Stockport
NHS Foundation Trust

RISK MANAGEMENT STRATEGY AND POLICY

2022-2025

CONTENTS

THE PROCESS - AT A GLANCE

Stockport NHS Foundation Trust recognises that the provision of healthcare and associated activities related to service provision are by their very nature inherently risky. However by understanding the risks we face and managing them appropriately and in a consistent manner we will enhance our ability to improve our services, make better decisions and achieve our principle objectives as an organisation.

Steps within the risk management process are explained as follows:

1. Step 1: Determine Priorities
   As a Trust it is important to set out clear objectives that we aim to achieve.

2. Step 2: Risk Identification
   This involves considering and identifying potential sources of risk to the Trust that may stop us from achieving our objectives Risks may relate to safety, quality, finance, reputation, transformation and innovation etc.

3. Step 3: Risk Assessment and Scoring
   A thorough assessment of risk, including a detailed review of the controls in place to mitigate the risk allows us to score the risk based on the likelihood of the risk happening and the severity/ consequences if it did. This score allows the Trust to prioritise the management of risks and respond appropriately.

4. Step 4: Risk Escalation and Approval
   Dependent upon the risk score the Trust has an approval process for all risk assessments. Risks scoring 15+ are considered significant risks and must be escalated to the Risk Management Committee.

5. Step 5: Managing and Treating Risk
   The way the risk is managed will depend upon the risk appetite of the Trust in relation to that particular risk. Treatment options include: accept the risk, reduce the likelihood of the risk occurring, reduce the consequences of the risk occurring, transfer the risk, avoid the risk.

6. Step 6: Monitoring and Review
   Risk management is a continual process whereby risks should be reassessed in line with the expectations set out within the Risk Management Strategy.

1. EXECUTIVE SUMMARY

Stockport NHS Foundation Trust (here after known as 'the Trust') recognises that the principles of good governance must be underpinned by an effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks. This will support the Trust in achieving its principal objectives, and in doing so maintain the safety of its patients, service users, visitors and staff.

Risk management is an integral part of the Trust's management activity and is a fundamental pillar in embedding high quality, sustainable services for the people we serve. As provider of complex services in a challenging and ever changing health landscape, it is accepted that risk is an inherent part of the day to day operational management of the Trust. Robust risk management ensures the Trust is resilient and able to deal with any unanticipated exposure to risk that could threaten our success.

Through the implementation of this Risk Management Strategy and Policy, the Trust aims to ensure that there is a systematic approach for the management of risk that enables the organisation to realise its strategic ambition, as set out in our principal objectives. Stockport NHS Foundation Trust has implemented a Board Assurance Framework which describes the risks against achievement of our principal objectives, alongside a significant risk register which documents additional serious risks to the organisation. Whilst the Trust Board carries overall responsibility for risk management, the key to success is local leadership. It is the responsibility of all staff to identify and report risks that impact on the quality, safety and effectiveness of service provision. The Trust is committed to an integrated risk management system which incorporates all aspects on risk including strategic, clinical, financial, workforce, infrastructure, health and safety, operational, compliance and reputational risk.

We recognise that risk management is the responsibility of every employee and requires commitment to collaboration from both clinical and non-clinical staff. Managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational working and service delivery.

CHIEF EXECUTIVE

2. SCOPE AND PURPOSE

The Risk Management Strategy and Policy describes Stockport NHS Foundation Trust's approach to managing risk both at a strategic and operational level and also serves as a guide to staff on the identification, assessment and management of the risks associated with delivering healthcare at all levels of the organisation.

All risks regardless of their nature or origin will be managed via the process set out in this document. Risk assessments will be maintained via risk registers held on the Risk Management System (Datix).

Risk management is everyone's responsibility. This policy applies to all employees, contractors and volunteers. All employees are required to co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised within the Roles and Responsibilities section of this document.

