Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

POLICY NAME:	**Risk Management Policy**
POLICY ID NUMBER:	**TW10-002**
VERSION NUMBER:	**2**
APPROVING COMMITTEE:	**Risk Management Group (RMG)**
DATE THIS VERSION APPROVED:	**October 2021**
RATIFYING COMMITTEE	**PARG (Policy Approval and Ratification Group)**
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AUTHOR (S) (JOB TITLE)	**Head of Risk**
DIVISION/DIRECTORATE:	**Corporate**
LINKS TO ANY OTHER POLICIES/PROCEDURES:	**TW10-002 Risk Management Framework, TW10-002 SOP 1Risk Management Process, Assurance and Escalation Framework**
CONSULTED WITH:	**RMG, Board of Directors**

DATES PREVIOUS VERSION(s) APPROVED	Version: 1	Date: June 2018
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MANAGER RESPONSIBLE FOR REVIEW (Must be Authors Line Manager)	**Director of Corporate Affairs**	

The WWL Way

AT ALL TIMES, STAFF MUST TREAT EVERY INDIVIDUAL WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY

CONTENTS PAGE

1 INTRODUCTION

1.1 This policy sets out how all staff should approach the management of risks within their Team, Department, Service, Division or the wider Trust.

1.2 This policy complements the Board Assurance Framework (BAF) and risk registers through which strategic and operational risks to the Trust's objectives are managed.

2 POLICY STATEMENT

2.1 The Trust is committed to ensuring the safety of its patients and staff and will do this by actively managing the uncertainties of strategic and operational risks through the implementation of a clear and robust risk management framework[1]. We will seek to adopt best practice in risk management, employ new technologies to help manage risk and ensure that our staff are appropriately trained to manage the risks associated with our activities.

2.2 The Trust acknowledges that it is not possible or desirable to eliminate all risks and we will encourage positive risk-taking in keeping with our statement of risk appetite where risks may result in positive benefits for our patients, staff and visitors.

3 KEY PRINCIPLES

3.1 This policy applies to all employees of the Trust and requires active leadership from managers at all levels. The policy sets out respective responsibilities for strategic and operational risk management.

3.2 The methods used to assess, monitor and mitigate both strategic and operational risks effectively are detailed within the Risk Management Process Standard Operating Procedure (SOP).

4 RESPONSIBILITIES

The following paragraphs set out the respective duties and responsibilities for specific committees, groups and individual members of staff.

4.1 ORGANISATIONAL

4.1.1 Organisational Accountability: Trust Committees

4.1.1.1 Board of Directors

The Board of Directors is corporately accountable for ratifying, adhering to, and delivering on the Risk Management Framework and plan, and the Trust's Risk Appetite Statement.

4.1.1.1.1 It is the responsibility of the Board of Directors to ensure that the Board Assurance Framework (BAF) is fit for purpose, monitored and mitigated against, and that risks are identified and managed in compliance with the Risk Management Process (SOP).

4.1.1.1.2 The Committee will seek assurance on the effectiveness of controls relating to key strategic risks, how they are being managed and mitigated against to secure results in the achievement of the Trust's strategic objectives. The committee will map and record this assurance and provide input to influence and direct action in relation to identified controls as necessary to assist in delivering mitigation.

[1] Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, s12 (2a&b).

4.1.1.2 **Quality and Safety Committee (Sub Committee of the Board of Directors)**

4.1.1.2.1 The Quality and Safety Committee focuses on reviewing and monitoring aspects of the Trust's strategic risks relevant to the Committees Terms of Reference.

4.1.1.2.2. The function of the committee includes an in-depth evaluation of particular high risk areas which have been escalated from the Risk Management Group (RMG) and a monthly overview of the risk tracker.

4.1.1.2.3 In addition to this, the Committee is responsible for the periodic review of risks recorded on the Corporate Risk Register and monitoring and review of relevant risks recorded on the BAF.

4.1.1.2.4 The Quality and Safety Committee will regularly review risks relevant to its specialist area as part of its agenda.

4.1.1.3 **Audit Committee (Sub Committee of the Board of Directors)**

The Audit Committee oversees the Trust Risk Management processes to ensure these are operating effectively. The Audit Committee will:

4.1.1.3.1 Conduct an annual review of the Board Assurance Framework (BAF);

4.1.1.3.2 Conduct a bi-annual review of risks that score 15 or more to ensure that the processes for the escalation of risks are operating effectively.

