

# The Newcastle upon Tyne Hospitals NHS Foundation Trust

## Risk Management Strategy

Effective: October 2009   Revised January 2011   Review: October 2012

### 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, within a fair blame 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, including the NHS Litigation Authority (NHSLA) Risk Management Standards.

#### 4. 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).

#### 5. 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 NHSLA, Maternity Clinical Risk Management Standards and the registration requirements of the Care Quality Commission (CQC).

#### 6. Accountabilities, Responsibilities and 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.

## 6.1 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:

1. 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;
2. It identifies sources of assurance and evaluates them for suitability. The Assurance Framework then provides the Audit Committee and Corporate Governance 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 Audit Committee and the Trust Board.

Risks graded as 20 or above will be reported to the Trust Board via the Corporate Governance Committee and the Audit Committee.

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 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. Clear plans of action must be put in place to reduce extreme risks and will be overseen by the Audit Committee and the Corporate Governance Committee.

## 6.2 Statement on Internal Controls

The Chief Executive is responsible for "signing off" the Annual Statement on Internal Control, 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 Statement on Internal Control 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 Statement on Internal Control.

### 6.3 Key forums for the management of risk

Overall decisions on prioritisation of risk issues and resource allocation will be made by the Corporate Governance 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 **Corporate Governance 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. The Corporate Governance 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 in place proper processes 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.

The **Clinical Policy Group** advises the Trust on matters of clinical policy and ratifies both clinical and non-clinical policies. In addition it is a route through which matters can be raised for consideration by the Trust Board and Standing Panels. The terms of reference for this group which contributes to the Assurance Framework are provided as Appendix 5.

The **Clinical Risk Group** is responsible for implementation of guidance from the NPSA and the MHRA. This group is also responsible for dissemination of

learning from incidents (including near misses), complaints and claims. The terms of reference for this group which contributes to the Assurance Framework are provided as Appendix 6.

### **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.

## 6.4 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 will enable ready transfer of information across all sources and will facilitate local and organisational learning from adverse events and risk assessment processes in addition to supporting an integrated approach to risk analysis.

### **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. Operational Responsibilities for Managing Risk**

The Trust Corporate Structure is illustrated in Appendix 1.

7.1 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.

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

### 7.3 **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 will require each Directorate to submit an annual Clinical Governance Report to ensure that their objectives have been met and reviewed by the Executive Team.
- 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.
- 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.

### 7.4 **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.

7.5 The **Risk Management and Safety Manager** 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.

## **7.6 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
- developing and facilitating the local clinical governance committee 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
- 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 both Performance and Clinical Practice and Standards reviews on the Directorate risk management performance in addition to new and emerging risks, major changes of priority on existing risks and key actions
- monitoring and submitting an Annual Clinical Governance report outlining achievement of their governance and risk objectives to the Medical Director for review by the Executive Team.

## **7.7 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.

## **7.8 Additional responsibilities for Directorate/Department Managers, Clinical Directors and Department Heads**

In addition to the corporate responsibilities outlined above, Directorate/Department Managers, Clinical Directors and Department Heads are responsible for ensuring effective risk management within their own specialist areas. These include primary 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 Directorate Manager, Clinical Director or Department Head is responsible for bringing the issue to the attention of the Risk Management and Safety Manager and if necessary to the Medical Director, in order to agree decisions about subsequent management of the risk.

## **7.9 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 on-going 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 Risk Management training.

As a large emphasis within the Risk Management Strategy is to develop an environment where the focus and culture is on reporting and learning from mistakes and near misses, formal disciplinary action will not usually be taken as a result of a risk management incident investigation. However a serious breach of safety regulations or negligence causing loss or injury will be regarded as gross misconduct and will be considered within the Trust Disciplinary Procedure Policy. Disciplinary action will ensue where it is found that a member of staff has acted illegally, maliciously or recklessly.

## **8. Strategy Dissemination, Implementation and Monitoring**

### **8.1 Dissemination**

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, Primary Care Trusts, NHSLA, CQC, Internal and External Auditors, Partner Organisations, and published on the Trust Intranet.

## 8.2 Implementation

Implementation of the Strategy will be as outlined in the Performance Indicators detailed in Appendix 7.

