Stockport
NHS Foundation Trust

Risk Management Strategy and Framework

2018-2020

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FOREWORD

Our mission is that our patients' health is our priority, and our staff work together to provide high quality, safe health care services across Stockport, the High Peak and surrounding areas. Stockport NHS Foundation Trust (the Trust) is a complex organisation with an annual budget of around £303 million and the Trust employs over 5,500 staff to provide access to care for over 500,000 patients a year.

This Risk Management Strategy and Framework (the Framework) forms part of the Trust's wider internal control and governance arrangements. The Framework defines the strategy, policy, principles and mandatory requirements for how risk is managed across the organisation; highlights key aspects of the risk management and assurance process, and identifies the main reporting and escalation procedures

The Framework aims to follow good practice in risk management as described in ISO 31000 *Risk Management – principles and guidelines and UK Corporate Governance Code.* Monitoring and review of the development of the Framework will incorporate adoption of the *NHS Improvement - Developmental reviews of leadership and governance using the Care Quality Commission (CQC) well-led framework: guidance for NHS trusts and NHS foundation trusts*

The aim of effective risk management is to improve safety and reduce the probability of failure to meet regulatory compliance requirements or achieve strategic and operations objectives. This Framework describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed and an effective internal control, assurance and escalation system is in place.

This provides the Board of Directors with assurance about how the organisation is able to identify, monitor and escalate and manage risks in a timely manner at an appropriate level to enable effective decision-making. The Framework is a Trust wide document, and is applicable to employees, as well as seconded and sub-contracted staff at all levels of the organisation

Effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff, it is also significant in informing the business planning process, links closely to the Operational Plan 2018-20, Quality Improvement Plan 2018-20, performance management framework and overall public accountability in delivering health services

The Trust's primary objective is to provide high quality, safe health care and treatment to our patients and their families and has developed a Quality Governance Framework (QGF). The QGF defines the structures by which the Board of Directors can be assured that required quality, safety and experience standards are achieved.

The Trust recognises that the principles of governance must be supported by an effective risk management framework designed to deliver improvements in patient safety and the quality and effectiveness of care we provide as well as the safety of its staff, patients and visitors. Effective dynamic risk management at all levels, and a positive safety culture, is critical for the sustainability and on-going success of the Trust.

There are a number of strategy and policy documents which underpin this Framework. These documents include:-

- Trust Strategy
- Quality Governance Framework
- Quality Improvement Plan
- Clinical Audit Strategy
- Incident Reporting Policy (under review)
- Serious Incident Policy (under review)
- Complaints and Concerns Policy (under review)
- Operational Plan

Chief Nurse and Director of Quality Governance

1. INTRODUCTION

This framework, alongside other strategies/frameworks highlighted below is a key enabler for the successful delivery of the Trust's vision, values, behaviours and strategic objectives contained within the strategic domains, which we all have a part to play in delivering. The Board of Directors needs to be assured that there is a clear assurance and escalation framework in place to enable staff to escalate issues and risks. In order to do this the Board of Directors will foster a culture of transparency, openness and continual learning centred on patients, underpinned by our vision, values and behaviours.

2. DUTIES AND RESPONSIBILITIES

Chief Executive

The Chief Executive Officer (CEO) has overall responsibility for ensuring that an effective governance system, including risk management, is in place across the Trust, meeting all statutory requirements and adhering to guidance issued by NHS Improvement and the Department of Health in respect of governance and risk management. To fulfil this responsibility the CEO will ensure that:

- full support and commitment is provided and maintained in risk management activities;
- an appropriate Board Assurance Framework is in place; and
- the Annual Governance Statement adequately reflects the risk management issues within the organisation.

Chief Nurse & Director of Quality Governance

The Chief Nurse & Director of Quality Governance is the responsible Executive for the development and maintenance of the organisation wide risk management systems and processes

Executive Directors

The Executive Directors have delegated responsibility for their respective functions from the Chief Executive. However, responsibility for the day to day management of risk is devolved to the Business Groups and Corporate Departments.

Non-Executive Directors

Non-Executive Directors have a duty to ensure that the Trust has sufficient control measures in place to be able to effectively manage risk. Non- Executive Directors are members of both the Quality Committee, which is the Board sub-committee with overarching responsibility for organisational and clinical risk, the Performance and Finance Committee, which is the Board sub-committee with overarching responsibility for financial risk, and the Audit Committee with independent oversight of risk management systems and processes.

Deputy Director of Quality Governance

The Deputy Director of Quality Governance has lead responsibility for ensuring that the Trust has appropriate systems and processes in place to manage the function of integrated governance which include the following:

- Board Assurance Framework and processes
- Risk Management – systems and processes
- Incident Reporting
- Patient Safety
- Health and Safety, which includes manual handling and fire
- Governance, which includes Information Governance

Business Group Senior Management Teams / Heads of Corporate Departments

Accountability for the Business Groups lies with the Associate Medical Directors, Business Group Directors, and Associate Directors of Nursing (Senior Management Team). Corporate team escalation is via the Deputy Director of Quality Governance or Executive Lead membership.

Each Senior Management Team/Head of Corporate Department is accountable for the management of risk within their Business Group/Corporate Department. They will ensure that their risks on the Risk Register are reviewed in line with this strategy and framework. They are responsible for implementing and monitoring any identified risk management control measures needed within their designated area(s), ensuring that they are suitable and sufficient. Risks will be monitored corporately if they score 15 or above (guide) using the Trust's risk scoring matrix. Action must be undertaken by management in the Department/Business Group where the risk has been identified.

Business Group Governance Managers

The Business Group Governance Managers work within the four Business Groups and Corporate teams, including Estates and Facilities Department. They co-ordinate the risk management and governance agenda in the Business Groups and provide real time information to support risk mitigation. They are responsible for the day to day direction of the risk agenda in the Business Groups working with their Senior Management Teams. They are members of the Safety and Risk Group, providing a direct escalation route from the Business Groups through the Governance structure.

Other Managers in the Trust

All managers have a delegated responsibility for the management of risk in their Departments, Wards and any other areas. Risk management is integral to their day to day management responsibilities, and managers are authorised to mitigate risks identified at a local level wherever possible. If risks cannot be mitigated locally, issues should be escalated through the management lines of accountability, and action undertaken by management in the Department, Business Group or area where the risk has been identified.

All Trust Staff and Volunteers

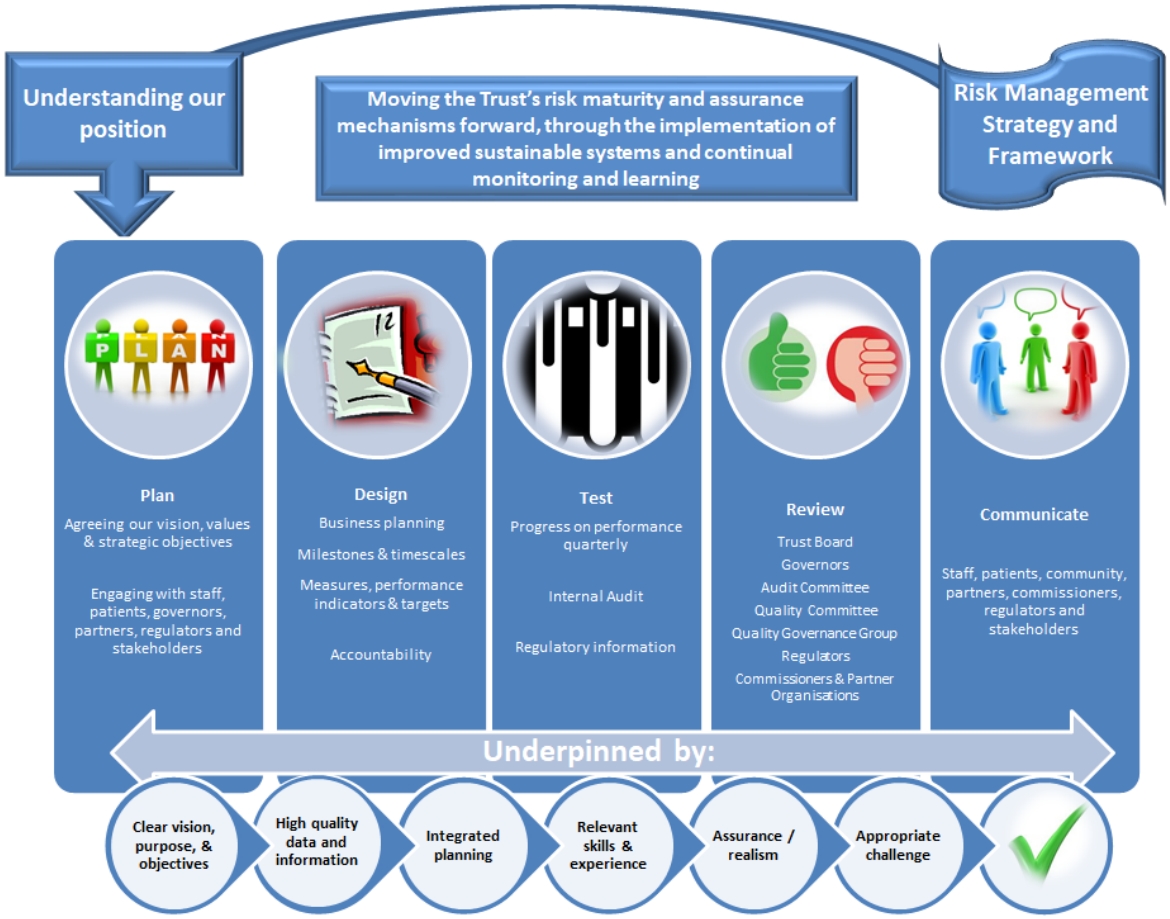
The management of risk is the responsibility of all managers, staff and volunteers throughout the organisation and they have a responsibility to be risk aware at all times. Every effort should be made to maintain a safe environment and safe systems of work, thereby reducing the potential to cause harm to patients, staff and others and hence negatively affect the reputation and assets of the organisation. The Trust aims to achieve this within a progressive, honest and open environment, where risks, incidents, accidents, mistakes / errors and 'near misses' are identified quickly and acted upon in a positive and constructive way, which either eliminates the risk or reduces the likelihood of future occurrence or impact. Staff will be provided with education, training and support to enable them to meet this responsibility through the mandatory training programmes as a minimum.

All employees and volunteers have a personal responsibility to, as appropriate:

- comply with Trust strategies, policies, procedures and guidelines;
- be aware of risks at all times and take reasonable action to identify, eliminate where possible, or control them;
- work within their own level of competence;
- notify line managers of risks they have identified which cannot be adequately managed;
- participate in risk management education and training;
- use any safety equipment, personal protective equipment and adopt safe working practices; and
- co-operate with management, representatives of enforcement agencies and auditors in respect of Health and Safety issues and the investigation of incidents.