The key objectives of the Risk Management Strategy and Policy are to provide a structure through which the Trust will:

- Embed a positive risk management culture throughout the organisation
- Ensure that there are effective risk management systems and processes in place and that these are continually monitored
- Ensure that staff are aware of the process for the identification, assessment and management of risk at a local, divisional and Trust level along with the committee structures in place to support effective risk management and escalation throughout the organisation
- Ensure staff are aware of their duties in relation to risk management, with clearly defined roles and responsibilities for the management of risk, and clear levels of authority in relation to risk approval and escalation
- Support the population and development of the Board Assurance Framework, significant risk register, divisional and local risk registers
- Identify processes through which the Trust will review, scrutinise and monitor risks at the most appropriate level
- Ensure that staff have the required competencies and capabilities to support a proactive approach to risk management
- Support and promote on-going development as a learning organisation and in doing so maintain a safe environment for patients, employees, contractors and visitors

3. DUTIES AND RESPONSIBILITIES

This section defines the responsibilities for risk management within the Trust. Specific responsibilities reside both with individuals and with committees and groups. These responsibilities are set out below:

3.1. Responsibilities of individual officers and Board Members

The Chief Executive has overall accountability for risk management across the Trust and exercises this responsibility through membership of the Trust Board and through being the Chair of the Risk Management Committee. The Chief Executive delegates general responsibility to those listed below. It is the Chief Executive who signs off the annual governance statement on behalf of the Board.

Executive Directors are accountable to the Chief Executive for the identification, assessment and management of risks arising from areas linked to their executive responsibilities. The Board as a whole is required to provide leadership of the organisation within a framework of prudent and effective control that enables risk to be assessed and managed.

Non-Executive Directors are responsible for providing independent judgement in relation to risk management issues and satisfying themselves that the systems of risk management are robust and reliable. Via the Board level committee structure they provide an additional layer of scrutiny.

The Deputy Director of Quality Governance has responsibility for the development and implementation of the Risk Management Strategy and policy, the effective management of the risk management system (Datix) used to support the effective documentation of risk, and ensuring appropriate monitoring of compliance with the Risk Strategy and Policy. They are also responsible for ensuring risk management training is available for staff across the organisation.

The Trust Secretary has delegated responsibility to work with the Trust Executive Team to produce the Trust Board Assurance Framework (BAF) and to ensure that the BAF is presented to Board and where delegated the assurance committees of Board.

The Head of Quality Governance has day-to-day responsibility for supporting, training and providing advice to staff in the management of risk. They shall oversee the effective utilisation of risk management processes across the Trust. They shall analyse and distil risk exposures populated on Datix, ensuring a clear and up-to-date picture of risk is available at all times. The Head of Quality Governance will be visible and act as central reference point for risk management issues, providing advice and challenge. They shall oversee day-to-day administrative responsibility of the risk management system (Datix).

The Risk and Safety Team has responsibility for the maintenance of the risk management system (Datix) and ensuring that it supports the management of risk across the organisation. They are responsible for ensuring that all staff can access and report risks in line with the Risk Management Strategy and Policy and will provide support in development and management of risks.

Divisional Directors, including Associate Medical Directors and Deputy Nurse Directors and Head of Midwifery have responsibility for day to day management of risk within their Division, including identification, management and appropriate

escalation of risk within and beyond the Division.

Divisional Quality and Governance Managers have responsibility to support the Divisional Triumvirates in the management and oversight of risk related to the Division including appropriate escalation of risks in line with the Risk Strategy and Policy.

3.2. Responsibilities of managers and staff

All Managers have responsibility for the management of day to day risks of all types, including health and safety. They are charged with ensuring risk assessments are undertaken in their area of responsibilities when a risk is identified, and that action is carried out. They are responsible for escalating any concerns in relation to known risks in their area of work.

All Trust Staff have a duty to ensure that identified risks are reported to their immediate line manage, in order that a risk assessment can be completed where required and any necessary actions considered. Individual members of staff should:

- Work to Trust policies and procedures
- Maintain safe systems of work
- Safeguard confidentiality
- Take care of their own safety and that of their colleagues
- Report risks, incidents and near misses and take remedial action in accordance with Trust policies and procedures
- Attended training as required
- Ensure that the meet professional registration requirements, including those relating to continuing professional development

3.3. Committee structure and responsibilities

The Trust has constituted a number of committees and sub-committees that have responsibility for risk management issues. An organigram of the Board committee structure is shown at Appendix 1.

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

- The Trust's principle objectives are agreed
- Principle risks to those objectives are identified and documented within the Board Assurance Framework, including oversight of controls in place to eliminate or reduce risks
- Keep under review the Trust's risk exposure as recorded in the Trust risk register.

The Audit Committee is a committee of the Board of Directors and provides the Board with an independent and objective review of the effectiveness of risk management and

internal controls within the Trust.

The Risk Management Committee is chaired by the Chief Executive and takes overall responsibility for the oversight of significant risks scoring 15 and above across the Trust. It also receives regular risk reports from Divisional and Corporate services. The Risk Management Committee reports to the Audit Committee.