## 8.3 Monitoring

An annual risk management report will be provided to the Corporate Governance Committee on progress with implementation of the Strategy and achievements against the Performance Indicators (Appendix 7) supplemented by ad hoc reports on specific risk management priorities as required.

Local measures will be audited through an annual Directorate-level self assessment based on criteria outlined in Appendix 8 which will be incorporated into the annual risk management report.

All departments and directorates are required to undertake risk assessments of a range of issues and to demonstrate compliance with this through quarterly Health and Safety Compliance audits.

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

The Board and the Audit Committee will also receive the minutes of the Corporate Governance Committee. The Corporate Governance Committee will oversee the management of risks, incidents and litigation and will monitor actions initiated in response to specific highlighted risks.

Additionally, the Trust Secretary will periodically review the scope of committee minutes to be presented to the Trust Board.

The Internal Audit Department will formally monitor progress with implementation of risk management, including the organisational controls assurance standards on an ongoing basis, reporting formally to the Audit Committee. The Corporate Governance Committee will be responsible for implementation and further development of the risk management strategy and for ensuring that systems are in place to identify and control key risks. This role is complemented by that of the Audit Committee, which is responsible for verifying that the system of internal control is effective in managing risks in the manner approved by the Board.

In order to support further development, the Trust will continue to benchmark performance against national and international best practice. This will include

participation in both formal external assessments (including NHSLA and Care Quality Commission Standards) and informal processes, including those facilitated by Monitor and the National Patient Safety Agency (or any successor body), the MHRA and the HTA.

#### 8.4 Associated Policies and Procedures

- Aggregating Data and Learning from Incidents, Complaints and Claims Policy
- Being Open Policy
- Business Continuity Policy
- Claims Management Policy
- Concerns and Complaints Policy
- Disciplinary Policy/Procedure
- Dress and Appearance Policy
- Hand Hygiene Policy
- Incidents, Accidents and the Trust Disciplinary Process - Guidelines for Managers, Clinical Directors and Employees.
- Induction Policy
- Major Incident Plan
- Management and Reporting of Accidents and Incidents Policy
- Mandatory Training Policy
- Maternity Clinical Risk Management Strategy
- Risk Register-Policy for Management and Use
- Serious Untoward Incident Reporting and Management Policy
- The ordering, storage and administration of all medicinal substances in The Newcastle upon Tyne Hospitals NHS Foundation Trust policy
- Training in the Safe Use of Medical Devices policy
- Health & Safety Operational Policy
- Procedure for the Prescribing Recording and Administering of Medicines.

Appendix 1 - Foundation Trust Framework and Corporate Structure

Appendix 2 - Corporate Governance Committee terms of reference

Appendix 3 - Audit Committee terms of reference

Appendix 4 - Clinical Governance and Quality Committee terms of reference

Appendix 5 - Clinical Policy Group terms of reference

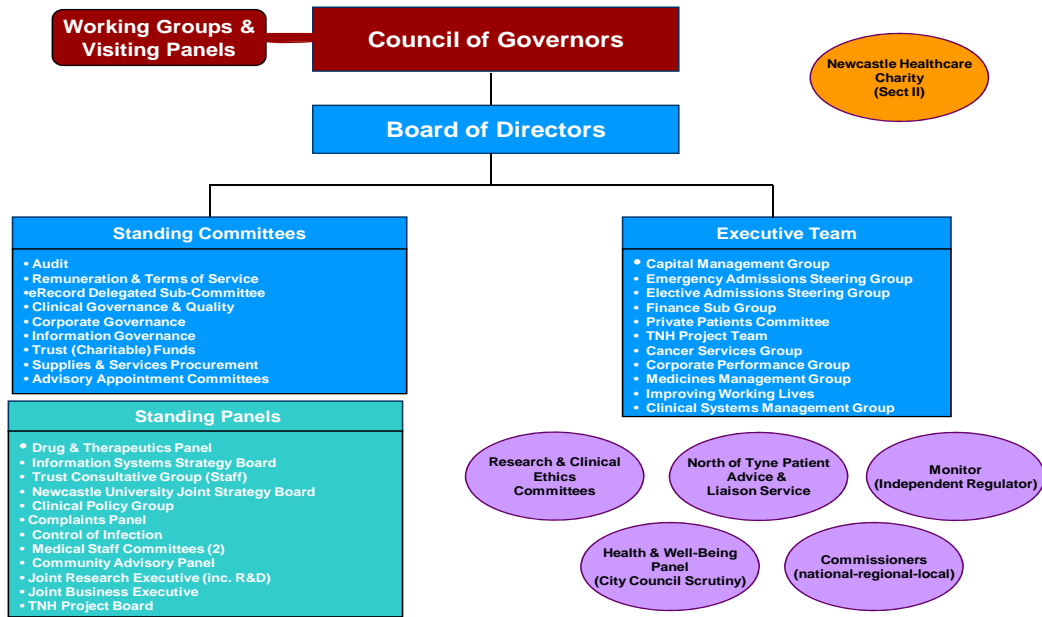
Appendix 6 – Clinical Risk Group terms of reference

