The Royal Wolverhampton
NHS Trust

Risk Management Assurance Strategy

1 July 2019

The Royal Wolverhampton NHS Trust

Trust Board Report	
Meeting Date:	1st July 2019
Title:	Risk Management Assurance Strategy review
Purpose of the Report:	To advise Trust Board on the updates made to the Risk Management Assurance Strategy as part of its routine annual review.
Summary:	This report outlines the necessary amendments and updates made to the Strategy and rationale where appropriate.
Recommendation:	To review and approve the changes/updates made to the Strategy.
Action required:	**Approval**
Clinical implications and view	The Strategy has been reviewed at by the Policy Group with input from clinical members.
Patient, carer, public impact and views	NA
Resource implications/ resources not confirmed	NA
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Assure	• The Risk Management Assurance Strategy is reviewed annually to incorporate enhancements that strengthen internal controls. • Grant Thornton conducts an independent annual audit of the Risk Management Assurance Strategy and arrangements in practice, which include specific areas of focus. • A resultant action plan is developed to take forward the recommendations from the independent annual audit.
Advise	• The Grant Thornton Risk Management audit action plan has been developed and will be monitored at Quality Governance Assurance Committee (QGAC). • A Trust annual audit of Risk Management implementation is due in July 2019. The focus will include for example, the occurrence and content of governance meetings, escalation of risks, external incident reporting and serious incident performance.
Alert	The latest Grant Thornton audit report (March 2019) concluded Partial Assurance with 3 medium and 2 low rated recommendations relating to the: • alignment and escalation of risks between Board Assurance Framework (BAF) and Trust Risk Register (TRR); • prompt escalation of risks from operational areas to the TRR; • review of the model and function of the Central Governance Team to undertake proactive work; • review of Risk Management training uptake for senior

	managers and all staff.
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Links to Assurances	The Strategy links to a number of enabling policies described within the scope of the document (section 2).
Resource Implications(where not managed in existing resource):	**None**
Risks:	Risks contained within the BAF, TRR and Local Risks registers held across the Trust.
Risk register reference:	As above
Other formal bodies involved:	The Risk Management Assurance Strategy has been reviewed by: Policy Group – June 2019 QGAC – June 2019
References	CQC Well Led standards and KLOE Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Report Details	
1	The Trust's Governance and Risk Management arrangements are well established and subject to a routine review (internal and independent). The changes made to the Risk Management Assurance Strategy in this year's review are minimal and minor, mainly to ensure alignment to recommended practice changes in year. The Grant Thornton recommendations have not necessitated changes to this Strategy. However, changes and clarifications are added to the procedures within OP10 Risk Management Reporting Policy namely around the process for risk escalation follow up, the alignment of TRR and BAF risks and risk management training requirements for all staff. **The main changes/updates to the strategy are detailed below:** • Name changes throughout including Head of Governance, NHS Resolution, and Strategy names.

	• Section 2 – Outlines the Risk Management approach applied to integrated/acquired/expanded services. • Section 3 – New template heading of staff requirements added. • Section 6.0 – Clarification of Governance and Risk Management training for all staff. • Section 5.2.3 – Sharing Lessons – Strengthened arrangements for Learning and improvement (Change Implementation Review framework drafted). • Section 5.5 and 5.8.3 – Update on functions and embedding of the new group reporting structure (QSIG, COG). • Section 5.6 – Updates on Local Procedure governance arrangements. • Section 5.8.2 – Added summary of Workforce and Organisational Development Committee remit. • Section 8 - Evaluation and Review – Update to monitoring measures. • Section 10 – Reference update – Kirkup Report 2018. • Appendix 3 page 31 and 32 – Update to sub-group reporting structure.

