The Newcastle upon Tyne Hospitals NHS Foundation Trust

Risk Management Strategy

Version No.:	3.4
Effective From:	02 March 2018
Expiry Date:	06 January 2019
Date Ratified:	19 February 2018
Ratified By:	Risk Management and Assurance Committee

1 Introduction

The Newcastle upon Tyne Hospitals NHS Foundation Trust recognises that effective risk management is essential to the overall performance of the organisation.

The strategic approach to risk management as reflected in this document is fundamental to the delivery of the Trust's organisational objectives in relation to performance, governance and controls assurance. Effective risk management systems and the development of a committed approach to learning will ensure that The Newcastle upon Tyne Hospitals NHS Foundation Trust continues to develop and improve its services.

2 Aims

The aims of the strategy are to ensure that:

- the organisation recognises risk management as a key element of integrated governance
- risk management systems and processes are embedded locally across clinical directorates and in corporate services including business planning, service development, financial planning, project and programme management and education
- all risks are identified that have a potential adverse effect on the quality of care, safety and well-being of patients, staff, volunteers and visitors, and on the business, performance and reputation of the Trust
- the organisation adopts a co-ordinated and multi-disciplinary approach in managing its risks through a systematic process of identification, analysis, learning, control and management of risk

3 Objectives

The principal objective of the Risk Management Strategy is to provide the Board of Directors with sufficient assurance that appropriate structures and processes are in place to minimise risks and loss of assets and reputation and that reporting processes for risk are maintained. The strategy will also seek to:

- ensure that the risk management processes are integral to the organisational working practices and culture
- encourage the reporting of incidents, whilst promoting a non-punitive culture ensuring that lessons are learned and preventative measures introduced

- ensure that, through the strengthening of risk management arrangements, there are continual improvements to patient safety
- minimise claims for accident or injury against the Trust
- support systems which eliminate, transfer or reduce risks to as acceptable a level as possible
- secure the highest possible standards of risk management in terms of external validation.

4 Duties and Responsibilities for Managing Risk

The Trust Corporate Structure is illustrated in **Appendix 1**.

4.1 Chief Executive

The **Chief Executive** has overall responsibility for risk management, on behalf of the Board of Directors of the Trust. In addition, the Chief Executive is responsible for ensuring that the Trust is in a position to provide an overall assurance that the organisation has in place the necessary controls to manage its risk exposure.

In order to make such a statement, the Chief Executive and Board of Directors will need to provide evidence that the Trust's Risk Management Strategy is being implemented with systems and processes being regularly reviewed and that, where deficiencies are identified, developments and improvement mechanisms are being put in place with the overall aim of continuous improvement.

4.2 Non-Executive Director

A **Non-Executive Director** with a delegated responsibility for Risk Management sits on the Board and chairs the Risk Management and Assurance Committee, overseeing on behalf of the Trust Board the organisation's progress with the Risk Management Strategy.

4.3 Executive Team

Specific responsibilities are delegated to members of the Executive Team as follows:

- The **Medical Director** has delegated responsibility for the implementation and further development of the Risk Management Strategy. The Medical Director shall be responsible for strong medical leadership, working closely with Clinical Directors to develop and maintain standards of clinical care. He/she shall be responsible for leading the development and promotion of clinical governance, research and development, medical education, GMC revalidation and acting as the Trust's Caldicott Guardian.

- The **Finance Director** has delegated responsibility for the management of risk in relation to finance issues and to support implementation and further development of the Risk Management Strategy.

4.4 The **Director of Quality and Effectiveness** will support the Directors of the Trust with implementation and development of the Risk Management Strategy. The Director of Quality and Effectiveness will be responsible for integration of Corporate Governance systems, with the aim of developing and improving reporting, analysis and learning on all aspects of clinical governance and risk including health and safety, complaints, litigation and claims. He/she will be required to work closely with the Trust Secretary and Head of Patient Safety and Risk to review the Board Assurance Framework.

4.5 Trust Secretary

The Trust Secretary is responsible for coordinating the regular review of the Board Assurance Framework to ensure any gaps in assurance or control are identified. The Trust Secretary ensures that corporate risks are identified and regularly updated.

4.6 Head of Patient Safety and Risk

The Head of Patient Safety and Risk will support the Director of Quality and Effectiveness in the overall co-ordination and integration of risk management systems including training and education programmes and database development. In addition the Head of Patient Safety and Risk is responsible for providing regular reports on risks to the Risk Management and Assurance Committee and Audit Committee and an Annual Report on compliance with this strategy. He/she will contribute to the regular review of the Board Assurance framework.

4.7 Internal Audit

The Internal Audit Department will undertake independent reviews of the systems of internal control, the effectiveness of the Trust's risk management processes, and compliance with the Trust's Risk Management Strategy using a risk based approach, reporting to the Audit Committee.

4.8 Clinical Directors and Directorate/Department Management Teams

Directorate/Department Management Teams will be responsible for ensuring that the Risk Management Strategy is implemented effectively across all services, which will include:

- dissemination of the Strategy details and allocation of responsibilities for implementation to service managers and staff
- undertaking the Directorate/Department self assessment risk management framework – Appendix 6.

- developing and facilitating the local clinical governance group to evaluate implementation of risk management systems and strategies and agree service changes as necessary
- identifying Directorate/Department specific risk management issues that might not have been addressed explicitly within the Risk Management Strategy
- Responsibility for identification, investigation and follow up of all risk issues. Where initial assessment indicates a high level of risk and /or where the level of risk warrants reporting to an external body, the issue will be reported to the Head of Patient Safety and Risk and if necessary to the Medical Director, in order to agree decisions about subsequent management of the risk.
- ensuring that risk management is incorporated into the Directorate/ Department decision-making, service planning, performance management, project management and other related processes
- establishing key risk indicators which are monitored, reviewed and reported on a regular basis
- ensuring that there are effective risk management processes in place in relation to the identification, assessment, evaluation, control, monitoring and review of risks and that the Directorate/Department has trained risk assessors to undertake regular risk assessment
- ensuring that all clinical and non clinical risks are reported on the Risk Register, with appropriate controls, action plans to reduce risks and regularly reviewed
- ensuring that risk management is included as a core agenda item at management team meetings
- introducing risk management responsibilities for managers as part of the performance and development appraisal process
- reporting via Patient Safety and Quality reviews on the Directorate risk management performance in addition to new and emerging risks, major changes of priority on existing risks and key actions
- submitting regular updates outlining achievement of their governance and risk objectives to the Medical Director via CGARD..

4.9 Directorate/Department Managers

In addition to contributing to the responsibilities as outlined above, Directorate/Department Managers will have responsibility for:

- identification of Risk Management training needs to ensure that staff and volunteers are able to work safely and comply with Trust procedures, including incident reporting and mandatory training requirements
- development and maintenance of local risk management policies and procedures
- investigation and learning from incidents, complaints and claims
- ensuring that there is promotion of risk awareness responsibilities amongst employees, service users, contractors and partners
- maintaining robust reporting systems within their service area to inform risk strategy

- ongoing monitoring and review of the Risk Register.

4.10 Responsibilities of all employees (including temporary staff)

It is the responsibility of all staff, including Directors and Non-Executive Directors to identify, assess and manage risk on an ongoing basis. The Trust aims to support staff with their responsibilities by creating a culture of openness and willingness to admit mistakes. The Trust is committed to learning from mistakes, incidents, complaints and claims by continually analysing situations and improving systems. As an employee of the Trust, everyone has responsibility for and a role to play in managing risk, which includes:

- managing risks within their job
- alerting managers to any risks within the service area that require urgent attention
- participation in any Risk Management related training.

