Medway NHS Foundation Trust
Corporate Risk Management Strategy and Policy

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Medway NHS Foundation Trust
Risk Management Strategy and Policy

Document Control / History	
Revision No	**Reason for change**
7	Combined Risk Strategy & Policy
8	Page 8 - Detail added regarding training levels across the Trust
9	Reviewed – more detail added regarding reporting structures
10	Reviewed – Job titles and risk appetite statement updated, Risk Assurance Group and Risk Manager details added.

Consultation
Executive Group, Trust Board

Medway NHS Foundation Trust
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Table of Contents

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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.

4.1.1 The Board will receive a Corporate Risk Register for consideration and adoption, as recommended by the Integrated Audit Committee & Performance Committee every six months. The Board will also receive a quarterly Board Assurance Framework, proposed by the Trust Secretary. The Board will use both of these documents to guide its agenda setting, further information and assurance requests and to inform key decision making, particularly about the allocation of financial and other resources.

4.1.2 To this end, both the Corporate Risk Register and the BAF will be sent to

4.1.2.1 the Finance Committee to inform financial decision making and budget setting

4.1.2.2 the Integrated Audit Committee to inform the planning of audit activity

4.1.2.3 the People Committee to inform human resources and training and development decisions

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. Members of the Integrated Audit Committee 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 Deputy Chief Executive** 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.

4.5 **The Trust Secretary** has the responsibility for developing and implementing the Board Assurance Framework.

4.6 **The Head of Corporate Governance and Legal** reports to the Deputy Chief Executive and is responsible for overseeing the development and implementation of a robust Risk Management Strategy and Framework; working with Executive Directors, Chief Operating Officer and Divisional 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.

4.7 **The Assistant Head of Corporate Governance & Legal** assists in the review of the Strategy, Policy and SOP, supporting the Risk Manager in their role and is a key member of the Risk Assurance and Risk Learning Groups.

4.8 **The Risk Manager** is responsible for the management and training of managers on the Trust's electronic Risk Management platform – RiskAssure. Works closely with the Executives and all management levels across the Divisions supporting them to maintain the corporate risk register and divisional risk registers. Ensures that processes are developed and maintained to support the organisations system of internal control; processes will include risk profiling, risk appetite statement, evidence based assurance processes supporting the corporate governance framework; development of an evidence based annual governance statement. Design and deliver a comprehensive risk management training package and develop and embed the Risk Management Strategy and policy across the Trust to ensure there is an effective Risk management System in place.

4.9 **The Chief Finance Officer** 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 Integrated Audit Committee and the Quality Assurance Committee. The Chief Finance Officer seeks the Internal Auditor's Opinion on the effectiveness of Internal Control and Internal Financial Control.

4.10 **The Chief Medical Officer and Chief Nursing and Quality Officer** has responsibility for identifying 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. 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

4.11 **The Chief People Officer, The Director of Communications and Engagement, Director of Transformation, and the Trust 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.

4.12 **The Chief Operating Officer and The Director of Estates and Facilities** 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

4.13 **The Divisional Governance Teams** - are responsible for managing their Divisional Risk register, utilising the agreed process and methodology, ensuring that it is regularly reviewed in appropriate governance meetings across the divisions and at the Divisional Management Board meetings.

4.14 **Risk Assurance Group (RAG)** - Ensures that the Clinical and Corporate Divisions are identifying and reviewing risks at all levels across the Trust and taking appropriate action to mitigate these, and have robust governance arrangements in place to manage this with evidence. Escalate risks to the Executive Group particularly when a risk or group of risks is escalating and has potential to affect the delivery of the annual or strategic plans and objectives. Ensure the Trust Risk Management Policy is reviewed annually and there are robust systems in place for identifying, managing and mitigating risk with a clear escalation process in place. To review all risks with no movement over four months.

4.15 **The Integrated 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.

4.16 **Executive Committee / Quality Assurance / Nominations and Renumeration/ Financial and Sub Board Committees**

4.16.1 **All committees** have a responsibility to provide to the Board assurance that in respect of 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 and report to the Board.

