Medway NHS Foundation Trust
Risk Management Strategy and Policy

Author:	Fiona Egan – Head of Risk & Regulation Quality Assurance
Document Owner	Lynne Stuart – Director of Corporate Governance, Risk, Compliance and Legal
Revision No:	7
Document ID Number	POLCGR028
Approved By:	Trust Board
Implementation Date:	29th September 2016
Date of Next Review:	29th September 2017

Medway NHS Foundation Trust
Risk Management Strategy and Policy

Document Control / History	
Revision No	**Reason for change**
7	Combined Risk Strategy & Policy

Consultation

Medway NHS Foundation Trust
Risk Management Strategy and Policy

Table of Contents

Medway NHS Foundation Trust
Risk Management Strategy and Policy

To be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 All activities contain inherent risks. Risk management and internal control is central to the effective running of any organisation. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach. Medway NHS Foundation Trust (MFT) will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

1.2 Although the key strategic risks are identified and monitored by the Trust Board, operational risks are managed on a day-to-day basis by staff throughout the organisation. In order that progress in managing all risks can be acknowledged, the Trust has a Standard Operating Procedure in place for Risk management (SOP0064), enabling provision of a record of all risks to the organisation via an electronic platform RiskAssure.

1.3 At the heart of the Trust Risk Management Strategy and Policy is the desire to learn from events and situations in order to continuously improve management processes. Where necessary, and where appropriate, changes will be made to the Trust's systems to enable this to happen.

2 Purpose / Aim and Objective

2.1 Risk Management Strategy and Policy Statement

Risk management is the key system through which strategic, clinical (Quality & Safety), operational, corporate and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. It is through this system of internal control and accountability the Chief Executive fulfils their responsibility as accountable officer and the Board fulfils its responsibility of stewardship. Key systems will be fully embedded at every level of the organisation and will ensure compliance with current and future risk management related standards and legislation; these systems are described within SOP0064 Standard Operating Procedure for Risk Management.

2.2 Assurances will be provided to the Trust Board through an agreed scheme of delegation according to principles and systems which will allow the Board to be able to make accurate judgements as to the degree to which risks to its objectives are being managed effectively and efficiently. This Board Assurance Framework will contribute to the ability of the Trust to be able to confidently sign the Annual Governance Statement, Annual Accounts and Annual Quality Account and it is through this process MFT monitors adherence to the requirements of the Care Quality Commission and other regulators. SOP0165 Medway NHS Foundation Trust Procedure for the Board Assurance Framework describes the assurance process.

3 Definitions

3.1 **Risk** is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives.

3.2 **Risk management** is the assessment, analysis and management of risks. It is a way of recognising which events (hazards) may lead to harm in the future and minimising their potential consequence(s) and likelihood of occurrence.

3.3 **Risk Appetite** - The levels and types of risk the Organisation is prepared to accept in pursuance of its objectives. This informs all planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks.

4 (Duties) Roles & Responsibilities

4.1 **The Trust Board** is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives. The Board Assurance Framework (BAF) is described in a Standard Operating Procedure SOP0165.

4.2 **Non-Executive Directors** have responsibility for reviewing 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). This supports the achievement of quality and the organisation's objectives. In particular, as members of the Audit Committee, Quality Assurance Committee and Finance and Performance Committee, Non-Executive Directors will review the adequacy of the Risk Management Strategy, Policy and procedures and receive regular monitoring information against the management of risks judged as significant and provide verification to the Trust Board through the Board Assurance Framework on the systems in place for the management of risk within the Trust.

4.3 **The Chief Executive** is the Accountable Officer and is accountable for ensuring:

- The Trust's Principal Strategic Objectives are agreed.
- Sound systems of internal control exist, which are based on an ongoing management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically.
- Systems of internal control exist which are underpinned by compliance with the core controls assurance standards of Governance, Financial Management and Risk Management.
- Internal Audit Plans are aligned to risk areas and review the effectiveness of the system of internal control

The Trust Board Sub Committees are the principal means by which these responsibilities are discharged and through which effectiveness of risk management systems is monitored.

4.4 **The Director of Corporate Governance, Risk, Compliance and Legal** is the Executive with responsibility for ensuring that the Trust has robust risk management resources and systems. They are responsible for ensuring that mechanisms for risk management are robust so as to assure the Trust Board that risks are being managed and that the Trust complies with the risk management standards. They are the Executive with responsibility for developing and implementing the Board Assurance Framework

4.5 **The Director of Finance** is accountable to the Trust Board and Chief Executive for the Trust's financial risk management activities and has close working arrangements with other Executive Directors with regard to ensuring that Financial Planning and Financial Risk Management integrates with the Trust's Clinical and Organisational Risk Management activities and is closely involved in consideration of the recommendations of the Audit Committee and the Quality Assurance Committee. The Director of Finance seeks the Internal Auditor's Opinion on the effectiveness of Internal Control and Internal Financial Control.

