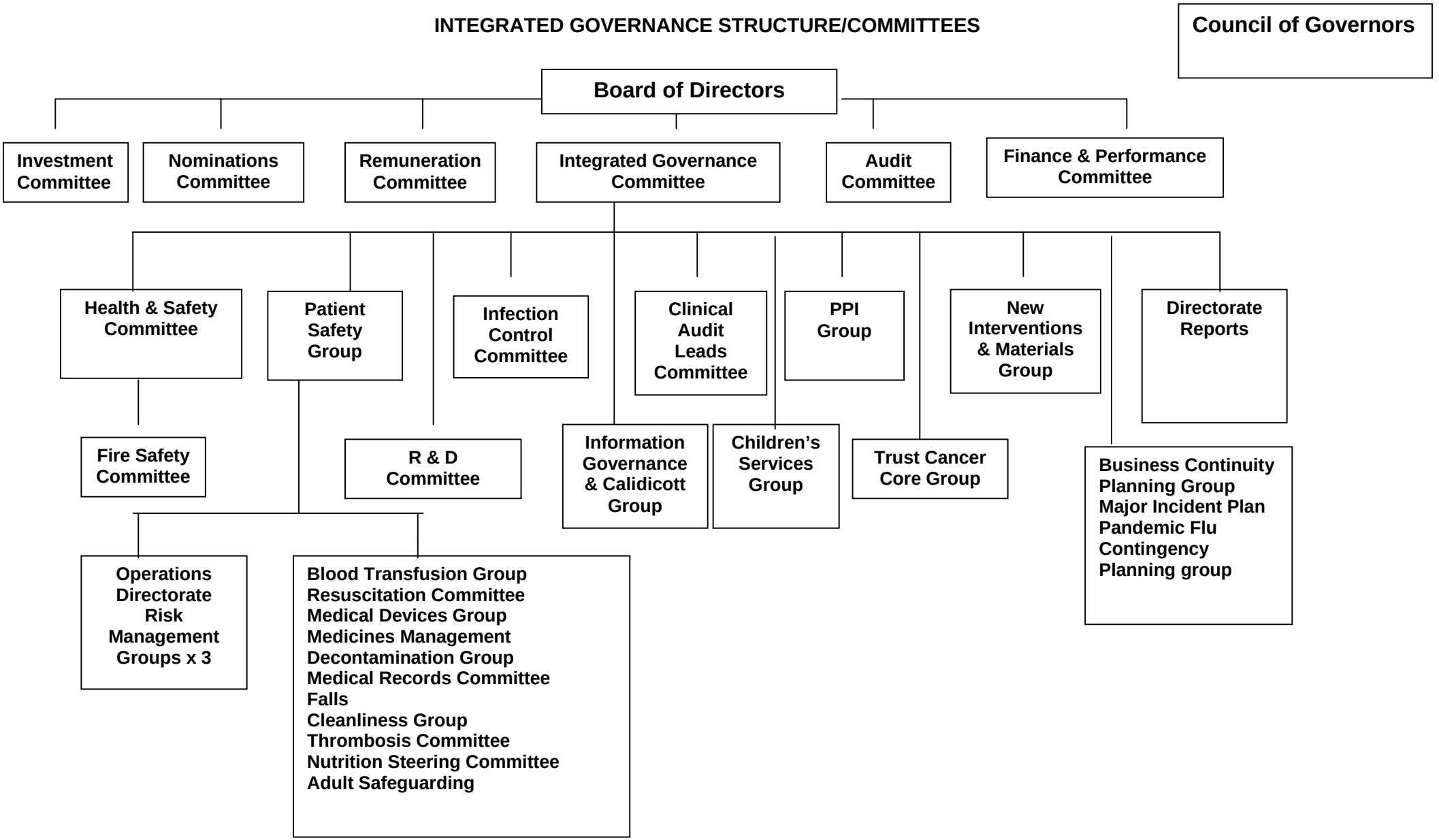
New Interventions and Materials Group – a multidisciplinary group which assesses clinicians requests to introduce new procedures and materials in line with national Health Circular and NICE requirements. It reports into the Integrated Governance Committee following its reviews of applications through the Deputy Medical Director.
Contact Roger Callender, Deputy Medical Director
Infection Control Committee – is a broad based multidisciplinary group that supports the Infection Control Team in its work across the Trust. This involves setting policies, standards and guidelines for the prevention and control of infection, identifying and managing risk, providing education and training programmes for staff, and the surveillance, audit and monitoring of infections. It reports into the Integrated Governance Committee by the tabling of its minutes by the Director of Infection Prevention and Control.
Contact Elizabeth Rees, Consultant Microbiologist or Dawn Westmoreland, Infection Control Nurse Consultant
Research and Development Committee – is a multidisciplinary group responsible for the governance of all research carried out within the Trust. It operates within a Research Governance Policy agreed by the Trust Board, and works closely with the Local (District-wide) Research Ethics Committee. The Director of R&D reports monthly to the Integrated Governance Committee.
Contact George Kitas, Consultant Rheumatologist or Margaret Marriott, Research & Development Facilitator
Clinical Audit Leads Committee – is responsible for developing a culture where evaluation is seen as important, ensuring clinicians evaluate their clinical practice, assist departments and specialties to draw up programmes of clinical audit and ensure that national standards and guidelines are available to and used by clinicians. There is a lead consultant for Clinical Audit within each main speciality. Trust Clinical Audit Lead reports monthly to the Integrated Governance Committee.
Contact Elizabeth Rees, Consultant Microbiologist or Derek Eaves, Deputy Nursing Director
Patient and Public Involvement Steering Group – is a Trust wide Committee that develops the Trust's strategy for patient involvement. It develops standards and guidelines for patient information and feedback and is encouraging the involvement of patients and the public in planning services in the future. It is closely links with the PALS. It reports into the Integrated Governance Committee by the tabling of its minutes by the Head of customer Relations and Communications.
Contact Denise McMahon, Director of Nursing

Cancer Core Group/Local Implementation Group – a co-ordinating group liaising with national and local network bodies to ensure that the Trust complies with national standards/cancer plan and effective cancer care is in place across all specialties. The Trust Cancer Lead reports by exception to the Integrated Governance Committee.
Contact Nick Whear, Consultant Max Fax
Children Services Group – a group that coordinates and develops care for children, making certain that all areas across the Trust that provide services for children, understand the unique and specific needs of children and their families and ensure that services reflect theses needs. It reports into the Integrated Governance Committee by exception through the Risk and Patient Safety Director.
Contact Yvonne O'Connor, Risk and Patient Safety Director
Information Governance and Caldicott Group – to co-ordinate and monitor the Information Governance programme of work across the Trust, including the production of policies and procedures, submitting the annual compliance requirements in the IG Toolkit, undertaking audit and investigating incidents. It reports into the Integrated Governance Committee by exception through the Director of Finance and Information.
Contact Roger Callender, Deputy Medical Director
Directorate Risk Management Reports – to achieve an integrated approach to risk management, each Director (the Risk and Patient Safety Director for the Operations Directorate) will report on any key risk management issues monthly to the Integrated Governance Committee.
Contact relevant director
Business Continuity Planning Group – The following groups report into the Business Continuity Group – the Major Incident Planning Group (Internal and External Incidents) and the Pandemic Flu Contingency Planning Group. It reports into the Integrated Governance Committee by exception through the Risk and Patient Safety Director.
Contact Paul Oxley, Project Manager

Appendix 2

THE DUDLEY GROUP OF HOSPITALS NHS FOUNDATION TRUST

INTEGRATED GOVERNANCE STRUCTURE/COMMITTEES



Appendix 3

The eight elements of Integrated Governance which constitute the High Level Governance Framework

1. **Resources** – be financially sustainable (probity, regularity, balance at year end), sufficient human resources, estate fit for purpose, appropriate information technology

2. **Efficiency and Economy, Effectiveness and Efficacy (4Es)** – the organisation can be run effectively, efficiently and economically and challenged – why are we doing this actively could someone else do it and do it better?

3. **Compliance with authorisations** – will be compliant at all times with its authorisation to operate (Monitor, Health and Safety, Drug and Research Management etc)

4. **Compliance with Standards for better Health and national targets** – meet and exceed core standards and demonstrate progress with the developmental standards

5. **The duty of quality as reflected in clinical governance** – continue to improve services for patients and be governed in accordance with current best practice

6. **The duty of partnership** – cooperate with local health economies

7. **The duty of patients and public involvement (Section 18 of the NHS Act)** – have a growing and representative membership to which it is responsible and accountable. In particular in the planning of services

8. **The ongoing development of the Board**

Appendix 4

PROCESS FOR THE IDENTIFICATION, ASSESSMENT, REPORTING AND MINIMISING OF ALL RISKS

1. INTRODUCTION

Risk management is a series of processes that identify risks, assess the potential impact of such risks and plan and implement actions to reduce risk within an overall management and monitoring framework.

2. IDENTIFICATION OF RISKS

- Risks will be identified from both local complaints, claims, incidents, accidents and concerns raised by staff (from specific major ones or from trends) as well as from national issues/directives and from risks to achieving the Trust's objectives.
- Corporate and operations directorates risk management groups are responsible for having systems in place to ensure the following processes occur.
- The Lead for Governance will be responsible for ensuring the Board has systems in place to identify, assess and manage the strategic risks

3. ASSESSING RISK

All staff, managers and risk leads are required to ensure that risk assessment is documented on the attached proforma. It is important that those undertaking the assessment ensure that the outcome is shared with the designated Risk Management lead for the directorate concerned. The process and proforma to record the risk assessment includes:

- The Source of the risk/Trust objective
- Description of risk e.g. what can go wrong, how can it happen, what could be the effect
- Risk score – Likelihood, Consequence and overall score
- Controls already in place
- The residual risk with these controls in place
- Gaps in controls
- Action Plans to mitigate risk with target dates
- Sources of Assurance and
- Gaps in Assurance
- Date of review

a. Source of Risk/Trust Objective

As indicated above, the source of the risk may be from one or more of the following: local events (complaints, incidents, claims – specific or trends) or from national issues. This should be documented on the proforma. It also needs to be documented which Trust objective is at risk of not being met.

b. Description of Risk

As well as indicating the subject of the risk, it is necessary to indicate the nature of the risk (What could go wrong? How could it happen? What could be the effect?).

c. Control already in place

The next stage is to describe the controls already in place to minimise the risk, e.g. policies, procedures, training etc.

d. Risk Score

It is then necessary to score the risk at this stage i.e. the risk with the present controls in place.

The system developed by the National Patient Safety Agency for scoring incidents has been adopted by the Trust for all risk assessments.

The scoring is undertaken in two parts: likelihood and potential consequence.

Likelihood (How often is it likely to go wrong?)

You should use a combination of professional judgement and information on, say, claim and adverse incidents recorded over the past year to determine an average of how often the risk occurs. Your score should take account of existing controls (how they actually operate – not how they might have been planned to operate)

From this analysis you should identify the most appropriate score.

LIKELIHOOD RATING	DESCRIPTION
Certain	**Will occur, possibly frequently**
Likely	**Will probably occur, but it is not a persistent issue/concern**
Possible	**May occur occasionally**
Unlikely	**Do not expect it to happen**
Rare	**Can't believe such an event will happen**

Potential consequence

As shown below, there are potentially three ways in which this may be assessed:

Impact on the individual
Numbers of people affected
Impact on organisation

Also shown are examples of the types of consequence that might constitute "catastrophic", "major" etc.

It should be noted that the descriptions – which were specifically designed in respect of patient incidents – will not necessarily be directly applicable to the risk you are assessing. You may need to think in equivalent terms.

A risk should be scored by reference to the whole grid, with the final score being determined by the "worst" assessed impact.

DESCRIPTION	IMPACT ON INDIVIDUAL (e.g. patient, staff member etc) (actual or potential)	SCORE OF IMPACT IN TERMS OF VOLUME OF PEOPLE PER INCIDENT (actual of potential)	IMPACT ON ORGANISATION (actual or potential)
Tragic	**Unexpected death Suspected Homicide**	**>50 e.g. cervical screening concern, vaccination error**	**- International adverse publicity - Extended service closure - High litigation costs**
Major	**Permanent injury (physical or psychological)/ill health/damage/loss of function**	**>16-50**	**- National adverse publicity - Temporary service closure - Increased length of stay >15 days**
Moderate	**Semi-permanent damage to patient (emotional, psychological or physical) For patients, likely to resolve within one year. For staff, likely to result in > 3 days absence**	**>3-15**	**- Local adverse publicity - Increased length of stay >8-15 days - Staff sick leave**
Minor	**No permanent damage. Patient Injury (emotional or physical) will probably resolve in about one month. Staff injury likely to result in up to 3 days absence.**	**<1-2**	**- Increased length of stay <7 days**
Insignificant	**No identifiable damage to patients. Injury to staff not resulting in absence.**	**N/A**	**- Minimal impact, no service disruption**

Overall score

Both the likelihood and Potential Consequence Ratings are plotted on the following matrix to give an overall risk rating:

Likelihood	CONSEQUENCE				
	Insignificant	**Minor**	**Moderate**	**Major**	**Tragic**
Almost Certain					
Likely					
Possible					
Unlikely					
Rare					

Very Low Low Moderate High

e. Gaps in control

Any gaps in controls should then be identified. It may be that the present controls are not working as they should be or that further controls are required.

f. Mitigating actions

Plans should be then be drawn up to minimise the risk further e.g. extra training, staff awareness, new equipment, new policy and procedures etc. In some cases you may have established that controls originally designed to reduce the risk (e.g. policies/procedures) are not working appropriately, and your action plan will need to address this issue. It is expected that the prioritisation of action plans will be driven by the overall risk rating; for example it would be expected that action plans would be produced and implemented for all assessments in the “high” category.

Action plans should include target dates, persons responsible and a date for review.

g. Residual risk

The residual risk score is then calculated using the process above. This is the expected risk that will remain once the further actions in the plan above are put in place.

These final two issues are only completed for the High risks that will go onto the Trust risk register:

h. Sources of assurance

This refers to the ways in which the Board of Directors is able to assure itself that the risks are being managed effectively and will include external and internal assurances. External assurances may be from agencies that undertake audits reviews and inspection visits and provide reports e.g. Internal and External auditors, Royal College Visits, Health Care Commission reports. Internal assurances may be via internal reports to the Board e.g. audits of policies, procedures and guidelines, performances monitoring data. These should be specific and identify where possible the frequency of when the Board is likely to receive the reports.

i. Gaps in assurance

This identifies where the Board is not receiving any assurance that the risk is being managed.

j. Dates of Assessment and Review

The dates of when the risk assessment was undertaken and when it is due for review are recoded.

Risk Acceptance

In some instances it may not be possible to put action in place to reduce the risk or the degree of action and effort is greater than likely outcome to make it not worth the effort. In these instances the Board may accept that there has to be some degree of risk.

4. RISK REPORTING AND COMMUNICATION

Copies of the whole risk assessment should be kept at ward/department level, with copies being sent to the designated Risk Management lead within the Directorate and being made available to other designated officers such as the Health and Safety manager on request. For all risks categorised as “High” your Directorate Risk Management lead should be notified immediately to ensure that the agreed actions are suitable and/or to make a decision about acceptance of the risk if immediate action cannot be taken.

All high risks must be reported to the Integrated Governance Committee and reported in the high-risk register to the Board of Directors.

Identified risks are communicated at a number of levels. Within Directorates, all risk assessments are seen by the relevant group (for the Operations Directorate, one or all of the 4 risk management groups). The Patient Safety Group is a forum for risks relating to the Operations Directorate and Trustwide clinical issues to be shared with

relevant groups. Members must ensure that they communicate risks and action plans raised at this meeting with their own directorate Risk Management Group.

The Integrated Governance Group if a forum for sharing and learning from risks of both a clinical and non-clinical nature and action taken across the whole Trust and from the wider NHS. Members must ensure that these are communicated to their own team to ensure learning takes place.

All action plans must be agreed and subsequently monitored by directorate risk management teams, the Integrated Governance Committee or the Trust Board. In addition, these groups and their chairs will ensure that the information gained from the risk management process links into business planning and service development.

Appendix 5

THE DUDLEY GROUP HOSPITALS NHS FOUNDATION TRUST

Subject:

Directorate: **Department/specialty:**

Trust objective: **Source of Risk:**

Describe/identify the risk			Describe controls as they actually work	Risk assessment			Gaps in control
What could go wrong	How could it happen	What could be the effect		Cons	Like	Score	

Mitigating actions	Date	Lead	Residual risk			Sources of assurance	Gaps in Assurance
			Cons	Like	Score		

Date of Assessment: **Person undertaking risk assessment:** **Date for review:**

Manager: **Director:**

THE DUDLEY GROUP OF HOSPITALS

MEDICINES MANAGEMENT POLICY

1. Introduction

Medicines are used in all areas of the Trust and are the responsibility of all healthcare professionals. The importance of appropriate procedures to ensure the safe, effective and economic use of medicines is paramount and is a key component of clinical governance. All members of staff dealing with medicines need to contribute to maximising their effective use, minimising medicine related morbidity for our patients and using Trust resources effectively.

This Medicines Management Policy and appendices identify the role and responsibilities of all staff groups and the standard of practice expected when prescribing, supplying, administering, supplying or storing medicines.

2. Duties and Responsibilities

2.1 Trust Board

The Trust Board is responsible for this policy, and authorising its implementation and that of the appendices. They will maintain an overview of significant risks through the Risk Committee and by monitoring the risk register.

2.2 Clinical Directors and Medical Heads of Service will oversee the application of this policy into their services and ensure its implementation is undertaken within their management structure. They will promote the policy to consultants, and they, in turn, to their teams

2.3 Matrons will be familiar with the applicable sections of the policy, liaising with medical, managerial and pharmacy colleagues to ensure implementation of the policy.

2.4 Ward and Departmental Managers will be familiar with the applicable sections of the policy. They will ensure that staff have access to the policy and its appendices, have an understanding of the policy, and practice in line with the policy.

2.5 All staff will ensure they are familiar with all relevant sections of the Medicines Management Policy and appendices and will follow correct procedures when undertaking any medicine-related task. They will report any concerns relating to medication risk to their line manager or pharmacist so action can be taken. Staff are required to report any medication incidents or near misses using the Trust Incident Reporting processes.