All other Board Level Committees have responsibility for overseeing the management of risks in line with the committee's individual remit, as set out in their terms of reference. Committees should ensure that risk issues are reflected in meeting agendas, work plans and information provided to the committee.

Corporate and Divisional Assurance Groups are responsible for review of divisional and corporate risk registers and the appropriate management and escalation of risk to Directors in line with the Risk Strategy and Policy.

4. GLOSSARY OF TERMS

Term	Definition
Board Assurance Framework	A method for the effective and focused management of the principal risks that rise in meeting the Trust's principle objectives
Consequence	Outcome or impact of an event
Control	The mitigating action intended to reduce the likelihood or consequence of the risk occurring
Initial risk	Exposure arising from a specific risk before any action has been taken to manage it
Likelihood	Used as a general description of probability or frequency
Residual Risk	Risk remaining after implementation of risk treatment
Risk	The combination of the probability of an event and its consequence. Risk is considered in terms of the chances of something happening that will have an impact upon objectives.
Risk Appetite	The amount and type of risk that an organisation is prepared to seek, accept or tolerate
Risk Assessment	The overall process of risk identification, analysis and evaluation
Risk Management	The culture, processes and structures that an organisation applies in order to realise potential opportunities, whilst managing adverse effects

Risk Score	Magnitude of a risk expressed in terms of the combination of consequences/ severity and their likelihood
Significant Risk Register	All risk assessments scoring 15+ are brought together to form the risk register

5. THE RISK MANAGEMENT PROCESS

The risk management process outlined below describes how risks will be identified, assessed, controlled and monitored.

5.1. Step 1: Determine Priorities

Risk is defined as the effect of uncertainty on the objective. It is therefore essential to be clear about objectives for the Trust and each service and to express these in specific, measurable and achievable ways with timescales for delivery. Priorities will be determined by the Board of Directors and expressed through Divisions, services and personal objectives.

5.2. Step 2: Risk Identification

Risk identification involves examining all sources of potential risk that the Trust may be exposed to from the perspective of all stakeholders throughout the organisation. When identifying potential risk there are two key approaches; the top down and bottom up approach.

Identifying strategic risk (Top down) – Strategic risk management is undertaken through Board and Committee structures and enables the identification, assessment and recording of strategic risks which threaten the achievement of the Trust's principle objectives. In addition to this strategic risks may also be identified via upward escalation of operational risks.

Identifying operational risk (Bottom up) – Operational risk management is supported by staff working in adherence to the organisation's policies and procedures. Operational risks may present themselves via incidents, complaints, patient feedback, inspections or external reviews etc. which may impact on the organisation's ability to meet its objectives.

Types of risk to consider include:

- Risks related to safety and quality
- Risks to resources including:
  - Financial/ value for money
  - People/ staffing
- Risks to Trust reputation
- Risks to regulatory compliance
- Risks to transformation and innovation

The identification of risk is an on-going process and should never be static.

5.3. Step 3: Risk Assessment and Scoring

Once a risk is identified it must be documented within the risk management system (Datix). The risk assessment must include:

- Risk title – This must provide a summary of 'what the risk is' in a clear and concise way
- Risk cause, risk circumstance and risk consequence – Combined these provide an overview of what has caused the risk (for example - high staff sickness), what the circumstances are (for example - unavailability of specialist clinical staff), and the consequence (for example - a potential impact upon delivery of safe care).
- Details of controls in place at the time of assessment, to prevent the risk occurring
- Details of any gaps in control
- Assurance sources in place at the time of assessment
- Actions to be implemented to reduce the risk coming to fruition

Once this detail has been considered and assessed the risk should then be scored. This allows for the risk to be assigned a score which determines at which level the risk will be managed within the organisation. It also assists in prioritising risk and setting investment priorities via revenue and capital budgets and allocations.

Each risk assessment should have three risk scores:

Initial Risk Score: This is the score when the risk is first identified and assessed with existing controls in place. This score will not change for the lifetime of the risk and can be used to measure the impact of the risk controls and mitigations in place.

Residual Risk Score: This is the current risk score at the time the risk was last reviewed. It would be expected that the residual risk score will reduce as actions are completed, and additional controls are implemented. However there may be occasions where residual risk scores increase, for example if external forces on the risk are outside of the Trust's control.