Appendix 7 - Performance Indicators

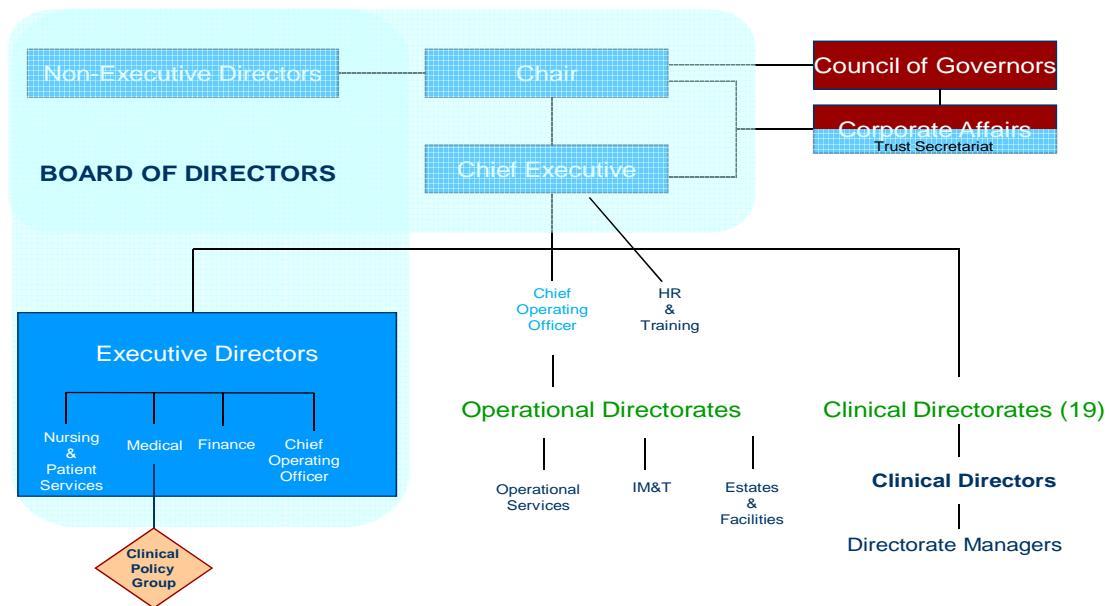
Appendix 8 - Directorate self assessment tool

# Appendix 1

## Foundation Trust Framework



## Foundation Trust Corporate Structure



## Appendix 2.

### THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

#### CORPORATE GOVERNANCE COMMITTEE

#### CONSTITUTION AND TERMS OF REFERENCE

##### **Membership:**

Non-Executive Director (Chair)  
Finance Director  
Medical Director  
Director of Nursing and Patient Services  
Director of Personnel  
Director of Estates  
Internal Audit Manager  
Trust Secretary  
Director of Quality and Effectiveness

**Quorum** Chairman plus three other standing members, of which at least one shall be an Executive Director. It is expected that members of the group attend at least three meetings per year.

**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 Corporate Governance Committee will be accountable directly to the Board of Directors.

**Liaison with:** Audit Committee  
Health & Safety Committee  
Major Incident Group  
Trust Security Group  
Clinical Risk Group  
Medical Devices Steering Group

**Overall Purpose:** To provide the forum that develops and advises the Trust on strategy, policy, priorities and implementation of risk management. In particular, the Corporate Governance Committee will co-ordinate and facilitate risk management activity across the Trust, including the drive for integrated governance, performance management of the Risk Management structure and implementation of NHSLA Standards. 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.