The emphasis of the Risk Management Strategy is to develop an environment where the focus and culture is on reporting and learning from mistakes and near misses, therefore formal disciplinary action will not usually be taken as a result of a risk management incident investigation..

5 Definitions

Risk is the chance that something will happen that will have an impact on the Trust's aims and objectives. It is measured in terms of likelihood (probability or frequency of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

Risk management process is the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk (adapted from Australian/New Zealand 1999 Standard 4360).

6 Principles

The following principles underpin the strategy:

- that risk management will be embedded in the core processes and systems of the Trust, including guidelines and procedures, operational policies, the business planning cycle, business case development, performance management and corporate governance
- that these core systems will be reflected in the Directorate management arrangements
- risks will be actively managed and positive assurance sought
- the risk register will be a live, actively managed and reviewed document and not simply a passive repository of risks

- that risk management is the responsibility of all staff within their own sphere of work, so that the person best placed to manage each identified risk is the one that does so
- that high-risk areas and activities will attract greatest focus and attention
- that there will be learning from analysis of incidents, complaints and claims and explicit roll-out of identified improvements
- the strategy will actively promote and underpin the acquisition of relevant accreditations, including the registration requirements of the Care Quality Commission (CQC).

7 Organisational Framework

It is recognised that effective risk management requires commitment and active involvement of all employees and it is therefore vital that the risk management process is communicated and embedded throughout the organisation. There is also a need for robust mechanisms to monitor risk management performance at every level of the organisation. The audit and scrutiny functions will play an important role in testing the effectiveness and embedding of risk management throughout the Trust.

7.1 Assurance Framework

The Assurance Framework provides the Board with assurance that the risks to the organisation are being managed appropriately throughout the organisation.

The Assurance Framework has two key purposes:

i) It is a high level management assessment process and record of the primary risks relating to the delivery of key objectives and the strength of internal control to prevent these risks occurring;
ii) It identifies sources of assurance and evaluates them for suitability. The Assurance Framework then provides the Audit Committee and Risk Management and Assurance Committee with the context in which they receive and review actual assurances (i.e. published reports from internal or external sources) and, in the case of the Audit Committee, use the findings to confirm or modify management's opinion of the adequacy of internal control.

The Assurance Framework is under regular review by the Risk Management and Assurance Committee, the Audit Committee and the Trust Board.

There should be a clear relationship between the Assurance Framework and the Trust's Risk Register. For example, if a report is received by the Trust that heightens the risk of not achieving a particular corporate objective then that should be featured within the Assurance Framework and also identified as a significant risk within the Risk Register. Similarly if a major risk featured in the Risk Register has the potential to impact on the achievement of corporate objectives then, as such, this should be recorded in the Assurance Framework.

All Corporate risks, actual and potential, are reviewed and updated bi-monthly by the Executive team prior to the Risk Management Assurance Committee. Risks rated 20 and above and corporate risks are then reviewed by Risk Management and Assurance Committee and a decision taken as to whether they should be included in the Assurance Framework.

In addition, the Board Assurance Framework is sent for twice yearly review by the key risk owners to ensure the content is up to date. Clear plans of action must be put in place by the risk owners to reduce extreme risks and the progress of the actions will be overseen by the Risk Management and Assurance Committee and the Audit Committee.

7.2 Annual Governance Statement

The Chief Executive is responsible for "signing off" the Annual Governance Statement, which forms part of the Statutory Annual Report and Accounts.

To provide this Statement, the Board needs to demonstrate that its members have been properly informed through assurances about the totality of risks, not just financial, and have arrived at their conclusions based on all the evidence presented to them. The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with senior managers of the Trust and approved by the Audit Committee, which should provide a reasonable level of assurance. The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. As such, it is one source of assurance that the Board takes into account in making its Annual Governance Statement.

7.3 Key forums for the management of risk

Overall decisions on prioritisation of risk issues and resource allocation will be made by the Risk Management and Assurance Committee and where necessary referred to the Trust Board.

The Trust Framework including Standing Committees and Standing Panels is illustrated in Appendix 1. Within the organisation the key forums with responsibility for the management of risk are as follows.

The **Risk Management and Assurance Committee** is a Standing Committee of the Board of Directors with delegated responsibility on behalf of the Board for the management and monitoring of all risk management arrangements. This Committee provides the forum that develops and advises the Trust on strategy, policy, priorities and implementation of corporate governance and risk

management. The terms of reference for this group which contributes to the Assurance Framework are provided as Appendix 2.

The **Audit Committee** is a Standing Committee of the Board of Directors. Its purpose is to provide the Board with an independent and objective review of financial and organisational controls and risk management systems and practice; assurance of value for money; compliance with law; compliance with all applicable published guidance, regulation, codes of conduct and good practice; and to advise the Board of Directors with regard to the position of the Trust as a "going concern". The terms of reference for this group which contributes to the Assurance Framework are provided as Appendix 3.

The **Clinical Governance and Quality Committee** monitors key risks to clinical quality. As a Standing Committee of the Trust its purpose is to ensure that there are proper processes in place for continuously monitoring and improving clinical quality by building upon existing control systems and standards. The terms of reference for this group which contributes to the Assurance Framework are provided as Appendix 4.

7.4 Directorate/Department Risk Groups or Governance Committees

All Directorates have local clinical governance committees or risk groups where risk management systems and strategies are evaluated and service changes agreed as necessary. The Directorate/department groups also act as forums for disseminating the learning from the Clinical Risk Group.

Required Frequency of Attendance at Committee Meetings

It is highly important that members attend Committee meetings on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances. Where appropriate a delegated deputy should attend the meeting in the absence of a Committee Representative.

7.5 Risk management systems and processes

The risk management process has five key stages:

- Identification and management of risk
- Risk evaluation
- Risk control
- Risk reporting
- Monitoring, review and audit.

The Trust is committed to ensuring that the risk management processes become embedded in the management of both threats and opportunities, in terms of strategic and operational issues in the functioning of the organisation. In order to underpin an integrated approach to risk management activities across the organisation, the Trust will maintain and continue to develop the single Trust-wide risk management system for:

- Accident/incident reporting

- Risk register entry, review and collation of reports
- Complaints management
- Litigation and claims management.

These systems are electronically linked and networked across the Trust, via an integrated software system. This enables ready transfer of information across all sources and facilitates local and organisational learning from adverse events and risk assessment processes in addition to supporting an integrated approach to risk analysis.

7.6 Trust Board Risk Appetite

Risk Appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take in pursuit of value. Or, put simply, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.

The Trust sets its strategic objectives annually and these are reflected within the Trust Operational Plan and Assurance Framework (AF).

The regular monitoring of the AF by the Risk Management & Assurance Committee and the Board is the key process for managing and assessing the strategic and operational risks during the year.

The amount of risk the Trust is willing to accept in making decisions is defined in the Trust Board risk appetite statements. All staff should be aware of the Statements when making decisions relating to Trust business.

The Trust Board has defined its risk appetite as:

Key Elements	Risk Level	Appetite	Statement
Quality/ Outcomes	1 (Minimal)	Low	The quality of our services, measured by clinical outcomes, patient safety and patient experience is paramount. We will provide high quality and safe services to our patients and will rarely accept risks that could limit our ability to fulfil this objective. We are strongly averse to risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.
Financial/ VFM	2 (Cautious)	Moderate	We will strive to deliver our services within the budgets modelled in our financial plans and will only consider exceeding these constraints if a financial response is required to mitigate risks associated with patient safety or quality of care. All such financial responses will be undertaken ensuring optimal value for money in the utilisation of public funds.
Compliance / regulatory	2 (Cautious)	Moderate	The Trust sees regulatory compliance as important in optimising quality and financial sustainability. The Trust

Key Elements	Risk Level	Appetite	Statement
			Board is willing to take a cautious approach to risks in this area.
Innovation	4 (Seek)	Significant	We will continue to encourage a culture of innovation within the Trust. We are willing to accept risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach.
Commercial	2 (Cautious)	Moderate	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trusts core purpose – to deliver health services to those in need.
Reputation	1 (Minimal)	Low	We will maintain high standards of conduct, ethics and professionalism. The Board's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of significant repercussion for the organisation.