2.5.1 Organisations expectations in relation to staff training

All staff involved in the regular use of medicines (supply, prescribing, administration etc) must ensure that they attend mandatory medicines management training as described in the Trusts Training Needs Analysis. Individual staff requirements are available from each line manager and are detailed in the ward/department mandatory training reports.

2.6 Head of Pharmacy Services has statutory responsibility as superintendent pharmacist under the Medicines Act 1968. The postholder is responsible for Medicines Management throughout the Trust on behalf of the Chief Executive, and for the operation of the Trusts Medicines Management committees.
The postholder also has responsibility for auditing practice, highlighting medication risks, reviewing financial medicines pressures and managing the introduction of new medicines. The role is also responsible for the review of this policy and its appendices

2.7 Members of Pharmacy team will promote the operation of the Medicines Management policy, supporting others in their undertaking of medicines relating activities

2.8 Drug and Therapeutics Committee and sub-committees will provide oversight of the implementation of the policy on behalf of the Trust Board, ensure the appropriate use of controlled drugs and manage the introduction of new medicines either directly or through the Area Medicines Management Committee.

2.9 Chair of Drug and Therapeutics Committee will provide advice and support to the Trust in conjunction with the Head of Pharmacy Services in the introduction of new medicines and new policies relating to the handling of medicines

3. Process for monitoring compliance

The Trust shall monitor the implementation and success of the Medicines Management Policy by the following indicators

Prescribing medicines **Accuracy of all prescription charts**	Annual audit as part of the medicines management audit programme Presented and reviewed internally within pharmacy and at Drug and Therapeutics Committee
Administration of medication	Annual audit as part of the medicines management audit programme Presented and reviewed internally within pharmacy and at Drug and Therapeutics Committee Quarterly audit relating to missed doses Presented and reviewed internally within pharmacy, within contract quality discussions with commissioners and at Drug and Therapeutics Committee
Self administration	Annual audit as part of the medicines management audit programme in areas where self-administration operates Presented and reviewed internally within pharmacy and at Drug and Therapeutics Committee
Safe disposal of controlled drugs	Annual audit as part of the medicines management audit programme Presented and reviewed internally within pharmacy, at Drug and Therapeutics Committee, and at Local Intelligence Network meetings
Organisations expectations in relation to training	This will be monitored by all managers receiving the quarterly mandatory training report and the Finance and Performance committee receiving a six monthly Trustwide report.

Originator: Head of Pharmacy Services

Approving Committee: Patient Safety Group

Ratifying Committee: Risk Committee

Date of Ratification: October 2010

Date of Review: October 2013

This policy replaces DGOH Medicines Management Policy Aug 2010

Equality Screened: Y Date: August 2010

Equality Impact Assessment: N/A

Appendix 1

Administration of Medicines

The aim of administration is to ensure that the correct drug is given to the correct person, in the correct quantity, at the correct time and via the correct route.

Where a prescription does not comply with the prescribing guidelines outlined in (Appendix 2) the drug must not be administered and the chart returned to the prescriber for re-writing.

Nursing staff must not administer drugs unless allergy status information is completed.

A1.1 How to administer medicines

Before administering any medicine, the person administering must ensure that any special storage requirements have been adhered to (Appendix 4).

The person administering a drug will follow the NMC guidelines and before giving it will: -

- Check the identity of the patient.
- Check for recorded allergy/sensitivity. (Appendix A2.3)
- Check the drug label against the prescription.
- Check the drug name, dose form, strength, date and time.
- Check the route of administration. The drug must not be administered by any other route than that prescribed. If the route is wrong for the formulation contact the prescriber to have them change the prescription **before** administration.
- Check for any additional instructions, including safety considerations.
- Check that the drug has not already been administered.
- Check the expiry date of the drug.
- Calculate the dose if appropriate.

Where administration of a dose involves any calculation (not including number of tablets/capsules), it is required that another doctor, pharmacist or registered nurse checks the calculation.

When administering any medication, the prescription chart must be taken to the patient to ensure that the medicine is administered appropriately.

Administration must be completed and signed on completion. This means that the patient has swallowed the medicine or received an injection or suppository, There are a few exemptions e.g. sub-lingual tablets, nebulised drugs, syringe drivers or patients self administering drugs.

Where the administration of liquid preparations involves the use of volumes other than 5ml spoonfuls, then only ORAL / Enteral syringes must be used. (Appendix A1.18)

A1.1.1 ensuring a patient centred approach to administering medicines

When medicines are being administered the nurse or appropriately trained healthcare professional should consider the patient, taking particular note of

- The patients' age
- Any choice they have exercised relating to their medicines
- How their lifestyle may influence their compliance with regimens
- Any cultural and religious beliefs which may affect the patients approach to having their medicines given to them
- Any appropriate allergies and intolerances as detailed below
- Any existing medical conditions and prescriptions the patient has and the opportunity for any interaction between medicines and disease
- Any previously occurred or potential adverse drug reactions

A1.2 Who can administer medicines

A doctor, registered nurse or other healthcare professional must only administer a medication when it has been prescribed by an approved prescriber, using an official prescription chart, provided by the Dudley Group of Hospitals NHS Trust unless special arrangements exist or registered healthcare staff may, where authorised, use Trust Patient Group Directions. This also applies to drugs brought into hospital by a patient and drugs administered by registered nurses in the patient's own home.

Drugs must be administered by a doctor, other healthcare professional or registered nurse or other healthcare professional who is qualified to do so, with an appropriate witness where required

Student nurses may administer medication under the direct supervision of a first level registered nurse. The supervising qualified nurse remains accountable for the administration.

Where bank or agency nurses are involved it is the responsibility of the nurse manager to decide if it is necessary that they should be accompanied for checking purposes when administering medicines to a patient.

Clinical Support workers who have received appropriate training and are assessed as competent are authorised to administer enteral feeds provided they have been prescribed on the inpatient chart by a doctor, non-medical prescriber or dietician and they must record the administration there. They are also authorised to administer medicines under the supervision of a first level registered nurse. The supervising qualified nurse remains accountable for the administration.

A1.3 Checking prior to administration

A single individual administration system is used unless administration involves

- A intravenous medicine
- An oral cytotoxic medicine
- Calculation of a dose
- Administration to children under 16 years of age
- Doses expressed by weight or surface area
- Administration of controlled drugs

The second individual who performs the check verifies the following

- The medication is prescribed and it is due for administration
- The correct medication is selected
- Any calculations made are correct
- The medication and dose are prepared for use correctly
- The patient to whom it is being administered is correct
- The route is correct
- In the case of controlled drugs, witnessing the actual administration

A1.4 Recording Administration

A clear, accurate, and immediate record of administration must be made. The individual will sign the relevant box on the administration section of the drug chart. Where a check of the administration is required by a second person their initials must also be recorded.

Where Controlled Drugs are administered both administrator and witness must sign the CD register.

Administration of medicines prescribed on an Emergency Department record sheet, Outpatients notes or anaesthetic record sheet must be recorded adjacent to the signed prescription including the date/time and the signature of the person who has administered the medicine.

Multi dose containers of parenteral products must only be used for single patients. If the preparation of the drug is in a multi-dose container, then the patients name and time and date of its first use must be clearly recorded on the container.

Where a maximum number of doses to be given is stated or a specified maximum length of treatment, that number or length must not be exceeded, without the prescription being re-written.

A1.5 Omitted Doses and Nil by Mouth

If for any reason, and after due consideration, a medicine is not administered, a record to that effect must be made on the prescription chart, utilising non-administration codes. This must be dated and initialled. The appropriate doctor must be kept informed of non administration of prescribed medication. Any medication or remainder not administered must be destroyed immediately.

Omission of a dose must be indicated by writing the appropriate non-administration code in the drug chart's administration section.

N.B. 'Recording non-availability of a medicine as a reason for non-administration is only acceptable after full consideration of the impact of missing a dose on patient care. Wherever doubt exists, contact the senior nurse or ward pharmacist for advice. All details relating to such incidents must be recorded in the nursing notes'

Patients classified as Nil by Mouth (NBM)

Patients classified as NBM prior to a diagnostic procedure or operation should still have their prescribed oral medicines administered to them at the prescribed time unless specifically advised AND DOCUMENTED otherwise. It is the responsibility of the prescriber to provide clear written instructions to nursing staff concerning omission of prescribed doses.

A1.6 Adverse Drug Reactions

If a patient suffers a suspected adverse reaction to a prescribed medicine, over-the-counter (General Sales List) or herbal medicine, the adverse reaction should be reported via the Yellow Card Scheme. Guidance on adverse reaction reporting and the Yellow Card Scheme are contained within the BNF.

Additional guidance on how Yellow cards should be completed and further supplies of the cards are available from pharmacy. Please note ANY health care professional may complete a yellow card. In addition patients can register ADR's themselves directly with the MHRA.

Copies of all Yellow Cards submitted by DGOH staff are to be forwarded to the Head of Pharmacy Services. Summary information will be included in the full year Medicines Management report.

A1.7 Administration of medicines to children

In the context of this policy, children will be defined as any patient under the age of 16 years. The policy will apply to any clinical area where children are cared for.

Where children's drug doses are calculated according to the weight of the child, it is essential that this is recorded in kilograms on the prescription chart. The weight of the child must be recorded on the in-patient prescription chart. The child's weight must be checked at regular agreed intervals, according to their plan of care. It is a statutory requirement that the date of birth is recorded on the prescription.

A1.7.1 Checking of medicines to be administered to children

It is required that all drugs administered to children will be checked (whether a dose calculation is required or not).

The second check may be provided by:

- A first level registered nurse
- A second level registered nurse
- A Clinical Support Worker (higher level) who has been assessed as competent in Clinical Assessment.
- A student nurse who has been assed as competent in Clinical Assessment of Practice Document (Term 2 CFP) with regards to drug calculations and safe checking and administration of medicines.
- A doctor
- A Pharmacist
- In exceptional circumstances a parent/guardian of a patient under 16 may be asked to perform the second check. This is only acceptable if none of the above are available, the drug administration does not involve a calculation **AND** the parent/guardian agrees to undertake the check.

Second nurse checking is not required when administering the following drugs to children:-

- Paracetamol
- Ibuprofen
- Vitamin supplements
- Nystatin suspension and cream
- Salbutamol nebules

- Eardrops
- Dietary supplements
- Laxatives
- Emla® cream or Ametop® Gel
- Immunisations

It is good practice for medical staff who do not commonly undertake drug calculations to have any drug calculations checked prior to administration. **Nurses have the unconditional right to request another nurse to check the listed drugs if they consider this to be necessary.**

A1.7.2 Children who refuse medication

All staff administering drugs to children should take into account their age and understanding. Where it is considered that a child recognises the implications of refusing medication medical staff will be informed and the incident recorded in the medical records. If the child is considered incapable of recognising the implications of refusing medication, provided parental consent is given, medication should be administered.

A1.7.3 Self of Parent/Guardian administration to children

In the case of patients under 16 years, parents/guardians may administer the prescribed medicine to their child, but the Nurse must take the overall responsibility for ensuring the medication has been given to the child. Drugs given by the nebuliser route must be set up and the nebuliser treatment commenced by the Nurse. Parents/guardians can be left to hold their child during the administration of a nebulised medicine; however parents/guardians must not be allowed to switch on the oxygen for the nebuliser treatment. When the nebulised medicine has been given the Nurse is responsible for turning the oxygen off.

Where appropriate and with appropriate assessment self administration by children is permitted.

A1.8 Intravenous administration

This remains the joint responsibility of nursing and medical staff who must

- Work within the NMC/ GMC Code of Professional Conduct.
- Not administer a drug by the intravenous route unless she is satisfied with her competence.
- Be aware of her accountability.
- Be trained and work within the Trusts Scope of Professional Practice policy on IV administration.
- Be familiar with the patient, the drug and the administration device.
- Be available to monitor the response to treatment and administer further care.
- If these criteria cannot be met, a doctor must administer the drug and monitor the patient accordingly.

All intravenous access devices will be flushed as per the Trust Policy

A1.9 Cytotoxic Drugs

A1.9.1 Intravenous administration of cytotoxic drugs

The administration of cytotoxic drugs is not part of the routine administration of medicines within all areas of the Trust. The Procedure for Prescribing, Safe Handling

and Administration of Cytotoxic Chemotherapy and Related Monoclonal Antibodies must be followed in every instance of the administration of cytotoxic medicines.

Nursing staff **will not** be involved in the preparation and reconstitution of cytotoxic drugs. This is the responsibility of the Pharmacy Department. In the event of an urgent requirement, the consultant requesting the drugs will contact the on-call pharmacist for advice.

Cytotoxic drugs may only be administered in designated ward/department areas.

A1.9.2 Intrathecal administration of cytotoxic drugs
The procedure for intra-thecal chemotherapy must be followed each time a cytotoxic medicine is administered intrathecally

A1.10 Infusion devices
All drugs which require administration by an infusion device must be administered using a pump/infusion device of the appropriate risk category according to the classification of the drug risk as defined in the Dudley Group of Hospitals "Management & Use of Mechanical IVI Devices".

A1.11 Use of strong potassium chloride injection
Strong potassium chloride injection is only available in limited clinical areas (i.e. ITU) and pharmacy. It must be stored separately, securely and handled as a controlled drug. Pre-prepared diluted potassium should be used where possible.

A1.12 Medication incident/error reporting
All incidents/errors/near misses relating to the use of medicines must be reported using the current Dudley Group of Hospitals adverse incident reporting system. Copies of ALL such incidents are to be forwarded to the Head of Pharmacy Services via the Trust Adverse Incident Reporting System. Such incidents are reviewed by the Safe Medicines Practice Committee who will identify trends and ensure incidents are used to reduce risk of future occurrence.

A1.13 Dispensing labels
If the dispensing label on any container is damaged, altered or obliterated, the container must be returned to the Pharmacy for replacement. Staff must not make any alterations to labels except to indicate the addition of a prescribed drug to a container of intravenous fluid or to mark the date of first use on a container. If the appearance of the product differs from normal, the advice of a pharmacist should be sought.

A1.14 Transfer of medicines from one container to another
Transfer of any medicinal item from one labelled container to another is not allowed, except by pharmacy staff. All medicines must be kept in their original container and NOT decanted into other boxes or drawers etc.

A1.14.1 Inter-ward transfer
Any Patient's Own Medicine OR individually dispensed drugs for a patient held on the ward MUST be transferred with the patient if they move to another ward.
A patient transferred temporarily (for special treatment e.g. chemotherapy OR investigation) must have his prescription sheet sent with him, along with any specifically required drugs (NOT including Controlled Drugs).

A1.15 External applications
External applications must not be administered unless they have been either prescribed or specified in a written protocol, e.g. Ametop Gel.

A1.16 Patient group directions
Patient Group Directions must be developed in the first instance by relevant senior medical, nursing, AHP and Pharmacy staff. The Trust PGD policy must be adhered to.

Pharmacy will maintain a database of all approved Patient Group Directions and will initiate their regular review

Templates for completion of Patient Group Directions are available from Pharmacy and on the Hub.

A1.17 Staff requiring medication
NB Self-medication with drugs which are the property of the Dudley Group of Hospitals NHS Trust by nursing, medical and all other staff is strictly prohibited.

Medical staff and other prescribers are referred to the GMC statement on Good Practice in Prescribing Medicines (2008).

Emergency, short term supplies may be made at the discretion of the pharmacist prescriptions will be treated as private prescriptions and charges for drugs supplied will be levied.

A1.18 Oral Liquid Medicines
Where oral liquid medicines require measurement of a dose that is not a multiple of 5ml an ORAL/Enteral SYRINGE will be used to measure the dose. Oral syringes are available as:
Sterile, single use syringes for use in neonates, children under 6 months of age and immuno-compromised patients.
Non-sterile multiple use syringes for use in all other situations. These can be washed and re-used for a single patient.

DO NOT USE standard sterile injection syringes for measuring oral liquid medicines.

A1.19 Crushing of solid oral medicines
Advise on the crushing of solid oral medication is available from the pharmacy department.

Where patients are unable to swallow solid oral medicines the pharmacy should be contacted about the availability of alternative liquid formulations. Where a liquid is not available tablets may be crushed using a crushing syringe or tablet crusher available from pharmacy. To prevent cross contamination mortar & pestle must not be used.

Do not crush tablets without advice from pharmacy.

A1.20 Covert administration of medicines
As a general principle, by disguising medication in food or drink, the patient is being led to believe that they are not receiving medication, when in fact they are. This covert administration of medicines is only likely to be necessary or appropriate in the

case of patients who actively refuse medication **but** are judged not to have the capacity to understand the consequences of their refusal.

The covert administration of medicines is not to be confused with the administration of medicines against a person's will which may be considered unlawful. Nurses must refer to the NMC Medicines Management advice sheet on this issue.

Nurses and those administering medicines in such circumstances are referred to the NMC statement on covert administration of medicines

A1.21 Administration of drugs to patients who refuse treatment
Medicines, as with all form of treatment must only be administered with the patients consent. This is in the main implied – by the fact that the patient takes the prescribed drug. The only situation in which medicines may be administered without the patients consent is under the Mental Health Act 1983 – see 2.10. For detailed advice the Mental Health Act Administrator for Bushey Fields Hospital should be contacted via switchboard.

Appendix 2

Prescribing

Prescribing and the prescription form: -

a. Provide a permanent legal record of the patient's medication.
b. Facilitate the provision of the correct medicine from Pharmacy.
c. Direct administration of the medicine to the patient.

The prescription must be an accurate and unambiguous description of medicine treatment. Only registered medical staff or non-medical prescribers may prescribe drugs for administration by other healthcare professionals.

A2.1.1 **Ensuring a patient centred approach to prescribing medicines**
When medicines are being prescribed, the doctor or appropriately trained healthcare professional should consider the patient, taking particular note of

- The patients' age
- Any choice they have exercised relating to their medicines
- How their lifestyle may influence their compliance with or effect of likely regimens
- Any cultural and religious beliefs which may affect the patients approach to having their medicines prescribed for or given to them
- Any appropriate allergies and intolerances as detailed below
- Any existing medical conditions and prescriptions the patient has and the opportunity for any interaction between medicines and disease
- Any previously occurred or potential adverse drug reactions

A2.1.2Writing the prescription and ensuring the accuracy of all prescription charts
Prescribers are referred to General Medical Council, Nursing & Midwifery Council, and General Pharmaceutical Council guidance on good prescribing practice and advice given in the British National Formulary.