#### **TERMS OF REFERENCE**

1. To undertake and maintain an ongoing assessment of clinical 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 advise the Board of Directors as appropriate on further integration of governance functions across the Trust.
5. To ensure that the Trust-wide risk register is both maintained and updated and regularly reviewed, in order to provide the Board of Directors with early identification of key risks, along with appropriate mitigation measures.
6. To oversee the process of implementation of the requirements of NHSLA Standards and to receive regular reports on the state of readiness for NHSLA inspection and accreditation.
7. To foster and improve upon the quality of risk management across the Trust.
8. To undertake and maintain an ongoing assessment of the risk management framework and its effectiveness, in support of the Corporate Governance Committee remit and ensuring that the framework meets local and nationally determined priorities and requirements.
9. 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 this regard, the Corporate Governance Committee shall determine the priorities of CGARD, in the context of national guidance and local needs.
10. To receive regular reports on Serious Untoward Incidents and to identify any trends within Departments, Directorates, or functions.
11. To receive a quarterly analysis of litigation claims.
12. To secure an efficient and effective mechanism for the timely and appropriate distribution of Central Alert System (CAS) notifications and to receive reports on new alerts and any alerts where action plans exceed nationally prescribed implementation timetables.
13. To review risk management-related policies (whether existing or new) and make recommendations to the Board of Directors for their adoption,

ensuring that mechanisms are in place for effective communication of such policies across the Trust.

14. To secure the production of required NHSLA and any other risk management reports.
15. To monitor the application of identified policies relating to NHSLA and CQC 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.
16. To review the Constitution and Terms of Reference at least every two years.

## Appendix 3.

### THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

#### AUDIT COMMITTEE

##### CONSTITUTION AND TERMS OF REFERENCE

- Members:** 3 Non-Executive Directors (excluding Trust Chairman)
- In Attendance:** Chief Executive  
Finance Director  
Medical Director  
External Auditor  
Internal Auditor  
Trust Secretary  
Director of Quality and Effectiveness  
Other officers by invitation
- Quorum:** 2 Non-Executive Directors
- Frequency:** Minimum of 4 meetings per financial year (further meetings may be convened as and when required)

#### 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. It provides a forum for direct contact between the Trust and its auditors.

#### 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) changes in and compliance with accounting policies and practices
- ii) major judgemental areas
- iii) significant adjustments resulting from the annual audit.

##### 2. *Governance, Internal Control and Risk Management*

- 2.1 To liaise with the Corporate Governance 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 Corporate Governance 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 and clinical 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 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 Corporate 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 Statement on Internal Control and declarations of compliance with Standards for Better Health), 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 Monitor, Care Quality Commission, Audit 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 the National Security and Counter Fraud Service.
  - 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.
- 3.2 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. These would ordinarily be provided by the external auditor.
- 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 if 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 "*Annual Audit Letter*" addressed to the Board of Directors.

#### 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, Corporate Governance Committee and any other Risk Management 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.
- 5.5 In conjunction with the Corporate Governance Committee, to monitor the application of identified policies relating to NHSLA and CQC 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.

## 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 ensure it is 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.

## Appendix 4.

### THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

#### CLINICAL GOVERNANCE AND QUALITY COMMITTEE

##### CONSTITUTION AND TERMS OF REFERENCE

<b>Members:</b>	Non-Executive Director - Chairman Medical Director Nursing and Patient Services Director Director of Infection Prevention and Control Chair - Public and Patient Involvement Forum Lead Consultant – Clinical Audit Lead Consultant – (RVI) Chair - Medical Staff Committee (Freeman) Chair - Medical Staff Committee (RVI/NGH) Chair - Clinical Ethics Advisory Group Chair - Drug and Therapeutics Committee Lead Consultant - University of Newcastle upon Tyne Director of Quality and Effectiveness Director of Pharmacy
<b>By Invitation:</b>	Members of the Council of Governors
<b>Cooption:</b>	Power to co-opt as and when required
<b>Quorum:</b>	Four members including a minimum of one Executive Director
<b>Frequency:</b>	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 reflects the already established principles of Corporate Governance and all that entails by providing the framework for professional self regulation at a local level.

#### **Overall Purpose**

As a Standing Committee of the Trust to ensure that there is in place proper processes for continuously monitoring and improving clinical quality by building upon existing control systems and self regulation standards.