4.16.2 **All to ensure they act on lessons learnt from risks incidents and they review the risk reports on a quarterly basis.**

4.17 **Wards and Departments**

4.17.1 To identify, assess and monitor risks as they arise or are anticipated in accordance with the Risk Assessment Procedure (SOP0186). Risks may be identified as a result of

4.17.1.1 Incidents

4.17.1.2 Complaints

4.17.1.3 Claims

4.17.1.4 Serious Incidents Requiring Investigation and Never Events

4.17.1.5 Risk Assessments

4.17.1.6 External and internal reviews, inspections and assessments

4.17.1.7 External and internal audit activity

4.17.2 All such risks will be referred to and recorded on Care Group or Divisional Risk Registers, which will then be used to ensure the effective management of those risks.

4.18 **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.

5 Risk Appetite

5.1 See Risk appetite statement – Appendix 1

5.2 Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

5.3 Risk appetite is a core consideration in any corporate risk management approach. No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take.

5.4 The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

5.5 Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run. The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

5.6 The Trust's risk appetite is expressed in two key ways. Firstly, through the score attributed to particular risk impacts, and secondly through the approach to risks which have specific overall risk scores.

5.7 The Trust uses a risk matrix which is common across the NHS and globally recognised standard for risk measurement and management.

5.8 Good Governance Institute – Risk Appetite Descriptions – see appendix 2

5.9 Risk Appetite Summary Table – see appendix 3

6 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Every year	Head of Corporate Governance & Legal	Executive Group and Trust Board Risk Assurance Group	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 divisional governance groups monthly	Divisional Governance Teams	Executive Group and Trust Board Risk Assurance Group	Where gaps are recognised action plans will be put into place

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
The Integrated Audit Committee	Oversight of Risk Management and systems of control every six months	Chair of the Audit Committee	Trust Board	Where gaps are recognised action plans will be put into place
A review of all risks with no movement	Every four months	Chair of Risk Assurance Group	Executive Group	Where gaps are recognised action plans will be put into place
A review of closed risks	Every six months	Chair of Risk Assurance Group	Executive Group	To ensure learning is take place, where gaps are recognised action plans will be put into place

7 Training and Implementation

7.1 To support the implementation and embedding of the risk management policy and procedures the following training is available.

7.1.1 Every two years Risk Management training is provided by an external company to the Board.

7.1.2 A more in depth risk training presentation, Risk Management for Governance Staff, is delivered by the Risk Manager for staff in Governance roles.

7.1.3 As a result of in depth Risk Register Reviews by the Risk Manager, bespoke training is available to all staff teams, tailored to their specific needs and includes advice and guidance on the management of risk in their area and support with development of risk registers.

8 Equality Impact Assessment Statement & Tool

A screening process has been carried out and this policy does not require a full impact assessment.

9 References

Document	Ref No
References:	
Trust Associated Documents:	
SOP0064 - Risk Management Standard Operating Procedure (1 attachment)	SOP0064
SOP0165 - Board Assurance Framework (1 attachment)	SOP0165
SOP0166 - Producing Risk Register Reports from RiskAssure (1 attachment)	SOP0166
SOP0186 - Risk Assessment Procedure (1 attachment)	SOP0186

SOP0039 - Serious Incident SI - Procedure (1 attachment)	SOP0039

10 APPENDIX 1 - Risk Appetite Statement

The Trust Board has considered and agreed the principles regarding the risks that Medway NHS Foundation Trust is prepared to seek, accept or tolerate in the pursuit of its objectives.

The Trust Board has taken a cautious view regarding the risks that it is prepared to take in terms of risks to quality and patient safety, compliance and regulation, reputation, workforce and external stakeholders.

In recognition of a challenging financial climate, the Trust Board has taken a view to reduce its risk appetite for financial controls.

In all these areas the Trust expresses a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward.

Alternatively, the Trust Board has set a high appetite for innovation, indicating an open approach and willingness to consider all potential delivery options while also providing an acceptable level of reward, (value for money).

This Statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds therefore supporting delivery of the Trust's Risk Management Strategy and Policy.