3. THE RISK MANAGEMENT STRATEGY AND FRAMEWORK

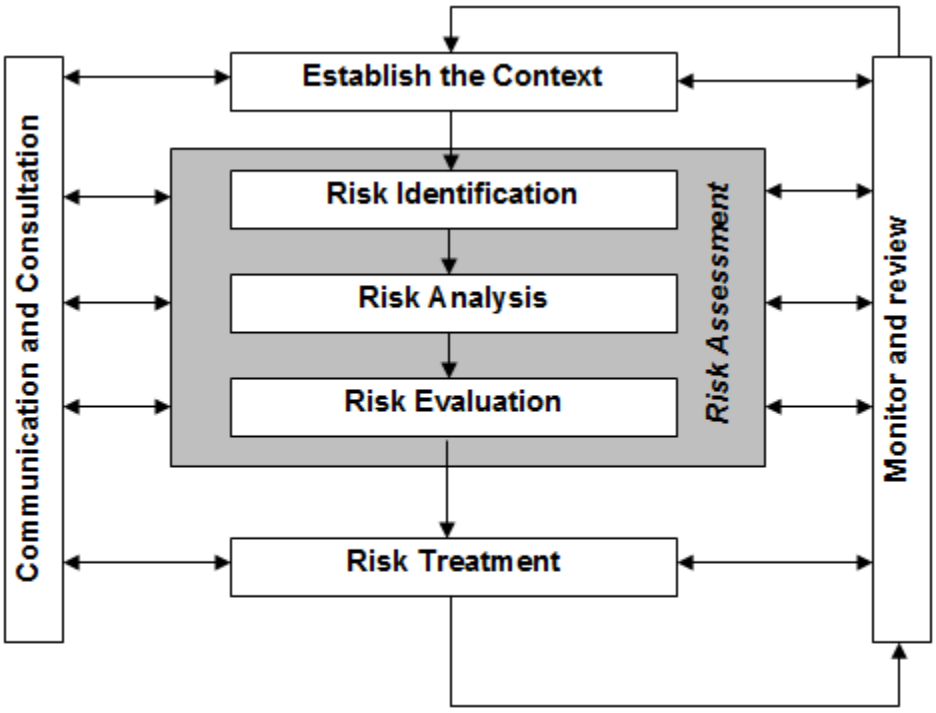
The Risk Management Strategy and Framework document has been developed in response to internal and external audit recommendations, an internal review of our risk management systems and processes and feedback from Board members regarding opportunities for improvement. This is the first iteration of a new combined strategy and framework which will undergo an early review by October 2018, with subsequent at least annual reviews taking into account feedback from staff in divisional and corporate teams, internal / external audit and other external sources / inspections. Progression against implementation of the six key risk management priorities for 2018/20 (Section 12) will be monitored and reported on a quarterly basis from April 2018. The diagram below details the steps we are taking on a continual basis to deliver this strategy & framework



4. IMPLEMENTING THE RISK MANAGEMENT STRATEGY AND FRAMEWORK

Risk management process

To ensure consistency the Trust operates a standard risk management process. The main stages are shown below, with a detailed overview of each step provided below



Source: ISO 31000

Step 1: Establish the context

To 'establish the context' or scope means to define the internal and external parameters to be considered when identifying and managing risks to objectives. One of the most important aspects of the risk assessment is accurately identifying the potential hazards and the Trust's Risk Assessment Procedure provides additional detail on how to approach this based on Health & Safety Executive guidance.

Establishing the context is basically answering the question ***'What are we trying to achieve?'*** as we cannot start any venture without first clearly defining its scope and clarifying the objectives that are at risk.

Internal context includes all the internal environmental parameters and factors that influence the Trust's ability to achieve its objectives. It includes its internal stakeholders, its approach to governance (structure, policies, objectives, roles, accountabilities, and decision-making process), its contractual relationships and its capabilities (knowledge and human, technological, capital, and systemic resources), culture and standards.

External context includes all the external environmental parameters and factors that influence the Trust's ability to achieve its objectives. It includes external stakeholders (values, perceptions, and relationships) as well as key external drivers and trends that influence objectives (social, cultural, political, legal, regulatory, financial, technological and economic environment).

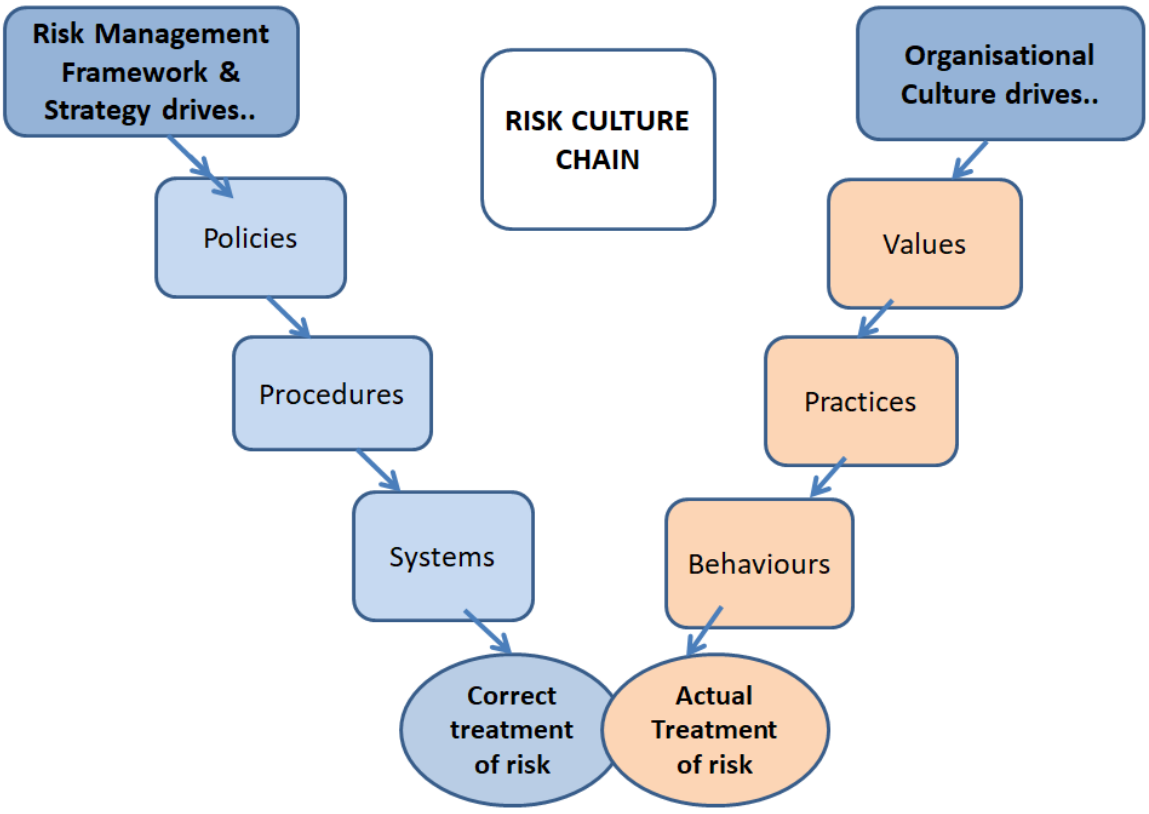
Risk Culture

Essentially risk management is a decision making process. We all make decisions about risk throughout our daily lives, influenced by our personal circumstances, health and safety considerations and our evaluation of the benefits or harm likely to come as a result of our decision. Generally we calculate how much risk will be involved by considering what has happened before in similar circumstances. Where the result was positive we are more inclined to make the same or similar decision than if the previous decision resulted in substantial loss or harm.

The Risk Culture Chain

The individual response towards risk greatly influences decision making and in the work setting this inevitably has an effect on organisational decision making and therefore risk management. Not everyone will have the same perception of the likelihood and possible consequence of each risk; each member of staff will have a strong preference for a specific response to risk based on their individual responses to risk. For effective risk management it is essential that, as far as possible, individual bias is removed and a subjective assessment of risk is made.

Managing risk effectively takes time but the rewards gained through **improved decision making**, **increased organisational resilience** and an increased **ability to take advantage of positive opportunities** are benefits which go beyond the assurances that risk management provides. Risk and safety culture surveys and associated actions should form part of our Quality Improvement Priorities for 2018/19.



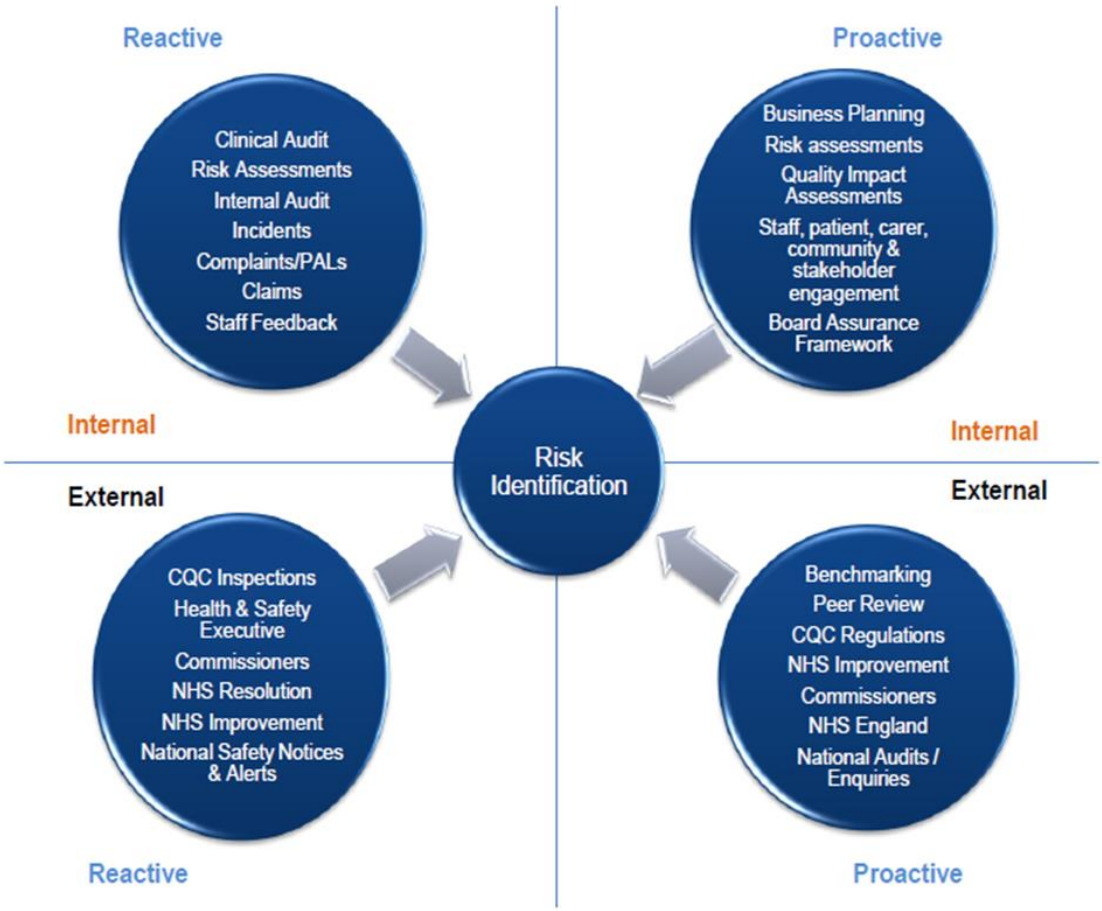
If Strategy and Culture are fully aligned then Actual and Correct Risk Treatment will match

Step 2: Risk assessment

Risk assessment is made up of three processes: identification, analysis and evaluation. In step two we are attempting to answer the following questions: **'What could affect us achieving our objectives?'** and **'Which of those things are most important?'**

Risk identification

Risk identification involves finding, recognising and describing the risks that could affect the achievement of objectives. It finds possible sources of risk as well as conditions, behaviours, events and circumstances that could affect objectives. It also includes identifying possible causes and potential consequences. There are a variety of risk identification techniques, each of which has strengths and weaknesses, so we should use more than one approach to identify risks. A specific risk owner should be identified for each risk. Ideally the risk owner will also own the related objective or significantly influence its achievement. If an individual owns a risk, it is more likely to be understood and monitored, and appropriate controls are more likely to be in place. The diagram below provides examples of risk identification / source