#### **Terms of Reference**

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

- 2 To ensure that leadership skills are in place and improved upon at clinical directorate, specialty and sub-specialty levels.
- 3 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.
- 8 To ensure that problems of poor clinical performance are systematically recognised at an early stage and reporting pathways are developed to enable issues to be dealt with accordingly.
- 9 In conjunction with the Corporate Governance Committee and Audit Committee, to monitor the application of identified policies relating to NHSLA and CQC 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.
- 10 To ensure that all professional development programmes adequately and consistently reflect the principles of Clinical Governance.
- 11 To review the quality of clinical record keeping and the data required to monitor clinical care and treatment outcomes and to recommend change in practice where improvement is called for.
- 12 To encourage and support all of the professionals involved in developing Clinical Governance.
- 13 To facilitate support and monitor the effectiveness of continued professional development for all disciplines in the workplace.
- 14 To promote individual self-assessment processes that generate an awareness in terms of quality, outcome and risk.
- 15 To provide regular reports to the Board on the quality of clinical care provided.
- 16 To provide regular reports to the board on the quality and provision of clinical care.
- 17 To draw together and publish an annual report.

- 18 To promote clinical appraisal skills and encourage practice through integrated care pathways and guidelines.
- 19 To monitor Research Governance and ensure there is ongoing compliance in accordance with local and national guidelines.
- 20 To ensure that all new procedures are considered by the Committee prior to being offered and undertaken as routine clinical treatment.

### **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 and for monitoring continued effectiveness.

External communications will, for example, include contact with:

Strategic Health Authority  
Primary Care Organisations  
National Institute for Clinical Excellence

### **Reporting Mechanisms**

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

The Clinical Governance and Quality Committee will receive reports from the following groups:

Clinical Practice and Standards Group  
Clinical Effectiveness, Audit and Guidelines Committee  
Clinical Risk Group.

## Appendix 5.

### The Newcastle upon Tyne Hospitals NHS Foundation Trust

#### Clinical Policy Group

##### CONSTITUTION AND TERMS OF REFERENCE

Members: Medical Director -Chairman  
Chief Executive  
Director of Nursing and Patient Services  
Assistant Medical Directors  
Chairman, Medical Staff Committee (FH)  
Chairman, Medical Staff Committee (RVI and NGH)  
Clinical Directors  
Dean of Clinical Medicine  
Director of Infection Prevention and Control

**Frequency:** Monthly, together with extra-ordinary meetings as necessary.

**Quorum:** Ten Members including a minimum of one Executive Director.

#### Overall Purpose

The overall purpose of the Clinical Policy Group is to advise the Trust on matters of clinical policy. In addition it is a route through which matters can be raised for consideration by the Trust Board and Standing Panels.

#### Terms of Reference

1. To consider, devise, refine and promulgate clinical policy in the Trust. The Clinical Policy Group is the body responsible for the formal approval of all clinical policies.
2. To address the clinical and associated service implications for the Trust of national and other external policy initiatives and advise in relation to implementation within the Clinical Directorates.
3. In conjunction with the Clinical Governance and Quality Committee and Corporate Governance Committee, to monitor the application of identified policies relating to NHSLA and CQC assessments and reviews.
4. To advise Executive Directors and Senior Managers on the clinical implications of policy initiatives.
5. To communicate Trust Board level policy to the Clinical Directorates.
6. To collaborate with the University Heads of Schools in relation to policy issues of mutual importance.
7. To assess and determine priorities, when called upon, in relation to service investment and delivery.

## Appendix 6

### THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

#### Clinical Risk Group

#### Constitution and Terms of Reference

##### Membership

Medical Director (Chair)  
Nursing and Patient Services Director  
Clinical Directors  
Directorate Managers  
Director of Quality and Effectiveness  
Medical Records Manager  
Personnel Manager  
Trust Solicitor  
Rehabilitation Manager

##### Frequency of Meetings

Meeting will be held on a quarterly basis.

**Quorum:** Eight Members of the group.

##### Reporting Arrangements

The group reports to the Clinical Governance and Quality Committee. In addition, it will where necessary communicate with the Corporate Governance Committee in order to ensure an integrated approach to clinical and non-clinical risk management across the Trust.