Only *"bona fide"* and current patients of DGOH may be prescribed drug therapy at NHS expense.

All prescriptions must be completed in indelible blue or black ink and comply with the following: -

i. The patient's full name, sex, weight on admission (if aged 16 or under), date of birth, ward, hospital number, and responsible lead clinician. (Affix addressograph if available.) Information relating to drug allergies must be recorded in the appropriate section by the prescriber when initially completing a prescription chart. If none are known then this should also be indicated.
ii. Be authorised, verified (signed) and dated by the prescriber who must be a registered prescriber employed by the Trust i.e. cannot be a medical student or clinical attachment. Contact details and GMC number are also required.
iii. The drugs prescribed in the approved generic name and clearly printed (except where a proprietary name defines a specific formulation or combination).

iv. The dose stated in terms of the quantity of active ingredient not, for example, the number of tablets or volume of liquid except in the case of compound preparations.
v. The route of administration and an indication of where the treatment (e.g. topically to leg) must be given. Combinations of routes are not acceptable, e.g. PO/IV. Specified routes 'Intrathecal' and 'epidural' must be written out in full.
vi. Indicate clearly, by the prescriber, the time that each drug must be administered, utilising the 24-hour clock.
vii. Give an indication and frequency of administration of *'as required'* drugs by clearly defined stated intervals with maximum dose over 24 hours to be included (PRN alone is unacceptable). Where defined by clinical policy a maximum duration must also be stated.
viii. Any alteration must result in the re-writing of that prescription apart from pharmacist annotation.
ix. The duration of treatment must be clearly indicated by the prescriber where this is less than the number of day/time spaces available on the prescription sheet.
x. Variable dose prescribing must clearly state the dosage range and the criteria, which determines the dosage given.
xi. If abbreviations are used, only those on the following approved list are permitted: -

PO	by mouth	PV	vaginally
mg	milligram	SL	sublingual
IM	intramuscular	Neb	by nebuliser
g	Gram	OD	once daily
IV	intravenous	BD	twice daily
kg	kilogram	TDS	three times a day
SC	subcutaneous	QDS	four times a day
L	Litre	OM	in the morning
PR	rectally	ON	at night
ml	millilitre	PRN	As required

When using abbreviations the prescriber should ensure that the initials used are clear and unambiguous e.g. SL and SC.

Prescriptions should be written to avoid, where possible, the use of a decimal point, e.g. 0.5 g should be written as 500 mg. If the prescription is ambiguous or illegible, then the drug MUST NOT be administered. The prescriber must be contacted immediately and the prescription must be re-written.

Dietetic products can be prescribed by approved Dieticians in line with the DGOH dietetic prescribing policy.

Refer to Appendix 6 for prescribing new medicines

A2.2 Reducing the opportunity for error

Hospital pharmacists may clarify prescriber's intentions, e.g. adding the generic name, clarifying ambiguous prescribing. However, this must be done in green ink and initialled.

Other unsigned alterations invalidate a prescription.

In writing prescriptions, the following must be observed:-

a. The In-patient's prescription chart should always be available. Not more than one prescription chart must be in use at any one time for any one patient, unless the number of items prescribed exceeds the available spaces. Cross-reference must be made to drugs prescribed on specific charts, e.g. oxygen therapy PCA & epidural infusions, TPN etc. If a patient requires TWO or more drug charts the number of charts should be clearly identified on each chart.

b. When the chart is full, all current prescriptions must be cancelled and the cancellations must be signed and dated by an appropriate prescriber. The current therapy must then be entered by appropriate prescribing staff on the new chart. Cancelled charts must be retained with the patient's notes.

A2.2.1 Discontinuing medicines
Prescriptions should be cancelled by drawing a single bold line through the prescription and administration section. The cancellation should be signed and dated by the doctor AND the action and rationale recorded in the patient's medical notes. Discontinued drugs that have been individually dispensed for that patient should be returned to pharmacy for disposal as per the Dudley Group of Hospitals NHS Foundation Trust Waste Disposal Policy

A2.3 Allergy status
Dudley Group of Hospitals requires all appropriate healthcare practitioners to enter known drug allergies and sensitivities on prescribing documents together with their manifestations OR specify that there are no known allergies. Each prescribing document includes an allergy status section which must be completed. This entry should be initialled and dated.

Nursing staff must not administer drugs unless allergy status information is completed.

A true allergy may be classified as one or more symptoms consistent with an immune reaction, including breathing difficulties, swelling, rash, itching, loss of consciousness or anaphylaxis.

Intolerance may be classified as an adverse effect that may be predicted from the known side effect profile or pharmacological action of a drug or an idiosyncratic or unpredictable reaction to a drug, e.g. GI bleeding secondary to a NSAID or neutropenia with clopidogrel.

When taking a medical history it is important to:

1. Verify the allergy status or drug intolerance.
2. Establish the length of time the patient has had the reported allergy/intolerance and whether there is a record of when the drug was prescribed or administered in the patient's notes.
3. Document the allergy/drug intolerance details clearly in the notes when taking the patient's history, indicating the type of reaction or intolerance described by the patient.
4. Decide whether you would consider it appropriate to administer that drug or a drug in the same class to the patient based on the information available.

5. Document the allergy/drug intolerance details on the prescription chart providing sufficient information for other prescribers to be able to make appropriate prescribing decisions.

e.g. Severe penicillin allergy (anaphylaxis) – this may be a warning to prescribers that they need to avoid all penicillins and take great care with cephalosporins.
Acute renal failure or GI bleed with NSAIDS – avoid – this gives a clear message for prescribers to avoid NSAIDS.

Mild diarrhoea with erythromycin – if the antibiotic is needed, reassurance that the symptoms are a common side effect may be all that is needed.

A2.4 Medicines Reconciliation (MR)

Medicines reconciliation is a process which ensures that all medication a patient is currently taking is correctly documented on admission and at each transfer of care. It encompasses the collection, checking and communicating of information relating to the medicines a patient is currently receiving. It is the responsibility of all staff involved in the admission, prescribing, monitoring, transfer and discharge of patients requiring medicines. MR can be considered to occur at different stages (or levels) which depends on the training and capability of the available staff

NICE/NPSA Patient Safety Guidance 001/2008 expects all organisations admitting adult patient to ensure that all medicines are reconciled following admission.

A2.4.1 Summary of levels of medicines reconciliation

Level	Brief description	Patient groups	Referral criteria to next level
First	Admission or transfer-led	All	No reliable information source
Second	Pharmacy consolidation	Defined	High risk or targeted patients
Third	Medication review	High risk or targeted patients	

Definitions

A2.4.2 First level – admission led

- Patient group – all adult admissions
- By: admitting doctor or other healthcare professional who has received appropriate training
- Collection method: Using a checklist, MR will include allergy/hypersensitivity history and medications taken prior to admission. Any concerns about the validity of the information is an indication for referral for Second Level MR (pharmacy consolidation) or if the patient is high risk referral for a medication review
- Sources: preferably 2, ideally 3 of the following more reliable sources of information: patient and/or carer, GP admission letter, recent printout from GP computer screen, repeat prescription slips; patients own drugs. Hospital out-patient visit notes; recent discharge prescriptions; verbal and written contact with care home; GP surgery or community pharmacy; district nurse, mental health team
- Time frame: within 6 hours of admission
- Communication: Patient medical record, prescription chart

A2.4.3 Second level – pharmacy consolidation

- Patient Group – specific adult admissions and referred first level patients
- By: accredited members of the pharmacy team
- Collection method: using a checklist supported by the pharmacy department. MR will include allergy/hypersensitivity history and medications taken prior to admission. Patient may be referred for third level medication review if complex issues identified
- Sources: At least 2 if not 3 of the more reliable sources available (See under first level)
- Time frame: within 48-72 hours
- Communication: no confirmation of first level MR on drug prescription chart plus referral request. Documentation of unintentional difference - patient medical record, verified and signed by pharmacist

A2.4.4 Third level – High risk/targeted patients requiring a medication review

- Patient Group: identified high risk / targeted patients including referred from first and second level
- By: Clinical pharmacist.
- Process: a full medication review following trust standard operating procedure.
- Collection method: Information should be gained from the patient using an agreed checklist and ideally corroborated by at least 2 other of the more reliable sources of information detailed in first level MR above
- Checking: This involves ensuring that the medicines, doses and formulations that are prescribed for the patient are correct. During the checking step discrepancies maybe identified as intentional or unintentional. The identified discrepancies, whether intentional or unintentional, need to be communicated as below
- Communicating: MR data added to the designated section on the front page of the Drug Prescription Chart. This information will be included in the patients' medical notes with the insertion of the chart following writing up of a new chart or discharge of the patient.

A2.5 Verbal instructions via the telephone

In exceptional circumstances, verbal instructions for the administration of drugs can be given by a doctor only to a registered nurse/midwife. Non-medical prescribers may not issue verbal prescriptions.

When accepting verbal prescriptions, the dose must be stated by the prescriber and confirmed by the nurse/midwife in words and numbers, for example fifteen (one five) milligrams. The nurse must always get a second registered nurse to speak to the doctor in order to confirm the instructions. If a second registered nurse is not available the prescriber must visit to write up the prescription.

Such prescriptions must be recorded indelibly, in black or blue ink, including the name of the prescribing doctor and the words 'verbal order' written by the nurse/midwife on the patient's prescription chart in the once only section and witnessed by the second nurse/midwife. The ORIGINAL doctor must countersign this within 12 hours.

A repeat dose must not be given until the doctor has countersigned the prescription. The nurse has the unconditional right to refuse to give a drug ordered verbally.

When doing so she must notify the doctor of her refusal and document her reasons according to local guidelines.

VERBAL INSTRUCTIONS VIA THE TELEPHONE MUST NEVER BE GIVEN OR ACCEPTED FOR NEWLY PRESCRIBED CONTROLLED DRUGS.

A2.6 Verbal instructions face to face

In an emergency situation, drugs (including Controlled Drugs) may be given by medical/nursing staff prior to formal prescription on an approved prescription chart. It is the responsibility of the prescribing doctor to ensure that this is recorded on the approved chart, and for the administering staff to then sign as necessary.

A2.7 Prescribing of controlled drugs

Please refer to appendix 5

A2.8 Non-medical prescribing (nmp)

For full details see the Trust Non-Medical prescribing Framework

Non-medical prescribers must write their directions in full, except when prescribing on an inpatient treatment chart when the guidance on the front of the treatment chart should be followed.

If a non-medical prescriber is no longer carrying out prescribing duties because they have been suspended or removed from the register or they have left employment it is the Clinical Specialty Team's responsibility to inform pharmacy such that

- existing pads are destroyed where appropriate
- no further prescription pads are ordered
- all unused prescription forms issued to that nurse relating to that employment are recovered and returned to pharmacy.

The Trust NMP Lead will keep an up to date database of all non-medical prescribers their signatures and scope of expertise. Both full name signature and initial signature, if both are commonly used, must be held on the database. Pharmacy must have access to this database thus enabling pharmacists to check whether a prescription is bona fide. Non-medical prescribers must provide a specimen signature to their Nonmedical prescribing Lead before commencing prescribing. If there is any change in signature due to name change or any other reason then a new specimen signature must be provided prior to using the new signature.

Independent non-medical prescribers and supplementary prescribers should prescribe on standard drug stationery and each prescription should be annotated with 'NMP' to indicate nonmedical prescriber.

A2.9 Security of controlled stationary

The security of the prescription forms is the responsibility of the Trust and the prescriber.

For outpatient prescriptions

- The pharmacy will record the serial numbers of prescriptions received and subsequently issued to the individual prescriber.

- The prescriber should also keep a record of the serial numbers of prescriptions issued to them.
- Blank prescription forms must not be pre-signed
- Prescription forms must never be left unattended unless in a locked cupboard
- Pharmacy should be notified if prescription forms are lost or stolen.

Prescribers should be aware that they may need to be contacted by a Pharmacist who may wish to confirm an aspect of a prescription, recommend change or refrain from dispensing if they consider such action appropriate. An up to date bleep or phone number should be included on all outpatient prescriptions.

A2.10 Prescribing of medical gases

Medical gases are regarded as drugs and as such must be prescribed in writing by authorized prescribers on Dudley Group of Hospitals approved stationery e.g. supplementary drug chart (DW9492), Emergency Department notes or Anaesthetic record sheet.

The prescription must state:

- The medical gas required
- The delivery device i.e. mask, nasal cannula
- Rate
- Other instructions

Only Oxygen may be administered in an emergency (cardiac arrest or respiratory distress) without a prescription.

A2.11 Prescribing dressings

The Dudley Wound Care Formulary should be used to guide staff on therapy for treatment & management of wounds. With the exceptions of silver preparations, povidine iodine, medicinal honey & cadexomer it is not necessary for dressings included within this document to be prescribed before use. It is however essential that ALL dressings used and the rational behind their use are documented within the individual patient's nursing notes/care plan if the dressing is not prescribed.

A2.12 Prescribing without patient consent

Drugs for treating psychiatric disorders may be given without the patients consent if the patient is detained under the Mental Health Act 1983 which is in place to: "…provide a means to compulsorily admit and detail people on psychiatric units and to some times administer treatment without consent when a patient is suffering from a mental disorder and needs to be detained in the interest of their own health or safety or for the protection of others"

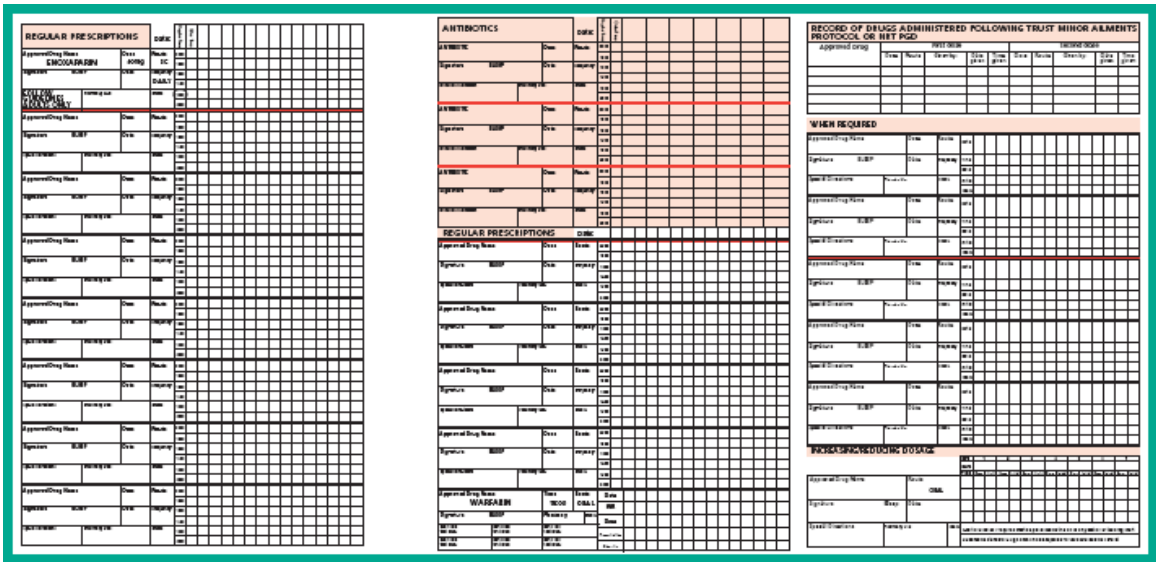
A detained patient will have been admitted to hospital against their will and are said to be "on a section". There are three main groups of compulsory order which can be for assessment and/or treatment:

1) Admission for assessment (Sections 2, 4, 5,135,136)
2) Treatment orders (Sections 3, 7)
3) Admission and transfer of patients concerned with criminal proceedings (Sections 37, 41, 47, 49).

The most important are sections 2 and 3 which provide for admission and treatment without the patient's consent. Treatment can continue for 3 months after the start of a section order after this a second opinion must be sought.
Further advice is available from the Bushey Fields Mental Health Act Administrator on ext 1962.

A2.13 Prescribing Stationery

For In-patients
Use the appropriate official Dudley Group of Hospitals NHS Foundation Trust Drug Prescription Chart.



Chart/ Supplementary Chart	Ward/ Departments	Code
08 Drug Chart	ALL (same code as 07 drug chart)	DW9489
PGD Administration records	ALL using PGDs/ Midwives	DW9491
Oxygen Therapy	ALL	DW9492
Infusion via Grasby	Palliative care patients	DW9493
Neonatal chart	Neonatal unit	DW9494
PCA infusion	Theatres/ High dependency areas	DW9495
Epidural infusion	Theatres/ High dependency areas	DW9496
Maternity insulin sliding scale	Maternity & Obstetrics	DW9498

For Discharge (commonly known as T.T.O.s (To Take Out))
Use the JAC electronic discharge process and only in exceptional circumstances use the appropriate Dudley Group of Hospitals NHS Foundation Trust Discharge Prescription. (WZZ7140)
Whenever possible this should be sent to Pharmacy 24 hours in advance, but at least 2 hours notice must be given. Usually TWENTY EIGHT days supply will be dispensed unless otherwise specified or the patient is part of the Dispensing for Discharge process.

For Out-patients
Use the appropriate Dudley Group of Hospitals NHS Foundation Trust outpatient prescription form. A maximum of TWENTY EIGHT days supply will be dispensed unless otherwise agreed (e.g. in ED). (A full course of treatment such as antibiotics will be dispensed where appropriate.)

N.B. These forms can only be dispensed at a Dudley Group of Hospitals NHS Foundation Trust pharmacy; prescribers should ensure patients are notified of this fact upon issue. When out-patients do not require immediate prescriptions OR GPs are requested to prescribe their choice of a particular class of agent ONLY individual drugs or classes of drugs approved within the Dudley Formulary are to be recommended.

For medication which the patient has received or which is not clinically urgent, the patients GP should be informed and the patient asked to discuss with GP.

In Out-patient Clinics a written request to administer medication can be made in the patient's medical notes.