Risk Appetite Score: This is the score that is intended after the actions to reduce the risk score are fully implemented. This should be aligned to the Trust's risk appetite relating to the type of risk being described.

Risk scores are calculated using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that risk coming to fruition together to give a score of between 1 and 25.

Severity/ Consequence Scoring: This focuses the risk assessor on how severe the consequences of the risk are likely to be. Severity is graded using a 5 point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm or loss. The risk assessor is required to be objective and realistic and to use their experience in setting these levels. The 'Matrix for Risk Managers' at Appendix 2

provides severity scoring guidance.

Likelihood Scoring: This focuses the risk assessor on how likely the risk is of coming to fruition. It is graded using a 5 point scale in which 1 represents an extremely unlikely occurrence and 5 represents a very likely occurrence. It is sensible to focus on the probability that the risk will be actualised given existing controls that are in place. The 'Matrix for Risk Managers' at Appendix 2 provides likelihood scoring guidance.

Utilising both the severity and likelihood score allows the assessor to determine the level of risk.

Severity/ Consequence x Likelihood = Risk score

	Consequence				
Likelihood	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Rare	1	2	3	4	5
Low/Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
High/Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

5.4. Step 4: Risk Escalation and Approval

An integral part of effective risk management is ensuring that risks are escalated through the organisation in line with the relevant governance committee structures. This will ensure visibility of risks throughout the organisation and appropriate management and prioritisation of resources.

Risks are escalated according to their initial risk profile score and/ or residual risk score as summarised below:

Risk Score	Level of Risk	Level of escalation, approval and management	Timescale for review
Score 1-3	Very Low Risk	Very low and low level risks are managed at local service/ ward/ department level in accordance with the identified review date or if any significant change occurs.	Very low and level risk review timescale is determined by local risk arrangements but must take place **at least once every financial year,** unless any significant change occurs.
Score 4-6	Low Risk		
Score 8-12	Moderate Risk	Moderate level risks require management attention and must be presented, and approved at the appropriate Divisional	Risks that are scored between 8 and 12 must be reviewed **at least quarterly** and presented to the

		or corporate group. The Divisional Director, Associate Medical Director and Divisional Nurse Director as a triumvirate team, or appropriate Corporate Director must have oversight of these risks.	appropriate Divisional or corporate group on a quarterly basis to ensure appropriate review and approval. The risk profiles (for risks ≥10) for all Divisions and corporate services are reviewed by the Risk Management Committee at least annually as part of a rolling programme of reviews.
Score 15-25	High Risk	High level risks require immediate escalation to the relevant Divisional Director, Associate Medical Director and Divisional Nurse Director as a triumvirate team. Any corporate risks scoring 15+ require immediate escalation to the relevant Corporate Director. All high level risks require escalation and approval at the appropriate Divisional or Corporate Group and will then be shared at the next Risk Management Committee for final approval and review.	Risks that are scored at 15 or above must be reviewed monthly and reported to appropriate Divisional or corporate groups on **a monthly basis** to ensure appropriate review and approval. All risks scoring 15+ will also be included in the significant risk register presented to Risk Management Committee (RMC). A report from RMC will be presented to the Audit Committee including all risks scoring 15+. Risks scoring 15+ will also be presented to Board on a quarterly basis.

In order to appropriately track approval of risks within the risk management system the

process at Appendix 3 must be followed for all risk assessments completed.

Where the review of risk identifies a change in risk score for example, from the initial risk score to a different residual risk score, the risk must be managed as at the new residual risk score.

5.5. Step 5: Managing and Treating Risk

Alongside the escalation and approval of risk it is imperative that the organisation undertakes a plan to manage any risk it identifies. There are a number of different options for responding to a risk. These options are referred to as risk treatment.

Risk treatment involves identifying the range of options for controlling or treating risk, assessing these options, preparing risk action plans and implementing them. The options available for treatment are:

- **Accept the risk** – if, after controls are put in place, the remaining risk is deemed acceptable to the organisation, the risk can be retained.

- **Reduce the likelihood of the risk occurring** – by preventative maintenance, assessment, relationship management, audit and compliance programs, supervision, policies and procedures, testing, investment training of staff, technical controls and quality assurance programmes etc.

- **Reduce the consequences of the risk occurring** – through contingency planning, disaster recovery and business continuity plans, public relations, emergency procedures and staff training etc.

- **Transfer the risk** – this involves another party bearing or sharing some part of the risk by the use of contracts, insurance, outsourcing joint ventures or partnerships etc.