4.1.1.3.3 The Audit Committee will regularly review risks relevant to its specialist area as part of its agenda.

4.1.1.3.4 discuss with the board its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so that management understands these parameters and expectations.

4.1.1.4 **Finance and Investment Committee (Sub Committee of the Board of Directors)**

4.1.1.4.1 The Committee will review the financial prospects of the Trust and will approve the key financial assumptions to be used in Strategic and Business Planning. The Committee will review the financial and activity aspects of any major changes in the economic, political and regulatory environment, and the potential consequences these may have on financial risks.

4.1.1.1.2 The Finance and Investment Committee will regularly review risks relevant to its specialist area as part of its agenda.

4.1.1.5 **Workforce Committee (Sub Committee of the Board of Directors)**

4.1.1.5.1 The Committee will provide assurance to the Board of Directors on workforce issues, taking account of local and national agenda's. The Committee will monitor and provide assurance to the Board of Directors on the specific workforce risks identified within the Board Assurance Framework (BAF).

4.1.1.5.2 The Workforce Committee will regularly review risks relevant to its specialist area as part of its agenda.

4.1.1.6 **Risk Management Group (RMG)**

4.1.1.6.1 The Group will provide advice and assurance to Sub Committees of the Board of Directors on the management of risks that score 15 or more by scrutinising those risks on a monthly basis.

4.1.1.6.2 The Group will review all risks on the Corporate Risk Register twice a year and seek assurances from Divisions that risks held at Divisional level are being monitored and scrutinised.

4.1.1.7 **Patient Safety Group**

4.1.1.7.1 These Groups provide leadership, driving local governance and divisional risk management agendas that include reviewing and monitoring arrangements for risk management.

4.1.1.7.2 They are responsible for undertaking a regular review of identified risks as part of the development and management of their respective Divisional and Corporate Risk Registers to provide assurance that effective controls are in place.

4.1.1.7.3 It is the responsibility of Patient Safety Groups to ensure that risks are monitored and mitigated against appropriately, and that risks are identified and managed in compliance with the Risk Management Framework, Policy and Process (SOP).

4.1.2 **Organisational Accountability and Responsibilities**

4.1.2.1 **The Board of Directors**

Executive and Non-Executive Directors share responsibility for receiving assurance on the successful management of the Trust, including the effective management of risk. In the context of risk management, the Board should:

4.1.2.1.1 lead the assessment and management of risk and take a strategic view of risks in the organisation.

4.1.2.1.2 ensure that there are clear accountabilities for managing risks and that officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently.

4.1.2.1.3 ensure that roles and responsibilities for risk management are clear to support effective governance and decision-making at each level with appropriate escalation, aggregation and delegation.

4.1.2.1.4 determine and continuously assess the nature and extent of the principal risks that the trust is willing to take to achieve its objectives - its “risk appetite” - and ensure that planning and decision-making appropriately reflect this assessment.

4.1.2.1.5 agree the frequency and scope of its discussions on risk to review how management is responding to the principal risks and how this is integrated with other matters considered by the board, including business planning and performance management processes.

4.1.2.1.6 specify the nature, source, format and frequency of the information that it requires.

4.1.2.1.7 ensure that there are clear processes for bringing significant issues to its attention more rapidly when required, with agreed triggers for doing so.

4.1.2.1.8 use horizon scanning to identify emerging sources of uncertainty, threats and trends.

4.1.2.1.9 assure itself of the effectiveness of the organisation’s risk management framework.

4.1.2.1.10 assess compliance and include explanations of any departures within the governance statement of the trust's annual report and accounts.

4.1.2.2 **The Chief Executive**

The Chief Executive is the Accountable Officer with overall responsibility for risk management and maintaining a sound system of internal control that supports the achievement of the Board's policies, aims and objectives, whilst safeguarding the public funds and organisational assets. Supported by the Audit Committee, the Chief Executive should:

4.1.2.2.1 periodically assess whether the trust's values, leadership style, opportunities for debate and learning, and human resource policies support the desired risk culture, incentivise expected behaviours and sanction inappropriate behaviours.

4.1.2.2.2 ensure that expected values and behaviours are communicated and embedded at all levels to support the appropriate risk culture.