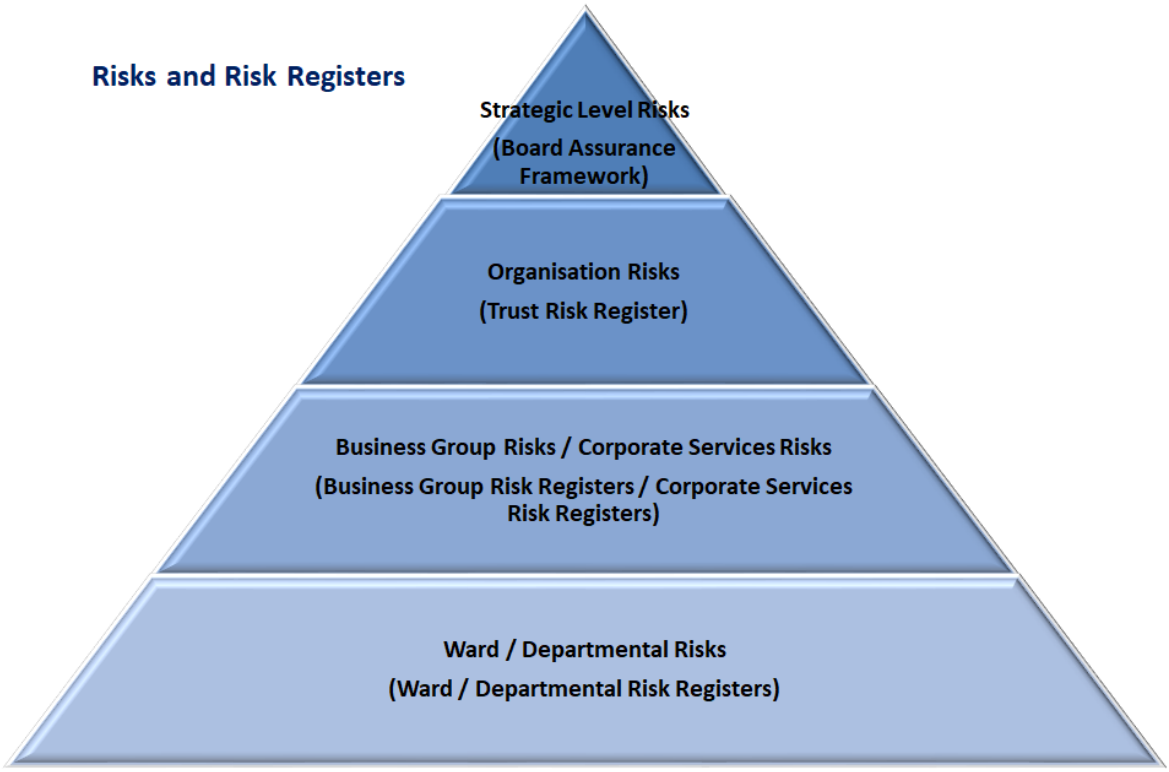


Risk analysis

Risk analysis determines a risk's significance by considering its potential impact/consequence if it were to occur and the likelihood of the risk occurring. Assessing impact/consequence and likelihood impact together produces an overall risk severity rating using the risk matrix. Each risk event on our risk registers has an initial, current, and target risk rating. Where risks are outside acceptable levels of tolerance, a target risk score should be agreed – the level that future mitigation should aim to achieve or better; this will vary over time and should be set and revised as per the policy in relation to authorities to manage risk.

Risk types (Risks and Risk Registers)

Authorities to manage risk and monitoring arrangements can be found in Step 4.



- **Strategic risks:** Impact on strategic objectives risks rated 20 & above*
- **Organisation risks:** Risks rated 15 & above*
- **Business Group /Corporate Services:** Risks rated 12 & above*
- **Ward/Department Risks** Risks rated 10 & below*

*Guide: lower rated risks may also be escalated – all risks must also sit on an operational risk register(s).

Risk categories

- Impact on the safety of patients, staff or public (physical/psychological harm)

  Includes, for example:
  - potential for or actual Injury/harm whether or not requiring treatment
  - increased length of hospital stay or time off work
- Quality/concerns/audit

  Includes, for example:
  - potential for adverse outcomes, treatment and overall service quality together with patient satisfaction.
- Human resources/organisational development/staffing/competence/training

  Includes, for example:
  - recruitment issues

- staffing levels
- staff satisfaction
- sickness/absence
- access to and attendance for training

- Statutory duty/ regulation/compliance

  Includes, for example:

  - breaches of regulation, statutory duties and/or compliance

- Adverse publicity/reputation

  Includes, for example:

  - potential for public concern
  - meeting expectation
  - media interest and rumour whether founded or not

- Business aims/projects

  Includes, for example:

  - potential for contract change
  - loss of service
  - income reduction
  - cost increase
  - schedule slippage

- Finance

  Including:

  - potential for small to major financial loss
  - claims
  - fraud

- Service/business interruption
  Includes, for example:
  - potential for short service interruption through to permanent loss of a service or facility including IT
- Environmental impact
  Includes, for example:
  - potential for minimal through to major impact on the hospital environment or more widely in the local area.

A summary of the matrices is provided below – a detailed matrix is provided in Frequently Used Forms on the intranet (Currently under review) and Step 4 details risk assessment categorisation, authority to manage risks and actions required.

Consequence / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Likelihood	Definition	Estimated Probability	Lessons Learned
Almost certain	This event may be imminent or there are strong indications it will occur in the future. Not confident risk can be managed at this level and contingency is required	More than 80% chance of occurring	A regular occurrence. Circumstances found frequently
Likely	This event is likely to occur in most circumstances. Requires additional mitigation/contingency. Little confidence risk can be managed at this level	51% to 80% chance of occurring	Has occurred from time to time and may do so again in the future
Possible	This event is likely to occur at some time even if controls operate normally. Confident risk can be managed at this level	21% to 50% chance of occurring	Has occurred previously but not often, and may have been in a limited way
Unlikely	Not expected, this event has a small chance of occurring at some time	6% to 20% chance of occurring	Has not happened, or happened in a very limited way
Rare	Highly unlikely, will occur only in very exceptional circumstances Very confident risk can be managed at this level Controls operate normally	Less than a 5% chance of occurring	Has rarely happened

Use of Risk Registers in Assurance Committees

Each assurance committee will review specified sections of the Trust Risk Register (risks above 15). The Chair of each committee will ensure that there is a focus throughout the agenda on the controls in place to manage the risks identified in the Trust Risk Register that relate to their own key area. Additionally, they will assess from the assurance received that the Trust Risk Register contains any of the risks highlighted or identified through assurance papers received. Whilst the Quality Committee will review the Trust Risk Register in its entirety, the role of the Audit Committee is to seek assurance that the Trust has systems and processes in place to manage risk.

Risk evaluation

Risk evaluation involves deciding the risk level and the priority for attention. Not all risks are equally important, so we need to filter and prioritise them, to find the worst threats (and the best opportunities). This will help us decide how to respond. When prioritising risks, we could use various characteristics, such as how likely they are to happen, what they might do to our objectives, how easily we can influence them, when they might happen, and how might they be amplified etc..

Reputational risk

One consideration in risk analysis is why some relatively minor risks or risk events, as assessed by risk leads, often elicit strong public concerns and result in substantial higher impacts than anticipated or than our technical risk assessment predicts. This is because they interact with psychological, sociological, and cultural perceptions of risk and what constitutes 'risky' behaviour, which can amplify public responses to the risk or risk event. In other words, the news media, stakeholder groups/networks, and others may amplify risk and amplified risk often results in secondary impacts above what we might anticipate. We should be cognisant of this fact and include the assessment of potential social amplification when undertaking our technical assessment of a risk and its impact and likelihood.

Step 3: Risk treatment

In step three we are attempting to answer the following questions: **'What shall we do about these risks?'** and **'Having taken action, did it work?'** In this process, existing controls are improved or new controls are developed and implemented. It involves evaluating and selecting options to deal with risks that have negative and/or positive consequences.

The options are:

- Eliminate – stop undertaking the task completely
- Avoidance – undertaking the activity in a different way to prevent the risk occurring
- Reduction – taking action to reduce the risk
- Transfer – movement of the risk to another individual/organisation
- Acceptance – all of the above options are not possible and a contingency plan is developed

After identifying and assessing each risk, risk registers should be updated.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways that they need to be informed about

Contingency Plans **–** if a risk has already occurred and cannot be prevented ***or*** if a risk is rated purple or red (extreme or high impact / consequence) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded in the action plan column on the register. Good risk management is about being risk aware and able to handle the risk and not being risk averse.

Risk proximity

This indicates when the risk is likely to materialise or anticipated timescale. There are three categories:

- Within three months;

- Between three and twelve months; or
- Twelve months or longer.

Considering the proximity, or how soon a risk may occur, can help to compare risks for decision-making.

Note: We can plan to address risks, but nothing will change unless we actually do something. Planned responses must be implemented in order to tackle individual risks and change risk exposure, and the results of these responses should be monitored to ensure that they are having the desired effect. Our actions may also introduce new risks for us to address.

Step 4: Risk monitoring and review

Monitoring and review must be continual and repeated, so that appropriate action can be taken as new risks emerge and existing risks alter due to changes in the Trust's objectives or the internal and external environment. The table below defines both the authorities to manage risk and mandated review dates.

Risk Rating	Priority	Level of Action	Authority to Manage Risk	Minimum Review Requirements by Designated Lead
Green Very Low (1 to 3)	Very Low	• No further action or records required. Manage via routine process	All staff undertaking assessments	-
Yellow Low (4 – 6)	Low	• Departmental / ward management action required to reduce risk as low as reasonably practicable	Ward / Department Manager	Annually
Amber Moderate* (8 – 12)	Medium	• Business Group / Coporate Service actin required to reduce risk as low as reasonable practicable • Monitored by Business Group Quality Board / Subcommittee as appropriate *Note – some risks may require escalation at this level	Business Group Directors / Deputy Directors / Directors	6 monthly
Red High (15 to 16)	High	• Business Group management action required to reduce risk as low as reasonably practicable • Approval of rating by Business Group Board • Quarterly Risk Report to Business Group Board • Risks rated 15 & above approved at Quality Governance Group ahead of inclusion to the Trust Risk Register • Monitoring through Quality Governance Group quarterly reports, with assurance to the Quality Committee and onward escalation	Business Group Directors / Deputy Directors / Directors	Quarterly

		to the Board of Directors as required		
Purple Extreme (20 and 25)	Extreme	• Business Group management action required to reduce risk as low as reasonably practicable • Approval of rating by Business Group Board • Monthly Risk Report to Business Group Board • Quarterly Risk Report to Business Group Board • Risks rated 20 & above approved at Quality Governance Group ahead of inclusion to the Trust Risk Register • Monitoring through Quality Governance Group quarterly reports, with assurance to the Quality Committee and onward escalation to the Board of Directors as required	Business Group Directors / Deputy Directors / Directors	Monthly

Step 5: Communication and consultation

We must continually and repeatedly communicate with and consult internal and external stakeholders, where possible, to gain input and agree ownership of risk assessment results. It is also important to understand stakeholders' objectives so you can plan their involvement and take their views into account in agreeing whether a specified risk level is acceptable or tolerable. Discussions could be about the existence of risks, their nature, likelihood, impact and significance, as well as whether risks are acceptable or should be treated, and what treatment options to consider.

As a Trust we should take advantage of our experience to learn lessons and benefit future ventures. This means that we should spend time thinking about what worked well and what needs improvement, and recording our conclusions in a way that can be reused by ourselves and others.