Key:

- **Low** = Minimal the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.

- **Moderate** = Cautious the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

- **High** = Open and being willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM).

- **Significant** = Seek and to be eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Or also described as Mature being confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

8 Training

Basic risk assessment and principles are included in the Trust induction. A range of risk related training is included in the mandatory training requirements and this will be provided to all nominated individuals with responsibilities for risk assessment and/or risk management. See Appendix 5 Performance Indicators- Education and Learning Systems.

9 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

10 Monitoring

The Trust Annual Report will contain a formal statement of risk management activity during the previous year and will highlight key issues arising.

Standard / process / issue	**Monitoring and audit**			
	Method	**By**	**Committee**	**Frequency**
Implementation of strategy and achievement of performance indicators	Annual risk management report	Head of Patient Safety & Risk	Risk Management and Assurance Committee	Annually
Monitoring of Board and sub-committees	Inclusion of monitoring matrix in Annual report Review of the scope of the sub committees	CGARD Trust Secretary	Risk Management and Assurance Committee Trust Board	Annually Annually
Board Assurance Framework is an up to date record of any gaps in assurance or control	Updated BAF	Trust Secretary	Risk Management & Assurance Committee	Bi-monthly
			Audit Committee	Quarterly
			Board	Twice a year
			Clinical Governance and Quality Committee	Three times a year
Directorate risk management self-assessments	Inclusion in risk management report	Head of Patient Safety and Risk	Risk Management and Assurance Committee	Annually

Effectiveness of risk management and controls assurance	Internal audit programme of assurance and standards	Internal Audit Manager	Audit Committee	Quarterly
Monitoring of extreme risks to ensure appropriate action is taken	Regular report on Risks >20 & Corporate Risks	Integrated Governance Manager	Audit Committee Risk Management and Assurance Committee	Quarterly Bi-Monthly
Directorates are effectively managing high risks	Rolling programme of Directorate reports of risk >14. Risks included in Performance reviews	Integrated Governance Manager Performanc e Manager	Risk Management and Assurance Committee	Bi-monthly /Quarterly

11 Implementation

The Risk Management Strategy will be disseminated and made available:

Internally – Directorate and Department managers will be expected to communicate the Strategy to all relevant staff and it should be integral to local induction procedures.

Externally – To Monitor, Commissioners, CQC, Internal and External Auditors, Partner Organisations, and published on the Trust Intranet.

Implementation of the Strategy will be as outlined in the Performance Indicators detailed in Appendix 5.

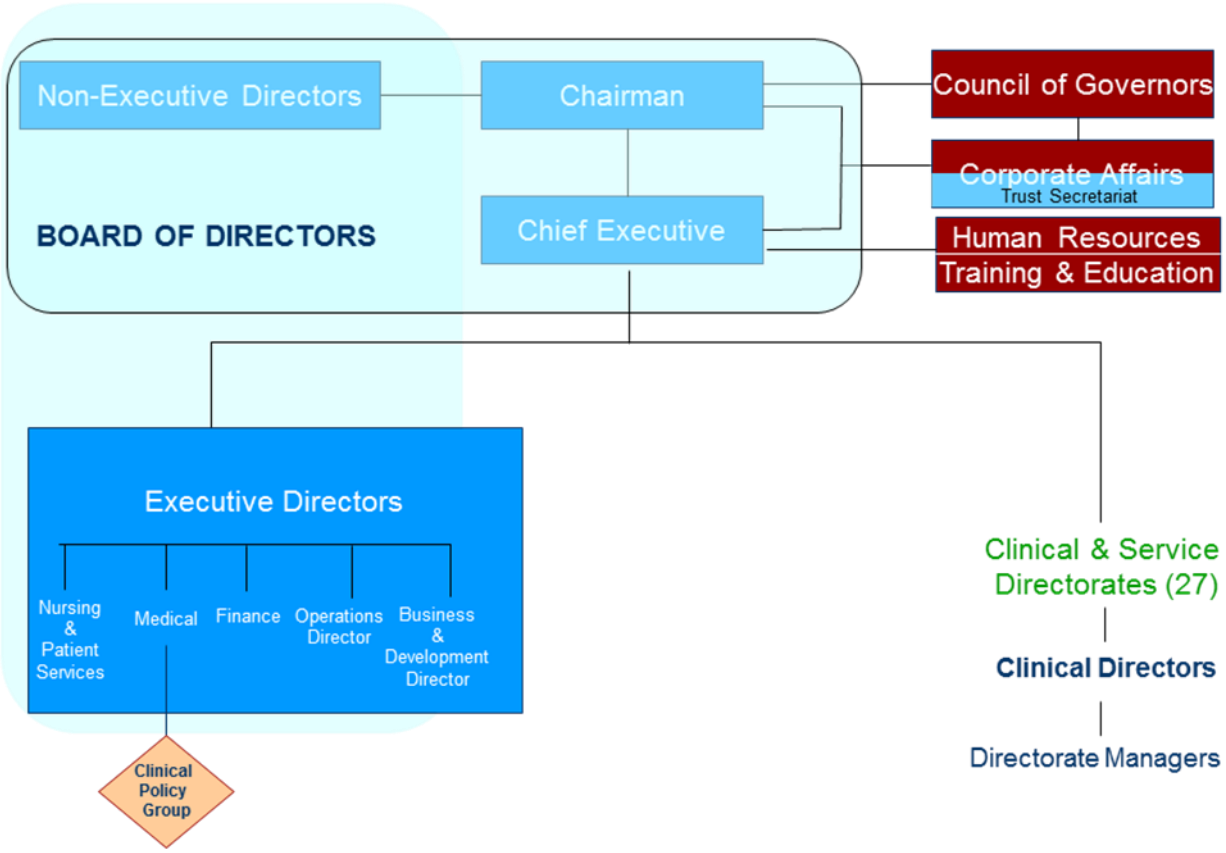
12 Associated Policies and Procedures

- Being Open Policy
- Business Continuity Policy
- Claims Management Policy
- Concerns and Complaints Policy
- Disciplinary Policy/Procedure
- Dress and Appearance Policy
- Hand Hygiene Policy
- Health and Safety Operational Policy
- Induction Policy
- Major Incident Plan
- Management and Prevention of Patient Slips, Trips and Falls Policy
- Management and Reporting of Accidents and Incidents Policy
- Mandatory Training Policy
- Maternity Clinical Risk Management Strategy
- Procedure for the Prescribing Recording and Administering of Medicines