4.1.2.2.3 designate an individual to be responsible for leading the trust's overall approach to risk management, who should be of sufficient seniority and should report to a level within the organisation that allows them to influence effective decision-making.

4.1.2.2.4 establish the trust's overall approach to risk management

4.1.2.2.5 establish risk management activities that cover all types of risk and processes that are applied at different trust levels.

4.1.2.2.6 ensure the design and systematic implementation of policies, procedures and practices for risk identification, assessment, treatment, monitoring and reporting.

4.1.2.2.7 consider the trust's overall risk profile, including risk management within arm's length bodies and the extended enterprise.

4.1.2.2.8 demonstrate leadership and articulate their continual commitment to and the value of risk management through developing and communicating a policy or statement to the organisation and other stakeholders, which should be periodically reviewed.

4.1.2.2.9 ensure the allocation of appropriate resources for risk management, which can include, but is not limited to people, skills, experience and competence.

4.1.2.2.10 Ensuring that employees and the public are properly protected against exposure to risks arising out of or as a result of the Trust's activities.

4.1.2.2.11 Signing the Annual Governance Statement in the annual report and accounts on behalf of the Board.

Day-to-day responsibility for risk management is discharged through the designated accountability of the Executive Team.

4.1.2.3 **Executive Directors**

Executive Directors will act as senior responsible officers for their respective areas. They are responsible for developing a culture which promotes effective risk management across the organisation in compliance with the Risk Management Framework and plan. They will ensure that within their area's risks are managed effectively, including:

4.1.2.3.1 Notifying Divisional Medical/Clinical Directors and Divisional Directors of Performance of any strategic or corporate risks which have the potential to affect the delivery of the Trust's objectives.

4.1.2.3.2 Scrutinising new risk assessments escalated on to the Corporate Risk Register, and where necessary, will challenge and seek assurance from Divisions on the effectiveness of control measures.

4.1.2.3.3 Seeking assurance that Divisional Risk Registers are maintained and actively managed within their area.

4.1.2.3.4 Ensuring all staff are aware of and fulfil their appropriate responsibilities for risk management.

4.1.2.3.5 Ensuring all activities are undertaken within their area are consistent with the safe operation of the Trust, in compliance with the framework laid out in the Risk Management Framework and SOP.

4.1.2.4 **Deputy, Associate and Assistant Directors, incl. Divisional Medical and Clinical Directors, Divisional Directors of Performance and Divisional Triumvirate**

4.1.2.5 They are responsible to their respective Executive Director and ultimately the Chief Executive for overall risk management within their designated areas. They understand the Trust's approach to risk management, including risk appetite and tolerance to ensure an appropriate and effective risk management process is in place within the scope of their responsibility. They are also responsible for ensuring that all staff are made aware of the risks within their work environment and of their personal responsibilities.

4.1.2.6 **Directorate Managers and equivalent Heads of Service**

Directorate Managers and equivalent Heads of Service are accountable for ensuring:

4.1.2.6.1 They understand the Trust's approach to risk management, including risk appetite and tolerance.

4.1.2.6.2 The requirements of the Risk Management Framework, Policy and SOP are effectively implemented within their areas of responsibility.

4.1.2.6.3 A robust framework is in place for the effective identification, management and control of all risks within their respective Division.

4.1.2.6.4 Suitable and sufficient risk assessments are proactively developed, reviewed and escalated in compliance with the Risk Management Process.

4.1.2.6.5 Identified control measures implement short-, medium- and long-term action plans to mitigate risks to the lowest level reasonably practicable.

4.1.2.6.6 Accurate and clear information flows are accessible to all and that plans are formulated to ensure risks and safety critical messages are clear and cascaded to their wider team.

4.1.2.6.7 They foster a culture of involvement that empowers all staff to engage in and contribute to the risk management process.

4.1.2.6.8 That staff are competent to contribute to the risk management process.

4.1.2.6.9 They provide leadership to drive and co-ordinate governance, quality and risk management arrangements in line with the Trust Risk Management Framework within the area(s) of their responsibility.

4.1.2.6.10 Directorate Performance Managers and equivalent Department Managers are accountable to their respective Divisional Director of Performance for the day to day management and application of the Trust Risk Management Framework, Policy and SOP.

4.1.2.7 **Ward Managers, Service and Team Managers**

Ward Managers, Service and Team Managers will lead on promoting a co-ordinated departmental approach to the various aspects of risk management. They are accountable for ensuring:

4.1.2.7.1 Risks within their Ward/Department/Service are effectively identified and managed in line with the Risk Management Framework, Policy and SOP.