- **Avoid the risk** – decide not to proceed with the activity likely to generate the risk, where this is practicable

When developing an action plan in order to mitigate/ reduce risk it may be helpful to consider:

- What are the existing controls and are there any gaps?
- What further controls are practical and sustainable?
- Are the controls currently in place designed well – how can they be strengthened?
- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

Action plans should be focused on gaps in control and should have clear timescales for completion, a responsible lead for completion and must be appropriate to the level of the current risk. All actions must be documented within the risk management system (Datix).

5.6. Step 6: Monitor and Review the risk

In line with the timescale for review of the risk based upon the risk score, the risk should be monitored and reviewed on an ongoing basis to ensure adequacy of controls and any additional actions required.

6. RISK APPETITE

Risk appetite is defined as the amount and type of risk an organisation is prepared to take in order to meet its strategic objectives. This decision is made after balancing the potential opportunities and threats to a situation. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

Every organisation will have a different perception of the level of risk it is willing to seek, accept or tolerate. Risk appetite levels may also vary dependent upon circumstances, for example an organisation may have a low tolerance on risks impacting upon staff and patient safety but may be more willing to tolerate a higher level of risk in relation to service developments which will ultimately bring benefits to the organisation.

6.1. Risk Appetite Statements

The Trust Board has considered its risk appetite utilising the Good Governance Institute 'Risk Appetite for NHS Organisations – A Matrix to support better risk sensitivity in decision taking'. This is shared at Appendix 4.

Expressing risk appetite can support the organisation to take decisions based upon an understanding of the risks involved. The risk appetite statements below support the expectations for risk-taking to managers and improve oversight of risk by the Board.

Risk Category	Risk Appetite Statement
Quality and Patient Safety	The quality of our services and the safety of our patients is a priority for the Trust. Our preference is for risk avoidance and to keep quality and safety at the heart of what we do. We will, if necessary, take decisions of quality where there is a low degree of inherent risk and possibility of improved outcomes, and appropriate controls are in place.
Financial/ Value for Money	We are prepared to accept the possibility of limited financial risk. However VFM is our primary concern.
Compliance/ Regulation	We recognise that we operate in a regulated environment and as a Foundation Trust have a high level of compliance required from numerous regulatory sources. We have a minimal risk appetite in relation to this and will avoid decision making that may result in heightened regulatory challenge, unless there is clear evidence where similar actions have been successful.
Reputation	We have a minimal risk appetite relating to reputational risks. Risk is limited to those events where this is no change of significant reputational

	repercussions. The reputation of services from our local population and system partners is important to us as we move forwards.
People	We have a low risk appetite in relation to our staff safety at work however we are prepared to accept the possibility of some workforce risk as a direct result of innovation. The current workforce challenges faced across the NHS require us to look at the potential to improve recruitment, retention and development opportunities for our staff.
Innovation	The Trust has a greater risk appetite to pursue innovation, challenge current working practices and take opportunities where there are anticipated benefits for our local population. We will support a focus on growth and service development but priority will be given to improvements that protect current operations.

6.2. Expressing Risk Appetite

The Trust will express risk appetite as set out below:

- **Agreement of an escalation boundary on the risk matrix (likelihood and consequence)**
  All risks that score 15 or above on the risk matrix will be entered onto the Trust significant risk register and will be presented to the Risk Management Committee on a monthly basis. A risk score of 15 or above should therefore be treated as a trigger for a discussion and some challenge as to whether the Trust is willing to accept this level of risk.
- **Risk Appetite Rating**
- All risks will have a risk appetite rating documented within the risk management system (Datix). This will be derived from the risk appetite matrix at Appendix 4 and in light of the risk appetite statements included in the Risk Management Strategy and Policy.

7. Training

The training and development of staff is integral to the Trust's approach to risk management.

- Monthly risk management training will be available to all members of staff involved in risk assessment and management. This will be coordinated by the Deputy Director of Quality Governance in conjunction with Learning and Development.
- All Board members will be invited to be part of a risk based Board development session. This will be coordinated by the Trust Company Secretary and supported by the Deputy Director of Quality Governance.
- Ad-hoc support for risk management will be available upon request through the Divisional Governance and Quality Manager or The Risk and Safety Team.