The Royal Wolverhampton NHS Trust

Risk Management Assurance Strategy

Content

Sections	Page
1.0 Aims / Objectives	5
2.0 Scope	6
3.0 Strategic Context/Background	7
4.0 Communication of Strategy	8
5.0 Risk Management Assurance Structure	8
6.0 Roles and responsibilities	23
7.0 Equality Statement	25
8.0 Evaluation & Review	26
9.0 Resource Assessment	26
10.0 References	26
11.0 Appendices	28

Appendix 1 – Glossary and abbreviations

Appendix 2 - Risk assurance and escalation framework

Appendix 3 – Trust Committee structure

1.0 Aim / Objectives

The aim of this strategy is to support the Trust's vision to be 'An NHS organizationthat continually strives to improve patients' experiences and outcomes', by defining the systems, processes, structures, roles and responsibilities that underpin internal controls and the means by which assurance on risk management will be provided to the Board. The strategy builds on existing Governance arrangements to strengthen internal controls and improve quality and safety within our services over the next three years.

This strategy is aligned to the Trust objectives:

- To improve the culture of compassion, safety and quality in every department and service we offer
- To build a reputation for excellence by achieving top 25% performance against key measures
- To proactively seek opportunities to improve health services in our local health economy through collaboration and supportive partnerships
- To have an effective, well integrated organizationwhich operates efficiently
- To maintain the financial health of the organizationand seek appropriate investment opportunities that enable further enhancement of patient services
- To attract, retain and develop all employees and improve employee engagement year on year

This strategy describes a risk management framework designed to deliver the following high level aims:

- Produce and challenge evidence based assurance
- Clear accountability for Risk Management demonstrated in practice
- Continuous Quality and Safety improvements through sound systems, processes and outcomes
- Strengthen governance arrangements across central, divisional and corporate areas
- Maintain regulatory, performance and contractual standards (e.g. Care Quality Commission, Monitor, Commissioners, NHS Resolution, National Patient Safety Agency, Department of Health etc.)
- Effective aggregation and reporting of Risk Management and Compliance information to inform quality improvement
- Adequate and accurate Risk Management reporting to the Board and senior management
- Enable a supportive and open culture to share learning, best practice and continuously improve the patient experience
- Continuously improve safety culture and outcomes including reduced adverse incidents, patient harms and litigation claims

2.0 Scope

The strategy applies to all Trust staff, contractors and third parties working in all areas of the Trust. The strategy and assurance framework is supported by operational governance documents as well as the following Trust policies:

- **Governance Policy GP01** – Details the principle and underpinning Board activities as required following Nolan Principles and Turnbull report.
- **Review and implementation of NICE guidance (National Institute for Health and Care Excellence) Policy OP56** – Outlines the process for management and response to NICE guidance.
- **Implementation and review of National Guidance and National Confidential Enquiries Policy OP64** – Outlines the process for management and response to relevant National guidance.
- **Management of external agencies visits, inspections and accreditation and external recommendations Policy OP61** – Details the preparation and response process for inspections carried out by external agencies.
- **Being Open Policy OP60** – Explains the practice, approach and necessary documentation for implementing the Being Open process.
- **Risk Management Reporting and Patient Safety Policy OP10** – Details both the reactive and proactive systems for risk identification / incident reporting, trends analysis, investigation, controls and action monitoring. The policy instructs staff practice at all levels of the organisation.
- **Health and Safety Policy HS01** – Details the actions and monitoring required across the Trust to ensure the safety of patient, staff and the public is achieved.
- **Clinical Audit and Effectiveness Policy OP45** – Details the audit process including implementation and monitoring of clinical audit.
- **Legal Services Policy OP31** – Details the system and process for claims handling and links with operation risk management to reducing litigation costs.
- **Information Governance Policy OP13** – Identifies patient expectations for confidentiality and specifies how the Trust undertakes to protect those expectations.
- **Development and control of Trust Policy and Procedural documents OP1** – Provides standards for the development and management of strategies, policies, guidelines, protocols which require board or committee approval.
- **Safeguarding Children in Hospital CP41** – Describes the arrangements within the Trust to safeguard and promote the welfare of children and young people.
- **Safeguarding adults at risk in hospital and the Community CP53** – Describes the Trust arrangements for safeguarding adults and delivery of the inter-agency strategy.