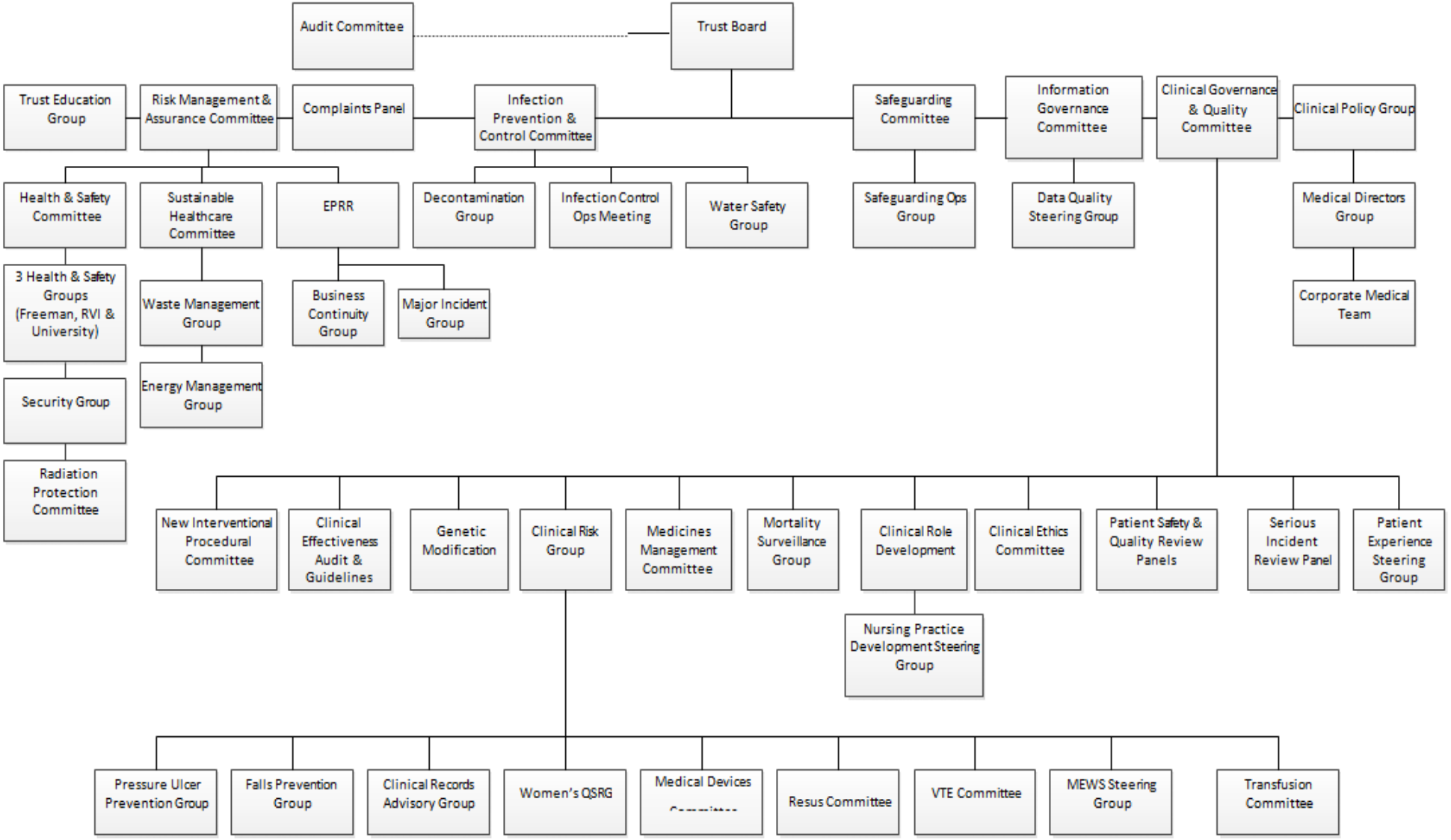
- Reporting and Management of Serious Incident Policy
- Risk Register-Policy for Management and Use
- Training in the Safe Use of Medical Devices policy

Appendix 1

Foundation Trust Corporate Structure



Corporate Quality Governance Structure (September 2017)



Appendix 2

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

RISK MANAGEMENT AND ASSURANCE COMMITTEE

CONSTITUTION AND TERMS OF REFERENCE

Membership:
Non-Executive Director (Chair)
Finance Director
Medical Director
Nursing and Patient Services Director
Business and Development Director
Director of Human Resources
Director of Estates
Trust Secretary
Director of Quality and Effectiveness
Chief Information Officer
Head of Patient Safety and Risk

Members should appoint a designated deputy to attend in their place if they are unavailable to attend a meeting.

Each Committee member will be entitled to a vote.

Quorum A Non-Executive Director plus three other standing members, of which at least one shall be an Executive Director. It is expected that members of the Committee attend at least four meetings per year.

When considering if the meeting is quorate, only those individuals who are members can be counted, deputies and attendees cannot be considered as contributing to the quorum.

Frequency At least quarterly, with other meetings convened as necessary.

By Invitation: Individuals or groups as and when required to enable informed decision making.

Accountable to: As a Standing Committee of the Trust, the Risk Management and Assurance Committee will be accountable directly to the Board of Directors.

The minutes of all the Risk Management and Assurance Committee meetings shall be formally recorded and submitted to the Trust Board for noting and comment.

Liaison with: Audit Committee
Safeguarding Committee
Clinical Governance and Quality Committee

Overall Purpose: To provide the forum that develops and advises the Trust on strategy, policy, priorities and implementation of risk management. In particular, the Risk Management and Assurance Committee will co-ordinate and facilitate risk management activity across the Trust, including reviewing and reporting on the overall Trust risk profile, ensuring effective assurance mechanisms are in place and performance management of the Risk Management structure. Key to these roles will be securing best use of the available resources, maximising the benefit of capability and capacity in an integrated and coherent manner.

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference.

CHAIRMANSHIP

The Committee will be chaired by the designated Trust Non-Executive Director.

RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the Committee have a responsibility to:

a) attend at least 75% of meetings, having read all papers beforehand;
b) disseminating information as appropriate;
c) identify agenda items, for consideration by the Chairman at least 12 days before the meeting;
d) prepare and submit papers for a meeting, at least 7 days before the meeting;
e) if unable to attend, send their apologies to the Trust Secretary prior to the meeting; and
f) when matters are discussed in confidence at the meeting, to maintain such confidences.

DECLARATIONS OF INTEREST

The Chairman will ask at the beginning of each meeting whether any member has an interest about any item on the meeting agenda. If a member has a direct or indirect conflict with an issue on the agenda which may impact on his or her ability to be objective, it should be declared at the meeting and recorded in the minutes. On the basis of the interest declared, the Committee will make a decision as to whether it is appropriate or not for this member to remain involved in considering the agenda item in question.

TERMS OF REFERENCE

1. To undertake and maintain an ongoing assessment of risk management that is sensitive to both local and nationally determined priorities, strengths and requirements.

2. To consider and determine the relative priorities for respective risk management programmes and projects, ensuring transparency in the determination of organisational and development priorities.

3. To monitor the progress of existing risk management programmes/projects and to secure evaluation of the benefit of programmes/projects on completion.

4. To ensure that the Trust-wide risk register is maintained, updated and regularly reviewed, in order to provide the Board of Directors with early identification of key risks, along with appropriate mitigation measures.

5. To receive the Board Assurance Framework (the 'Framework') at each meeting and to ensure that the Framework is updated with any significant risks identified from the risk register or other Committee reports, along with any gaps in control and gaps in assurance.

6. To provide assurance to the Trust Board of Directors that the Trust has a robust Risk Management Strategy in place which is reviewed and approved regularly by the Committee.

7. To provide an assurance to the Board of Directors that risks of all types are identified, and controlled to an acceptable level, and to undertake a detailed consideration of significant risks (those with a residual score of 20 or above).

8. To foster and improve upon the quality of risk management across the Trust through raising awareness and understanding of risk management at all levels and among all professions in the Trust.