For other patients
Patients in theatre have medication documented on the trust approved anaesthetic records and patients prior to admission in the Emergency Department have treatment including drug therapy documented in the trust approved ED sheet. In units provided with the green FP10 (NC) prescription pads, once written, these prescriptions may be dispensed at any community pharmacy with an NHS dispensing contract. All DGOH prescribing restrictions apply to FP10 prescriptions including the Dudley Formulary and restrictions as to duration of supply.

Appendix 3

Supply of medicines

Pharmacy staff may only dispense prescriptions that comply with all legal requirements and are completed in accordance with the procedures outlined in this policy.

There is a full range of standard operating procedures in Pharmacy relating to the supply of medicines. These are compliant with the requirements of the Royal Pharmaceutical Society.

The issue to a patient of pre-packed containers of medicine, supplied by the Dudley Group of Hospitals NHS Trust (e.g. in ED), is the responsibility of the relevant medical & nursing staff in accordance with local procedures, which identifies the responsibilities of these staff.

A3.1 Pharmacist ward visit

Each ward within the Dudley Group of Hospitals NHS Trust has a designated pharmacist who will visit the ward regularly, at times agreed between the Pharmacy and the senior nursing staff.

Pharmacists will monitor the prescription sheets, both in the dispensary and on the ward, assessing prescribing for accuracy, legibility, safety, interactions and appropriateness of therapy in line with department standards and evidence based clinical practice. Any clarification of a prescription made by a pharmacist will be carried out in indelible green ink and initialled, following, where appropriate, consultation with the prescriber.

Pharmacy staff will assess the need for non-stock and Dispensing for Discharge medicines and arrange their requisition on an 'individual named' basis from Pharmacy. All medication will be labelled with the approved 'generic' name of the preparation except where a proprietary name defines a specific formulation or combination.

Pharmacists will record interventions made using the DGOH incident reporting system.

A3.2 Pharmacy stock top-up

Specific wards will be visited at a designated time each week by a Pharmacy technician or assistant. This person will ensure stocks of pharmaceutical products for that area are replenished to agreed stock levels. The stock levels will be agreed after discussion between the relevant ward pharmacist, senior technician and appropriate medical and nursing staff. These levels will be reviewed at regular intervals by the staff concerned. Pharmacy staff must be notified by nursing staff if unusual amounts of any item are being utilised to allow stock levels to be re-calculated.

A3.3 Delivery of drugs to wards/departments & community teams

All medicines will be delivered to the ward/department/community base in a dedicated tamper evident container. The nursing/department staff are responsible for the security of this container on the ward/department and for transferring the contents of the container into the appropriate locked cupboards immediately upon receipt. Items requiring special storage conditions (e.g. refrigeration) will be clearly

labelled and must be stored appropriately immediately upon receipt on the ward/department. (*For Controlled Drugs see appendix 5)*

A3.4 Dispensing for discharge

Medicines will be dispensed for individual patients labelled ready for discharge. The Department of Pharmacy will provide this Dispensing for Discharge (DfD) service for selected wards. The ward pharmacist and ward nursing staff will initially assess the patient's pharmaceutical needs. This will include the potential of utilising the Patient's Own Drugs and the possibility of self administration.

Controlled Drugs cannot be included in the Dispensing for Discharge scheme

The pharmacist will review the prescription for clinical appropriateness & will sign the prescription to authorise supply.

Supply will be made by either:

- The medicines management technician, who will manage the supply of drugs to patients', once they are clinically checked.
- The ward staff who will request supply from the pharmacy.

DfD supplies will be stored in the locked part of the patient's bedside locker.

The ward technician will visit the ward each week day at a pre-assigned time to manage the patients' stocks of drugs.

A3.4.1 Discharge from Hospital:

Once the decision to discharge a patient has been made a Discharge Prescription (TTO) must be written. The medicines element of the TTO can be completed by a member of the medical staff, non-medical prescriber or appropriately trained healthcare workers as agreed at Drug and Therapeutics Committee.

Ward DfD supplies should be checked by the ward pharmacist, accredited pharmacy technician or experienced first level registered nurse to ensure:

- That all prescribed medication is available.
- That more than 2 weeks supply is available.
- That the label directions are legible and match those of the current prescription.
- That the available medication is not damaged.

If pre-labelled TTO stocks are available for the patient to take home the TTO should be marked to indicate that DfD supplies are being used. The pharmacy department will re-label Patients Own Drugs that require the directions changing – without obscuring the original supplying pharmacies label.

For those patients indicating they have sufficient medication and further supplies are not needed, the TTO will be endorsed MAH (medicines at home)

A3.4.2 Nursing Responsibilities:

A nurse may only assess the quality of Dispensing for Discharge supplies when that nurse has been deemed competent by the appropriate lead nurse:

Nurses must be aware of the correct procedure for reviewing DfD stocks.
A nurse must be confident of his/her ability to initially assess the quality & content of DfD.

Nurses must be aware of the correct procedure for obtaining drugs from pharmacy when DfD stocks do not match the criteria above. All required documentation must be completed.

A3.4.3 Pharmacy Team responsibilities

The pharmacy team must ensure that:

- The patient receives safe, effective & clinically appropriate medicines.
- That relevant other standards are applied including:
- Dudley Group of Hospitals N.H.S. Trust Patient's Own Drugs scheme procedure.
- Dudley Group of Hospitals N.H.S. Trust Self Administration procedure.
- Existing clinical pharmacy standards are adhered to.
- Supplementary instructions are provided
- To ensure that any changes in medication are reflected in the DfD supplies (*i.e. changes in directions, drug additions or deletions*)
- To monitor the storage conditions particularly with relation to security.

Ward Medicines Management Technicians will review the contents of patient's lockers to ensure that adequate stocks are available.

A3.5 Patients own drugs (POD's)

Dudley Group of Hospitals operate a system to support the use of Patients Own Drugs for inpatients.

A3.5.1 Patient Selection:

It is important that only patients whose medication regime is stable (apart from minor changes) are included in this scheme. All staff should encourage patients to bring all their medication with them upon admission using the green Patient's Own Medicines bags.

POD's must be assessed by a senior ward nurse utilising the guidance for nursing staff given below. A pharmacist will provide additional assessments as needed within 48-72 hours of admission.

A3.5.2 Record Keeping:

All medicines administered to a patient must be prescribed. *(All requirements of the Dudley Group of Hospitals N.H.S. Trust Medicines Management Policy still apply)*
Drugs dispensed for a patient are their property. Their use within Dudley Group of Hospitals N.H.S. Trust requires the patient's permission

Drug charts are clearly marked that the patient is using their own drugs AND which drugs they are using.

A3.5.3 Nursing Responsibilities:

Nurses must be aware of the correct procedure for patient selection.

- A nurse must be confident of his/her ability to initially assess the quality of the patient's own medicines.

- Nurses must be aware of the correct procedure for obtaining drugs from pharmacy when the Patient's Own Drugs are unacceptable.
- All required documentation must be completed
- POD's must be stored in the correct way.
- Issue patient information leaflet to patient

NB. Controlled Drugs are only acceptable for re-use in exceptional circumstances and MUST NEVER be stored in patient lockers

A3.5.4 Pharmacy Team responsibilities

The pharmacy team must ensure that:

- The patient receives safe, effective & clinically appropriate treatment.
- The POD's have been assessed as being appropriate
- Existing clinical pharmacy standards are adhered to.
- Supplementary instructions are provided.
- Patient's own drugs are included within the discharge process

If drugs are unsatisfactory for use then Dudley Group of Hospitals N.H.S. Trust supplies must be made.
[Directions on POD's for discharge match the current prescription. Where directions do not match the current prescription the pharmacy can re-label the POD provided the supplying pharmacies name is not obscured.]

A3.5.5 Protocol for checking of Patient's Own Drugs before use

It is essential that drugs brought into Dudley Group of Hospitals N.H.S. Trust by patient's are assessed for appropriateness before use to ensure the patient's safety.

A3.5.5.1 Criteria for assessment:

1) **The expiry date has not been exceeded** – If no expiry date is included the medication may not be used if more than 3 months have passed since it was dispensed.
2) **The physical condition is satisfactory**:
   The tablets are NOT broken or discoloured,
   Mixed with other tablets/capsules.
3) **The container is labelled** (with a typewritten label) and includes the following information: drug name, strength, form, date, quantity
4) Instructions that match the hospital prescription – MUST be amended if not the same.
5) **The contents can be identified** – i.e. are blister packed with the drug name or are clearly marked individual tablets or capsules.
6) eye drops and creams – are dealt with according to pharmacy procedures

N.B. Medidose® or equivalent patient compliance aids MUST NOT be used as the individual products cannot be identified.

The assessment of patients own medicines should be within 72 hours of the patient's admission.

A3.6 Self Administration

Self administration allows patients to retain or regain the responsibility and control over the administration of their medicines. Within the hospital environment this needs to be operated under a procedure.

A3.6.1 Patient Selection:

It is important that only patients whose medication regime is stable (apart from minor changes) are included in this scheme.

A3.6.1.1 Protocol for the assessment of the suitability of patients to Self Administer

The objective of the scheme is to ensure that the patient receives safe & effective treatment via the self administration programme which will aid compliance upon discharge and develop the knowledge & competence of the patient.
Criteria for assessment:

- The agreement of medical staff managing the patients care has been given for the patient to move to self administration.
- Is the patient mentally alert & competent?
- Is the drug regime stable?
- Can the patient open the containers/pop the blisters/use the inhaler?
- Are the medications labelled with the CORRECT directions & can the patient read them?
- Does the patient understand the directions?
- Does the patient understand the self medication scheme?
- Does the patient agree to participate?
- Do they understand the actions of their drugs, the treatment regime and how to take them?
- Has the patient read, understood & signed the patient information leaflet?

Patient's may utilise the Patient's Own Drugs brought into the Trust by themselves OR drugs supplied labelled with instructions as part of the Dudley Group of Hospitals N.H.S. Trust Dispensing for Discharge scheme. **ONLY DRUGS WITH TYPEWRITTEN DIRECTIONS MAY BE USED**

Any drugs that are not currently prescribed must be removed from the self administration locker and if supplied by a community pharmacy placed in a Patient's Own Drugs sealed bag OR, if supplied by DGOH, returned to pharmacy for disposal.

Drug supplies for self administration patients will be managed by pharmacy staff under the Dispensing for Discharge Procedure.

A3.6.2 Stage of entry

The self medication process consists of 2 stages which progress on from either the Dudley Group of Hospitals N.H.S. Trust procedures on the use of Patient's Own Drugs or Dispensing for Discharge, where bedside locked drug cupboards are used for the storage of individual patient's drugs.

A3.6.2.1 Stage I

This is the entry stage for all patients initially assessed as potentially appropriate for self medication. Stage I supports the patient in developing their understanding of the timing for taking their medication. *Stage I should last no longer than 3 days before re-assessing the patient's ability to progress to stage II*:

- All medication is kept in the locked patient locker (see Procedure for Patient's Own Drugs/Dispensing for Discharge).

- At usual “drug round” times the nurse visits the patient’s bedside with the locker key and supports the patient in taking their medication. The nurse will monitor compliance & accuracy.
- The nurse will endorse the drug chart as self medicated and initial each dose as checked – to record supervision of the patient.
- The nurse will record in the patient’s care plan the patient’s level of competence.
- At any time the patient may be taught about their medicines e.g. side effects, special instructions (e.g. when to take – after food).
- Fridge items & Controlled Drugs will be brought to the patient as necessary.

A3.6.2.2 Stage II

This stage i**s not** an automatic progression from stage I. Only patients who have been assessed as competent at stage I and are physically able to access their medication without nursing support will progress to completely managing their own medicines. *Stage II should continue until discharge*.

- All medication is kept in the locked patient locker (see Procedure for Patient’s Own Drugs/Dispensing for discharge).
- The patient has their own key for the patient locker next to their bed & is responsible for taking their own drugs throughout the day.
- Nursing staff will validate the patient’s medication via questioning to ensure that the patient is compliant.
- Nursing staff will review a selection of self medicating patients each evening to ensure that medication is being taken – this will include visual inspection of dispensed medicines.
- All discrepancies will be discussed with the patient & noted in their care plan.
- At any time the patient may be taught about their medicines e.g. side effects, special instructions (e.g. when to take – after food).
- If a self medicating patient has items that require controlled storage – e.g. fridge items or Controlled Drugs they must call a nurse at the required time & request their drugs.

A3.6.3 Record Keeping:

It will be documented in the patient’s care plan that a patient is participating in the self medication programme together with the name of the nurse assessing the patient’s competence to participate.

Patient’s medication, doses & administration times must continue to be prescribed on their drug chart. Records of self medication will be recorded/validated dependent upon the stage achieved.

Drugs dispensed in the community for a patient are their property. Their use within Dudley Group of Hospitals N.H.S. Trust requires the patient’s permission.
The top of each page of the drug chart is clearly marked by the nurse assessing the patient **IN RED INK** that the patient is self medicating.

A3.6.4 Drug Storage:

Patient’s drugs are stored in the specified Dudley Group of Hospitals N.H.S. Trust patient bedside locker with integral drugs storage cupboard, which must be kept locked at all times when not in use. Before being provided with a key for this locker each patient must read, agree & sign the self medication patient information leaflet. Each ward will have a master key for the lockers present on that ward

Lockers must not be transferred between wards.

The requirement to return the self administration locker key must be included in any ward discharge procedure. *The cost of replacing keys will be charged to the relevant ward by Interserve.*

Patient's MUST be made aware of their responsibilities to keep the drugs storage cupboards locked to ensure the "safe custody" of their own drugs. Patient's who fail to secure their drugs on more than one occasion will be removed from the scheme.

A3.6.5 Nursing Responsibilities:

A nurse may only assess the competence of patients to self medicate when that nurse has been deemed competent by the appropriate ward manager:

- The nurse must be aware of the correct procedure for patient selection
- The nurse must be confident of his/her ability to initially assess the abilities of patient's to self medicate
- The nurse must be aware of the correct procedure for obtaining drugs from pharmacy when Patients Own Drugs or dispensed stocks run out.
    - Ensure all required documentation must be completed.
    - To ensure that all drugs used by self medicating patients are stored in the correct way.
    - Issue patient information leaflet to patient
    - Ensure locker keys are returned upon patient discharge.

A3.6.6 Pharmacy Team's responsibilities.

The pharmacy team must ensure that:

- The patient receives safe, effective & clinically appropriate treatment.
- That medical approval has been obtained.
- That relevant other standards are applied including:
    - Dudley Group of Hospitals N.H.S. Trust Patient's Own Drugs scheme procedure.
    - Dudley Group of Hospitals N.H.S. Trust Dispensing for Discharge procedure.
- Existing clinical pharmacy standards are adhered to.
- Supplementary instructions are provided
- the knowledge & competence of self administering patients is reviewed & report any concerns to senior ward /medical staff.
- any changes in medication are reflected in the self administration supplies (*i.e. changes in directions, drug additions or deletions*)
- the storage conditions are monitored particularly with relation to security.
- Drugs used by self administrating patients are recorded to allow their use for discharge.
    - If drugs are unsatisfactory for use then Dudley Group of Hospitals N.H.S. Trust supplies must be made & the unsatisfactory drugs disposed of.

- Directions on POD's & drugs dispensed for discharge match the current prescription.

Ward Medicines Management Technicians will review the contents of patient's lockers to ensure that adequate stocks are available.

A3.7 Emergency supply

At Russells Hall Hospital an "out of hours" cupboard from which medicines may be obtained is provided. The Duty Nursing Officer for the hospital must be contacted who will then access the cupboard.

When removing items from the emergency cupboard, the designated member of staff must record in the book provided the name of the items, the quantity and the ward to which these medicines have been supplied. Only complete packs may be removed. Individual tablets or strips of tablets MUST NOT be supplied to wards/patients.

Stock drugs may only be borrowed from another ward/unit under the instruction of a DNO. Borrowing from wards must not occur whilst the Department of Pharmacy is open. It is the responsibility of the Duty Nursing Officer to arrange the borrowing of drugs.

Drugs labelled for a specific patient may not be borrowed without the express consent of the on-call pharmacist.

Out of hours replacement boxes for clinical emergencies are available.
For details on the emergency supply of medication for patients being transferred from another hospital see section 4.13.

A3.7.1 Pharmacy opening times

The Department of Pharmacy at Russells Hall Hospital is open during the following times:

Monday to Friday:	9:00a.m.	to	7:00p.m.
Saturday	10:00a.m.	to	3:00 p.m.
Sunday	10:00a.m.	to	3:00 p.m.

The extended hours services provided after 5:00p.m. on weekdays and during the weekends are limited to emergency supply of non-stock items and urgently required discharge prescriptions.

Opening times at other sites is subject to change and are posted outside individual departments.

A3.7.2 Out of hour's pharmaceutical service

The pharmacy provides a resident pharmacist service through a team of pharmacists who, when on duty, will be able to initially respond to requests for information within 3 minutes of being bleeped and will be able to attend the department within 20 minutes for clinically urgent supply requests. Doctors and senior nursing staff requiring pharmaceutical advice or the supply of additional drugs in an emergency should contact the resident pharmacist through the Trust switchboard.

Stocks of drugs that may be required urgently are available from the Out of Hours Medicines cupboard which can be accessed through the Duty Nursing Officer. Discharge prescriptions are not available via the “On Call” service.

If urgent discharge prescriptions are required when the pharmacy is closed and they are not already available in the patient’s locker, they may be obtained via the Out of Hours Medicines cupboard under the Emergency Discharge or “short leave” medicines supply procedure which is clearly displayed in the cupboard.

A3.8 Unlicensed medicines

An unlicensed medicine is one, which does not have a product licence under the Medicines Act 1968.

The informed use of some ‘unlicensed medicines’ or ‘licensed medicine for unlicensed indications’ is necessary in clinical practice. The decision to use such medicines should only be made if the product offers the best prospect of benefit for the patient. The decision should also be based upon the best practice and evidence available at the time.

A medicine is usually classed as unlicensed in certain situations:-

A. Where items are used on a named patient basis before commercial release.
B. Where products are imported on a named patient basis.
C. Where products are manufactured or assembled to a practitioner's order i.e. “specials”.