5. RISK DOCUMENTATION

The Quality Governance Team provides a standard risk register template that should be used to capture risks. An exception would be if alternative, robust programme or project management arrangements were in place which includes / covers risks appropriately

Description of risk	A simple phrase that describes the risk: *"There is a risk that <risk event> as a result of <cause> which may lead to <impact>."*
Cause(s) and consequence(s) / impact	Causes (also referred to as risk drivers or influencing factors), both internal and external, should be explained. Consequences (also referred to as effects, impact or outcomes) should also be explained.
Link to objectives/ business plan priorities	Where possible, risks should be linked to our strategic objectives, legislative duties, major programmes/projects, business plan objectives or business-as-usual activities.
Existing controls	To aid risk assessment and action planning, the current measures to control the risk – and whether they are considered adequate – are recorded.
Assessment of risk and control	Risk ranking (impact and likelihood): to assist with prioritisation, risks are scored/given a ranking using the Trust's impact/consequence and likelihood matrix; this enables the 'most significant' risks to be identified. Current/residual scores and target risk scores are assigned.
Risk and control owner(s)	Owner (lead person): you need to assign risks and controls to a lead person responsible for ensuring they are adequately controlled and monitored.
Action(s)/treatment plans	Where a plan of action or treatments to address the risk have been agreed, they should form part of the register.
Dates	As the risk register is a 'living' document, it is important to record the date that risks are added or modified. If the register includes an action plan, you should provide target and completion dates for actions. To ensure all open risks are reviewed as per policy, you must provide a review date.
Comments/ updates	Where separate update/summary reports are not produced, risk registers should include a comments column to allow for useful updates, such as meetings to discuss the risk

Developmental areas to be included on the risk register include risk proximity, controls assurance assessment ratings, cost / benefit analysis and linkages to business continuity plans over the lifetime of this strategy & framework - Please refer to the six priority areas in Section 12

6. RISK APPETITE

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

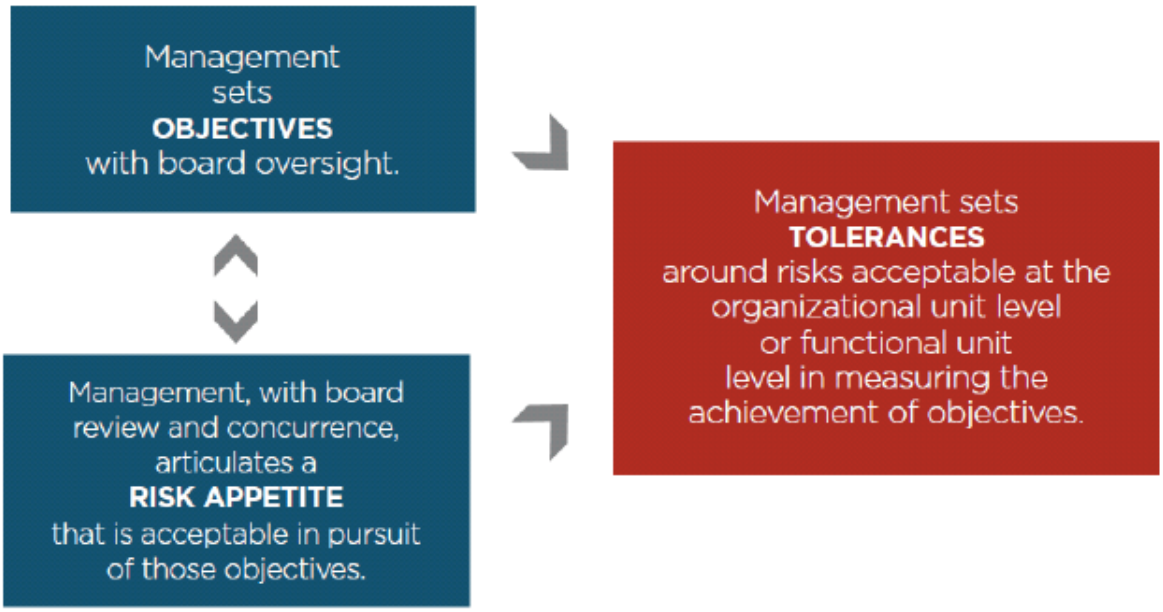
- The nature of the risks to be assumed;
- The amount of risk to be taken on; and
- The desired balance of risk versus reward.

The Board of Directors recognise that it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Indeed, only by taking risks can the Trust realise its objectives. It must, however, take risks in a controlled manner, reducing its exposure to a level deemed acceptable by the Board of Directors and, by extension, external inspectors/regulators and relevant legislation. The range of identified risks which the organisation is prepared to accept, tolerate or be exposed to is its risk appetite.

Methods of controlling risks must be balanced in order that innovation and imaginative use of limited resources are supported when it is to achieve substantial benefit. In addition, the Trust may accept some high risks because of the cost of controlling them. As a general principle the Trust will seek to control all risks which have the potential to:

- cause harm to patients, staff, volunteers, visitors, contractors and other stakeholders
- endanger the reputation of the Trust
- have severe financial consequences which would jeopardise the Trust's ability to carry out its functions
- jeopardise significantly the Trust's ability to carry out its normal operational activities
- threaten the Trust's compliance with law and regulation.

As part of the development of the new Board Assurance Framework the Board of Directors are currently reviewing the risk appetite aligned to the strategic objectives. The statement will define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question. Risks throughout the organisation should be managed within risk appetite, or where this is exceeded, action taken to reduce the risk.
The diagram below demonstrates the link between objectives, risk appetite and tolerances



Source: COSO, *Enterprise risk management — integrated framework*

7. BOARD ASSURANCE FRAMEWORK (BAF)

Organisations exist to achieve a purpose and the primary function of the Trust is to drive the Trust forward in achieving this purpose, whilst upholding the values and behaviours of the organisation. The purpose (or mission) is translated into strategic objectives, operating across different components of the business that must work effectively together.

At any point in time the Trust needs to be aware of the current state of progress with regard to its strategic objectives. Whilst there will always be elements of uncertainty, the Board of Directors need to be assured (positively or negatively) as to what is feasible and practicable with regard to the delivery of its strategic objectives. In order for the Board of Directors to receive the necessary assurance, the following governance components and processes are in place:

Strategic Objectives (strategic/business group level) which must be clear and measureable (other components of governance cannot function effectively or efficiently unless these clear objectives and associated success measures are in place);
Controls (policies, procedures, structures, staffing etc.) which must be put in place by management in order to achieve core objectives (taking into consideration known risks to achievement);
Performance against tangible measures of success should be regularly reviewed (and shortfalls/weaknesses identified as a risk to the achievement of the objectives);
Risks to the achievement of objectives and individual tangible success measures should be identified. Risks should be assessed and graded in terms of their impact on a particular or specific aim/objective and escalated for consideration as required;
Risk management decisions should be taken in light of: risk appetite; risk tolerance; and the cumulative impact and likelihood of any or all of the risks threatening achievement of a single objective;
Action should be taken in response to risk, including additions or amendments to the control framework to ensure it is effective.

The Board of Directors reviews risk principally through the following three interlocking and related mechanisms:

a. The Board Assurance Framework (BAF) sets out the strategic objectives, identifies key risks in relation to each strategic objective along with the controls in place and assurances available on their operation. Additionally, the BAF is cross-referenced to significant risks included on the Trust Risk Register (TRR) and will be supported by a developing assurance mapping exercise which will identify both gaps and also where assurance is duplicated or is disproportionate to the
risk or activity leading to efficiency / resource gains.

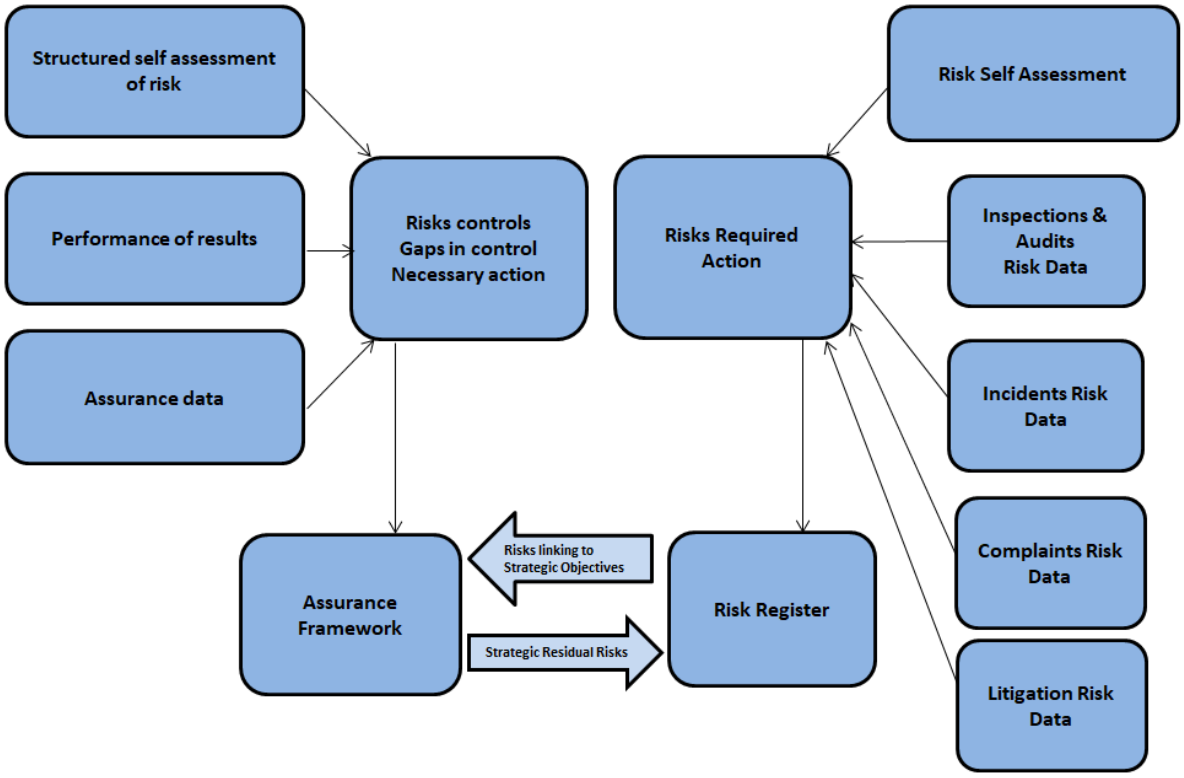
b. The Trust Risk Register (TRR) is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. The Executive Team are responsible for the escalation and de-escalation of risk from, and to the TRR.

c. The Annual Governance Statement is signed by the Chief Executive Officer. It sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the Board of Directors with the accounts

Our new Board Assurance Framework will:

- be a succinct document of the assurances generated around each strategic objective, rather than principal risks;
- record the Board's confidence in achievement of each strategic objective at any given point in time, given all the information available to them;
- be 'live' and support effective decision-taking and provide evidence and justification for the decision making process;
- influence the Board of Directors agendas according to where the largest gaps are perceived to exist in either a) confidence in current position or b) achievement against strategic objectives.
- be considered for every piece of information the Board of Directors receive and how it may affect its confidence about the likely achievement of a strategic objective.
- provide an opportunity to identify gaps in assurance or where existing controls are failing in an efficient and effective manner; and
- identify assurance is duplicated or is disproportionate to the risk or activity leading to efficiency / resource gains.

The diagram below demonstrates the linkages between the Board Assurance Framework and the Trust Risk Register.