- **Patient Experience Engagement and Public Involvement Strategy 2019 - 2022** - Sets out the Trust approach to measuring, capturing and improving patient experience.
- **Infection Prevention Strategy** – Describes arrangements to ensure the Trust has suitable and sustainable infection prevention and control arrangements in place.
- **Information and Communication Technology (ICT) Strategy** - highlights the direction of travel for ICT including the major outcomes and associated action required.

In addition to acute and community services, the Trust is comprised of GP services (since 2016) and the newly formed Black Country Pathology Service (BCPS) (since 2018).

To ensure the appropriate application of this strategy to service intergration, acquisitions and expansions, due diligence reviews are conducted and a risk prioritised approach taken to the adaptation of systems and processes including risk escalation, incident reporting, compliance reporting and audit. A local integration plan is devised for transitional arrangements with subsequent final plans adopted into policy. Wherever possible the service integration/acquisition/expansion will merge with existing Trust policies, systems and processes and integrated into Trust reporting arrangements.

3.0 Strategic Context/Backgound

Organisational failures over a number of years within both the public and private sectors have been attributed to poor governance or failings in risk management. The response to this has been heightened control in these areas via legislation and publications of governance codes and guidance.

Within this environment assurance has become an increasingly important concept which requires a clear description that is well understood and applied by the organisation. Accountability is further strengthened by an Annual Governance Statement requiring public organisations to demonstrate effective and efficient controls and organisational stewardship.

The Risk Management Assurance Strategy will outline the arrangements to deliver sound assurance. In so doing the process will seek to identify and eliminate duplication of effort and resources, reduce the burden of bureaucracy and provide a central point of expertise in relation to governance and risk management assurance.

This strategy applies to all existing and new services acquired by the Trust.

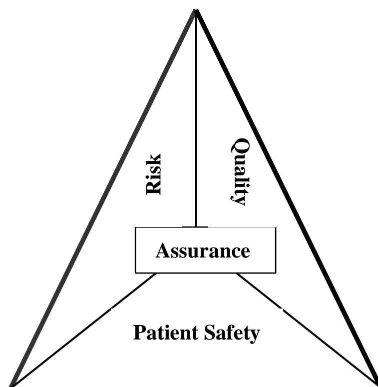
3.1 Strategy statement

The Royal Wolverhampton NHS Trust is committed to minimising risk to all its stakeholders through a comprehensive system of internal controls that allows maximum potential for flexibility, innovation and improvement.

The Trust seeks to apply the coordinating principle of integrated Risk Management to inform its intelligence and assurance of overall risk and to direct proactive management action. This approach enables a better alignment between service delivery outcomes and its impact on patient outcome and Trust objectives.

Integrated Risk Management operates through a series of processes applied Trust wide to identify and manage risks, measure quality and harvest results which inform organisational decision making and action.

Risk Management Assurance is informed by close links with Quality and Patient Safety Initiatives and their related monitoring:



3.2 Staff Requirements

This strategy describles the systems, processes and structures that staff must work within to deliver good Governance and Risk Management systems that maintain quality and safety across Trust services. Staff must ensure they comply with arrangements contained in this strategy and comply with related policies outlines under section 2 scope above. Staff must comply with mandatory and role specific training outlined in the Mandatory Training Policy (OP41). (refer section 6 below)

All staff are required to demonstrate trust values in their behaviour and in the way they carry out their roles.

4.0 Roles and responsibilities

Chief Executive

The Chief Executive has overall responsibility for maintaining a sound system of internal control within the Trust and for preparing an Annual Governance statement. Operationally, the Chief Executive has delegated responsibility as outlined below. The chief executive is accountable to the chair and non-executive directors for ensuring that the board is empowered to govern the organizationand that the objectives set are accomplished through effective and properly controlled executive action.