The unlicensed use of a licensed product is commonly termed ‘off-label’ use. In the situations (A) to (B) above and where possible in situation (D) a practitioner prescribing (and nurse administering) an unlicensed product will be advised by pharmacy staff that the product is unlicensed.

All unlicensed drugs will require a Dudley health economy New Product request form completing and clinical approval by the Drugs & Therapeutics committee PRIOR to supply. This will ensure that any risks associated with that agents use are assessed and managed. In clinically urgent situations “one off” approval may be sought from the Chair of D&T and Head of Pharmacy Services.

If any unlicensed medicine in (a) to (b) above, originally prescribed in the hospital, is to be continued in the community, the clinician responsible must continue to manage the patient and arrange supplies through the Hospital Pharmacy, unless the patient’s General Practitioner is happy to accept clinical responsibility for the treatment. These drugs/products are supplied on a strict 'NAMED PATIENT' basis. Each drug/product is supplied specifically for that patient at the direct request of their consultant. Under no circumstances may the drug/product be given to another patient.

In general, it is not necessary to take any additional steps when using such medication, beyond those taken when prescribing licensed medicines. However the prescriber should obtain the informed consent of the patient, parents, carers or children to prescribe or administer any unlicensed medication. This must be recorded within the patient’s notes. Patients will also be provided with an “unlicensed drug patient information leaflet” upon dispensing.

A3.9 Preparation of “medidose” type patient compliance aids.

Patients may require compliance aids such as Medidose to help with their compliance with their medicines. The patient’s community pharmacy may be able to fill such devices on discharge from hospital.

The community pharmacy will need some notice of discharge to be able to complete the request. Advice from DGOH Pharmacy is available about the suitability of the patient and their medicines for compliance aids.

The pharmacy team for the ward should be contacted if information or support is required around the use of compliance aids.

Appendix 4

Safe and secure storage of medicines

Medicines must be stored safely and securely. The level of security (to reduce theft and diversion) must be balanced with safety (risk of maladministration or urgency of need)

This section applies to inpatient units, out-patients and other clinical settings where drugs are stored. It does not apply to patients' homes.

On any occasion where wards or departments wish to change their medicines storage facilities the Head of Pharmacy Services must be contacted for advice and approval.

All medicines storage areas should be locked when not in use

The nurse in charge is accountable for the safe and secure storage of medicines in their area.

All wards & departments have their facilities for the safe & secure storage & handling of medicines assessed by senior pharmacy staff on an annual basis using the DGOH standard ward audit form. The outcomes, action plans and completion of actions will be reviewed by DGOH Patient Safety Group and its subcommittees.

A4.1 Storage

Each ward/department requires storage accommodation where relevant as follows:-

A4.1.1 Controlled drugs cupboard

Contains those drugs controlled by the Misuse of Drugs Act (1971) and subsequent amendments. Such storage MUST comply with the Misuse of Drugs (Safe Custody) Regulations 1973.

A4.1.2 Internal medicines cupboards

Contains preparations for internal administration other than those, which are, controlled drugs. Such Storage MUST comply with the British Standard specification for Cupboards for the storage of medicines in health care premises (BS2881:1989)

A4.1.3 External medicines cupboard

Contains preparations for external use. Such Storage MUST comply with the British Standard specification for Cupboards for the storage of medicines in health care premises (BS2881:1989)

A4.1.4 Refrigerator designated for medicines & parenteral fluids

The temperature of this refrigerated storage must be monitored by means of a thermometer DAILY – This temperature must be recorded. Temperatures outside 2-8^{O}C should be investigated.

A4.1.5 Medicine trolley

Contains those medicines in current use. Must be securely attached to a wall and locked when not in use.

A4.1.6 Individual patient locked cupboards

For the storage of medicines dispensed to individually named patients. These must be secure.

These storage facilities must be kept locked at all times when not in use.

A4.1.7 Intravenous and sterile topical fluids.

In addition, clean conditions are required for the storage of intravenous and sterile topical fluids.

IV fluids should not be stored as singles.

Individual bags of IV fluids should not be decanted from the original box

A4.2 Custody of keys

The nurse (or ODP) in charge remains responsible for the safe and secure storage of medicines. This task may be delegated but not the responsibility.

Any loss of drug cupboard keys must be reported to pharmacy, investigated urgently to trace and recover, failing this complete and submit an incident form and a call to replace the lock must be made urgently to the Interserve help desk.

Custody of keys remains the responsibility of the nurse in charge.

A4.2.1 Wards

- Keys for controlled drug cupboards must be kept separately from other ward keys.
- The keys for the other drug cupboards (A4.1.2- A4.1.7 above) must be kept separately from the keys to cupboards used to store other items.
- The overall responsibility for Drugs storage keys lies with the nurse designated in charge of the ward/department who must be identified on the duty rota.
- To ensure that Controlled Drugs are readily available, the Charge Nurse or designated person in charge of the ward/department may devolve responsibility to a registered nurse.

A4.2.2 Operating Theatres (including Day Cases)

- Keys for controlled drug cupboards, IV-Patient Controlled Analgesia, and epidural pumps, must be kept separately from other theatre keys. The keys for the other drug cupboards (A4.1.2- A4.1.7 above) must be kept separately from the keys to cupboards used to store other items.
- The overall responsibility for these keys lies with the nurse designated in charge of the Theatre who must be identified on the duty rota.
- To ensure that Controlled Drugs are readily available, the Charge Nurse or designated person in charge of the Theatre may devolve responsibility to a registered nurse or qualified Operating Department Practitioner.
- During the working day drugs cupboards (NOT including Controlled Drugs) may be kept unlocked to facilitate safe clinical practice following the agreement of the Head of Pharmacy.
- When the Theatres are not in use keys must be locked in the secure cabinet provided.

A4.2.3 Other areas: (Including X-Ray)

It is the responsibility of other service leads to ensure the safety & security of drug cupboard keys within their area of responsibility.

Where Controlled Drugs are stocked the keys must be kept under the control of a registered nurse or medical practitioner.

The use of digital key safes is acceptable provided the combinations are regularly (every 6 months) changed.

A4.2.4 Digital Key Safes

For advice relating to digital key safes please contact pharmacy

A4.3 Transfer of stocks

Only in exceptional circumstances must drugs supplied for ward stock be used on another ward. This will be at the discretion of the designated Duty Nursing Officer and must only occur when the pharmacy is closed.

Controlled or other recorded drugs may only be transferred for administration to an individual patient and the Controlled Drug register must transfer with the drug until administered. It must be noted in the drug register that the drug was administered to a patient on a different ward.

Stocks of controlled or recorded drugs must never be transferred to another ward. Pharmacy staff must be involved when a ward is opened, closed or decanted.

A4.4 Discrepancy of stock balance

In the event of a suspected discrepancy in the stock balance at ward or department level, the designated nurse in charge must be informed immediately. She will inform the pharmacist during normal opening hours. If a Controlled Drug is involved the on-call pharmacist should be contacted. If there is a suspicion of ‘medicines abuse’, then this should be reported to the Matron (On-Call manager – out of normal hours) and a senior pharmacist (on call pharmacist – out of normal hours). An incident form must be completed in line with the Trust incident reporting policy.

A4.5 Accidental loss

Any drug spilled or tablet dropped must be destroyed in accordance with the Dudley Group of Hospitals NHS Trust Waste Management Policy. Disposal of dropped/spilled/broken vials of controlled drugs must be as carried out in appendix 5. An incident form must be completed in line with the Trust incident reporting policy. The drainage system MUST NOT be used for disposal of pharmaceutical products

A4.6 Clinical emergencies (i.e. Cardiopulmonary arrest)

All wards/departments have a source of urgent supplementary medicinal products. These boxes are tamper-evident and must not be held in a locked cupboard but at strategic and accessible sites. Once a box has been opened, its seal has been broken or its expiry date has been reached a replacement shall be obtained from Pharmacy. The nurse in charge must check daily that these boxes are intact and in date.

A4.7 Controlled drugs and illegal substances brought to hospital - refer to appendix 5

A4.8 Controlled stationery

Controlled stationery is any stationery, which, in the wrong hands, could be used to obtain drugs fraudulently.
The following stationery is considered controlled by the Dudley Group of Hospitals NHS Trust and as such must be stored in a secure manner:-

- Controlled Drug order book.
- Controlled Drug register.
- ALL FP10 forms.
- Out-patient prescription form.
- Accident & Emergency prescription forms.
- Stock drug requisition books.
- Record of Controlled Drugs Brought into Hospital by individual patients

A4.9 Monitoring of Drug Refrigerator temperatures

The nurse in charge / ODP / Service head of a ward or department must ensure that the temperature of drug refrigerators is monitored and recorded daily. A maximum/minimum thermometer must be available in each drug refrigerator to provide temperature readings. Ward staff must notify Interserve staff if fridge temperatures fall outside the approved temperature range 2 ^{o}c to 8^{o}c.

A4.10 Records of nursing staff signatures.

To allow for tracing of staff administering medicines the Nurse in Charge of each ward/department must maintain a register of ward staff signatures and initials used on drug charts and for ordering medicines. These must be kept for 3 years after an individual has ceased to work on that ward/department.

This signature register is not the same as that for Controlled Drugs as it must include ALL nursing staff who may administer or witness administration of drugs on a ward.

A4.11 Disposal of drugs

All pharmaceuticals must be disposed of in accordance with Trust waste disposal policies. Acute hospital stocks must be returned to the pharmacy. Patients own drugs must only be returned for destruction if written approval has been given by the patient or their parent/guardian.

Hazardous Drugs (Cytotoxic or Cytostatic agents) are segregated within pharmacy and are disposed of as Hazardous Waste. All other drugs are destroyed by incineration via Interserve approved waste contractor.

Nursing staff must not remove any drugs from a patient's home without WRITTEN consent from the patient or authorised carer.

When a patient dies or medication is discontinued the community nurse must either obtain written consent from the family to remove the drugs OR instruct the family to dispose of the drugs immediately by returning them to the supplying pharmacy or dispensing doctor. In exceptional circumstances (e.g. When the patient lives alone) the nurse may return such items for appropriate disposal. Full records of the nature of the drugs, quantity and disposal method must be maintained within the patient's records. All drugs must be carried in a locked case.

A4.12 Cold chain storage

Dudley Group of Hospitals NHS Trust staff who perform duties away from their normal base must ensure that any pharmaceutical requiring refrigeration are stored in an appropriate temperature controlled container (i.e. Cooler bag with ice packs). Items that require refrigerated storage MUST NOT be allowed to return to room temperature before re-chilling. Particular care must be taken during summer months.

Appendix 5

Controlled drugs

This appendix is in line with Safer Management of Controlled Drugs (a guide to good practice in secondary care (DH 2007).

Where the term 'approved witness' is used, this refers to a second registered nurse/midwife, doctor, pharmacist, qualified Operating Department Practitioner (ODP) or a student nurse (who has received formal classroom instruction on the administration of Controlled Drugs).

A5.1 Prescribing of controlled drugs

The prescriber is referred to

- Appendix 2 of the DGOH medicines management policy
- the current edition of the British National Formulary under the section CONTROLLED DRUGS and DRUG DEPENDENCE.

However, as a summary, prescriptions ordering controlled drugs should be:
In the Prescriber's own handwriting, in indelible black ink **OR** be computer generated from a prescribing system and the prescription must state: -

i. The name and address of the patient.
ii. The preparation, e.g. morphine sulphate.
iii. The form and where appropriate the strength of the preparation e.g. tablets 10mg.
iv. The total number of dose units, in both words and figures, e.g. fourteen (14) or if a liquid preparation the total volume in word & figures e.g. One Hundred (100) ml. N.B. The MAXIMUM length of supply for any CD is capped at 30 days.
v. The dose and frequency.

The prescription must then be *dated and signed by the prescriber and will be valid for 28 days only.*

Self prescribing of Controlled Drugs is not permitted.

A5.1.1 Pharmacist amendment of CD prescriptions

The only errors that pharmacists can amend are minor typographical errors or spelling mistakes or where the total quantity of the preparation of the CD or the number of dosage units as the case may be is specified in either words or figures but not both i.e. they can add the words or the figures to the CD prescription if they have been omitted.

N.B. Technical errors on Controlled Drugs Prescriptions
Pharmacists may make certain amendments to Schedule 2 and 3 CD prescriptions provided that:

- having exercised all due diligence the pharmacist is satisfied on reasonable grounds that the prescription is genuine and they are supplying the CD in accordance with the intention of the prescriber.
- the pharmacist amends the prescription in ink or otherwise indelibly to correct the minor typographical errors or spelling mistakes or so that the

prescription complies with the Misuse of Drugs CD prescription requirements as the case may be; and
- the pharmacist marks the prescription so that the amendment they have made is attributable to them

A5.2 Administration of controlled drugs

The nurse is referred to Appendix 1 of the DGOH medicines management policy

The administration of all Controlled Drugs must be second checked by a doctor or a midwife, registered first level nurse or registered second level nurse (who has undertaken an approved training programme and been assessed as competent).

Both practitioners should witness

- the preparation of the CDs to be administered
- the CD being administered to the patient
- the destruction of any surplus drug

In administration settings where a recognised approved witness is not available a second designated Trust employee (e.g. Healthcare Assistant) may be asked to check Controlled Drugs.

With the home administration of Controlled Drugs it is recognised that a second check will not be available. It is the nurse's responsibility to confirm the correct drug & dosage required are administered and documented.

The individual doctor/nurse must be aware of their responsibilities with controlled drugs.

Only in exceptional cases medical staff may administer Controlled Drugs without a second check however Controlled Drug register entries must be completed at all times. It is good practice for medical staff to i) administer with a second check and ii) have any drug calculations checked prior to administration.

A5.3 Ordering of controlled drugs

It is the responsibility of each registered nurse who may be required to order controlled drugs to ensure that her name is registered with Pharmacy. The standard controlled drug requisition book (HMSO 90-500) must be used at all times. It is essential to give full information regarding ward, name of drug, dose form, strength and quantity required. Only ONE item may be requisitioned on each page. Nurses must sign and date the order and also print their name.

A5.4 Deliveries from pharmacy

All controlled drugs in transit to wards or departments will be transported within a sealed or locked container – "CD tin". When delivered by a messenger, the drugs will be handed to a registered nurse (or in theatres a registered Operating Department Practitioner - ODP) who will sign the order book for receipt of these drugs.

An entry will be made in the Controlled Drug register by that registered nurse or ODP and an approved witness. A record of receipt and issue of all controlled drugs must be kept. This comprises of a Controlled Drug ordering book and a Controlled Drug register. These documents must be kept for 2 years from the date of the last entry.

NB: The messenger is classified as anyone employed to act as a courier. They are responsible for ensuring security of the drug in transit. There is no requirement to check amounts being transported.

Boxes containing Controlled Drugs received from pharmacy must never be left unattended. Ward staff **MUST** promptly receive Controlled Drug deliveries from messengers and ensure that they are immediately secured into the wards Controlled Drugs cupboard and relevant entries are made in the CD register.

N.B. If, at the time of delivery, a Registered Nurse / ODP is not available the drugs will be returned to pharmacy and the ward / theatre will be responsible for making arrangements for collection.

A5.5 Inspection & checking

The nurse in charge is accountable for the inspection and checking of controlled drugs

A5.5.1 In-patients areas:

The designated registered nurse will check the stock balance of Controlled Drugs **daily** with an approved witness and record that this has been undertaken in a format agreed by the ward manager.

A5.5.2 Theatres:

Stocks are to be checked at the beginning and end of each list by two staff. One of these must be a first level Registered nurse (or a second level Registered nurse who has successfully completed unit 4 of NVQ 3 Operating Department Practice) and the other a doctor, ODP, Pharmacist, Pharmacy technician or another registered nurse. A record must be made of each stock check in a format agreed by the theatre manager.

A5.5.3 Radiology:

CD stocks are to be checked weekly by the designated radiology nurses. Second checks may be provided by an appropriately trained radiographer.

ALL controlled drugs and their storage in in-patient facilities will be checked by a pharmacist at least every six months.

A5.6 Discrepancies in controlled drugs stocks

Any discrepancies in stock or error of entry discovered must be immediately investigated by a senior nurse manager within the area. If the problem cannot be reconciled then a senior pharmacist must be informed and a Trust incident form must be completed.

If an error CAN NOT be reconciled and corrected the Head of Pharmacy Services as Accountable Officer MUST be informed. Any member of staff who has concerns about the use or misuse of Controlled Drugs must contact the Accountable Officer on ext. 2213.

A5.7 Additional precautions to be taken when handling controlled drugs

Preparation and administration must be carried out in the presence of an approved witness.
The Controlled Drug register must be completed at the time of administration of the controlled drug within an inpatient setting.

- Any of the following circumstances must be reported immediately to the senior nurse/midwife who will inform the pharmacist during normal working hours:-
- Any incorrect entry in a register (do not erase or alter except by a further note)
- Any error.
- Any actual or suspected drugs loss. If any drug appears to be lost due to misuse or theft, the senior nurse **and** matron (DNO if outside normal office hours) must be informed immediately. It will be her responsibility to notify the on call Pharmacist who will advise the Principal Pharmacist (Operational Services) or deputy on the next working day.
- Any drug spilled or tablet dropped must be destroyed, adhering to the Waste Management Policy, and a record to this effect entered in the Controlled Drug register. This must be signed by a witness and reported to the nurse/midwife in charge.

Following the use of intravenous patient controlled analgesia or similar infusion, any remaining controlled drug will be discarded and recorded, adhering the waste management policy.

A5.8 Return of unwanted/out of date controlled drugs to pharmacy
Such drugs may only be returned to Pharmacy by a pharmacist. Nursing staff **MUST NOT** under any circumstances remove Controlled Drugs from the ward for transport to Pharmacy.

A5.9 Collection and transport of controlled drugs

A5.91 When Controlled Drugs are collected from the pharmacy:
If the person collecting the Schedule 2 CD is the patient or the patient's representative the pharmacy staff will request evidence of that person's identity and may refuse to supply the CD if they are not satisfied as to the identity of the person.

Pharmacy Staff have the discretion to decide whether to ask for proof of identity and also the discretion to supply the CD, even if there is no ID available, or refuse to supply if they are not satisfied that the person collecting is who they say they are.