9. To undertake and maintain an ongoing assessment of the risk management framework and its effectiveness, in support of the Risk Management and Assurance Committee remit and ensuring that the framework meets local and nationally determined priorities and requirements.

10. To ensure that the Clinical Governance and Risk Department (CGARD) and associated functions provides an efficient and effective infrastructure to support and manage risk management in the Trust in the context of local and national guidance and need.

11. To receive a report on Business Continuity and Emergency Preparedness at each meeting. In addition, twice a year, to receive an update on the risks associated with Business Continuity and Emergency Preparedness, and Health and Safety, which may impact on the achievement of the Trusts strategy.

12. To receive regular reports on Health and Safety and any other Non-Clinical, Non HR Serious Incidents and to identify any trends within Departments, Directorates, or functions. Note that Clinical Incidents are monitored separately outwith this Committee.

13. To receive a twice yearly analysis of Trust-wide litigation claims, including HR, finance and Health & Safety.

14. To secure an efficient and effective system for the timely and appropriate distribution of Central Alert System (CAS) notifications and to receive six monthly reports on emerging risks and endorse, where applicable, proposed actions.

15. To review risk management-related policies (whether existing or new) and make recommendations for their adoption, ensuring that mechanisms are in place for effective communication of such policies across the Trust.

16. To secure the production of required risk management reports and the coordination of the production of Non-clinical, Non HR risk-related policies.

17. To ensure that there is an effective mechanism for reporting, managing and escalating significant risks to the Board or senior management.

18. To provide the Board of Directors with assurance that risk management training reflects the needs of all professions and that the content and delivery of such training is effective.

19. To ensure that there are effective mechanisms for reporting risks to the appropriate bodies both internally and externally.

20. To provide an assurance to the Audit Committee that the risk management structure contributes to an effective system of internal control.

21. To monitor the application of policies relating to CQC assessments and reviews, to ensure action plans are devised as appropriate to address any identified deficiencies and to monitor the implementation and effectiveness of those action plans through to completion.

22. To assist the Trust Board in defining acceptable risk in terms of the Trust Boards risk appetite within the Trust.

23. To review the Constitution and Terms of Reference at least annually, and produce a report to the Board setting out the work of the Committee, key risks and actions taken, combined a with a self-assessment of the Committees effectiveness.

24. To receive the minutes of the Health and Safety Committee and the Emergency Preparedness, Resilience and Response Strategy Group.

25. To receive a verbal report on Estates Risks and Governance at each meeting and to receive the minutes of the Estates Risk and Governance Group meetings.

ADMINISTRATION AND SECRETARIAL SUPPORT

The Trust Secretary will provide support to the Committee which will include taking and circulating minutes, organising meetings (dates; rooms), circulating papers, monitoring the effectiveness of the Committee, supporting agenda setting and developing a work programme.

Reviewed: December 2017 (RMAC) and January 2018 (Board)
Date Agreed: 25 January 2018
Date of next review: December 2018

Appendix 3

THE NEWCASTLE UPON TYNE HOSPITAL NHS FOUNDATION TRUST

AUDIT COMMITTEE

CONSTITUTION AND TERMS OF REFERENCE (REVISED OCTOBER 2011)

Members: 4 Non-Executive Directors (excluding Trust Chairman)

One of the members will be appointed Chair of the Committee.

In Attendance:
Chief Executive
Finance Director
Medical Director
Business and Development Director
Nursing and Patient Services Director
External Auditor
Internal Auditor
Trust Secretary
Director of Quality and Effectiveness
Associate Finance Director
HR Director
Estates Director
Fraud Specialist
Other officers by invitation

Designated deputies should attend in the place of regular attendees if they are unavailable to attend a meeting.

Quorum: 2 Non-Executive Directors

When considering if the meeting is quorate, only those individuals who are members can be counted, deputies and attendees cannot be considered as contributing to the quorum.

Frequency: Minimum of 4 scheduled meetings per financial year (further meetings may be convened as and when required), plus an extraordinary meeting for the review and approval of the statutory Annual Report and Accounts

Purpose

The Audit Committee is a Standing Committee of the Board of Directors. Its purpose is to provide the Board with an independent and objective review of financial and organisational controls and risk management systems and practice; assurance of value for money; compliance with law; compliance with all applicable published guidance, regulation, codes of conduct and good practice; and to advise the Board of Directors with regard to the position of the Trust as a "going concern". The Audit Committee does not in any way override or diminish the responsibilities of the Board of Directors with regard to the financial and organisational management of the Trust. The Committee is a Non-

Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. It provides a forum for direct contact between the Trust and its auditors.

The minutes of all the Audit Committee meetings shall be formally recorded and submitted to the Trust Board for noting and comment.

Chairmanship

The Committee will be chaired by the designated Trust Non-Executive Director.

Responsibility of Members and Attendees

Members of the Committee have a responsibility to:

a) attend at least 75% of meetings, having read all papers beforehand;
b) disseminating information as appropriate;
c) identify agenda items, for consideration by the Chairman at least 12 days before the meeting;
d) prepare and submit papers for a meeting, at least 7 days before the meeting;
e) if unable to attend, send their apologies to the Trust Secretary prior to the meeting; and
f) when matters are discussed in confidence at the meeting, to maintain such confidences.

Declarations of interest

The Chairman will ask at the beginning of each meeting whether any member has an interest about any item on the meeting agenda. If a member has a direct or indirect conflict with an issue on the agenda which may impact on his or her ability to be objective, it should be declared at the meeting and recorded in the minutes. On the basis of the interest declared, the Committee will make a decision as to whether it is appropriate or not for this member to remain involved in considering the agenda item in question.

Terms of Reference

1. Financial Reporting

To review the annual financial statements prior to submission to the Board of Directors and Council of Governors, focusing in particular on:

i) the wording in the Annual Governance Statement;
ii) changes in and compliance with accounting policies, practices and estimation techniques;
iii) major judgmental areas;
iv) unadjusted mis-statements in the financial statements;
v) letters of representation; and
vi) significant adjustments resulting from the annual audit.

The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference.

2. Governance, Internal Control and Risk Management

2.1 To liaise with the Risk Management and Assurance Committee and Clinical Governance and Quality Committee to ensure that issues of common concern are addressed appropriately and where necessary reported to the Board. The Audit Committee's role is not to manage risk, but rather to ensure that the overall system is in place and effective, leaving the oversight of operational management of risk to the Risk Management and Assurance Committee.

2.2 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. This shall include the determination of the need for any new sub-committees of the Board and how they shall report to the Audit Committee.

2.3 The Audit Committee has a responsibility to ensure that the corporate, clinical governance and information governance processes and outcomes can be used to provide assurance on the overall processes of risk management, governance and internal control. The Committee should therefore ensure that clinical and information objectives and risks are firmly included in the Assurance Framework and that there is an adequate process in place to give assurance on the management and control of these risks. The Committee should satisfy itself that the same level of scrutiny and independent audit is given to clinical risks as to strategic, financial or operational risks. To these ends, the minutes of the Risk Management and Assurance, Information Governance and Clinical Governance and Quality Committees shall be received routinely.

2.4 In particular, the Audit Committee will review the adequacy of:

i) all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with Care Quality Commission and Monitor licence conditions), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
ii) the structures, processes and responsibilities for identifying and managing key risks facing the Trust.
iii) the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out by NHS Improvement, Care Quality Commission, Department of Health and any other bodies which issue applicable directions or standards.
iv) the operational effectiveness of policies and procedures.
v) the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.
vi) the processes, structures and procedures to deliver value for money
vii) the standing of the Trust in terms of sustaining it as a "going concern".