##### Terms of Reference

1. To develop and monitor the implementation of clinical risk policy and operational procedures.
2. To assess new developments in clinical risk management and to oversee their application within the Trust.
3. To review themes and trends in clinical risk, via incident/near miss and other systems and to ensure appropriate action on priorities identified.
4. To highlight issues arising from identified risks or adverse events, in order to ensure that lessons are learned for the future.
5. To communicate key information on clinical risks to clinical directorate teams.

6. To ensure that significant clinical risks are communicated to the Clinical Governance and Quality Committee and Corporate Governance Committee.
7. In conjunction with the Clinical Governance and Quality Committee and Corporate Governance Committee, to monitor the application of identified policies relating to NHSLA and CQC 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.

### **Review**

These terms of reference will be reviewed on a biennial basis.

## Appendix 7.

### PERFORMANCE INDICATORS

Objective(s) and action	Responsibility	Timetable
<b>Dissemination of the Strategy across the organisation</b>		
Publish the Risk Management Strategy both internally and externally as outlined above.	Director of Quality and Effectiveness	Completed
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	Ongoing
<b>Implementation of the strategy across the organisation</b>		
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.	Corporate Governance Committee supported by Director of Quality and Effectiveness	Ongoing
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	Ongoing
Review progress against the Risk Management Strategy Performance Indicators.	Director of Quality and Effectiveness	Bi-monthly report to Corporate Governance Committee
To ensure that all staff groups receive Mandatory training/ Risk Management training as defined by the NHSLA Acute Standards.	Head of Training and Development	As indicated in Induction/Mandatory Training Policy
<b>Directorate Risk Management Support</b>		
<ul style="list-style-type: none"> <li>• Refinement of Directorate Risk Register</li> <li>• Review of the Directorate self assessment risk reviews</li> <li>• Implementation of a standardised approach to risk assessment for all identified key risks</li> <li>• Refinement of action plans to address key risks</li> <li>• Development/refinement of Trust based</li> </ul>	Directorate Management Team, supported by Risk Management and Safety Manager and Director of Quality and Effectiveness	Ongoing

process for the systematic and aggregated review, analysis and learning from incidents, claims and complaints information, including mechanisms to support changes in practice.		
Ongoing development of web-based DATIX risk management system.	Risk Management and Safety Manager	Ongoing review
Completion of a Trust-wide programme to assess risks to service continuity and development of effective contingency/business continuity plans where required.	Director of Quality and Effectiveness	Review by the Business Continuity Steering Group
<b>Education and Learning Systems</b>		
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	Ongoing
Training of relevant personnel in Root Cause Analysis / incident investigation training to ensure a systematic approach to investigation and analysis of incidents.	Risk Management and Safety Manager	As required for nominated individuals
Delivery of training in risk assessment and effective use of the Trust Risk Register.	Risk Management and Safety Manager	As required for nominated individuals
<b>Governance</b>		
Implementation and monitoring of performance indicators for Risk Management Strategy.	Corporate Governance Committee and Trust Education Group	Quarterly
Provision of regular reports on extreme risks to the Corporate Governance Committee and Audit Committee to inform decisions about priorities for action and resource allocation.	Risk Management and Safety 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
<b>External Assessments</b>		
Progress towards achievement of the CNST Maternity Risk Management Standards.	Risk Management Midwife	Monthly report to Clinical Improvement and Risk Group
Progress towards achievement of Level 3 NHSLA Risk Management Standards for Acute Trusts.	Director of Quality and Effectiveness	Review by the Corporate Governance Committee
Maintain Care Quality Commission registration standards for Healthcare Associated Infection.	Director of Infection Prevention and Control	Monthly report to Infection Prevention and Control

		Committee
Maintain Care Quality Commission registration standards.	Director of Quality and Effectiveness	Ongoing
<b>Incidents, Claims and Complaints</b>		
Further development of an integrated approach to learning and improvement from serious incidents, claims and complaints, identified through aggregated data reports.	Director of Quality and Effectiveness	Ongoing
Increase use of DATIX within incident, complaint and claims reporting and analysis.	Director of Quality and Effectiveness	Ongoing
Implement 'Slips, trips and falls in hospital, NPSA (2007)' recommendations.	Director of Quality and Effectiveness	Quarterly report to the Clinical Governance and Quality Committee