Divisional adoption of the Strategic Objectives

Divisional Boards develop divisional objectives based on the Trust's Strategic Domains and risks are identified through business planning processes with plans included in the overarching Trust Strategy 2017/18-2020/21, monitoring is via the Trust's performance management framework. Business Group Quality Boards may choose to adopt a divisional assurance framework locally, as appropriate

BOARD ASSURANCE FRAMEWORK – SUPPORTING OUR JOURNEY FROM REQUIRES IMPROVEMENT TO OUTSTANDING

Strategic Domain

Principal Risk	

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee

Risk Rating by Quarter *Graph here*	Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
	Rationale for the Current Risk Score									
	Links to BAF Objectives									
	Links to the Trust Risk Register									

Strategic Domain

Q1	To aspire to the delivery of 'outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework

Key Controls / Influences Established (What are we currently doing about the risk?)	Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
Adequacy of Assurance (Level of Confidence)			None	None		
Overall Assessment of Assurance						

Quarter 1 Commentary:
Quarter 2 Commentary:
Quarter 3 Commentary:
Quarter 4 Commentary:

Assurance Rating	*Significant Assurance*	*Significant Assurance with minor*	*Partial assurance with improvements*	*No assurance*


improvement opportunities
required

8. RISK GOVERNANCE

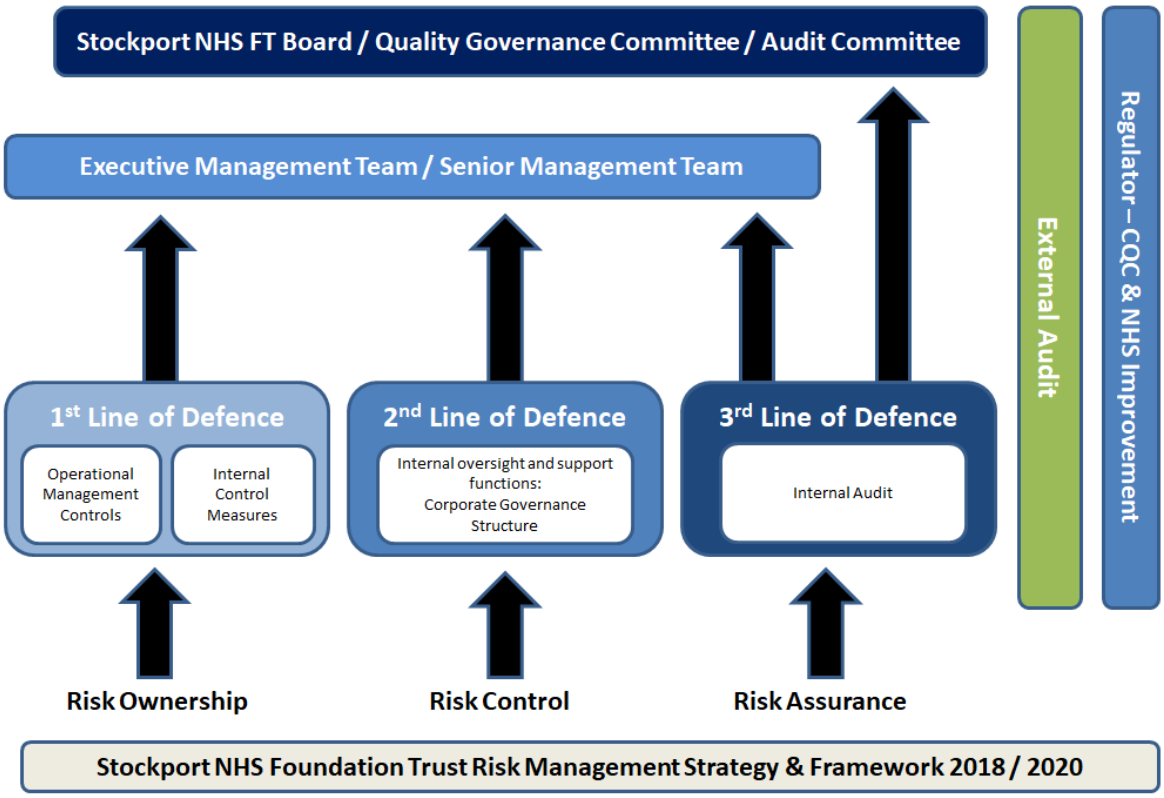
The Three Lines of Defence

The Three Lines of Defence model provides a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties. In the **Three Lines of Defence** model, management control is the first line of defence in risk management, the various risk control and compliance oversight functions established by management are the second line of defence, and independent assurance is the third. Each of these three 'lines' plays a distinct role within the Trust's wider governance framework.

First line – Information coming directly from front line operational teams may provide assurance that performance is monitored, risks identified and addressed and objectives are being achieved. Sources of assurance include, for example, good policy and performance data, risk registers and other management information.

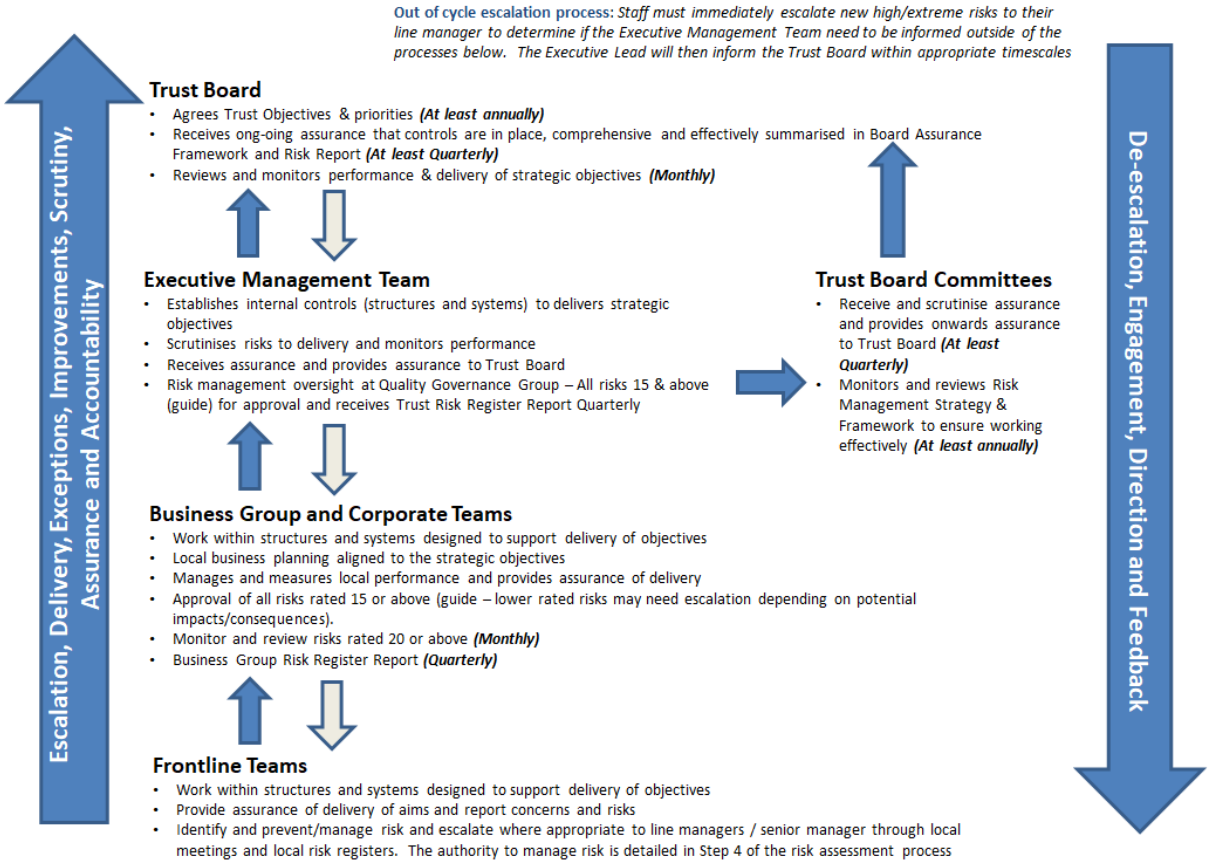
Second line - This work is associated with oversight of management activity and includes compliance assessments and reviews carried out to determine that policy or regulatory requirements are being met in line with expectations for specific areas of risk across the Trust; for example medicines management, health and safety and the delivery of the strategic objectives.

Third line - This level of assurance focuses on the role of internal audit, which carries out a programme of work specifically designed to provide an independent and objective opinion on the framework of governance, risk management and control. Internal audit will place reliance upon assurance mechanisms in the first and second lines of defence, where possible, to enable it to direct its resources most effectively, on areas of highest risk or where there are gaps or weaknesses in other assurance arrangements. It may also take assurance from other independent assurance providers operating in the third line, such as those provided by independent regulators, including NHS Improvement, the Care Quality Commission and the Health and Safety Executive.


Stockport NHS FT Board / Quality Governance Committee / Audit Committee
Executive Management Team / Senior Management Team
External Audit
Regulator – CQC & NHS Improvement
1st Line of Defence
Operational Management Controls
Internal Control Measures
2nd Line of Defence
Internal oversight and support functions: Corporate Governance Structure
3rd Line of Defence
Internal Audit
Risk Ownership
Risk Control
Risk Assurance
Stockport NHS Foundation Trust Risk Management Strategy & Framework 2018 / 2020

9. ESCALATION AND FEEDBACK MECHANISMS

Our process for reporting and escalating risks 'Ward to Board' is detailed in the diagram below. When we identify any significant control failings or weaknesses we must immediately report them, with details of corrective action, through local and corporate escalation routes.



Out of cycle escalation process

Staff must immediately escalate new high/extreme risks to their line manager / senior manager to determine if the Executive Management Team needs to be informed outside of the reporting and escalation process detailed above. The Executive Lead will then inform the Board of Directors within appropriate timescales.

Quarterly risk reports

The Trust Risk Register Quarterly Report (mitigated risks rated 15 and above / or lower rated risks which may significantly impact on objectives) will contain as a minimum: new/emerging risks, risks outside acceptable tolerance levels, progress of reviews and mitigation plans, shift, controls assurance assessment (in development), proximity of the risk and progress against the six key risk management priorities. This report will be presented for discussion and approval at the Quality Governance Group and for assurance at the Quality Committee with onward assurances / escalation to Board of Directors.

Quality Governance

This Framework, the Quality Governance Framework, and the Quality Improvement Plan 2018 – 2020 are intrinsically linked supporting the delivery of the Trust's Strategy 2017/18-20/21, incorporating the strategic objectives.

Quality governance is the combination of structures and processes at and below Board level to lead on Trust-wide quality performance which includes:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best practice; and
- identifying and managing risks to quality of care

Quality Led Organisation

A well led organisation puts quality at the heart of the work of the Board of Directors. Our Trust has the building blocks in plan or in place to ensure that we can provide confidence that we are delivering the strategic objectives and priorities.