Chief Nurse

The Chief Nurse has the following responsibilities:

- Ensuring adequate clinical governance systems and processes and internal controls (jointly with the Medical Director);
- Ensuring the effective operation of systems for the management of clinical and corporate risk
- Overall performance of Corporate Governance functions (including maintenance of the Board Assurance Framework with Executive Directors)

- Ensuring that there are robust systems and processes to manage the assurance against CQC registration regulations, NHSR risk history/profile and other national guidance;
- Executive Lead for Patient and Public Involvement
- Executive Lead for Health and Safety
- Executive Lead for the Governance
- Executive Lead for Safeguarding
- Executive Lead for Infection Prevention
- Executive Lead for Education - Non Medical Profession
- Executive Lead for Nurse Revalidation

Medical Director

The Medical Director has the following responsibilities:

- Ensuring adequate clinical governance systems and processes and internal controls (jointly with the Chief Nurse)
- Ensuring the effective operation of systems for the management of clinical and corporate risk
- Ensuring effective operation of Corporate governance processes (jointly with the Chief Nurse)
- Fulfill role of Caldicott Guardian
- Executive Lead for Mortality management
- Executive Lead for Information Governance
- Executive Lead for Clinical Audit, NICE guidelines and National Guidance
- Executive Lead for Medical Education and Training
- Medical Director is the Responsible Officer and executive lead for medical revalidation

Chief Finance Officer

The Chief Finance Officer has responsibility for financial governance and associated financial risk.

Executive Directors

The Executive Directors have responsibility for the management of strategic and operational risks within their individual portfolios. Responsibilities include the development of robust governance arrangements and systems that ensure monitoring, challenge and oversight of risk as well as compliance with statutory/legal responsibilities.

Head of Governance

The Head of Governance is accountable to Chief Nursing Officer for the management and leadership of the Central Governance Team; and for the operation of governance, risk management assurance processes.

Trust Board Secretary

Responsible for the delivery of Corporate Governance functions on behalf of the Board and related Committees, including Board meeting administration, board business planning, and provision of advice.

Chairman

The overall role of the chair is one of enabling and leading so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the chair are:

- leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda
- ensuring the provision of accurate, timely and clear information to directors
- ensuring effective communication with staff, patients and the public
- arranging the regular evaluation of the performance of the board, its committees and individual directors
- facilitating effective contribution of non-executive directors, and ensuring constructive relations between executive and non-executive directors

A complementary relationship between the chair and chief executive is important.

Non Executive Directors

Non executive Directors have a duty to ensure that the Trust has sufficient control measures to be able to effectively manage its risk.

Divisional Management

All Divisional management are responsible for implementing the Risk Management Assurance Strategy and its systems and processes. They are responsible for internal monitoring and operation of all internal control for assurance in their areas of responsibility e.g. risk registers, risk management and compliance processes.

Directorate Management

All Directorate management (including ward managers) are responsible for the implementation of Trust strategies, policies and procedures; and for implementing systems that support internal controls and assurance within the Trust.

All Staff

All staff have the responsibility to contribute to good governance by complying with all Trust policies, procedures and systems including reporting and investigation of incidents and near misses and reporting risks and hazards.

5.0 Structure and Approach

5.1 Risk Management Assurance Approach

Integrated Governance (a prerequisite of integrated risk management) is described as ‘the systems, processes and behaviours by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety and quality of service’.