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

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

3. Internal Audit

3.1 To recommend the provider of the internal audit functions to the Board of Directors.

1.2 To monitor and review the effectiveness of the internal audit function in the context of the Trust's overall risk management system.

3.3 To review and approve the Internal Audit strategy and Operational Plan, both of which are based upon risk assessments, and ensure that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.

3.4 To receive regular reports from the internal auditor on completed audit reports and the response by the respective accountable manager.

3.5 To review the annual report of the internal auditor and prior to consideration by the Board of Directors.

3.6 To approve and regularly review the Terms of Reference for the internal audit.

3.7 To advise the Board of Directors if it is considered that the level of audit resources will prejudice the ability of the internal auditor to deliver a service consistent with the definition of Internal Audit.

3.8 To approve performance measures and criteria for the internal audit function, which shall be set out in a Service Level Agreement.

3.9 To receive the results of any external quality reviews of the internal audit function.

3.10 To advise the Accountable Officer of the adequacy of management responses to internal audit advice and to make recommendations where required and appropriate.

3.11 To advise the Accountable Officer of the arrangements made for co-operation between internal audit, external audit and other review bodies.

4. *External Audit*

4.1 To provide advice as required to the Council of Governors with regard to the process for the selection and appointment of the external auditor.

4.2 To advise the Council of Governors on the appropriateness of proposed fees for audit or non-audit services and on the adequacy of those fees in securing an appropriately detailed audit.

4.3 To discuss the External Audit Plan with the external auditor prior to commencement of the external audit and in particular the extent of any reliance placed upon internal audit.

4.4 To receive and review reports of the studies and work of the external auditor.

4.5 To discuss any problems or reservations arising from the external auditor's work and any matters which the external auditor may wish to discuss. Without exception, there shall be an opportunity at the completion of the Agenda for the Non-Executive Directors to meet with either or both of internal and external audit, collectively or separately.

4.6 To review the detail arising from the "International Standard on Auditing (ISA) 260 Report" addressed to those charged with governance.

5. *Other Assurance Functions*

5.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

5.2 These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

5.3 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance and Quality Committee, Risk Management and Assurance Committee and any other appropriate committees that are established.

5.4 In reviewing the work of the Clinical Governance and Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

6. *Other Matters*

6.1 To consider the content of any report involving the Trust issued by the Public Accounts Committee or the Comptroller and Auditor General and to review management proposed response, prior to submission to the Board of Directors.

6.2 To review and recommend to the Board of Directors where called for proposed changes to the Corporate Governance Manual; Standing Orders; Standing Financial Instructions; Scheme of Delegation and Reservation of Powers; Standards of Business Conduct for Staff; and the Fraud Response Plan.

6.3 To review periodically the Register of Directors' Interests; and Register of Gifts and Hospitality.

6.4 To review consultation and guidance documents issued by Monitor and pertaining to the business and financial affairs of the Trust and respond as required and appropriate.

6.5 To monitor the Assurance Framework and Corporate Risk Register and ensure they are both refreshed periodically and any high risk issues are reported to the Board of Directors.

6.6 To examine the circumstances associated with each and every occasion when Standing Orders are waived and vouch to the Board that the waiving was appropriate and necessary in each circumstance.

6.7 To review income recovery performance, year on year.

6.8 To review schedules of losses and compensation and make recommendations to the Board of Directors where called for.

6.9 To monitor the implementation of policy on standards of business conduct for Directors and staff (i.e. Codes of Conduct and Accountability) in order to offer assurance to the Board of Directors of probity in the conduct of the Trust's business.

6.10 To ensure that all members of the Committee receive appropriate and timely training, concomitant with their individual needs, both upon induction and on a continuing basis.

6.11 To conduct an annual self-assessment of the work of the Committee and compliance with the Terms of Reference and to present an annual report to the Board of Directors.

6.12 To satisfy itself that the Trust has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and to review the outcomes of work in these areas.

Access

The Committee will have the opportunity to meet privately with the internal and external auditors at the end of each meeting.

The Head of Internal Audit, representative of external audit and counter fraud specialist have direct right of access to the Chair of the Committee.

Administration and Secretarial Support

The PA to the Finance Director and the Trust Secretary will provide support to the Committee which will include taking and circulating minutes, organising meetings (dates; rooms), circulating papers, monitoring the effectiveness of the Committee, supporting agenda setting and developing a work programme.

Reviewed: November 2016
Date Agreed: February 2017
Date of next review: January 2018

Appendix 4

CLINICAL GOVERNANCE AND QUALITY COMMITTEE

CONSTITUTION AND TERMS OF REFERENCE
(REVISED January 2016)

Members: Non-Executive Director - Chairman
Medical Director/Chair – Clinical Policy Group
Assistant Medical Director
Clinical Directors x 3 – Patient Safety & Quality
Nursing and Patient Services Director
Director of Infection Prevention and Control
Chair - CEAG Committee
Chair - Clinical Ethics Advisory Group
Chair - Medicines Management Committee
Chair - Clinical Role Development Group
Chair - Genetic Modification Safety Committee
Chair – Sign up to Safety Steering Groups
Lead Consultant - University of Newcastle upon Tyne
Lead Consultant - NCEPOD
Director of Quality and Effectiveness
Director of Pharmacy & Medicines Management
Chair – Clinical Risk Group
Business Development – Performance Management representative
Head of Nursing
Matron

By Invitation: Members of the Council of Governors

Co-option: Power to co-opt as and when required

Quorum: A minimum one third of total membership including an Executive Director or nominated deputy.

Frequency: Bi-monthly (with other meetings convened as and when required)

Policy Statement

Clinical Governance is an integral part of the ethos, standard setting, and strategic direction of the Trust. It mirrors the already established principles of Corporate Governance and all that entails by providing the framework for ensuring patient safety and quality of care across the Trust

Overall Purpose

As a Standing Committee of the Board of Directors, to ensure that there are in place proper processes for continuously monitoring and improving clinical quality and patient safety by building upon existing control systems and self regulation standards.

Terms of Reference

1 To ensure that clinical quality and patient safety improvement processes are developed and integrated with the quality programme for organisation as a whole.

2. To ensure that evidence based practice is supported and applied routinely in everyday practice.

4 To ensure that good practice, ideas and innovations (which are evidence based) are systematically disseminated within and outside the organisation.

5 To ensure that clinical risk reduction programmes of a high standard are in place.

6 To ensure that effective procedures are in place to ensure that adverse incidents and events are detected, openly investigated, and any lessons learned promptly applied and appropriately disseminated in the best interests of the organisation.

7 To ensures that problems of poor clinical performance are systematically recognised at an early stage and reporting pathways followed to enable issues to be dealt with accordingly.

8 In conjunction with the Corporate Governance Committee and Audit Committee, to monitor the application of identified policies relating to CQC Fundamental Standards, assessments and reviews, to devise action plans as appropriate to address any identified deficiencies and to monitor the implementation and effectiveness of those action plans through to completion.

9 To encourage and support all of the professionals involved in developing Clinical Governance.

10 To receive an annual report from the Patient Safety and Quality Review Panel summarising the outcomes from the Directorate Quality Review process

11 To ensure that all new procedures are considered by an appropriately constituted Committee prior to being offered and undertaken as routine clinical treatment.

12 To monitor the strategic direction and implementation of the Sign up to Safety Campaign, to receive reports on the implementation of the Sign up to Safety priorities and any associated risks.

Organisational Relationships

The Chief Executive has the ultimate responsibility for assuring the quality of services provided by the Trust.

The Medical Director is responsible for ensuring that systems and practice are in place within the Trust for promoting and securing clinical quality and patient safety and for monitoring continued effectiveness.