✓ **Quality Improvement Plan**
Sets out our quality priorities and commitment to quality improvement

✓ **Quality Governance Framework & Risk Management Strategy and Framework**
Focuses on managing the risks associated with the delivery of our services

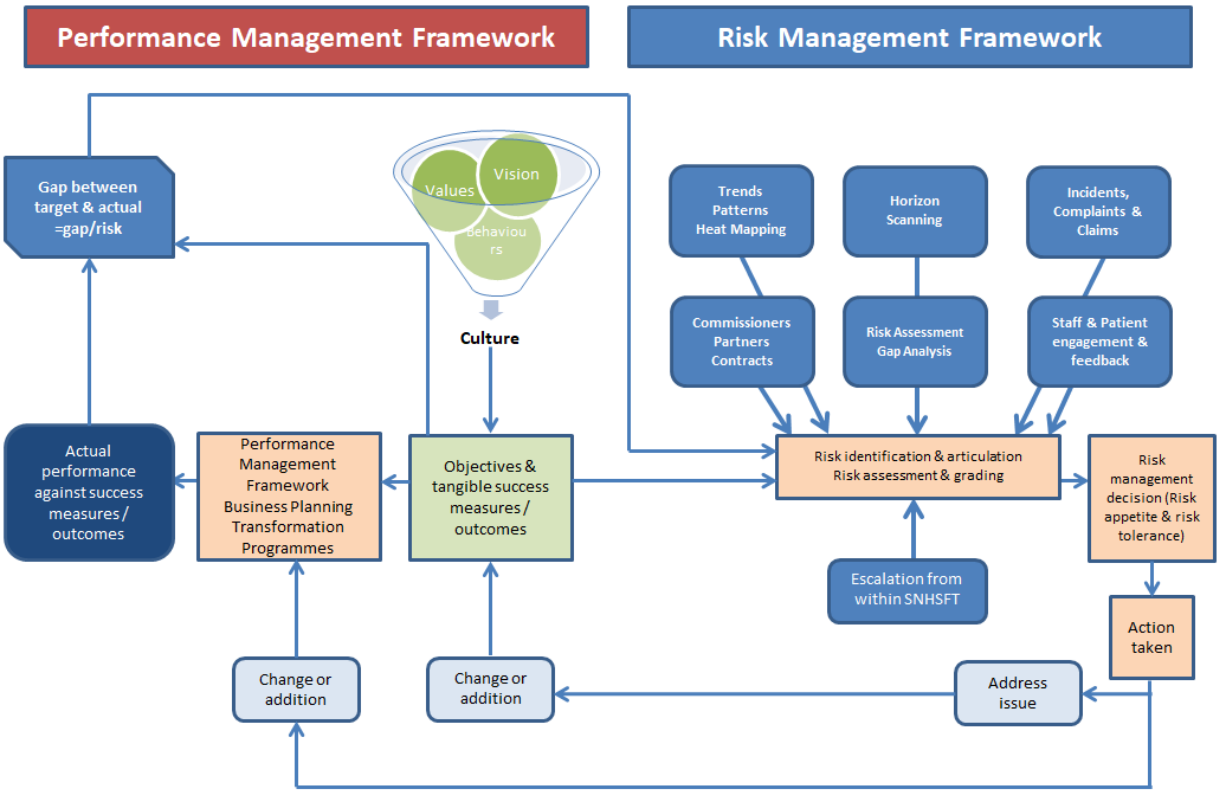
✓ **Assurance**
Providing confidence that the Trust is delivering the strategic objectives and priorities

✓ ✓ ✓ **Quality led organisation**

Together they put quality at the heart of the Trust Board's work

10. GOVERNANCE, RISK AND THE PLANNING & PERFORMANCE MANAGEMENT FRAMEWORK

Performance management and risk management are both integral parts of governance, as both are concerned with ensuring achievement of the strategic objectives. The Trust has a performance management framework in place with local business plans identifying risks to achieving objectives and service delivery improvements / changes. The diagram below details the components of governance and the relationship between performance management framework (currently under review) and risk management.



11. RISK MATURITY

We have identified six key priorities over the next three years to move along the risk maturity pathway. Risk Maturity is defined by the Institute of Internal Auditors as:

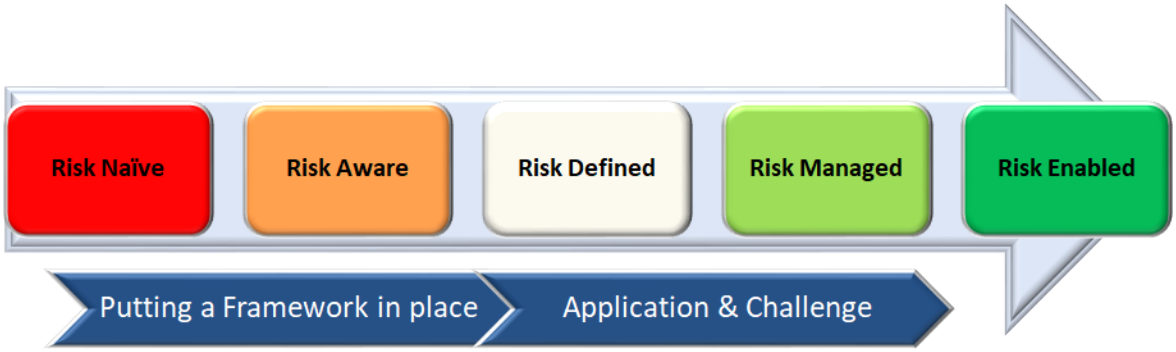
'The extent to which a robust risk management approach has been adopted and applied as planned by management across the organisation, to identify, assess, decide on responses to, and report on opportunities and threats that affect the achievement of the organisation's objectives.'

Risk maturity can be assessed on the basis of:

- the commitment to risk management by senior levels of management;
- the presence of working risk registers (with prioritised risks; assigned actions and assurances feeding back into the process) and an aggregated shortlist of highest risks reported to the Board;
- the extent to which risk management is embedded throughout the organisation; and
- co-ordination with strategic partners; and evidence that risks and opportunities are considered to inform decision making.

The Trust must assess itself against whether it is:

Risk Naïve
Risk Aware
Risk Defined
Risk Managed
Risk Enabled



Risk Naïve	No formal approach for risk management *(The organisation has little of no awareness of the importance of risk management)*
Risk Aware	Scattered silo based approach to risk management *(The organisation has considered risk management, and needs to embed systems)*
Risk Defined	Strategy and policies in place and communicated *(The organisation has considered risk management, and put in place strategies led by the risk management team. Strategy and policies are in place and communicated. Risk appetite is defined*)
Risk Managed	Trust-wide approach to risk management developed and communicated *(Staff throughout the organisation are aware of the importance and the organisations response to risk)*
Risk Enabled	Risk management and internal control fully embedded Trust wide (*Driven by the Board, staff at all levels actively consider issues of risk in all areas of activity and develop control and assurance processes to manage those risks. Risk management and internal controls are fully embedded into the operations*)

12. OUR SIX PRIORITIES FOR 2018/2020

1. New approved Risk Management and Strategy Framework 2018 / 2020 (April 2018)

Expected outputs and outcomes

1	The risk maturity of the organisation will progress from 'Defined to Enabled' by 2019/20.
2	The Board of Directors will be assured that the risk profile of the Trust is known and there is balance between local ownership and central monitoring and assurances with clear escalation routes.
3	Clear ownership of risks at senior management and sub-committee / group level.
4	Clearly defined risk appetite.
5	Moderation process of risks in place across the organisation.
6	Sighted on and managing risks with partner organisations (Governance between organisations).
7	Clear mechanisms in place to support front line teams and managers from Corporate Services.
8	Alignment with and supporting the 2020 Vision, Clinical Strategy, Workforce and Organisational Development Strategy, and the Quality Improvement Plan.

Priorities for 2018/2019
a) Review underpinning risk management and assurance policies, the categorisation matrix for risk assessment, procedures & guidance and update accordingly.
b) Engage with partner organisations in relation to shared governance, risk and assurances (governance Between Organisations) to enable a wider health economy approach to risk & assurance.
c) Develop a revised Quarterly Risk Management and Risk Register Report from quarter 1 2018/19 for Quality Governance Group and Business Group Quality Board versions.
d) Training needs analysis and delivery (risk based approach) to support delivery of the strategy and framework.
e) Develop the SNHSFT Risk Management Early Warning System metrics by Q3 2018/19.
Monitoring progress: Quality Governance Group.
Board Sub-Committee: Quality Committee.
Internal assurances: Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework.
External assurances: Internal Audit 2018/19 programme, Care Quality Commission Well Led Assessments.

2. New Board Assurance Framework (BAF) document development and implementation

Expected outputs and outcomes

The BAF becomes a 'well thumbed' document by the Executive Team and is considered as part of the business planning processes.	
2	The Non-Executive Directors use the BAF as a tool to constructively challenge at sub-committee and Board level.
3	A 'Live' document supporting effective decision taking and provides evidence and justification for the decision making.
4	The BAF is used as an assurance mechanism with NHS Improvement, Care Quality Commission, Commissioners and other stakeholders.
5	Supports the Annual Governance Statement
Priorities for 2018-2019	
a) Development and implementation of a new BAF and quarterly report	
Monitoring progress: Quality Governance Group. **Board Sub-Committee:** Quality Committee. **Internal assurances:** Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework. **External assurances:** Internal Audit 2018/19 programme, Care Quality Commission Well Led	

3. Risk Registers established – Moderation exercise & controls assurance assessments required with education & training / support

Expected outputs & outcomes:	
1	The Board will be assured that the risk profile of the Trust is known and there is balance between local ownership and central monitoring and assurances.
2	Board members will be fully sighted on the risks and implications to the Trust with a strong

	association between risk management and managing the business.
3	Risk management informs the planning process with contingency arrangements in place.
4	Key component of supporting a quality led organisation.
5	Shift in risk profile with a lower proportion of higher rated risks.
Priorities 2018/19:	
a) Review of the description of risks and further analysis of the existing control measures with an assessment and definitions to ensure a consistent approach; b) Obtaining assurances that the existing control measures will lead to the desired outcome; c) Obtaining assurances that controls are implemented & adhered to; d) Linkage to the new Board Assurance Framework document; e) A full review of all risk registers including risk descriptors, ratings mitigating actions and control measures - supporting managers & leads; f) Review the process for assurances for high impact risks (those rated extreme for impact and low for likelihood); g) Develop a risk profiling approach on the system; h) Review other sources of risk identification including Control of Substances Hazardous to Health (COSHH) and manual handling; i) Continued horizon scanning and analysis of sources of risks; j) Triangulation of risk information with other sources including dashboard development at ward, department, business group and corporate level; k) Develop a register of risk registers; l) Undertaking a risk based training needs analysis for managers and clinicians regarding risk and assurance; m) Review the Risk management early warning system; and n) Work with internal audit to plan a year one review of progress and outcomes.	
Monitoring progress: Quality Governance Group. **Board Sub-Committee:** Quality Committee / Audit Committee **Internal assurances:** Quarterly Risk Management Report & NHSI Well Led Framework Developmental Reviews. **External assurances:** External / internal auditors reports, Annual Governance Statement, Care Quality Commission – Well Led Assessments	

4. New committee structure in place from April 2018. Review of lower group reporting structures is required.

Expected outputs & outcomes:	
1	There will be clear lines of reporting and escalation routes with the Board receiving the right quality assured information, in a timely manner in a format that allows the Board of Directors to make informed decisions about risks to the strategic objectives.
Priorities 2018/19:	
a) Review the lower group governance structure and implement changes accordingly. b) Review effectiveness post implementation annually.	
Monitoring progress: Quality Governance Group **Board Sub-Committee:** Quality Committee / Audit Committee **Internal assurances:** Quarterly Risk Management Report and NHSI Well Led Framework Developmental Reviews. **External assurances:** External auditors – Annual Governance Statement, Care Quality Commission – Well Led Assessments.	

5. Safety Culture assessments undertaken: cycle of assessments to be implemented and triangulated with other information / data

Expected outputs & outcomes:	
1	Determine gaps in assurances regarding incident reporting and escalation systems.
2	Identify 'pre incident' issues – staff concerns / 'noise' in the system – early warnings.
3	Understanding practice regarding undertaking proactive risk and impact assessments when introducing change.
4	Survey can heat map and find out the 'what' is happening and interviews will find out 'why'.
Priorities 2018/19	
a. Review national tools; b. Implement a cycle of assessments with feedback mechanisms; c. Triangulate findings through dashboard development / collective intelligence; and d. Through continual staff engagement develop a feedback matrix with optimum feedback mechanisms for specific staff groups.	
Monitoring progress: Quality Governance Group **Board Sub-Committee:** Quality Committee, and others as appropriate to risk nature **Internal assurances:** Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework. **External assurances:** Inclusion on internal audit programme 2017/19, Care Quality Commission- Well Led Assessments.	