Circumstances where ID may not be required includes when the person collecting the CD is known to the pharmacist (the patient, close relative or friend) or when the pharmacist feels that asking for ID may compromise patient confidentiality.

Pharmacy are also obliged to record the details of the person collecting the drug

A5.10.2 Healthcare professional:
If the person collecting the Schedule 2 CD is a healthcare professional acting in their professional capacity on behalf of the patient, the pharmacist must obtain the name and address of the healthcare professional and, unless they are already acquainted with that person, they must request evidence of that person's identity. However, even if ID is not provided the pharmacist may still supply the CD.

A5.10.3 Types of ID:
Types of ID that may be considered suitable include:
Professional registration number for a healthcare professional
Driving licence (including photo card section)
Any NHS official photo ID

Passport
Cheque guarantee, debit or credit card
Birth / marriage certificate
Cheque book
Utility bills (two different ones but NOT mobile phone statement)
Pension or benefit book
Council tax payment book
Recent bank or building society statement (within last 6 months)
Bank or building society book
Store charge card (not a loyalty card)
Council rent book
National savings book

A5.11 Record keeping:
The identify of those people collecting CDs must be recorded and the records kept for 2 years.

A5.12 Transport of Controlled Drugs:
All Controlled Drugs must be transported securely. If clinical staff are required to deliver drugs to patients homes during the course of their job then such items must be locked in a Controlled Drugs tin in the boot of the staff members care whilst being transported. CD's must not be left unattended in the car. CD's MUST NOT be returned to the RHH pharmacy by staff members

A5.13 Storage of Controlled Drugs (see appendix 4)
The registered nurse, midwife or ODP is responsible for the safe and secure storage of CDs in their area. The task can be delegated but not the legal responsibility.

A5.14 Disposal of Controlled Drugs
Disposal of controlled drugs will be undertaken line with legal and regulatory guidance. For pharmacy stock, this will routinely involve supervised destruction within the pharmacy and in line with the pharmacy standard operating procedures. The accountable officer will nominate a witness for destruction, who is not involved in the procurement, supply, prescribing or administration of controlled drugs.

A5.15 Use and Recording of Patients Own Controlled Drugs
Temporary storage of patients own controlled drug on the ward may be necessary whilst they await removal to the pharmacy or return to the patient's home.

It may be appropriate to use a patients own CD whilst they are in hospital (for example where hospital stock is unavailable) The CD should be checked as suitable for use, and the patient's permission to use the medication obtained. A record must be made of administration. Upon discharge, where possible, the CDs should be returned to the patient

Patients own CDs should be

1. clearly marked with the patients name
2. stored in the CD cupboard
3. recorded in the "Record of Controlled Drugs Brought into Hospital by Individual Patients" register

THE DUDLEY GROUP OF HOSPITALS

RISK MANAGEMENT STRATEGY AND POLICY

1. Introduction

The Dudley Group of Hospitals is committed to delivering the highest level of safety for all of its patients, staff and visitors. The complexity of healthcare and the ever-growing demands to meet health care needs means that there will always be an element of risk in providing high quality, safe health care services. This document both sets out the strategic direction of how the Trust intends to meet these demands and provides an overview of key risk management structures, responsibilities and processes.

The Trust recognises that risk management is an integral part of good management practice and to be most effective should become part of the Trust's culture. The Board is therefore committed to ensuring that risk management is an integral part of its philosophy, practice and planning and that the responsibility for implementation is accepted at all levels of the organisation.

In 2010, the Trust Board has reviewed both its overall objectives and its management and committee structures. In September, a new sub-committee of the Trust Board was established, the Risk Committee. This document has been one of the first outcomes of that committee and, as the work of the committee develops, elements of this strategy and policy are likely to evolve and change.

This strategy and policy is the overarching document for risk management in the Trust and as such should be read in conjunction with other documents such as the Incident Reporting policy and 'Being Open' policy. This Risk Management Strategy covers the requirements of the Assurance Framework, the Care Quality Commission, Monitor and the NHS Litigation Authority. Many of the fundamental features of risk management, health and safety, occupational health and quality improvement overlap, therefore it is necessary to develop these systems in a seamless way to prevent duplication or missed opportunities.

2. Strategic Intent

The Trust Board has as the highest priority the safety of patients, staff and visitors and is committed to ensuring that risks to individual users of the service, the providers of the service and local community are kept to a minimum.

It is the intent of the Trust to incorporate risk information into the strategic direction-setting activity of the organisation and have an organisation-wide approach to managing risk at the strategic, operational and project level. In practical terms this means:

- helping staff identify the likelihood and consequences of activities
- identifying risks that impact on strategic and operational outcomes
- making informed decisions about the best way to achieve objectives
- targeting resources appropriately towards extreme-rating risks

- understanding the risks and benefits of new activities
- continue a culture of learning that helps mitigate future risks

3. Risk Management Objectives

Considerable work has already been achieved in laying the foundations for an integrated approach to risk management. The key objectives for 2010/13 are:

- To actively pursue the identification of potential risks in order that threat can be mitigated and opportunity utilised.
- To continue to develop a risk and safety awareness culture throughout the Trust.
- To ensure that an integrated approach to risk management is embedded in the day-to-day working practices of the Trust.
- To ensure that the risk management process covers the full range of the Trust activities.
- To continue developing the systems and structures in place for identifying, assessing, mitigating, and reporting risk.
- To ensure that the Board and senior management are provided with adequate assurances that risks are being appropriately identified, assessed, and mitigated.
- To comply with all external requirements and standards in relation to risk management.
- To implement the Datix Risk Management and Performance Accelerator systems to support the above risk management processes

4. External Requirements

The Trust must ensure that its risk management arrangements are effective and meet the requirements of a number of national bodies.

4.1 External Bodies

- **The National Health Service Litigation Authority (NHSLA)** as part of its approach to reducing risk across the NHS has set out in detail the standard it expects NHS organisations to achieve in their risk management arrangements. The DGOH Trust is required to meet the Risk Management Standards for Acute Trusts and the Clinical Negligence Scheme for Trusts (CNST) Maternity Standards. The Trust is compliant with the acute standards at Level 1 and CNST Maternity at level 0. The strategic aim is to maintain level 1 acute In October 2010 and attain level 1 Maternity in January 2011 then work towards compliance at level 2 by 2012/13.
- **Monitor** regulates NHS foundation trusts, making sure they are well-managed and financially strong so that they can deliver excellent healthcare for patients. Risk ratings for NHS foundation trusts are set annually, based on information supplied to Monitor in annual plans. The Trust Board is required to self certify at the start of the planning year and quarterly that the Trust is compliant with its terms of the authorisation. This includes confirmation that a Statement of Internal Control (SIC) is in place.
- **The Care Quality Commission** registration includes risk management as part of its essential standards of quality and safety which all NHS

organisations must achieve or be able to adequately demonstrate working towards achieving.

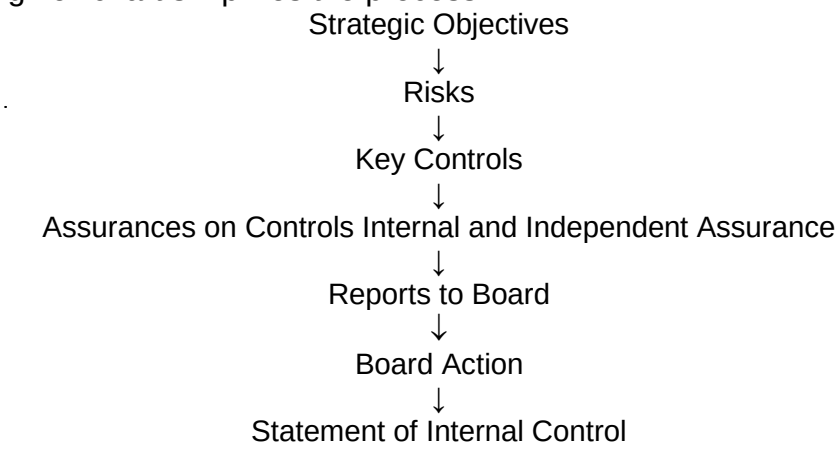
4.2 Assurance Framework

The Assurance Framework provides the structure by which the Board of Directors responsibilities are fulfilled. It encompasses the Trust's strategic objectives within a framework of Quality, Innovation, Productivity, Prevention (QUIPP) together with Staff Engagement and Patient Experience. It is imperative that the Trust is aware and manages all risks which may impact on its ability to achieve the strategic objectives set out in the overall framework. The responsibility for the identification, assessment and the placement of these risks on the Trust risk register are detailed in the Duties section 5 below.

In accordance with Monitor guidance, all NHS Trusts are required to submit an annual Statement on Internal Control signed by the Chief Executive underpinned by the Assurance Framework. The Assurance Framework and Risk Register provide the Board and relevant external bodies with the confidence that systems are safe and subject to appropriate scrutiny. The Board members are able to demonstrate that they have been informed about key risks affecting the Trust.

The assurance process is undertaken through the review of the agreed performance and quality targets at the Finance and Performance Committee with an overview by the Audit Committee. Any targets or standards where non compliance or poor performance and a potential risk is identified will be escalated to the Risk Committee.

The following flowchart simplifies the process:



The Trust has constituted a number of committees that are totally, or partially, responsible for risk management issues; relationships between these committees are described below under Duties and are shown in Appendix 1/2.

5. Duties of key individuals and groups

5.1 The Chief Executive

The Chief Executive has overall responsibility for Risk Management. The Chief Executive has delegated this responsibility to an Executive Lead for Risk (Director of Nursing). The Executive Lead for Risk is responsible for reporting to the Trust Board

on the development and progress of Risk Management, and for ensuring that the Risk Management Strategy/Policy is implemented and evaluated effectively.

5.2 Executive and Non Executive Directors

The Executive Directors are accountable and have overall responsibility for ensuring that their Directorates are implementing the Risk Management Strategy/Policy and related policies. They also have specific responsibility for managing the Trust's strategic risks, which relate to their Directorates. For example:

- The Director of Finance for overseeing and mitigating the Trust's principal risks relating to ensuring financial balance, information and information technology
- The Nursing Director for overseeing and mitigating the principal risks relating to infection control as Director for Infection Prevention and Control (DIPC), workforce planning and the co-ordination of quality regulatory requirements.
- The Director of Operations for overseeing and mitigating the Trust's principal risks relating to operational management, business continuity, clinical care, Health and Safety and PFI contractual issues.
- The Medical Director for overseeing and mitigating risks associated with Medical Workforce planning.

The Executive and Non Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives. They are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfill this role.

5.3 Nursing Director as lead for Risk Management

The Nursing Director is responsible for maintaining and updating appropriate and compliant Risk Management policies and procedures and is responsible for co-ordinating, updating and obtaining Trust Board approval of the Assurance Framework.

The Nursing Director is responsible for ensuring the Trust has a comprehensive, current and dynamic Risk Register and working with the other Directors to ensure that they understand their accountability and responsibilities for managing risks in their areas.

5.4 Clinical Directorate Management Teams

Clinical Directorate Management Teams, led by the Clinical Director and co-ordinated by the General Manager, are accountable for and have authority to ensuring appropriate risk management processes are implemented within their respective directorates and areas of authority. Each Clinical Directorate Management Team is required to:

- Understand and implement the Risk Management Strategy/Policy and related policies.
- Ensure that appropriate and effective risk management processes are in place within their delegated areas.
- Ensure Directorate activity is compliant with national risk management standards e.g. NHSLA/CNST Risk Management Standards.
- Develop specific objectives within their service plans which reflect their own risk profile and the management of risk.
- Risk assess all business plans/service developments including changes to service delivery.
- Ensure that risk assessments, both clinical and non-clinical, are undertaken throughout their areas of responsibility and are placed on the Performance Accelerator software, as this becomes operational. The risks identified will be scored and prioritised and action plans formulated and monitored.
- Maintain the directorate risk register (clinical, non-clinical and financial). Formally reporting extreme and high risks through the Operations Director to the Risk Committee.
- Report all incidents in accordance with the Incident Reporting Policy and identify action taken to reduce or eliminate further incidents.
- Undertake investigation into all red rated and externally reportable serious incidents (SIs), in accordance with the Incident Reporting and associated policies, providing evidence of local resolution and learning.
- Disseminate learning and recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their areas of responsibility.
- Monitor and report on the implementation and progress of any recommendations made.
- Ensure that all staff are made aware of risks within their working environment and their personal responsibilities within the risk management framework.
- Identify their own training needs to fulfill the function of managing risk as a senior manager.

5.5 Departmental/Ward Managers

Departmental/Ward Managers are accountable and have authority for the following:

- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility as outlined in this strategy and related risk management policies.
- Incidents are reported and investigated thoroughly
- Disseminating learning and implementing recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their area of responsibility.
- Monitoring and reporting on the implementation and progress of any recommendations made which fall directly within their area of responsibility.
- Maintaining a departmental risk register

- Ensuring that where extreme and high risks are identified these are brought to the attention of the Clinical Directorate Management Team.
- Ensuring that all staff are made aware of the risks within their work environment and made aware of their individual responsibilities.
- Ensuring that all staff have appropriate information, instruction, and training to enable them to work safely.
- Ensuring that all new staff attend Trust Induction, receive a departmental induction and are released for mandatory training.

5.6 Specialist Coordinators

Managers and staff are supported and facilitated to meet their risk management requirements by specialist staff, with the following individuals providing specific support in undertaking, advising on and co-ordinating risk management activities:

Deputy Nursing Director	-	All Aspects of Patient Safety
Health and Safety Adviser	-	All Aspects of Health and Safety
Manual Handling Facilitator	-	Manual Handling
Fire Safety Officer	-	Fire Safety
Medical Devices Co-ordinator	-	Medical Devices use and maintenance
Resuscitation Training Officer	-	Resuscitation equipment/training and use
Security Management Specialist	-	Organisational Security; property & people

5.7 All Staff

All Staff are required to:

- Be conversant with the Risk Management Strategy/Policy and have a working knowledge of all related risk polices.
- Comply with Trust policies, procedures and guidelines to protect the health, safety, and welfare of any individuals affected by Trust activity
- Acknowledge that risk management is integral to their working practice within the Trust.
- Report all incidents in accordance with the Incident Reporting Policy and take action to reduce or eliminate further incidents.
- Report any risk issues to their line manager and undertake risk assessments with support from their manager
- Participate in the investigation of any incidents as requested.
- Attend mandatory training appropriate to role.

5.8 The Risk Committee is a sub committee of the Trust Board. It is the high level committee for risk for the organisation and is chaired by a non executive director. This group has overall responsibility for risk and is accountable for overseeing the effective operation of the Trust's corporate risk register. It is in place to challenge the levels of assurance throughout the organisation and is responsible for ensuring effective management and mitigation of corporate risks (see Appendix 1 below).

5.9 Other groups with a responsibility for risk

A number of other groups have a responsibility for elements of risk. These are outlined in Appendix 1 below

6. Authority of all managers with regards to managing risk

All managers have the authority and responsibility to ensure that appropriate and effective risk management processes are in place within their delegated areas, as described above. If they are aware of deficiencies in areas outside their responsibility they have the authority and responsibility to bring this to the attention of the relevant Clinical Directorate Team or a Director.

7. Organisational risk management structure detailing all those committees and groups which have responsibility for risk

Based on the philosophy that risk is everyone's responsibility, any committee or group may identify risk, however, all high and extreme risks need to be brought to the attention of the high level committee with responsibility for risk, which is the Trust Risk Committee. A number of groups report into the Risk Committee (see Appendix 1/2) and all Executive Directors sit on the Risk Committee, ensuring that risks identified by committees not directly reporting into the Risk Committee are brought to the committee's attention. The terms of reference/duties of the Risk Committee are included in Appendix 1. In addition, a summary of the groups reporting into the committee are included. The potential routes of Risk flows are charted in Appendix 3.

8. Risk Register and Risk Management Arrangements including assignment of responsibility for different levels of risk

The Trust Board will identify risks to the agreed strategic objectives and individual Directorates and individual wards/departments will identify risks with regards to achieving their specific responsibilities. All risks will be placed on the Trust risk register. The Risk Committee takes responsibility for monitoring both the high and extreme strategic risks and the high and extreme risks from the individual directorates (the corporate risk register). All individual Directorates take responsibility for ensuring that systems are in place to monitor and review all of their risks.

8.1 Process for the management of risk centrally and for the generation and review of the organisation wide risk register

The Trust Board conducts an annual review of the strategic objectives through the assurance framework. It then identifies and assesses the risks to achieving these strategic objectives through workshops and discussions (using the Trust risk assessment process and proforma – Appendix 4/5). This assessment identifies the key controls intended to manage these risks, any gaps in controls and further action required with timescales and responsibilities agreed where gaps have been identified. Each risk is allocated to an Executive Director lead. With assistance from the Deputy Nursing Director, the high and extreme strategic risks are placed on the Trust Corporate Risk Register.

The Trust Risk Committee monitors and reviews all high and extreme risks (corporate risk register). The extreme risks are monitored monthly and the high risks are monitored quarterly.

The Risk committee reviews a summary of the whole Trust risk register at least annually.

8.2 Process for the management of risk locally

Each Directorate will have risk management arrangements based on the principles and processes outlined in this document. The Operations Directorate and the small corporate Directorates co-ordinate, identify, assess and manage risks and keep comprehensive local risk registers, based on the Trust risk assessment process and proforma (Appendix 4/5), with each risk having an assigned manager. In particular, the Operations Directorate manages this process through the three co-ordinating risk management teams: Medicine, Maternity & Children's and Surgery & Critical Care with further input from the Transformation Team and Estates and Facilities.

Each Directorate ensures that the Risk Committee is made aware of all locally identified extreme and high risks.

Each Directorate will review its low and medium risks on the register at least annually. They will in addition review all high risks at least quarterly and extreme risks monthly.

Each Directorate will ensure that it has a system in place for approving all new or emerging risks which will be placed on to the risk register ensuring that action plans for minimising and managing these risks are in place.

The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place.

The Directorates' risk registers form part of the complete Trust risk register. These risks will be combined with the strategic risks thus allowing for a bottom up top down approach to identifying the Trust's principal risks and informing the Assurance Framework. This proactive approach to risk management is holistic and identifies all risks to the organisation, including clinical, organisational, health and safety, business, marketing and financial.