8. Monitoring Compliance

The following mechanisms will be used to monitor compliance with the requirements of this document:

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 ,16,17,18,1 9	Evidence of review of significant risk exposure by the Risk Management Committee at each formal meeting of the committee.	Deputy Director of Quality Governance	Monthly	Risk Management Committee	Deputy Director of Quality Governance/ Chief Nurse	Board of Directors
	Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee	Audit Committee	As requested	Audit Committee	Audit Committee	Board of Directors

9. References/ Associated Documentation

- Good Governance Institute (May 2020) Board guidance on risk appetite

10. IMPACT ASSESSMENT

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

Office Use Only

Submission Date:	8 July 2022
Approved By:	N Baynham
Full EIA needed:	No

Equality Impact Assessment – Policies, SOP's and Services not undergoing re-design

1	**Name of the Policy/SOP/Service**	**TRUST RISK MANAGEMENT STRATEGY & POLICY 2022-2025**	
2	**Department/Business Group**	Quality Governance	
3	**Details of the Person responsible for the EIA**	**Name:**	Natalie Davies
		Job Title:	Deputy Director of Quality Governance
		Contact Details:	Natalie.davies@stockport.nhs.uk
4	**What are the main aims and objectives of the Policy/SOP/Service?**	To outline the strategy and process of effective risk management across the Trust	

For the following question, please use the EIA Guidance document for reference:

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a differential impact on any of the protected characteristics below?** **Please state whether it is positive or negative.** **What data do you have to evidence this?** **Consider:** • What does existing evidence show? E.g. consultations, demographic data, questionnaires, equality monitoring data, analysis of complaints. • Are all people from the protected characteristics equally accessing the service?	**B) MITIGATION** **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Produce action plan if further data/evidence needed ✓ Re-visit after the designated time period to check for improvement.	**Lead**
Age	Positive Impact	See general comments	

	Trust Workforce: Largest age band: 46-55 (average 44.5 years)		
Carers	Positive Impact Trust Workforce: No Data	See general comments	
Disability	Positive Impact Trust Workforce: 3.32% report disability. 11.94% not declared	See general comments	
Race / Ethnicity	Positive Impact Trust Workforce: BAME make up 16.18%	See general comments	
Gender	Positive Impact Trust Workforce: 79.9% female	See general comments	
Gender Reassignment	Positive Impact Trust Workforce: No Data	See general comments	
Marriage & Civil Partnership	Positive Impact Trust Workforce: 54.9% married & 0.7% Civil Partnership	See general comments	
Pregnancy & Maternity	Positive Impact Trust Workforce: 2.14% on maternity or adoption leave*	See general comments	
Religion & Belief	Positive Impact Trust Workforce: 52.47% Christian	See general comments	
Sexual Orientation	Positive Impact Trust Workforce: 2.12% LGBT 20.09% did not want to declare	See general comments	
General Comments across all equality strands	This Policy is likely to have a positive impact on all protected groups. The policy describes the process to be followed when identifying, assessing and managing risks, confirms the responsibilities of staff and provides user guides to aid them in effective risk management and reporting, taking into consideration protected characteristics and ensuring mitigations/adjustments are put in place. All information will be provided in accessible formats to meet an individual needs/requirements	See general comments	

Action Plan
What actions have been identified to ensure equal access and fairness for all?