6. Electronic system in place – requires development to embed web based solution with intelligent reporting and triangulation of data and information

Expected outputs & outcomes:	
1	Centralisation will enable a whole systems review of risks, assurances and improvement plans and support the triangulation of information providing collective intelligence enabling prioritisation of improvements, alignment to the strategic objectives and support the business planning process.
2	Strengthening of our organisational learning through a programme of continual engagement, identifying preferred feedback routes by all staff groups and embedding improvements.
Priorities 2018/19	
a. Cleansing exercise of existing risks; b. Review capability of the system – developmental fields to enable cost / benefit analysis, risk profiling, controls assurance assessment and risk specific categories; c. Schedule of implementation to be agreed with governance managers and business group leads; d. Development of reports and 'live' access facilities at ward and departmental level; e. Development of dashboards at ward/department/corporate level with landing page; f. Development and roll out of the improvement planning module; g. Development of the information governance web form supporting; and h Development of a feedback matrix for preferred feedback an organisational learning routes for all staff groups.	
Monitoring progress: Quality Governance Group. **Board Sub-Committee:** Quality Committee / Audit Committee **Internal assurances:** Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework. **External assurances:** Inclusion on internal audit programme 2018/19, Care Quality Commission Well Led Assessments	

13. HORIZON SCANNING

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trusts strategic objectives, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- legislation;
- national clinical guidance;
- Government white papers;
- Government consultations;
- socio-economic trends;
- international developments;
- NHS England, NHS Improvement, Care Quality Commission, Health & Safety Executive, Information Commissioners Office and wider healthcare publications.

14. DUTIES/RESPONSIBILITIES OF GROUPS AND COMMITTEES

The terms of reference for groups/committees will be reviewed periodically. All groups/committees have a remit to provide assurance on risk relating to their specific terms of reference. Changes in the terms of reference for Trust groups/committees will be approved by the relevant committee/board to which they report. The committees within the governance structure will have standardised terms of reference, action points, an annual work plan and will produce an annual report.

The Board of Directors

The Board of Directors are ultimately responsible for managing risk. Board members have a corporate responsibility for the management of risk, and each member must be aware of the obligations to promote this and protect the public from risk in the normal course of events within local NHS provision. The Board will review its corporate objectives through the Board Assurance Framework on a minimum of a quarterly basis. Additionally the Director of Nursing and Quality and the Medical Director will provide information and assurances on any high level risks and incidents on a monthly basis to the Board. During the year, as additional risks to objectives are identified, these will be added to the Board Assurance Framework.

There is an established system of risk management throughout the Trust in accordance with the law and Government policy in order to:

- minimise the risk to the Trust's patients, assets, its employees, visitors and business
- comply with its contractual commitments with commissioning bodies and others for the volume and quality of its services, within its statutory responsibilities, financial and otherwise
- identify, prioritise and treat risks.

The Board is accountable for ensuring a system of internal control which supports the achievement of the organisation's objectives is in place. The system of internal control ensures that:

- the Trust's principal objectives are agreed;
- the principal risks to those objectives are identified;
- controls which eliminate or reduce these risks are implemented;
- the effectiveness of these controls are independently assured;
- reports on unacceptable or serious risks, and the effectiveness of control mechanisms, are received from the Executive Directors and independent assurors;
- action plans are agreed to improve control over serious or unacceptable risks; and
- policies are in place to determine what level of risks should be retained.

The Board of Directors receives minutes and assurances from the Audit Committee, the Quality Committee (QGC), the People and Performance Committee (PPC), the Finance and Performance Committee (F&PC) and the Remuneration Committee.

Audit Committee

The Audit Committee provides independent assurance to the Board of Directors that there are adequate controls in place to ensure that the Trust's key objectives and statutory obligations are being met (both clinical and non-clinical). This is the Board sub-committee with overarching responsibility for the scrutiny of risk management systems and processes, and the maintenance of an effective system of internal control on behalf of the Board. Membership comprises of Non-Executive Directors with attendance from other executives, senior managers and professionals as required. The Audit Committee's terms of reference are based on those recommended by the NHS Audit Committee Handbook and are compliant with the NHS Improvement Foundation Trust Code of Governance.

Quality Committee (QGC)

The Quality Committee is the Board sub-committee with delegated responsibility for providing the Board of Directors with assurances in matters relating to risk management and governance, for ensuring the effective implementation of this strategy and framework and for receiving reports on risk management and the steps taken to progress risk maturity. Links with this Committee and the Performance and Finance Committee are formed through shared Executive membership.

Finance and Performance Committee (F&PC)

The Finance and Performance Committee is the Board sub-committee with overarching responsibility for financial risk and performance. Links with this committee and the Quality Governance Group are formed through shared Executive membership.

People and Performance Committee (PPC)

The People and Performance Committee is the Board sub-committee with responsibility for providing assurance to the Board that the Trust is effectively leading, developing and delivering the Trust's People and Organisational Development Strategy, together with ensuring the development of the Trust's approach to transformation and overseeing delivery of the major transformation programmes (internal and external).

Quality Governance Group (QGG)

The Quality Governance Group is a subgroup of the Quality Committee and has overarching management responsibility for risk management and governance, for ensuring the effective implementation of this strategy and for receiving reports on the incidence of risk and the steps taken to manage it. Links with this committee and the Finance and Performance Committee are formed through shared Executive membership. Links to the Business Group Boards occurs through membership of the Associate Directors of Nursing and Associate Medical Directors.

Safety and Risk Group (S&RG)

The Safety and Risk Group is a subgroup of the Quality Governance Group and is chaired by the Deputy Director of Quality Governance. This group is responsible for the operational management of risk and governance and has membership from across the organisation.

Health and Safety and Risk Group (H&SG)

The Health and Safety Group is responsible for providing information and assurances to the Quality Governance Group that the Trust is monitoring, and continuously improving, compliance with health and safety legislation, and escalating any significant risk issues. The committee is chaired by the Deputy Director of Quality Governance with representation from management and staff side.

Business Group Boards (Risk/governance reporting arrangements)

Business Group Boards are responsible for reviewing all local risks pertaining to their area, ensuring robust action plans are in place and monitoring the action plans to ensure that they are delivered on time. The Business Group Boards will escalate risks which are outside of their control or which have financial implications which cannot be managed within the Business Group. As a minimum the following will be discussed and minuted at Business Group Boards on a monthly basis, this maybe in the form of exception reporting from the Business Group board sub-groups responsible for risk and governance issues:

- Business Group risk register – approve all risks rated 15 and above for escalation to the Quality Governance Group (Guide – lower graded risks / high impact low likelihood risks may also be escalated);
- Monitor risks rated 20 and above on a monthly basis;
- Receive a quarterly risk register report (Risks rated 12 and above (guide));
- Review significant incidents (graded major or catastrophic);
- Review serious complaints;
- Consider risk spanning more than one Business Group;
- Review significant claims;
- Responses to Safety Alert Broadcasts;
- External agency visits, inspections and accreditations involving the Business Group; and
- Will provide escalation of key areas of concern or achievement to the Board of Directors as required.

Council of Governors

The Council of Governors has no formal oversight or Executive role with regard to risk management. However, risk related information is provided to governors through standard reporting mechanisms. Governors can also address questions and issues to the Chair of the Board of Directors (who is also Chair of Council of Governors) and seek resolution of concerns via the appointed Senior Independent Director.

15.EXAMPLES OF CONTROL MEASURES AND SOURCES OF ASSURANCE

Examples of internal controls

- Board Sub Committee structure
- Management Committee structure
- Targets, standards and Key Performance Indicators
- Corporate services performance review
- Business plans, delivery plans, action plans & implementation plans
- Incident reporting and management
- Policies and Procedures
- Clinical Audit Programmes
- Staff Appraisals
- Business Group /Team meetings
- Staff education & development programmes
- IT systems and management information
- Delivery, exceptions, action, assurance, and accountability, direction, controls, scrutiny, monitor and feedback – key issues reports

Examples of assurance

Management Assurance

- Risk Register
- Finance Reports
- Annual Reports (e.g. Quality, Health & Safety)
- Integrated Performance Reports
- Clinical Audit Reports & improvement plans
- Project and programme plans
- Inspection and Walkabout Reports
- Quality, Safety & Risk Reports
- Quality Reports to Board
- Training Records/Statistics
- Performance Reports
- Workforce Report

Independent Assurance

- Internal Audit
- External Audit
- Care Quality Commission Inspections
- Health & Safety Executive
- Commissioners

16. RISK MANAGEMENT EARLY WARNING SYSTEM (UNDER DEVELOPMENT)

Level One

Level One No Concerns Identified	Action	Monitoring and Management
All risks on the Trust Risk Register are on plan for review, assurance on control measures and actions are with timescales	Business as usual as per Risk Management Policy (under review)	Continue review of control measures as per Risk Management Policy
Extreme risks on the register, and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are within review requirements, assurance on control measures and actions are with timescales	Business as usual as per Risk Management Policy and Risk Assessment Procedure	Continue review of control measures as per Risk Management Policy and Risk Assessment Procedure
Root cause analysis action plans are within timescales	Business as usual as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Harm free care >95%	Business as usual	Quality, Safety and Experience section of Board Integrated Performance Report
All Central Alerting System (CAS) Alert(s) remain within the required timeframes	Business as usual	Monthly Governance Report.
All incidents reported on the web are analysed within Trust timescales	Business as usual as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Compliant with external agencies inspection / regulatory requirements	Business as usual.	Monthly Governance Report
Assurance that NICE guidance is actioned within Trust timescales	Business as usual.	Monthly Governance Report

Level Two

Level Two Emerging Concern (Variance may be in one Business Group)	Action	Monitoring and Management
Risks on Trust Risk Register behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 2 weeks	Escalation to Business Group Director. Review as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Extreme risks on the register, and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 2 weeks	Escalation to Business Group Director. Review as per Incident Reporting Policy (under review)	Continue review of control measures as Incident Reporting Policy (under review)
Root cause analysis action plans breaching timescales > 4 weeks	Escalation to Business Group Director	Safety and Risk Group monthly Quality Governance Group
Harm free care 85% - 94%	Trend analysis by Governance Team. Review by appropriate Business Group(s) and work-stream committee and initiate local actions	Quality, Safety and Experience section of Board Integrated Performance Report Quality Governance Group
CAS alert(s) due to breach within 2 weeks of specified timeframe	Escalation to Business Group Director.	Safety and Risk Group monthly Monthly Governance Report
All incidents reported on the web are analysed within Trust timescales	Business as usual as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Incidents reported on the web have breached Trust timescales for analysis by up to 10 days	Escalation to Business Group Director / Business Group Triumvirate Team	Monthly Web holding report Safety and Risk Group monthly
Delay in provision of evidence to comply with external agencies inspection / regulatory requirements within initial timescale	Escalation to Business Group Director / Business Group Triumvirate Team	Monthly Business Group Board Meetings
Lack of assurance that NICE Guidance is actioned and monitored within specified timescale (6 -12 weeks)	Escalation to Business Group Director / Business Group Triumvirate Team	1:1s with Business Group Governance Managers monthly