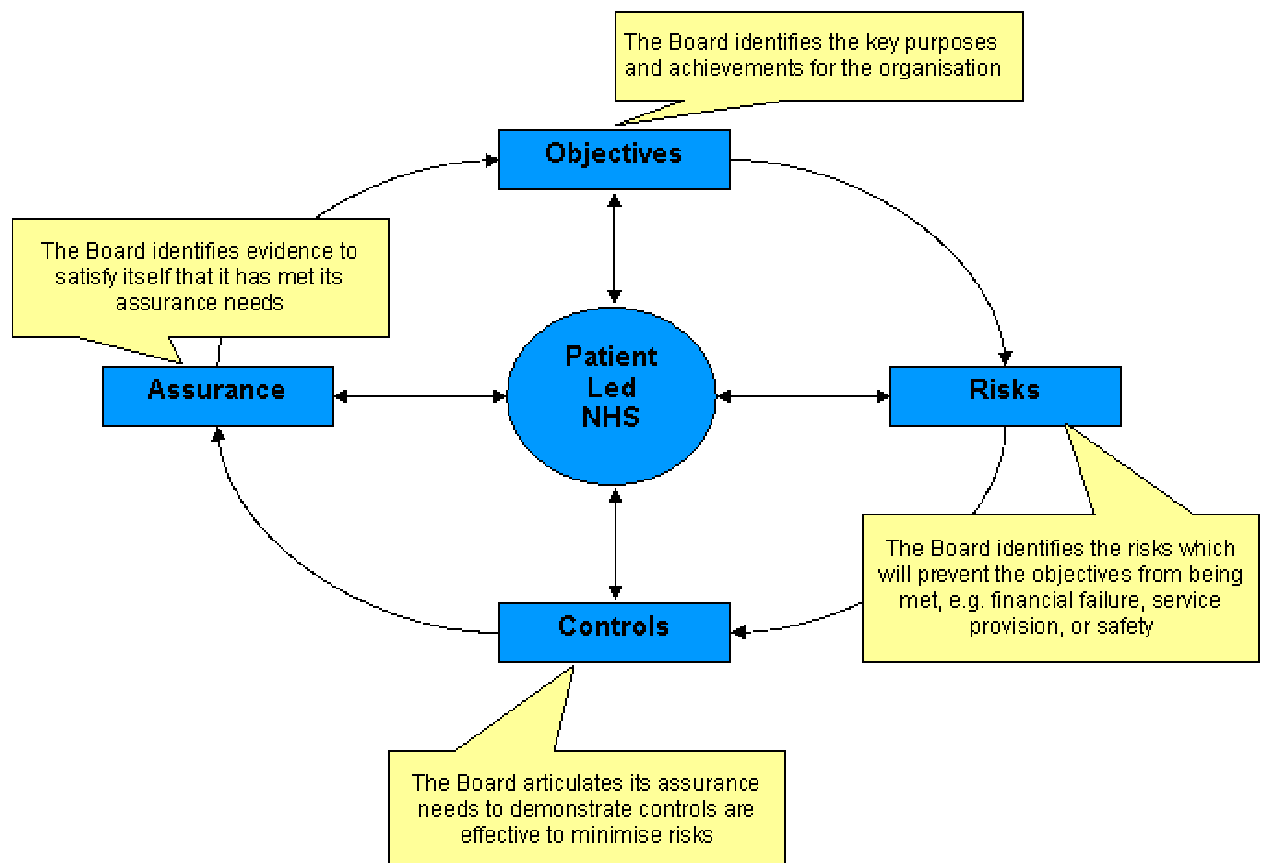
(Integrated Governance Handbook (2006)).

In practice this means:

- Developing standard risk management systems and processes to inform overall assurance
- Analysing Risk Management intelligence (reactive - from incident reporting, complaint and PALs feedback, claims, inquests, inspections etc.)
- Assessing Trust performance against national standards, best practice, benchmarks and regulation (proactive – risk assessment, prospective audit, compliance measurement)
- Identifying sources and assessing strength of assurance
- Triangulating internal and external intelligence to inform decisions and judgements
- Validation and quality assurance checks on data.
- Implementing a consistent approach to data collation
- Identifying and addressing all risks/gaps within the process

The Risk Management assurance framework will enable reporting on internal controls to support the Board in signing off the Annual Governance statement.