4.6 **The Medical Director** has responsibility for identifying with the Director of Nursing, the principal risks to the Clinical Governance arrangements and through working with the appropriate Directors of Clinical Operations, Clinical Directors, Clinical Leads, senior managers and clinicians, ensures risks identified through risk profiling / assessment are effectively managed, eliminated or reduced.

4.7 **The Director of Workforce**, **Director of Estates and Facilities**, **The Chief Quality Officer and the Company Secretary** are responsible for the management of risks within their areas of operational responsibility. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities.

4.8 **Directors of Clinical Operations** are responsible for ensuring that the Trust's risk management processes are fully implemented within their services, risk registers are maintained and ensuring that principal risks to the Trust's objectives are systematically managed i.e. identified, evaluated, eliminated or reduced. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities

4.9 **The Head of Risk and Regulation Quality Assurance** reports to the Director of Corporate Governance, Risk, Compliance and Legal and is responsible for overseeing the development and implementation of a robust Risk Management Strategy and Framework, working with Executive Directors, Directors of Clinical Operations and Directorate Governance Managers to embed good practice at all

levels of the Trust and ensure that the Trust's commitment to managing risk is co-ordinated, systematic, transparent and evident, they are responsible for the management of the Trust's electronic Risk Management platform – RiskAssure.

4.10 **Directorate Governance Managers** - are responsible for managing their Directorate Risk register utilising the agreed process and methodology, ensuring that it is regularly reviewed in appropriate governance meetings across the directorate and at the Directorate Management Board meetings.

4.11 **All Trust Staff** - Risk management is everyone's responsibility and it is important that potential risks are identified within all levels of the organisation; however it is also important that risks are articulated, recorded and acted upon appropriately and systems have been put in place to facilitate this as described in the Risk Management Standard Operating Procedure (SOP0064) which all staff are required to abide by.

4.12 **The Audit Committee** has a responsibility to provide to the Board assurance that in respect of Governance, Risk Management and Internal Control, effective systems across the whole of the organisation's activities (both clinical and non-clinical), support the achievement of the organisation's objectives.

5 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Head of Risk and Regulation Quality Assurance	The Board	Where gaps are recognised action plans will be put into place
Compliance with the Trust's Risk Management standard operating procedure.	Managed via the outputs of the Compliance and Risk Group bi-monthly	Director of Corporate Governance Risk, Compliance & Legal	The Executive Group	Where gaps are recognised action plans will be put into place
The Audit Committee	Oversight of Risk Management and systems of control	Chair of the Audit Committee	The Board	Where gaps are recognised action plans will be put into place

6 Training and Implementation

To support the implementation and embedding of the risk management policy and procedures;

- Mandatory training supported by an e-learning package 'Risk Management' available to all staff; and

- Bespoke and advanced risk management training is available to all staff teams, tailored to their specific needs. This includes advice and guidance on the management of risk in their area, peer reviews and / or support with development of risk registers.

7 Equality Impact Assessment Statement & Tool

7.1 All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." This obligation has been increased to include equality and human rights with regard to disability, age and gender.

7.2 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This strategy was found to be compliant with this philosophy.

7.3 Equality Impact Assessments will also ensure discrimination does not occur on the grounds of Religion/Belief or Sexual Orientation in line with the protected characteristics covered by the existing public duties.

7.4 Refer to appendix 1.

8 References

Document	**Ref No**
References:	
Trust Associated Documents:	
Standard Operating Procedure for Risk Management	SOP0064
Medway NHS Foundation Trust Standard Operating Procedure for the Board Assurance Framework	SOP0165
Producing Risk Register Reports from RiskAssure	SOP0166
Procedure for adding, revising & closing a risk on RiskAssure	SOP0167

Medway NHS Foundation Trust
Risk Management Strategy and Policy

Appendix 1

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:	no	
	▪ Age		
	▪ Disability		
	▪ Gender reassignment		
	▪ Marriage and civil partnership		
	▪ Pregnancy and maternity		
	▪ Race		
	▪ Religion or belief		
	▪ Sex		
	▪ Sexual orientation		
2	Is there any evidence that some groups are affected differently?		
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?		
4	Is the impact of the policy/guidance likely to be negative?		
5	If so can the impact be avoided?		
6	What alternatives are there to achieving the policy/guidance without the impact?		
7	Can we reduce the impact by taking different action?		

END OF DOCUMENT