Level 3

Level Three Concern Requiring Investigation (Variances in more than one Business Group)	Action	Monitoring and Management
Risks on Trust Risk Register review behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 6 weeks	Escalation to Business Group Director / Business Group Triumvirate Team. Review as per Risk Management Policy (under review).	Continue review of control measures as per Risk Management Policy (under review)
Extreme risks on the register and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 6 weeks	Escalation to Business Group Director / Business Group Triumvirate Team. Review as per Risk Management Policy (under review).	Continue review of control measures as per Risk Management Policy (under review)
Major patient safety incident occurs	Escalation to Executive Lead and Board of Directors Immediate actions to prevent recurrence. Investigation into incident as per Incident Reporting Policy (under review)	Monthly Governance monthly report to Quality Governance Group
Root Cause Analysis action plans breaching timescales > 8 weeks	Initiate trend analysis Targeted interventions based on analysis. Weekly analysis by Governance Team. Monthly monitoring by relevant work-stream committee	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Harm free care 74% - 84% for two consecutive months	Initiate trend analysis Targeted interventions based on analysis. Weekly analysis by Governance Team. Monthly monitoring by relevant work-stream committee	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
CAS alert due to breach within 1 week of specified time frame	Daily monitoring by Governance Team. Escalation to Business Group Triumvirate Team	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Incidents reported on the web have breached Trust timescales for analysis by up to 30 days	Escalation to Business Group Director	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Delay in provision of evidence to comply with external agencies inspection / regulatory requirements within extended timescale	Escalation to Business Group Director	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Lack of assurance that NICE Guidance is actioned and monitored within 13-20 weeks	Escalation to Business Group Director / Business Group Triumvirate Team.	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report

	Action plan to be produced by Business Group within 1 month of escalation	

Level Four

Level Four Material Issue (Serious event occurs or highly likely to occur / variances Trust wide)	Action	Monitoring and Management
Risks on Trust Risk Register review behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 12 weeks	Escalation to Executive Lead Immediate actions taken to review risk and gain assurance Review as per Risk Management Policy (under review) Business Group Director presents recovery position to Quality Governance Group	Continue review of control measures as per Risk Management Policy (under review)
Extreme risks on the register and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 12 weeks	Escalation to Executive Lead Immediate actions taken to review risk and gain assurance Review as per Risk Management Policy (under review) Business Group Director presents recovery position to Quality Governance Group	Continue review of control measures as per Risk Management Policy (under review)
Serious untoward incident occurs	Initiate investigation as per Incident Reporting Policy (under review) Immediate actions to prevent recurrence Support to affected area Escalation to Quality Governance Group and Board of Directors via Quality Committee External reporting as appropriate	Delivery and completion of action plan Action plan monitored by respective Business Group Quality Boards and overseen by the Governance Team.
Root Cause Analysis action plans breaching timescales > 12 weeks	Escalation to Executive Lead Continue escalation to Business Group Director Safety and Risk Group to intercede Business Group Director presents recovery position to Quality Governance Group	Quality Governance Group monthly
Breach of CAS alert specified time frame – potential for external agency scrutiny	Escalation to Executive Lead. Immediate actions to ensure compliance Governance Team to investigate reason for breach	Breached CAS alert report – Safety and Risk Group with escalation to Quality Governance Group monthly

Level Five

Level Five Significant Issue (Loss of control measures / Never Event occurs / failure to resolve material issue)	Action	Monitoring and Management
Risks on Trust Risk Register review behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached by >12 weeks.	Support to mitigate risks and ensure risks are reviewed within 24-48 hours Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee	Continue review of control measures as per Risk Management Policy (under review)
Extreme risks on the register and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached by >12 weeks	Immediate actions taken to review risk and gain assurance. Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee	Continue review of control measures as per Risk Management Policy (under review)
Never Event occurs	Initiate investigation as per Incident Reporting Policy (under review) Immediate actions to prevent recurrence Support to affected area Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee. External reporting as appropriate	Delivery and completion of action plan Action plan monitored by respective Business Group Director(s) and overseen by Integrated Governance
Root Cause Analysis action plans breaching timescales > 16 weeks	Escalation to Executive Lead. Continued escalation to Business Group Triumvirate Team. Quality Governance Group to intercede	Governance Group monthly
Harm free care <73%	Trend analysis Targeted interventions based on analysis Daily / weekly monitoring by Integrated Governance Immediate escalation to Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee.	Monthly reporting to Safety and Risk Group with escalation to Quality Governance Group and Board of Directors
Non-Clinical Fatality	Immediate escalation to Chief Executive Officer, Health and Safety Executive and / or Police Immediate support to family and staff affected Internal investigation (where appropriate)	On-going support to family and staff Implementation of any required changes as a result of investigation, monitored by Safety and Risk Committee
Enforcement notice from external agencies inspection / regulatory requirements	Immediate escalation to Chief Executive Officer and Board of Directors as appropriate. Immediate escalation to Quality Governance Group	Implementation of any required changes as a result of the enforcement notice monitored by Quality Governance Group with escalation to Board of Directors as appropriate

Lack of assurance that NICE Guidance is actioned and monitored within 28 plus weeks	Escalation to Executive Lead Business Group Director invited to Quality Governance Group	Governance monthly report to Quality Governance Group with escalation to Quality Committee.

17. GLOSSARY OF TERMS

Term	Description
Assurance	A positive declaration intended to give confidence
Effectiveness	The degree to which controls are successful in producing a desired result
Impact	The consequences of risk events if they are realised
Internal control	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method or device that modifies or manages risk. Controls are designed to provide reasonable assurance regarding the achievement of objectives
Likelihood	The probability of a risk event occurring
Operational risk	Major risks that affect an organisation's ability to execute its strategic plan. Operational risk is often defined as the risk of loss resulting from inadequate or failed internal processes, people and systems or from external events.
Principal risk	A 'principal risk' is a fundamental risk inherent in managing an organisation; it reflects the fact that there is always the possibility that through some set of circumstances, a particular risk could occur. For example, attracting and retaining competent people is key to delivering superior performance. However, there is a risk that we will fail to deliver our objectives if we cannot get the right people in the right roles at the right time and implement suitable controls to prevent human error.
Residual risk	Residual risk is the risk remaining after you have implemented your controls.
Risk	The effect of uncertainty on objectives
Risk appetite	The amount and type of risk that an organisation is willing to take to meet its strategic objectives
Risk culture	Risk culture consists of the norms and traditions of behaviour within an organisation that determine the way it identifies, understands, discusses and acts on the risk the organisation confronts and takes. Organisations get in trouble when individuals, knowingly or unknowingly, act outside the expected risk culture, or when the expected risk culture is either not well understood or enforced.
Risk driver, source or cause	Something that makes a difference to, or causes, a risk. A risk source is where a risk originates.
Risk exposure/ profile	Written description or summary of a set of risks. A risk profile or exposure can include the risks that the entire organisation must manage or only those that a particular directorate/region or part of the organisation must address
Risk interdependency	Where multiple risks could compound each other, or where a change in one risk can affect numerous others
Risk management	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, assessing, treating, monitoring and communicating risk.

Risk tolerance	The predetermined upper level of risk that can be posed to an objective. This might be set as an overall risk rating, or might specifically relate to an upper 'impact' or upper 'likelihood' rating which if reached must be mitigated at all cost

18. TRAINING AND SUPPORT

The Trust recognises that the successful implementation of this Strategy is dependent upon the provision of appropriate and sufficient training to all levels of the organisation. This is reflected into the Trust Training and Development Policy that includes the Trust Training Needs Analysis.

19. MONITORING OF THE STRATEGY

CQC Regulated Activities	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
1,2,3,4,5,7,8,9 ,16,17,18,19	Annual Report to Board against progress	Deputy Director of Quality Governance	Annually	Chief Nurse & Director of Quality Governance Medical Director Quality Governance Group	Chief Nurse & Director of Quality Governance Medical Director Quality Committee Audit Committee	Board of Directors

20. SOURCES/ REFERENCES

Cabinet Office Framework (2017) Management of Risk in Government
COSO (2004) Enterprise risk management – Integrated framework
HM Treasury (2012) Assurance frameworks
HM Treasury (2005) Principles of managing risks to the public
HM Treasury (2009) Risk management assessment frameworks
HM Treasury (2001) The orange book: management of risk – principles and concepts
HM Treasury (2006) Thinking about your risk: setting and communicating your risk appetite
IRM/Alarm/AIRMIC (2002) A risk management standard
ISO 31000 (2009) Risk management principles and guidelines
ISO/IEC 31010 (2009) Risk management – risk assessment techniques
National Audit Office (2011) Managing risks in government
OCEG 'Red Book' 2.0 (2009) A governance, risk and compliance capability model
Public Risk Management Association (2010) A structured approach to enterprise risk management (ERM) and the requirements of ISO 31000
UK Corporate Governance Code
NHS Improvement Single Oversight Framework (2016)
CQC Inspection Regime and associated documents
National Quality Board Shared Commitment to Quality (2016)
Next Steps on the NHS Five Year Forward View (2017)
Developmental reviews of leadership and governance using the well-led framework; guidance for NHS Trusts and NHS Foundation Trusts (2017)

21. ASSOCIATED DOCUMENTS

The following internal documents support the implementation of the Risk Management Strategy and Framework – this list is not exhaustive. These can be found on the Trust intranet site:

Trust Strategy 2017/18-2020/21
Annual Plan 2018/19
Quality Improvement Plan 2018 - 2020
Being Open Policy including the Duty of Candour
Health and Safety Policy
Incident Reporting Policy
Serious Incident Policy
Information Governance Policy
Risk Assessment Procedure
Whistleblowing (Raising Concerns) Policy
Emergency Preparedness and Business Continuity Plans
Security Policy
Complaints and Concerns Policy
Claims Management Policy
Datix system – User Guides

Key regional documents include:
Greater Manchester Health and Social Care Partnership
Stockport Together Plan
Commissioning Contractual Requirements

22. IMPACT ASSESSMENT

To be completed and attached to any policy or procedural document when submitted to the appropriate committee for consideration and approval.

Title Quality Strategy	
What is being considered?	Policy ☐ Guideline ☐ Decision ☐ Other (please state) ☐ Strategy Y
Is there potential for an adverse impact against the protected groups below? Age Disability Gender Reassignment Marriage and Civil Partnership Pregnancy and Maternity Race Religion and Belief Sex (Gender) Sexual Orientation Human Rights articles	Yes ☐ No x
If you are unsure, please contact the Equality and Diversity Specialist - 5229	
On what basis was this decision made? National Guidelines e.g. NICE / NSPA / HSE / DH (other) ☐ Committee / Other meeting x Previous Equality screening ☐	
With regard to the general duty of the Equality Act 2010, the above function is deemed to have no equality relevance Equality relevance decision by Date	
The Equality Act 2010 has brought a new equality to all public authorities, which replaced the race, disability and gender equality duties. This Equality Relevance Assessment provides assurance of the steps Stockport Hospital NHS Foundation Trust is taking in meeting its statutory obligation to pay due regard to: Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act Advance equality of opportunity between people who share a protected characteristic and those who do not Foster good relations between people who share a protected characteristic and those who do not For further information or guidance please contact – Safina.Nadeem@stockport.nhs.uk	

DOCUMENT INFORMATION BOX

Item	Value
Type of Document	Strategy
Title	Risk Management Strategy and Framework
Published Version Number	1
Publication Date	May 2018
Review Date	March 2019
Author's Name + Job Title	Alison Lynch. Chief Nurse & Director of Quality Governance
CQC Standard Measure	Outcomes 1,2,3,4,5,7,8,9,16,17,18,19,
Consultation Body/ Person	Executive Management Group Associate Directors of Nursing Business Group Directors Governance Leads
Consultation Date	December 2017, January and February 2018
Approval Body	Audit Committee
Approval Date	24 May 2018
Ratified by	Board of Directors
Ratification Date	24 May 2018
Author Contact	5078
Business Group	Corporate
Specialty (if local procedural document)	N/A
Ward/Department (if local procedural document)	N/A
Readership (Clinical Staff, all staff)	All Staff
Information Governance Class (Restricted or unrestricted)	Unrestricted