4.1.2.7.2 Suitable and sufficient risk assessments are proactively developed, reviewed and escalated in compliance with the Risk Management Process.

4.1.2.7.3 Identified control measures implement short-, medium- and long-term action plans to mitigate risks to the lowest level reasonably practicable.

4.1.2.7.4 Communication channels exist and that time is allocated to discuss, manage and challenge risks and their control measures.

4.1.2.7.5 They foster a culture of involvement that empowers all staff to engage in and contribute to the risk management process.

4.1.2.7.6 That staff are competent to contribute to the risk management process.

4.1.2.7.7 They provide leadership to drive and co-ordinate governance, quality and risk management arrangements in line with the Trust Risk Management Framework within the area(s) of their responsibility.

4.1.2.8 **All other employees and relevant stakeholders**

All employees including bank, agency staff, volunteers, students etc., and other relevant stakeholders have a responsibility to adhere to the requirements of this Policy, including associated strategy and procedures relating to risk management, in particular:

4.1.2.8.1 Familiarise themselves with the risk assessment process.

4.1.2.8.2 Assist managers in their undertaking of risk assessments within their area of work by contributing to the risk assessment process.

4.1.2.8.3 Identify risks where they arise and bring their concerns to the attention of their line manager, including identifying suitable controls to help mitigate the risk.

4.1.2.8.4 Comply with the safe systems of work identified within risk assessments.

4.1.2.8.5 Attend training as required to enable them to understand and participate in the risk assessment process to ensure they perform their work activities capably and safely.

4.1.2.8.6 Report all incidents and hazards to their line manager in accordance with the Trust's Incident Reporting Procedure, and act to prevent reoccurrence.

4.1.2.8.7 Cooperate fully on matters of risk management and health and safety.

4.1.2.9 **Third Party Organisations**

Specific risks identified by the Trust will be shared with any other relevant organisation working in partnership with the Trust, for example, CCG, SSDU, local authority, etc. Likewise, the Trust expects that any relevant risks identified by partners will be shared with the Trust.

4.1.2.10 **Fraud**

Wrightington Wigan and Leigh NHS FT (the Trust) accountable officer and chief finance officer have a responsibility to ensure that the organisation has adequate counter fraud measures in place to manage the risk of fraud in accordance with NHS Counter Fraud Authority (NHSCFA) counter fraud strategy.

4.1.2.10.1 The government functional standard 013 counter fraud applies to all NHS organisations from 1 April 2021. This standard requires all providers to carry out a comprehensive local risk assessment on an annual basis to identify fraud, bribery and corruption risks, and have a counter fraud provision that is proportionate to the level of risk identified.

4.1.2.10.2 Risk analysis is undertaken in line with government counter fraud profession fraud risk assessment methodology. It is recorded and managed in line with this risk management policy and included on the appropriate risk registers. Measures to mitigate identified risks, such as specific proactive reviews, are included in the annual counter fraud work-plan and progress is regularly reported to the audit committee.

4.1.2.10.3 The local counter fraud specialist (LCFS) will inform the Trust of potential fraud risks so they can be effectively assessed. Where risks are identified and are assessed are appropriate these will be included on the Trust risk register, so they can be proactively addressed. Similarly, all fraud risks identified by the organisation will be communicated to the LCFS.

4.1.2.10.4 The audit committee and the chief finance officer are kept abreast of any issues relating to fraud throughout the year.

4.1.2.10.5 In addition, the Trust will participate in national and local pro-active exercises throughout the year, designed to identify fraud and reduce the likelihood of specific fraud risks to which it may be vulnerable.

4.1.2.11 **Bribery**

The Bribery Act 2010 introduced a corporate offence of failure to prevent bribery by persons working on behalf of a business. However, for the to have a statutory

defence to the corporate offence, it must demonstrate that the 6 adequate procedures have been considered, assessed, and where appropriate, measures taken.

4.1.2.11.1 The 6 adequate procedures are as follows:

1. Proportionate procedures to prevent bribery.
2. Top level commitment.
3. Risk assessment.
4. Due diligence.
5. Communication (including training).
6. Monitoring and review.