Action	Lead	Timescales	Review &Comments

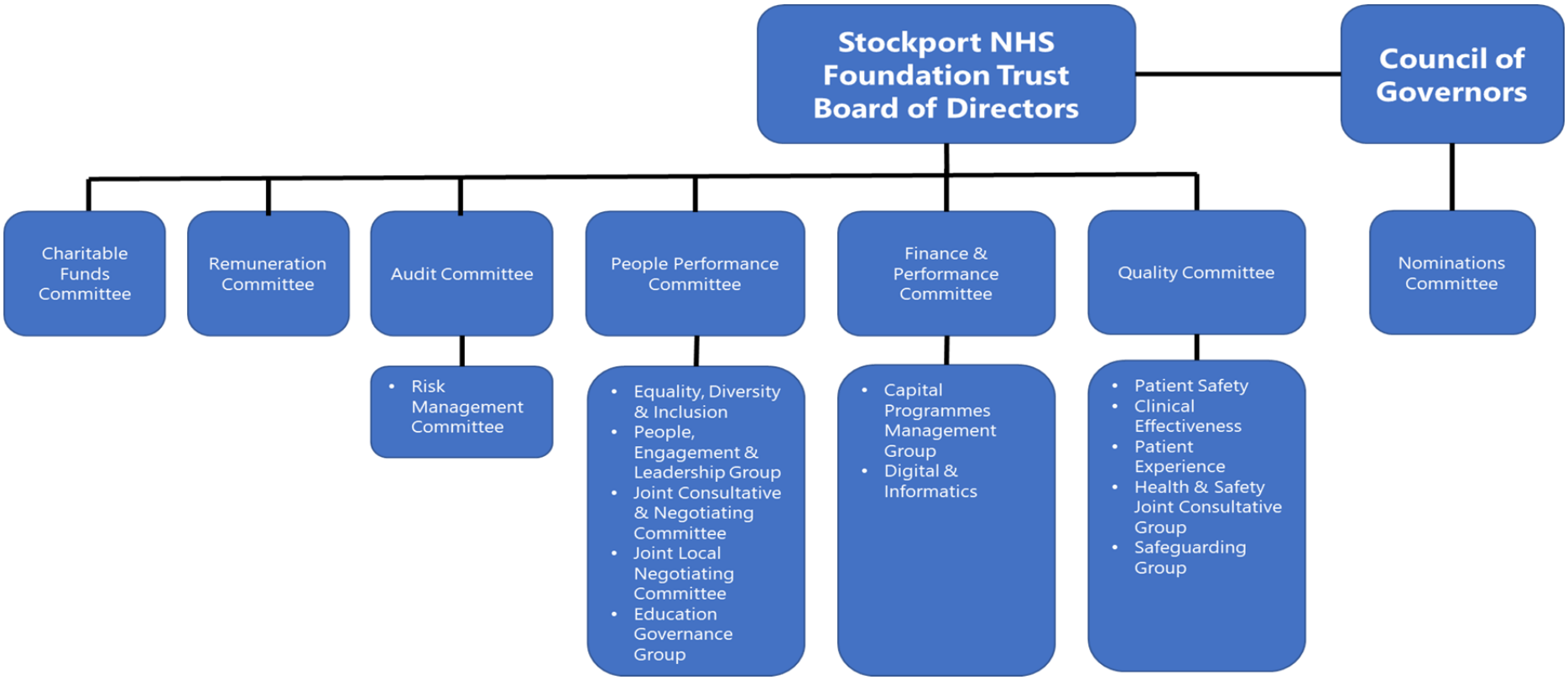
EIA Sign-Off	**Your completed EIA should be sent to the Equality, Diversity & Inclusion team for approval:** equality@stockport.nhs.uk

11. DOCUMENT INFORMATION BOX

Item	Value
Type of Document	Strategy/ Policy
Title	Risk Management Strategy and Policy 2022-2025
Version Number	V3
Consultation	Risk Management Committee
Recommended By:	Risk Management Committee
Approved By:	Trust Board
Approval Date	4 August 2022
Next Review Date	4 August 2024
Document Author	Natalie Davies, Deputy Director of Quality Governance
Document Director	Chief Executive
For use by:	All Staff
Specialty / Ward / Department	All
	Unrestricted

Version	Date of Change	Date of Release	Changed by	Reason for Change
3	**6 July 2022**		**Deputy Director of Quality Governance**	**Rewrite of the previous Risk Management Policy (v2) to become the Risk Management Strategy and Policy including further detail regarding steps of risk management, changes to appendices and inclusion of risk appetite section. EIA also updated and signed off 18 July 2022.**

Appendix 1: Board Committee Structure



Appendix 2: Guidance to severity and likelihood scoring

This grading guidance is taken from the National Patient Safety Agency document 'A Matrix for Risk Managers' (2008).