The Board understands that there is a balance to be maintained between key risk areas and that sometimes risks in some areas will need to be taken to manage risks to an acceptable level in other areas. The Trust's risk management framework requires that where the Trust's risk appetite is exceeded the risk review governance process includes:

- scrutinising the adequacy of mitigating actions and controls
- agreeing the timeline for bringing the risk within the acceptable risk tolerances
- monitoring progress
- determining any further actions and escalation routes if needed

Quality and Patient Safety

The Trust is responsible for ensuring the quality and safety of services it delivers. The provision of high quality services is of the utmost importance to the Trust and the Trust has low appetite for risks that impact adversely on quality of care. The Trust is strongly adverse to risks that could result in non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. The Trust has low appetite for options that impact on patient safety, the Trust will avoid taking risks that will compromise patient safety.

Compliance and Regulation

The Trust has been, and continues to be under regulatory scrutiny, having been rated "Requires Improvement" by the Care Quality Commission. The Trust is keen to move at pace on its "Better Best Brilliant" Programmes of improvement, as this is key to optimising quality and financial sustainability and the Trust takes a minimal or avoidance approach to

risks that will compromise this.

The potential for non-compliance with legal and statutory requirements undermines public and stakeholder confidence in the Trust and therefore the Trust has minimal appetite in relation to these risks. The Trust has a preference for safe delivery options rather than risk breaching legislative and regulatory obligations.

Reputation

The Trust recognises that patient confidence and trust in the organisation is important for good outcomes. The Trust therefore has a moderate appetite for risks that may cause reputational damage and undermine public and stakeholder confidence. The Trust's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of **significant** repercussions for the organisation.

The Trust will maintain high standards of conduct, ethics and professionalism and will not accept risks or circumstances that could cause reputational damage to the Trust and/or the wider NHS.

Finance

Until such times as financial sustainability is re-established, the Trust's strategy will be based mainly on low-risk opportunities and on a highly controlled basis. The Trust is cautious in accepting the possibility of some limited financial loss. Value for money is still a primary concern.

Workforce

The Trust will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual or a team's competence to perform roles or tasks safely, nor any incidents or circumstances, which may compromise the safety of any staff member or group.

The Trust will only tolerate lower substantive staffing levels where there is visible competent leadership, a robust management plan is in place and prevailing shortages of staff are supported by trained and competent temporary staffing to keep within safe staff numbers.

For patient safety, quality care and service and financial sustainability reasons the Trust is willing to consider risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.

External Stakeholders

The Trust has a greater appetite to seek out opportunities and take greater inherent risks for higher rewards in pursuit of partnership development and collaborative working where this is considered advantageous to the Trust or wider health economy through implementing sustainability and transformation plans.

Innovation

The Trust has greatest appetite to pursue innovation and challenge current working practices in terms of its willingness to take opportunities where positive gains can be

anticipated and it supports the use of systems and technology developments within service delivery. The Trust is eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risks). The Trust is supportive of innovation, with demonstration of commensurate improvements in management control. It supports the use of information and patient management systems and technological developments being used to enhance operational delivery of current operations.
The Trust will consider risks associated with innovative technology and research and development approaches to enable the integration of care, development of new models of care and improvements in clinical practice to support sustainability.

11 APPENDIX 2 - Good Governance Institute – Risk Appetite Descriptions

Appetite Level	Described as:
None (0)	**Avoid**: the avoidance of risk and uncertainty is a Key Organisational objective.
Very Low (1-4)	**Minimal** (as little as reasonably possible): the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Low (5-8)	**Cautious**: the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Moderate (9-15)	**Open**: willing to consider all potential delivery options and choose, while also providing an acceptable level of reward (and Value for Money).
High (16-25)	**Seek**: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

12 APPENDIX 3 - Risk Appetite Summary Table

The diagram below summarises the Trust's risk appetite across these domains.

Domain	Appetite	Range	Score (trigger level)
Quality and Patient Safety	Very Low	1-4	4
Compliance and regulation	Very Low	1-4	4
Reputation	Low	5-8	8
Finance	Moderate	9-15	9
Workforce	Moderate	9-15	9
External Stakeholders	Moderate	9-15	9
Innovation	High	16-25	16

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