Risk management strategy and policy

4.1.2.11.2 The Trust will assess the nature and extent of its exposure to potential external and internal risks of bribery on its behalf by persons associated with it. The organisation will ensure that its risk assessment procedures accurately identify and prioritise the risks it faces, whatever its activities, customers or sector.

4.1.2.11.3 The risk assessment will encompass the following characteristics:

- 4.1.2.11.3.1 oversight of the risk assessment by top level management
- 4.1.2.11.3.2 appropriate resourcing reflecting the scale of the Trust's business and the need to identify and prioritise all relevant risks
- 4.1.2.11.3.3 identification of the internal and external information sources that will enable risk to be assessed and reviewed
- 4.1.2.11.3.4 due diligence of associated persons (should be proportionate to the identified risk)
- 4.1.2.11.3.5 accurate and appropriate documentation of the risk assessment and its conclusions

4.1.2.11.4 Further information can be found on the Fraud page of the intranet

5 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this Strategy and they have, where appropriate, been fully reflected in its wording.

6 INCLUSION AND DIVERSITY

The Strategy has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

7 MONITORING AND REVIEW

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

7.1 The Trust's Annual Report will contain a formal statement of risk management/assurance of activity during the previous year and will highlight key issues arising.

7.2 Internal Audit opinion on the effectiveness of risk management arrangements, as determined by the Audit Committee, to inform the AGS (Annual Governance Statement).

7.3 The minutes of RMG and the Risk Tracker are presented to the Audit committee every month for scrutiny as required and then shared with Board of Directors.

7.4 Internal Audit will undertake an annual review of a selection of risks and the risk management process.

7.5 An Annual Report on the Corporate Risk Register will be presented to Board of Directors for information every 12 months.

8 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g., large print, Braille and audio CD.

For more details, please contact the HR Department on 01942 77(3766) or email equalityanddiversity@wwl.nhs.uk

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	Protected Characteristics														Reasons for negative/positive impact
	Sex	**Age**	**Ethnicity**	**Learning Disability**	**Hearing Impairment**	**Visual Impairment**	**Physical Disability**	**Mental Health**	**Gay/Lesbian/ Bisexual**	**Transgender**	**Religion/Belief**	**Marriage/Civil Partnership**	**Pregnancy & Maternity**	**Carers**	
Does the policy have the potential to affect individuals or communities differently in a negative way?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	
Is there potential for the policy to promote equality of opportunity for all/promote good relations with different groups – Have a positive impact on individuals and communities.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	If Yes, please state how you are going to gather this information.

Job Title	**Head of Risk**	**Date**	July 2021

IF 'YES and NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an EIA. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation.

POLICY MONITORING AND REVIEW ARRANGEMENTS **Appendix 2**

Para	Audit/Monitoring requirement	Method of Audit/Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location evidence is held
7.1	The Trust's Annual Report will contain a formal statement of risk management/assurance of activity during the previous year and will highlight key issues arising.	Confirm that the statement is included within the Annual Report	Board of Directors Secretary	Once a year	Board of Directors	Copy of Annual Report and Minutes of the Board of Directors	Board of Directors Secretary Office
7.2	Internal Audit opinion on the effectiveness of risk management arrangements, as determined by the Audit Committee, to inform the AGS (Annual Governance Statement)	Review of Audit Report and Action Plan	Associate Director of Governance	Once a year	Board of Directors	Copy of Audit Report and Minutes of the Board of Directors	Associate Director of Governance
7.4	RMG Chairperson's Report will escalate risks by exception to Quality and Safety Committee.	Reviewing the minutes of the Quality and Safety Committee	Associate Director of Governance	Once a year	Quality and Safety Committee	Copies of minutes of Q&SC	Governance and Assurance Office
7.5	The minutes of RMG and the Risk Tracker are presented to the Audit Committee every month for scrutiny as required and then shared with Board of Directors.	Reviewing the minutes of the Audit Committee	Associate Director of Governance	Once a year	Audit Committee	Copies of minutes of Audit Committee	Governance and Assurance Office
7.6	Internal Audit will undertake an annual audit of a selection of risks and the risk management process.	Audit Tool	Associate Director of Governance	Quarterly (annually for Divisions)	RMG		
7.7	An Annual Report on the Corporate Risk Register will be presented to Board of Directors for information every 12 months.	Annual Report to Board of Directors	Associate Director of Governance	Annual	Board of Directors	Copies of minutes of Board of Directors	