9. Process for ensuring a continual systematic approach to all risk assessments is followed throughout the organisation

To ensure a systematic approach to risk assessment the Trust has agreed a single system for the identification, assessment and documentation of risk (see Appendix 4).

The system is also continual due to the reviewing systems as described in Sections 8.1 and 8.2 above and as risk assessments are undertaken proactively by a review of previously identified risks and identified reactively from internal sources such as complaints, claims and incidents as well as the result of external sources such as national reports and issues.

The focus of action is on those identified as High and Extreme Risks. These risks are those which threaten the achievement of key objectives. It is acknowledged that it is not possible to remove all risks from any organisation, and that ability to respond to risk is always constrained – for example by funding or staff time. Hence it is important to prioritise risks and actions. For instance, at the level of "Low" risk it would be realistic to take no action (unless this was easy to take), effectively "accepting" the risk; equally it is reasonable to expect that there will be action plans linked to all risks assessed as "High" and "Extreme".

- Risk should always be seen in the context of the organisation's objectives – whether these are quantifiable (e.g. to achieve a measurable target) or less specific (e.g. to deliver high quality patient care).
- All staff have a duty to identify and minimise risk and either undertake risk assessments or bring the issue to the attention of their line manager.
- Any department/member of staff with a concern over an apparently unaddressed risk should raise such a concern initially with the manager of their line manager or if their concern remains unaddressed with their Director.

A summary of the systematic risk identification and assessment process is set out below (see Appendix 4 for details):

<u>Risk Identification</u>

- Risks will be identified in the following ways including:
- Actual risks (or near misses) already incurred – these can be extracted by reference to, for example, incident reports, claims, complaints, underachievement of targets and budgetary issues.
- Potential risks can be identified by such processes as Infection Control/Health and Safety audits, Trust wide multidisciplinary workshops, group self assessments etc.

Given the complexities and interdependencies of many of the Trust services and the possible diversity of action plans it is important to ensure that an appropriate mix of skills is involved in the identification of risk.

<u>Risk Assessment</u>

- A review/reassessment of risks already on the risk register is undertaken at regular intervals determined by the level of risk, at outlined in Sections 8.1 and 8.2.
- Assessment (i.e. scoring) of risks to identify which are of greater/lesser concern, and hence which are most important to address will use the standard Trust approach (Appendix 4). This system developed by the National Patient Safety Agency uses a combination of likelihood and potential consequences to come to an overall assessment of impact – either to the individual or the organisation. It is important to note that the assessment of potential impact – and, indeed any consequent action plan – should be linked to an evaluation of the risk after taking account of how any existing controls are operating. The

expected residual risk following any intended mitigating actions also needs to be assessed.

Key Controls

- The key controls to be identified are those which, when taken together, support staff in the achievement of the organisation's objectives and reduce the threat of risk. These include:
    - Management structure and accountabilities
    - Policies, procedures and guidelines
    - Clinical Governance processes
    - Incident reporting and risk management processes
    - Complaints and other patient and public feedback procedures
    - Staff training, education and management
    - Patient & Public Involvement and Patient surveys.
    - Statutory frameworks, for instance the Standing Orders, Standing Financial Instructions and associated Scheme of Delegation
    - Communications processes
    - Internal audit
- Gaps in controls

This identifies areas where further action can be taken to reduce or minimise the risk further.

Action Plans

- Action plans are drawn up to reduce, manage or remove the risk. Action plans should be absolutely clear as to what the action is, who is responsible for taking the action, and the deadline for completion. It is important that all responsible parties agree to the action plan and its deadline especially when individuals with action items are from outside the area where the risk has been identified.
- All action plans must be agreed and subsequently monitored by directorate risk management teams and the Risk Committee. In addition, these groups and their chairs will ensure that the information gained from the risk management process links into business planning and service development.
- It is not feasible to centrally define "acceptable" risk and it is for those involved in the assessment process to determine the extent of action plans in the knowledge that no action plan = accepted risk. Directorate risk management teams are responsible for ensuring that action plans are appropriate. The Risk Committee is responsible for monitoring that action plans to address high and extreme risks have been achieved and that further action is taking place when adverse exceptions are reported.

Assurances

For all Extreme Risks, the way in which the Board gains assurance that the risk is being managed should be listed and any gaps in assurance should be identified.

Maintaining and Monitoring Risk Registers

Risk registers are broken down into Corporate and Directorate levels. The risk register contains the following minimum information:

- Source of risk
- Description of risk
- Risk Score
- Controls and Gaps in control
- Residual Risk score
- Mitigating actions
- Date of assessment and date for review.

Where a mitigating action is identified, the following information should be included:

  - Individuals responsible
  - Timescales for completion

Services Provided by Summit Healthcare

In order to ensure that the Trust's approach to risk management is comprehensive, links with risk management processes undertaken by Summit (and/or its sub-contractors) in respect of services provided to the Trust have been developed and will be maintained. These include the following: -

Incident recording	Summit has instituted an incident recording system in respect of all its services and provides summaries – including identified actions on a monthly basis. These are monitored by the Trust's Head of Estates and FM and the Trust's Health & Safety and Patient Safety Groups.
General Risk assessments	Summit has instituted appropriate arrangements to assess risk in its own services provided to the Trust, to develop and implement appropriate actions for significant risks, and to keep the Trust informed on progress. To the extent that Summit/Interserve/Siemens need to involve Trust staff in risk assessments/action planning/implementation, the Trust co-operates. The converse also applies (i.e. where a "Trust" risk involves staff from Summit).
Specific Areas of Risk	A number of these topics are in respect of functions provided by Summit. The Trust remains responsible for ensuring risk assessments are undertaken and requires the co-operation of Summit to ensure appropriate actions are implemented.

10. Awareness Training – Governance and Risk Management

All Staff

- All members of staff are required to attend induction and mandatory refresher training which includes basic awareness of governance and risk management.

- Additional training for staff will be identified through the performance and development process and incorporated into Personal Development Plans.

Board Members, Executives and Senior Managers

- Training for Board Members, executives and Senior Managers (i.e. Clinical Directors, General Managers and Matrons) will be undertaken at least every two years. The training includes updates on Risk Assessment and Risk Management processes, and any relevant policy changes, as appropriate. This will be organised and records maintained by the Deputy Director of Nursing, who will also follow up any non-attendance.

11. Monitoring of Compliance with the strategy/policy

Organisational risk management structure detailing all those committees and groups which have responsibility for risk	The Trust Board will review annually the risk structures, responsibilities, workings of the committees, the overall risk assessment process and processes for reviewing the risk register
Process for risk committee review of organisation-wide risk register	
Process for the management of risk locally	The Risk Committee will annually review all local risk management processes and their contributions to the risk register.
Duties of key individuals	This will be monitored through the individual appraisal process
Authority of all managers with regards to managing risk	The Trust Board will review annually the risk structures, responsibilities, workings of the committees, the overall risk assessment process and processes for reviewing the risk register
Risk committee: **-Duties** **-Reporting arrangement to board** **-Membership** **-Required frequency of attendance** **-Reporting arrangements into risk committee** **-Quorum** **-Frequency of meetings**	
Process for ensuring that board members and senior managers receive relevant risk management awareness training **Process for recording attendance** **Process for follow up of attendance**	The Nursing Director will review this process every two years and report to the Risk Committee.
Process for assessing risk **Process for ensuring a continual, systematic approach to risk assessments is followed throughout the organisation** **Assignment of management responsibility for different levels of risk within the organisation**	The Trust Board will review annually the risk structures, responsibilities, workings of the committees, the overall risk assessment process and processes for reviewing the risk register

Risk Register contents: **Source of risk** **Description of risk** **Risk Score** **Summary risk treatment plan** **Date of review** **Residual risk rating**	

12. Conclusion

Effective governance and assurance arrangements are critical in ensuring the confidence of the Board, staff, patients and the public and partner organisations in the Trust and for the effective delivery and execution of its functions. Developing a culture of openness and transparency is integral to assuring all of the effectiveness of these arrangements, together with an environment that fosters and develops personal and organisational growth as a key to success.

Approving Group : Risk Committee/Trust Board

Date of Approval : Oct 2010

Date of Review : Oct 2013

Policy Supersedes : This policy supersedes part of the Integrated Governance Strategy approved in February 2010

Equality Screened : Y **Date : October 2010**

Equality Impact Assessment : NA

REFERENCES

Code of Practice on Openness in the NHS. DoH April 1994
Code of Conduct. Code of Accountability. In the NHS 2nd reved DoH 2004
Internal Control – Guidance for Directors on the Combined Code. The Institute of Chartered Accountants - England, Wales September 1999
NHS foundation Trust Code of Corporate Governance, Monitor 2005
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The Intelligent Board – Monitor (no date)
Assurance: The Board Agenda Department of Health Governing the NHS – A Guide for NHS Boards Department of Health NHS Appointments Commission 2003

Appendix 1

Membership and Terms of Reference

1. Risk Committee

Membership:	**Reporting arrangements into the committee:**
Non- Executive x 2 Chief Executive All Executive Directors : Nursing, Finance and Information, Medical, Operations Representatives from each Clinical Directorate Head of Human Resources Deputy Medical Director Deputy Nursing Director x 2 (All members can nominate deputies.)	• Reports from Patient Safety Group (Monthly), Infection Control (Bi-Monthly), Health and Safety Group (Quarterly), Drugs and Therapeutics (Bi-Monthly), Childrens Services (Quarterly), Medical Records (Quarterly), Safeguarding (Monthly), Caldicott and Information Group (Quarterly), New Interventions (post – meeting) • Trust Risk register • Serious incidents (Monthly) • Aggregated incident, complaints, claims reports (Quarterly)
Quorum:	**Chairing:**
3 members, one of which must be a Non-Executive	Non- Executive When absent, chaired by second Non-Executive
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary	
Exclusions:	
See conflict of interest below	
Frequency of Meetings and required frequency of attendance:	
Minimum 9 meetings per year Ad hoc meetings can be called by the Chair or Chief Executive if there are urgent risks to the Trust identified. Members themselves should attend at least half the meetings in a year as a minimum.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged as necessary to ensure a quorum is achieved	

Duties
To advise the Board on the co-ordination and prioritisation of risk management issues throughout the Trust and develop a strategy for risk management for approval by the Board. To encourage and foster greater awareness of risk management at all levels in the Trust. To provide the Board with regular assessments of the risks facing the Trust and provide assurance that actions are being taken to address those incidents, complaints and claims which have occurred and to ensure measures have been implemented to mitigate future occurrence. To provide the Board with a Risk Management Strategy and annual risk management report providing positive assurance that the Committee has met its terms of reference and key duties. Taken together with other Committee Annual Reports this should provide the Board with comprehensive assurance of integrated governance and support the Trust's Statement on Internal Control (SIC). To develop and maintain a comprehensive Corporate Risk Register which will be reviewed at each meeting and presented to the Board on a half yearly basis. To co-ordinate and maintain the review of the Board Assurance Framework and submit to the Board for consideration and approval at least twice a year ensuring alignment with Key Corporate Objectives. To oversee sub-ordinate committees which deal with risk specific issues and to agree their terms of reference and the reporting mechanism to the Risk Management Committee. To oversee implementation of the Risk Management Strategy and report its progress to the Trust Board. To make sure that appropriate monitoring systems are in place to ensure compliance against the relevant Trust internal controls systems, processes and policies, and in particular to monitor the implementation of the Trust's plans to maintain compliance with NHSLA and external agency risk management standards. To provide a forum for consultation and awareness training between all professions on methods for assessing risks of all types in a consistent fashion and to propose levels of acceptability for Trust Board approval. To agree the methodology for recording risks in the Risk Register and for treating risks for use by operational management and to propose the relationship between this and the business planning process. To ensure an effective mechanism for escalating issues from such groups to the appropriate body (Board, Audit Committee, external organisation etc). To consider significant urgent and ad hoc issues and where appropriate to refer them to the Board with risk action plans. To ratify all Trustwide policies.
Reporting Arrangements to Board
The Nursing Director will present the minutes of the meetings after each meeting to the Trust Board.
Conflict of Interests
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders.

2. Groups Reporting into the Risk Committee

A. Patient Safety Group

This group brings together patient safety issues from a number of operational groups, national requirements and addresses all aspects of patient safety. The terms of reference/duties are:

- To identify common issues and trends across the organisation that impact on patient safety, ensure that identified actions are developed to minimise any risk and monitor implementation.
- To monitor serious untoward incidents and trends in incidents across the organisation, ensure root cause analyses are undertaken and where appropriate and actions identified and implemented.
- To track action plans on a regular basis.
- To monitor trends in concerns, complaints, claims across the organisation and ensure action is taken to make improvements.
- To share good practice and ensure there is learning across the organisation from incidents, complaints and health and safety issues.
- To identify NPSA patient safety alerts and other national patient safety reports of relevance to the Trust and ensure actions are taken to meet the requirements.
- To review and approve clinical policies, guidelines and Patient Group Directions and ensure these are updated according to Trust policy.
- To ensure the organisation is prepared for external reviews e.g. NHSLA, Care Quality Commission reviews, StHA reviews.
- To act as a conduit for patient safety information from the Operations Directorate Risk Management Teams to and from the Risk Committee
- To receive information on the distribution of NICE Guidance
- Consider, agree and monitor action from the following leads/groups:

Falls	Nutrition
Resuscitation	Thrombosis
Tissue viability	Medical Devices
Decontamination	Blood Transfusion
Cleanliness	Radiation

- Provide the monthly minutes and report to the Risk Committee through the Deputy Nursing Director.

Membership of the Patient Safety Group: (Deputies may attend)

- Deputy Medical Director
- Deputy Nursing Directors
- Assistant Clinical Governance Co-ordinator
- Risk and Standards Manager
- Chairs of the three Operational Risk Management teams
- Radiology Manager
- Medical Consultant Representatives

- Consultant Microbiologist
- Head of Pharmacy
- PALS and Complaints Manager (quarterly)
- Specific topic leads (see table above) (attendance as per agreed schedule)

The Chair of this group is the Deputy Nursing Director. The Nursing Directorate will undertake the administration of the Committee.

Groups that report into the Patient Safety Group include:

Falls Group – is responsible for ensuring that the Trust complies with good practice with regards to patient falls and partakes in monitoring and audit various aspects of this topic.
Contacts Briony Howells, Matron, Christine Taylor, Falls Co-ordinator, Dr Michael, Consultant
Resuscitation Group – is a Trust wide group with responsibility for developing resuscitation policy and recommending good practice in resuscitation and the equipment used. It also ensures training programmes at different levels are developed and provided for staff and audits the outcome of resuscitation events.
Contacts Paul Innes, Consultant Anaesthetist or Ros Clarke, Senior Resuscitation Training Officer
Tissue Viability Group – is responsible for ensuring that effective systems are in place to prevent, monitor and investigate pressure sores and ensure that the Trust is complying with its obligations with regards to Tissue Viability.
Contact: Dawn Westmoreland, Infection Control Nurse Consultant
Decontamination Group – a co-ordinating group to ensure that all areas of the Trust comply with all relevant legislation and maintains good practice in decontamination of equipment.
Contact: Bal Kainth, Medical Devices Co-ordinator
Medical Devices Steering Group – is responsible for leading and coordinating the purchase and maintenance of medical devices and for ensuring there are training programmes for staff to operate them. The group is also responsible for the progress towards achieving the Controls Assurance Standard for Medical Devices.
Contact Mark Tindall, Consultant Anaesthetist or Bal Kainth, Medical Devices Coordinator
Blood Transfusion Group – a co-ordinating group ensuring the Trust complies with national blood transfusion directives and implements and monitors good practice.
Contact Craig Taylor, Consultant Haematologist or Caroline Stone, Transfusion Practitioner
Nutrition Steering Group – a multidisciplinary group to co-ordinate a systematic approach to the nutritional screening, treatment and monitoring of all patients.
Contact Sheldon Cooper, Consultant Gastroenterologist
Thrombosis Group – a multidisciplinary group set up following the recommendations of the House of Commons Select Committee report to raise best practice by adapting accepted risk assessment, treatment and monitoring guidelines and be a source of education and training for all staff dealing with patients at risk of venous thromboembolism.
Contact Paul Harrison, Consultant Haematologist
Cleanliness Group – a liaison group between Trust and Interserve staff which ensures and monitors environmental cleanliness.