Severity Score

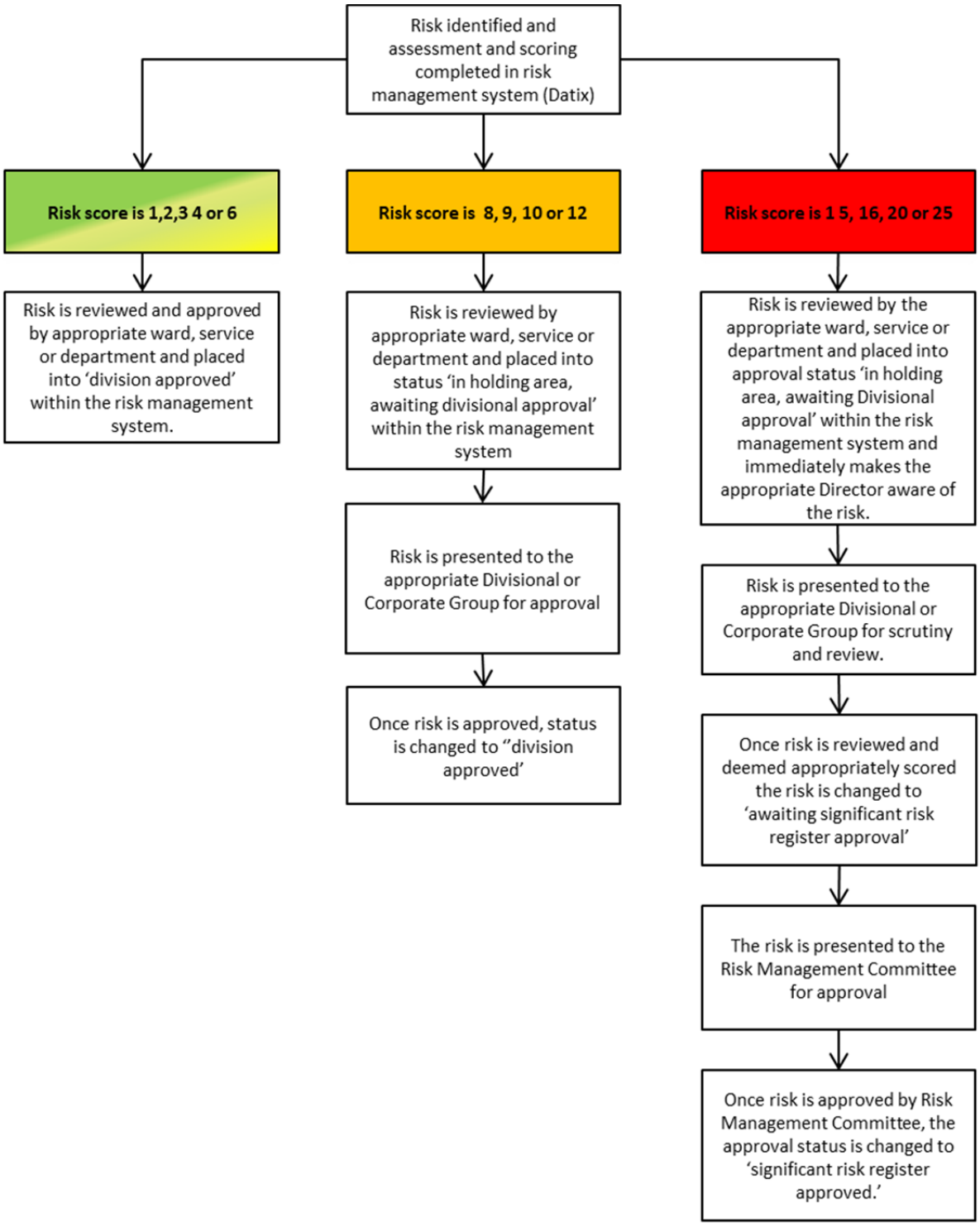
	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsm an inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interrupt i on of >1 hour Minimal or no impact on the	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruptio n of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood Score

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Appendix 3: Risk Approval Process



Appendix 4: Risk Appetite Matrix

Risk Level ⇒ Key Elements ⇓	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal (ALARP)** Preference for very safe delivery options that have a low degree of inherent risk and may only have a limited reward potential.	**Cautious** Preference for safe delivery options that have a low degree of residual risk and may only have a limited reward potential.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**Seek** Eager to be innovative and to choose options which may offer higher levels of reward, despite greater inherent risk.	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust and highly embedded.
Financial / Value for Money How will we use our resources	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Compliance / Regulatory How will we be perceived by our regulator	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality / Outcomes How will we deliver quality services	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputation How will we be perceived by the public and our partners	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Innovation How will we transform services	We have no appetite for decisions to innovate, our aim is to maintain or protect, rather than to create or innovate. General avoidance of system / technology developments.	We will avoid innovations unless essential or commonplace elsewhere. Only essential systems / technology developments to protect current operations.	We tend to stick to the status quo, innovations generally in practice avoided unless really necessary. Systems / technology developments limited to improvements to protection of current operations.	We support innovation, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new systems / technologies as catalyst for operational delivery.
Appetite	**None**	**Low**	**Moderate**	**High**	**Significant**	

(Adapted from Good Governance Institute Risk Appetite for NHS Organisations – A Matrix to support better risk sensitivity in decision taking')