External Relationships

CCG Alliance Quality Review Group
NHS England Area Team
Newcastle City Council re:Public Health matters

Reporting Mechanisms

The Clinical Governance and Quality Committee will report bi-monthly to the Trust Board.

The Clinical Governance and Quality Committee will receive minutes and an annual report and twice yearly from the following groups:

Clinical Effectiveness, Audit and Guidelines Committee
Clinical Risk Group
Medicines Management Committee
Clinical Ethics Advisory Group
Clinical Role Development Group
New Interventional Procedures Committee
Serious Incident Panel

In addition matters arising from the Groups will be reported by exception at each Committee.

Revised January 2016

Appendix 5

PERFORMANCE INDICATORS

Objective(s) and action	Responsibility	Timetable
Dissemination of the Strategy across the organisation		
Publish the Risk Management Strategy both internally and externally as outlined above.	Director of Quality and Effectiveness	Annual review
Ensure that all managers are aware of the Risk Management Strategy and that relevant staff recognise their specific risk management responsibilities as appropriate to their role.	Director of Quality and Effectiveness Directorate and Departmental management teams	Annual review
Implementation of the strategy across the organisation		
Ensure that all Board members, Senior Managers, Directorate Managers and Clinical Directors receive training in risk identification, analysis, control, monitoring and review including the management of project risks, and risk management in business development and service delivery.	Risk Management and Assurance Committee supported by Director of Quality and Effectiveness	Risk Management Annual Report
Ensure that all relevant Managers receive training on utilising key risk management information systems for the management of incidents, complaints, claims, risks and use aggregated risk information in decision making and business planning.	Director of Quality and Effectiveness	Risk Management Annual Report
To ensure that all staff groups receive Mandatory training/ Risk Management training.	Head of Training and Development	As indicated in Induction/Mandatory Training Policy
Directorate Risk Management Support		
• Refinement of Directorate Risk Register • Review of the Directorate self assessment risk reviews • Implementation of a standardised approach to risk assessment for all identified key risks • Refinement of action plans to address key risks .	Directorate Management Team, supported by Integrated Governance Manager and Head of Patient Safety and Risk	Annual Report to Risk Management and Assurance Committee Directorate level high risks >15 reported to RMAC

Objective(s) and action	Responsibility	Timetable
• Ongoing development of web-based DATIX risk management system.	Integrated Governance Manager and Head of Patient Safety and Risk	Ongoing review
• Completion of a Trust-wide programme to assess risks to service continuity and development of effective contingency/business continuity plans where required.	Medical Director/ Director of Quality and Effectiveness	Review by the Emergency Preparedness, Resilience and Response group (EPRR)
Education and Learning Systems		
• Training needs analysis for Risk Management training.	Head of Training and Development and Director of Quality & Effectiveness	Annual review at Training and Education Group
• Development of Risk Management training for all Board Members	Head of Training and Development	Ongoing
• Training of relevant personnel in Root Cause Analysis / incident investigation training to ensure a systematic approach to investigation and analysis of incidents.	Head of Patient Safety and Risk	As required for nominated individuals
• Delivery of training in risk assessment and effective use of the Trust Risk Register.	Integrated Governance Manager	As required for nominated individuals
Governance		
• Implementation and monitoring of performance indicators for Risk Management Strategy.	Risk Management and Assurance Committee and Trust Education Group	• Quarterly
• Provision of regular reports on extreme risks to the Risk Management and Assurance Committee and Audit Committee to inform decisions about priorities for action and resource allocation.	Integrated Governance Manager	• Individual Directorate/Departments as required and summary reports quarterly
• Provision of monthly reports to the Trust Board on incidents, claims and complaints via the Quality and Performance Account Reports.	Director of Quality and Effectiveness	• Monthly
External Assessments		
• Maintain Care Quality Commission Standards	Director of Quality and Effectiveness & Trust Secretary	Gaps in Assurance or control reported to Board via Assurance Framework
• Maintain Care Quality Commission registration standards for Healthcare Associated Infection.	Director of Infection Prevention and Control	Monthly report to Infection Prevention and Control Committee
Incidents, Claims and Complaints		
• Further development of an integrated	Director of Quality and	Quarterly integrated

Objective(s) and action	Responsibility	Timetable
approach to learning and improvement from serious incidents, claims and complaints, identified through aggregated data reports.	Effectiveness	governance report to Clinical Risk Group
• Implement 'Slips, trips and falls in hospital, NPSA (2007)' recommendations.	Patient Services and Nursing Director	Quarterly report to the Clinical Risk Group

Appendix 6

Framework for Risk Management

Self assessment tool for Directorates/Departments

Key element	Required action	Compliant? (please copy and paste symbols below into each line) ☑ ☒ N/A
Leadership	The Directorate/Department has a local clinical governance or risk management group which evaluates implementation of risk management systems and strategies and agrees service changes as necessary. The Directorate group considers matters pertaining to risk management including incidents, risks, complaints and claims. There is an identified lead for risk management who is part of the local clinical governance (or similar) group and whose remit includes sharing information and learning on incidents, complaints, claims and health and safety. The Clinical Director receives copies of all relevant guidance including NICE guidelines and Centralised Alerting System (CAS) alerts, national confidential enquiries and ensures that where necessary appropriate action is instigated.	
Culture	All leaders behave in a way which is consistent with and demonstrates commitment to being open and fair. The Directorate identify areas of required improvement through both corporate and local risk management systems and implement appropriately.	

Account-ability	Incidents, near misses and risks are regularly reported using the Trust risk management reporting system (DATIX). Incidents and near misses are investigated and analysed and where specific areas of learning are identified or changes to practice required appropriate action is taken. Incident investigation to the level appropriate for severity and final approval is undertaken within the agreed timescales (3 months).	
Major Incident Planning	The Directorate/Department managers are aware of the Trust Major Incident Plan. The Directorate/Department managers are aware of their responsibilities in relation to the Major Incident Plan. Where relevant staff have received briefing/training on the Major Incident Plan and associated procedures.	
Business Continuity Manage-ment	Directorate/Dept Business Continuity Management Plans are maintained. The Directorate/Dept teams participate in Business Continuity exercises.	
Strategy	The Directorate/Department is aware of the objectives of the Trust Risk Management Strategy and has formulated a plan to enable these to be achieved locally. The Directorate/Department has an action plan to meet local objectives related to risk management.	
External Assess-ments	The Directorate/Department Managers are aware of the safety and risk management standards as identified by external agencies such as the Care Quality Commission and NHS Litigation Authority. Requirements and achievements against external assessments are communicated to all relevant staff.	
External Reporting	Directorate/Department Managers are aware of their responsibilities in relation to reporting incidents and near misses to external agencies.	
Respons-ibility	All staff are aware of their responsibility in relation to risk management and health and safety.	
Induction	All permanent staff have attended the Trust corporate induction programme. All staff including temporary staff and volunteers have completed the local induction process.	
Training	A training needs assessment is undertaken within the	