Contact Andrew Rigby Facilities Services & Development Manager
Radiation Group – a group that ensures that the Trust complies with all necessary legislation and national requirements related to radiation
Contact Ghiz Morris, Radiology Manager
Operations Directorate Risk Management Teams – there are three teams:

- Medicine
- Maternity and Children's service
- Surgery and Critical Care

These teams develop a local specialty specific risk management strategy, identify, assess and manage the Directorates risks, address and take action on medical device and patient safety alerts, identify, assess and monitor health and safety, review complaints and take action to make improvements, investigate incidents and take action to minimise risks of recurrence, provide a route for sharing information; ensuring that individual members of staff and the Board of Directors have access to risk management information, ensure feedback is provided to individuals and/or groups on matters relating to governance and report both to the Patients Safety Group and the operations directorate risk management forum.
Contacts:J Pain (Medicine), P Smith (Maternity/Childrens), J Bree (Surgery/Critical Care)

B. Other Risk Groups reporting into Risk committee (see chart in Appendix 2)

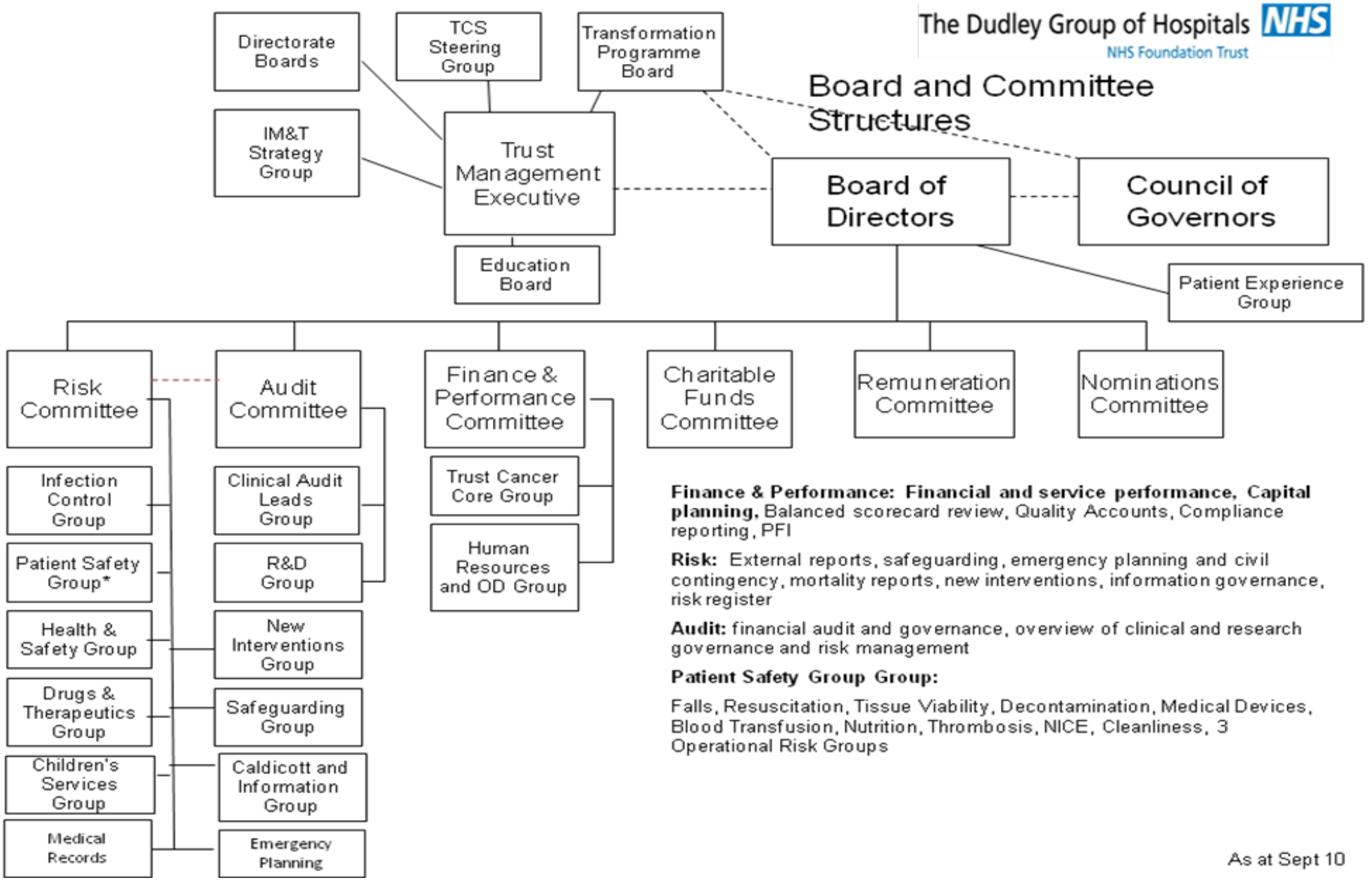
Infection Control Group – is a broad based multidisciplinary group that supports the Infection Control Team in its work across the Trust. This involves setting policies, standards and guidelines for the prevention and control of infection, identifying and managing risk, providing education and training programmes for staff, and the surveillance, audit and monitoring of infections. It reports into the Risk Committee by the tabling of its minutes by the Director of Infection Prevention and Control.
Contact Elizabeth Rees, Consultant Microbiologist or Dawn Westmoreland, Infection Control Nurse Consultant
Health and Safety Group – this monitors the performance of the Trust against health and safety requirements, and requires departments/directorates to undertake annual risk assessments and to develop action plans to address health and safety issues. It reports into the Risk Committee by exception through the Director of Operations.
Contact: Graham Dunn, Health and Safety Facilitator
Drugs and Therapeutics Group – has a role to promote a rational and cost effective approach to drug use and policies effecting drug use throughout the Trust and the local health economy. A key component of its activity is to encourage the safe and economic use of drugs.
Contact Richard Cattell, Head of Pharmacy Services

New Interventions and Materials Group – a multidisciplinary group which assesses clinicians requests to introduce new procedures and materials in line with national Health Circular and NICE requirements. It reports into the Risk Committee following its reviews of applications through the Deputy Medical Director.
Contact Roger Callender, Deputy Medical Director

Safeguarding Group – a co-ordinating group liaising with local Dudley inter-agency Children's Safeguarding and Vunerable Adults Boards and ensuring there are robust systems for safeguarding within the Trust.
Contact Denise McMahon, Nursing Director
Children Services Group – a group that coordinates and develops care for children, making certain that all areas across the Trust that provide services for children, understand the unique and specific needs of children and their families and ensure that services reflect theses needs. It reports into the Risk Committee by exception through the Deputy Nursing Director.
Contact Yvonne O'Connor, Deputy Nursing Director
Caldicott and Information Governance Group – to co-ordinate and monitor the Information Governance programme of work across the Trust, including the production of policies and procedures, submitting the annual compliance requirements in the IG Toolkit, undertaking audit and investigating incidents. It reports into the Risk Committee by exception through the Director of Finance and Information.
Contact Roger Callender, Deputy Medical Director
Medical Records Group – to ensure that the Trust has robust systems in place with regards to the management of clinical records
Contact John MacGowan, Head of Outpatients/Medial Records

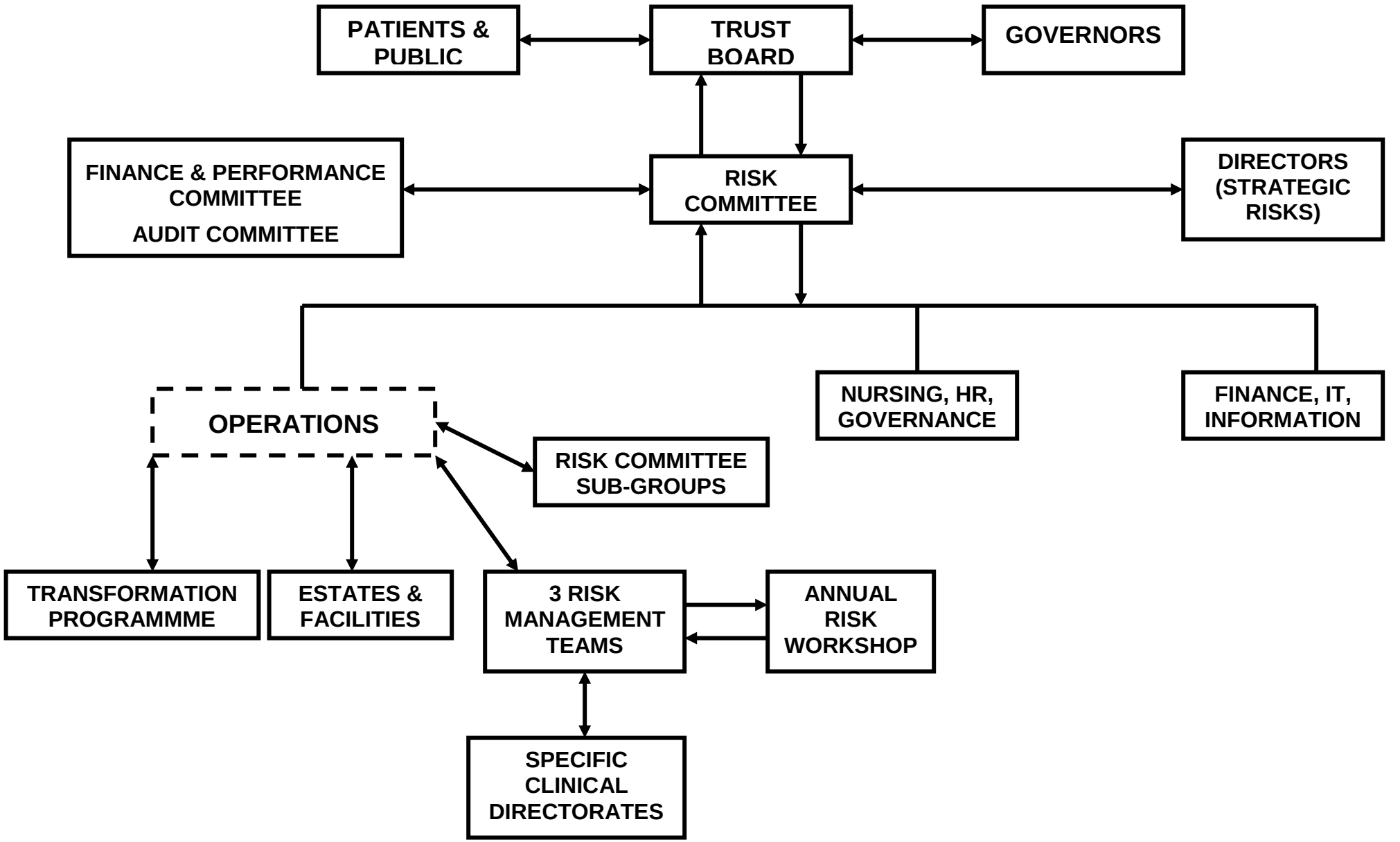
In addition, **Emergency Planning and Civil Contingency** *(Paul Oxley, Project Manager)* will provide reports by exception.

Appendix 2


The Dudley Group of Hospitals NHS
NHS Foundation Trust
Board and Committee Structures
Directorate Boards
TCS Steering Group
Transformation Programme Board
IM&T Strategy Group
Trust Management Executive
Education Board
Board of Directors
Council of Governors
Patient Experience Group
Risk Committee
Audit Committee
Finance & Performance Committee
Charitable Funds Committee
Remuneration Committee
Nominations Committee
Infection Control Group
Patient Safety Group*
Health & Safety Group
Drugs & Therapeutics Group
Children's Services Group
Medical Records
Clinical Audit Leads Group
R&D Group
New Interventions Group
Safeguarding Group
Caldicott and Information Group
Emergency Planning
Trust Cancer Core Group
Human Resources and OD Group
Finance & Performance: Financial and service performance, Capital planning, Balanced scorecard review, Quality Accounts, Compliance reporting, PFI
Risk: External reports, safeguarding, emergency planning and civil contingency, mortality reports, new interventions, information governance, risk register
Audit: financial audit and governance, overview of clinical and research governance and risk management
Patient Safety Group Group:
Falls, Resuscitation, Tissue Viability, Decontamination, Medical Devices, Blood Transfusion, Nutrition, Thrombosis, NICE, Cleanliness, 3 Operational Risk Groups
As at Sept 10

Appendix 3

POTENTIAL RISK FLOWS



Appendix 4

PROCESS FOR THE IDENTIFICATION, ASSESSMENT, REPORTING AND MINIMISING OF ALL RISKS

1. INTRODUCTION

Risk management is a series of processes that identify risks, assess the potential impact of such risks and plan and implement actions to reduce risk within an overall management and monitoring framework.

2. IDENTIFICATION OF RISKS

- Risks will be identified from both local complaints, claims, incidents, accidents and concerns raised by staff (from specific major ones or from trends) as well as from national issues/directives and from risks to achieving the Trust's objectives.
- Corporate and operations directorates risk management groups/teams are responsible for having systems in place to ensure the following processes occur.
- The Nursing Director will be responsible for ensuring the Board has systems in place to identify, assess and manage the strategic risks

3. ASSESSING RISK

All staff, managers and risk leads are required to ensure that risk assessment is documented on the attached proforma. It is important that those undertaking the assessment ensure that the outcome is shared with the designated Risk Management lead for the directorate concerned. The process and proforma to record the risk assessment includes:

- The Source of the risk/Trust objective
- Description of risk e.g. what can go wrong, how can it happen, what could be the effect
- Risk score – Likelihood, Consequence and overall score
- Controls already in place
- The residual risk rating with these controls in place
- Gaps in controls
- Action Plans to mitigate risk with target dates
- Sources of Assurance and
- Gaps in Assurance
- Date of review

a. Source of Risk/Trust Objective

As indicated above, the source of the risk may be from one or more of the following: local events (complaints, incidents, claims – specific or trends) or from national issues. This should be documented on the proforma. It also needs to be documented which Trust objective is at risk of not being met.

b. Description of Risk

As well as indicating the subject of the risk, it is necessary to indicate the nature of the risk (What could go wrong? How could it happen? What could be the effect?).

c. Control already in place

The next stage is to describe the controls already in place to minimise the risk, e.g. policies, procedures, training etc.

d. Risk Score

It is then necessary to score the risk at this stage i.e. the risk with the present controls in place.

The system developed by the National Patient Safety Agency for scoring incidents has been adopted by the Trust for all risk assessments.

The scoring is undertaken in two parts: likelihood and potential consequence.

Likelihood (How often is it likely to go wrong?)

You should use a combination of professional judgement and information on, say, claim and adverse incidents recorded over the past year to determine an average of how often the risk occurs. Your score should take account of existing controls (how they actually operate – not how they might have been planned to operate)

From this analysis you should identify the most appropriate score.

LIKELIHOOD RATING	DESCRIPTION
Certain	**Will occur, possibly frequently**
Likely	**Will probably occur, but it is not a persistent issue/concern**
Possible	**May occur occasionally**
Unlikely	**Do not expect it to happen**
Rare	**Can't believe such an event will happen**

Potential consequence

As shown below, there are potentially three ways in which this may be assessed:
1. Impact on the individual 2. Numbers of people affected 3. Impact on organisation

Also shown are examples of the types of consequence that might constitute "catastrophic", "major" etc.

It should be noted that the descriptions – which were specifically designed in respect of patient incidents – will not necessarily be directly applicable to the risk you are assessing. You may need to think in equivalent terms.

A risk should be scored by reference to the whole grid, with the final score being determined by the "worst" assessed impact.

DESCRIPTION	IMPACT ON INDIVIDUAL (e.g. patient, staff member etc) (actual or potential)	SCORE OF IMPACT IN TERMS OF VOLUME OF PEOPLE PER INCIDENT (actual or potential)	IMPACT ON ORGANISATION (actual or potential)
Catastrophic	**Unexpected death Suspected Homicide**	**>50 e.g. cervical screening concern, vaccination error**	**- International adverse publicity - Extended service closure - High litigation costs**
Major	**Permanent injury (physical or psychological)/ill health/damage/loss of function**	**>16-50**	**- National adverse publicity - Temporary service closure - Increased length of stay >15 days**
Moderate	**Semi-permanent damage to patient (emotional, psychological or physical) For patients, likely to resolve within one year. For staff, likely to result in > 3 days absence**	**>3-15**	**- Local adverse publicity - Increased length of stay >8-15 days - Staff sick leave**
Minor	**No permanent damage. Patient Injury (emotional or physical) will probably resolve in up to one month. Staff injury with no absence or likely to result in up to 3 days absence.**	**<1-2**	**- Increased length of stay <7 days**
No Harm	**No identifiable injury.**	**N/A**	**- Minimal impact, no service disruption**

Overall score

Both the likelihood and Potential Consequence Ratings are plotted on the following matrix to give an overall risk rating:

Likelihood	CONSEQUENCE				
	NO HARM 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
ALMOST CERTAIN 5	5	10	15	20	25
LIKELY 4	4	8	12	16	20
POSSIBLE 3	3	6	9	12	15
UNLIKELY 2	2	4	6	8	10
RARE 1	1	2	3	4	5

6 or less LOW **8-12 MEDIUM** **15-16 HIGH** **20 or above EXTREME**

e. Gaps in control

Any gaps in controls should then be identified. It may be that the present controls are not working as they should be or that further controls are required.

f. Mitigating actions

Plans should be then be drawn up to minimise the risk further e.g. extra training, staff awareness, new equipment, new policy and procedures etc. In some cases you may have established that controls originally designed to reduce the risk (e.g. policies/procedures) are not working appropriately, and your action plan will need to address this issue. It is expected that the prioritisation of action plans will be driven by the overall risk rating; for example it would be expected that action plans would be produced and implemented for all assessments in the "high" and "extreme" categories.

Action plans should include target dates, persons responsible and a date for review.

g. Residual risk

The residual risk score is then calculated using the process above. This is the expected risk that will remain once the further actions in the plan above are put in place.

These next two issues are only completed for the Extreme risks that will go onto the Trust corporate risk register:

h. Sources of assurance

This refers to the ways in which the Board of Directors is able to assure itself that the risks are being managed effectively and will include external and internal assurances. External assurances may be from agencies that undertake audits reviews and inspection visits and provide reports e.g. Internal and External auditors, Royal College Visits, Health Care Commission reports. Internal assurances may be via internal reports to the Board e.g. audits of policies, procedures and guidelines, performances monitoring data. These should be specific and identify where possible the frequency of when the Board is likely to receive the reports.

i. Gaps in assurance

This identifies where the Board is not receiving any assurance that the risk is being managed.

j. Dates of Assessment and Review

The dates of when the risk assessment was undertaken and when it is due for review are recoded.

Risk Acceptance

In some instances it may not be possible to put action in place to reduce the risk or the degree of action and effort is greater than likely outcome to make it not worth the effort. In these instances the Board may accept that there has to be some degree of risk.

4. RISK REPORTING AND COMMUNICATION

Copies of the risk assessment should be kept at ward/department level, with copies being sent to the designated Risk Management lead within the Directorate and being made available to other designated officers such as the Health and Safety manager on request. For all risks categorised as “High” and “Extreme” the Clinical Directorate Management Team or Director should be notified immediately to ensure that the agreed actions are suitable and/or to make a decision about acceptance of the risk if immediate action cannot be taken. All of these high and extreme risks must be reported to the Trust Risk Committee.

Appendix 5

THE DUDLEY GROUP HOSPITALS NHS FOUNDATION TRUST

Subject:

Directorate: **Department/specialty:**

Trust objective: **Source of Risk:**

Describe/identify the risk			Describe controls as they actually work	Risk assessment			Gaps in control
What could go wrong	How could it happen	What could be the effect		Cons	Like	Score	

Mitigating actions	Date	Lead	Residual risk			Sources of assurance	Gaps in Assurance
			Cons	Like	Score		

Date of Assessment: **Person undertaking risk assessment:** **Date for Review:**

Manager: **Director:**