**Appendix 8.**

**Framework for Risk Management**

**Self assessment tool for Directorates/Departments**

Key element	Required action	Compliant? (please copy and paste symbols below into each line) <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> N/A
<b>Leadership</b>	<p>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.</p> <p>The Directorate group considers matters pertaining to risk management including incidents, risks, complaints and claims.</p> <p>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.</p> <p>The Clinical Directorate team provide the Medical Director with an annual Clinical Governance report outlining their progress against directorate and corporate objectives.</p> <p>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.</p>	
<b>Culture</b>	<p>All leaders behave in a way which is consistent with and demonstrates commitment to being open and fair.</p> <p>The Directorate identify areas of required improvement through both corporate and local risk management systems and implement appropriately.</p>	

<b>Accountability</b>	<p>Incidents, near misses and risks are regularly reported using the Trust risk management reporting system (DATIX).</p> <p>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.</p> <p>Incident investigation to the level appropriate for severity and final approval is undertaken within the agreed timescales (3 months).</p>	
<b>Major Incident Planning</b>	<p>The Directorate/Department managers are aware of the Trust Major Incident Plan.</p> <p>The Directorate/Department managers are aware of their responsibilities in relation to the Major Incident Plan.</p> <p>Where relevant staff have received briefing/training on the Major Incident Plan and associated procedures.</p>	
<b>Business Continuity Management</b>	<p>Directorate/Dept Business Continuity Management Plans are maintained.</p> <p>The Directorate/Dept teams participate in Business Continuity exercises.</p>	
<b>Strategy</b>	<p>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.</p> <p>The Directorate/Department has an action plan to meet local objectives related to risk management.</p>	
<b>External Assessments</b>	<p>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.</p> <p>Requirements and achievements against external assessments are communicated to all relevant staff.</p>	
<b>External Reporting</b>	<p>Directorate/Department Managers are aware of their responsibilities in relation to reporting incidents and near misses to external agencies.</p>	

<b>Responsibility</b>	All staff are aware of their responsibility in relation to risk management and health and safety.	
<b>Induction</b>	All permanent staff have attended the Trust corporate induction programme.  All staff including temporary staff and volunteers have completed the local induction process.	
<b>Training</b>	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.	
<b>Patient and Public Involvement</b>	There is patient information available to support patients to be guardians of their own safety.  Patients and where relevant carers are informed of incidents.	
<b>Risk Assessment</b>	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.	
<b>Infection Control</b>	The Directorate/Department has a designated representative for infection control.  Infection control high risk areas have been identified and the Directorate/Department is	

	<p>working with the Infection Control Team to minimise and manage the risk.</p> <p>All relevant areas have access to infection control policies and procedures.</p> <p>There is evidence that staff receive appropriate training and updates in infection control issues.</p> <p>There is a system for reporting, analysing and learning from serious untoward incidents associated with infection.</p> <p>Each clinical team can demonstrate consistently high levels of compliance with the Hand Hygiene Policy and Dress and Appearance Policy.</p> <p>The local cleaning arrangements are informed by Trust Infection Control Policies.</p>	
<b>Medical Equipment and Devices</b>	<p>The Directorate/Department is aware of the Training in the Safe Use of Medical Devices Policy and implements this by:</p> <ul style="list-style-type: none"> <li>• Ensuring that all equipment used is recorded on the Trust inventory</li> <li>• 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</li> <li>• 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</li> <li>• Ensuring that users complete competency records for appropriate medical devices</li> <li>• Reviewing the inventory annually and/ or when new equipment/devices are introduced into their area of responsibility</li> <li>• Identifying training and assessment needs at appointment, local induction and as part of annual reviews.</li> </ul>	
<b>Risk Register</b>	<p>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.</p> <p>The Risk Register is reviewed and updated on</p>	

	<p>an ongoing, live basis.</p> <p>Where risks have been identified, risk reduction measures are developed and included in action plans</p> <p>The Risk Register is linked to local business planning and service development and is assessed at each Directorates Performance Review.</p>	
<b>Medicines Management</b>	<p>All clinical areas are aware of the Procedure for the Prescribing, Recording and Administration of Medicines.</p> <p>All medication errors are reviewed by a senior nurse, pharmacist and/or clinician.</p>	

**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**.....