	Directorate/Department on an annual basis. There is a system for monitoring attendance at mandatory training and for following up those who fail to attend. All permanent staff have completed the required mandatory training programme. The Directorate/Department participates in the system for assessment and training for medical equipment and devices. Relevant staff have received training in risk management techniques such as risk assessment and root cause analysis. Relevant staff have received training in incident reporting and management of the Risk Register.	
Patient and Public Involvement	There is patient information available to enable patients to make informed decisions. Patients and where relevant carers are informed of serious incidents in line with Duty of Candour.	
Risk Assessment	The Directorate/Department have undertaken risk assessments and reported compliance through the Health and Safety Compliance Audit quarterly. Risk assessment of patient falls is undertaken by nursing staff for patients on admission, if clinical condition changes or at a minimum weekly.	
Infection Control	The Directorate/Department has a designated representative for infection control. Infection control high risk areas have been identified and the Directorate/Department is working with the Infection Control Team to minimise and manage the risk. All relevant areas have access to infection control policies and procedures. There is evidence that staff receive appropriate training and updates in infection control issues. There is a system for reporting, analysing and learning from serious untoward incidents associated with infection. Each clinical team can demonstrate consistently high levels of compliance with the Hand Hygiene Policy and Dress and Appearance Policy. The local cleaning arrangements are informed by Trust	

	Infection Control Policies.	
Medical Equipment and Devices	The Directorate/Department is aware of the Training in the Safe Use of Medical Devices Policy and implements this by: • Ensuring that all equipment used is recorded on the Trust inventory • Agreeing with individual members of staff which equipment from the inventory they are expected to use and the process for training and competency assessment, including frequency of updates • Ensuring that training is made available for all users of devices where training is necessary, and that all equipment users are properly trained and competent • Ensuring that users complete competency records for appropriate medical devices • Reviewing the inventory annually and/ or when new equipment/devices are introduced into their area of responsibility • Identifying training and assessment needs at appointment, local induction and as part of annual reviews.	
Risk Register	The Directorate/Department has a Risk Register which is compiled and kept up to date by nominated, trained staff following risk assessments and data from incidents, complaints and claims. The Risk Register is reviewed and updated on an ongoing, live basis. Where risks have been identified, risk reduction measures are developed and included in action plans The Risk Register is linked to local business planning and service development and is assessed at each Directorates Performance Review.	
Medicines Manage-ment	All clinical areas are aware of the Procedure for the Prescribing, Recording and Administration of Medicines. All medication errors are reviewed by a senior nurse, pharmacist and/or clinician.	

Any areas of non-compliance should be identified on the Risk Register with appropriate controls, risk reduction measures and action plan.

Completed by……

Directorate/Department……..

Date……

Planned date of next review…..

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:**

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

Risk Management Strategy

3. **Name and designation of author:**

Jackie Moon, Head of Patient Safety and Risk

4. **Names & Designations of those involved in the impact analysis screening process:**

Lucy Hall, Equality and Diversity Lead

5. **Is this a:** Policy □ Strategy □√ Service □ Board Paper □

Is this: New □ Revised √□

Who is affected: Employees □√ Service Users □ Wider Community □

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

The aims of the strategy are to ensure that:

- the organisation recognises risk management as a key element of integrated governance
- risk management systems and processes are embedded locally across clinical directorates and in corporate services including business planning, service development, financial planning, project and programme management and education
- all risks are identified that have a potential adverse effect on the quality of care, safety and well-being of patients, staff, volunteers and visitors, and on the business, performance and reputation of the Trust
- the organisation adopts a co-ordinated and multi-disciplinary approach in managing its risks through a systematic process of identification, analysis, learning, control and management of risk

The principal objectives of the Risk Management Strategy are to provide the Board of Directors with sufficient assurance that

appropriate structures and processes are in place to minimise risks and loss of assets and reputation and that reporting processes for risk are maintained. The strategy will also seek to:

- ensure that the risk management processes are integral to the organisational working practices and culture
- encourage the reporting of incidents, whilst promoting a non-punitive culture ensuring that lessons are learned and preventative measures introduced
- ensure that, through the strengthening of risk management arrangements, there are continual improvements to patient safety
- minimise claims for accident or injury against the Trust
- support systems which eliminate, transfer or reduce risks to as acceptable a level as possible
- secure the highest possible standards of risk management in terms of external validation.

7. Does this policy, strategy, or service have any equality implications? Yes x☐ **No** ☐

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

This Strategy describes the processes and infrastructure that are in place to manage risk across the organization

8. Summary of evidence related to protected characteristics

Protected Characteristic	**Evidence** **What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing–** please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	**Does evidence/engagement highlight areas of direct or indirect discrimination?** For example differences in access or outcomes for people with protected characteristics	**Are there any opportunities to advance equality of opportunity or foster good relations**? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Mandatory EDHR Training	Nationally there is evidence of different health outcomes for BAME people in relation to some health conditions. This is	Include in related documents that each service should look at the risks in relation to inequity in access and health

	Provision of Interprets Information available in other formats on request Trust partnership work with 3rd sector organisations BAME Staff Network	being addressed within the Trust through EDHR and Patient Experience structures	outcomes and identify any actions required to minimize any risks identified.
Sex (male/ female)	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Mandatory EDHR Training Single Sex accommodation policy Women's Health and Sexual Health Services available for advice and support Trust partnership work with 3rd sector organisations	Nationally there is evidence of different health outcomes for men and women in relation to some health conditions. This is being addressed within the Trust through specific services and EDHR and Patient Experience structures	As above
Religion and Belief	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Chaplaincy Team available for advice and support. Religion, Belief and Cultural Practices Policy and Guidance	Nationally there is evidence of different health outcomes for some religious groups such as people of Muslim faith. This is being addressed within the Trust through EDHR and Patient Experience structures	As above
Sexual orientation including lesbian, gay and bisexual people	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Mandatory EDHR Training Trust partnership work with 3rd sector organisations Trust support of Northern Pride Sexual health training programmes and services LBGBT Staff Network	Nationally there is evidence of different health outcomes for LGB people in relation to some health needs. This is being addressed within the Trust through specific services and EDHR and Patient Experience structures	As above
Age	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Children and Young People's Services and Elderly Medicine Services Trust work in relation to Dementia Care Your'e Welcome Accreditation for Children and Young People's Services	Nationally there is evidence of different health outcomes in relation to age and some health needs. This is being addressed within the Trust through specific services and EDHR and Patient Experience structures	As above

	Services for teenagers for example Cancer Services Mandatory EDHR Training Trust partnership work with 3rd sector organisations		
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Psychological and Mental Health Services Rehabilitation Services Professions Allied to Medicine services Accessible Information Standard Provision of BSL Signers and Deaf Blind Guides LD Liaison Nurse, flagging of learning disability and patient passport. Trust work to support Carers Mandatory EDHR Training Trust partnership work with 3rd sector organisations Disability Staff Network	Nationally there is evidence of different health outcomes in relation to disability and some health needs. This is being addressed within the Trust through specific services and EDHR and Patient Experience structures	As Above
Gender Re-assignment	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Trust Gender Identity Working Group Mandatory EDHR Training Trust partnership work with 3rd sector organisations	Nationally there is evidence of different health outcomes for Trans people in relation to some health needs. This is being addressed within the Trust through specific services and EDHR and Patient Experience structures	As above
Marriage and Civil Partnership	Equality Analysis on Policies and Business plans Structures and staff in place to support the Trust to comply with the Equality Act 2010 Mandatory EDHR Training	No	As above
Maternity /	Equality Analysis on Policies and Business plans	Nationally there is evidence of	As above

Pregnancy	Structures and staff in place to support the Trust to comply with the Equality Act 2010 Maternity Services available for advice and support. Breast Feeding Policy and signage Mandatory EDHR Training Trust partnership work with 3rd sector organisations	different health outcomes for mothers and babies who have protected characteristics. This is being addressed within the Trust through specific services and EDHR and Patient Experience structures	

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified ?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement No

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

There are risks related to health outcomes that can impact on mortality and morbidity. This policy aims to reduce those risks.

PART 2

Signature of Author

Print name

Jackie Moon, Head of Patient Safety and Risk

Date of completion

02/06/2017

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)