The Risk Management assurance framework is developed with the patient as the central focus and driven primarily by the agreed objectives for the Trust. The following diagram summarises the model for the Trust:



Having identified the strategic objectives, the Trust Board will identify the strategic risks that threaten the achievement of the objectives as well as controls and actions as appropriate to manage risks. Effective Trust wide communication and cascade of the strategic objectives is vital to successful staff engagement and ownership at

local level. The cascade of strategic objectives to Divisions and Directorates will coincide with the delegation of risks where it is relevant for local management.

The Risk Management Assurance framework will utilise existing structures and processes to inform its evidence. Key processes are explained further below and include (non exhaustive):

- Risk management;
- Clinical audit/National benchmarks;
- National Standards and regulatory compliance;
- Quality and Safety Improvement indicators;
- Policy Governance;
- Internal/External/Peer review;
- Management/Governance/Committee reporting structures.

To realise the intended benefits it is important that the assurances are assessed in terms of value. The Trust will adopt methodology to assess assurance against strategic risks using the three lines of defence model contained in HM Treasury Assurance Framework publication (described in 3.3).

5.1.1 Levels of Assurance

There are various types of assurance that can be sought: verbal, written and empirical. All can be of use depending on the circumstances. Each will be valued differently depending on the necessity of the risk. However, it must be noted that verbal assurance in isolation can be the least relevant and must be substantiated as it may be deemed reassurance rather than assurance.

In line with HM Treasury Assurance framework guidance 2012 – three lines of defence, the Trust has adopted the following levels of assurance to be applied:

Level 1 – Operational (routine local management/monitoring, performance data)

Level 2 – Oversight functions (Committees, internal compliance assessment)

Level 3 – Independent (External Audits / Reviews / Inspections etc.)

This guidance provides essential support to managerial assertions about the adequacy and effectiveness of assurance/internal controls.

Regardless of the type, source and level of assurance the following further impact on assurance value and need to be considered:

Age – the time elapsed since assurance obtained

Durability – whether it endures as a permanent assurance on an historical matter e.g. Auditors' Report on Financial Statements, or work that loses relevance over passage of time e.g. clinical audit

Relevance – the degree to which assurances aligns to the specific area or objective over which it is required

Reliability – trustworthiness of the source of assurance

Independence – the degree of separation between the function over which assurance is sought and the provider of assurance

Through the review of assurance, vulnerabilities or duplication of effort can be identified and eliminated.

The value of assurances used for the Board must primarily be ascertained by the responsible manager/lead providing the assurance and is ultimately judged by the lead Director and the Board.

5.2 Risk Management Assurance System

5.2.1 Risk is an inherent part of the delivery of healthcare. Achievement of objectives is subject to uncertainty which gives rise to threats and opportunities. By implementing standard risk management systems and processes, the Trust seeks to minimise, though not eliminate threats and maximise opportunities to meet objectives and continuously improve.

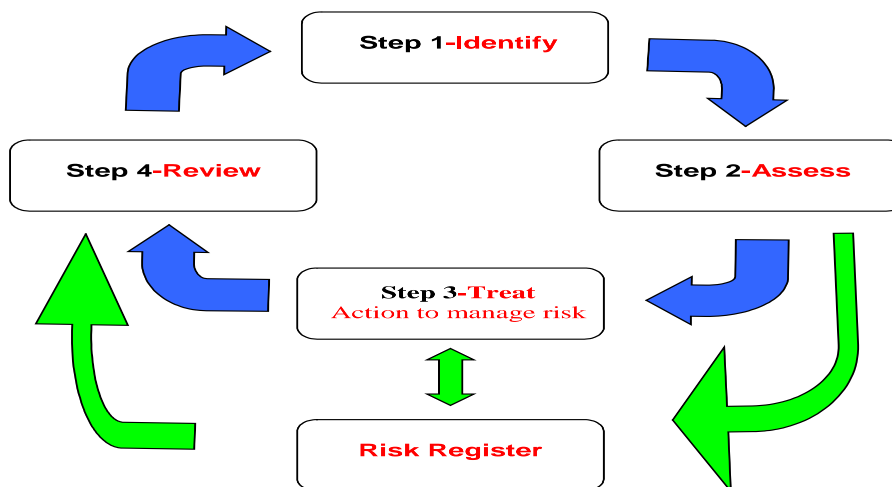
Risk management includes identifying, assessing, responding and where appropriate escalating risks. These main steps are carried out through:

1. Clear objectives
2. Identify risks to objectives
3. Defining and recording risks on a risk register
4. Maintenance of the risk register with controls and actions
5. Escalation and de-escalation of risks (in line with escalation thresholds)

Actual and potential risks are identified from numerous sources: incidents, complaints, claims, trends, investigations, compliance standards/benchmarks, audits, assessments/ inspections, cost improvement programmes and many more. The map below refers to some sources of risk management assurance but is not an exhaustive list. Some key areas are expanded upon below.

Staff are instructed via training and policy (OP10) to identify risks from all sources of service activity and to follow the process outlined in Procedure 2 OP10 for further management.

The risk management cycle is applied to all levels and types of activity:



Step 1 Risk Identification

Given the complexity and interdependencies of many Trust services, it is important to ensure an appropriate skill mix is involved in risk identification and management. Staff are guided to look for actual and potential risks from various sources:

Actual risks (or near misses) already incurred – these are extracted by reference to incidents, complaints, claims, inquests, trends review**,** underachievement of target, budgetary review, external visit or review outcome.

Potential risks can be proactively identified via Corporate/local objective setting, risk assessment processes for Infection Prevention and Control, Health and Safety, National guidance/ benchmarks or feedback raised by staff or other stakeholders.

Step 2 Risk Assessment

Risks and threats must be considered in all transactions. The Trust uses a categorisation matrix which grades the likelihood and consequence to determine the risk score. Risks (actual or potential) that have been assessed as 12 or greater (having an unacceptable residual or ongoing impact on quality, safety or patient experience) will be managed in line with the risk escalation process (see 5.2.2 below for risk escalation or for detailed information on risk assessment, risk escalation or registers refer to the Risk management reporting and Patient safety policy (OP10).

Step 3 Treat

This involves the identification of controls and or actions to manage and reduce the threat of risk. Controls can be identified to reduce the likelihood of occurrence or the impact if realised. Controls must be measurable to assess the mitigation of risk.

Mitigation can be achieved through:

- Management or staff accountabilities
- Policies, procedures and guidelines
- Systems and processes
- Feedback procedures/methods

– Staff training, education and management
– Key performance indicators/monitoring reports
– Internal/independent audit

To maintain integrity of the assurance framework, controls identified must have a sound evidence base and actions that are clear and measurable. The principles detailed in section 5.1.1 above are to be used to assess the value and reliability of controls and levels of assurance it will provide.

Treatment plans must also consider the 3 "T" options for managing risk i.e. Terminate - stop the activity, Tolerate - accept the risk with no mitigation or control or Transfer - to another party.

Step 4 Review

All local risk registers will be reviewed regularly and a process for risk escalation implemented (detailed in Procedure 2 OP10 Risk management and patient safety reporting policy).

The Trust risk register (TRR) and Board Assurance Framework (BAF) are reviewed regularly by the Trust Board and delegated Committees. Risk review outcomes are used to inform policy development, key performance indicators and internal/external audit plans.

5.2.2 **Risk Register framework:**

The Trust operates three levels of risk register in order to identify and manage risks – The BAF, TRR and local risk registers. This method of risk review allows a bottom up and top down approach to informing the Assurance framework (refer Appendix 2 Risk assurance and escalation framework). The approach is holistic as it includes all risks to the organizationincluding strategic, clinical, Health and Safety, business, marketing and financial.

The risk register contains the following minimum information:

- Source of risk;
- Description of risk;
- Risk score;
- Controls and gaps in controls;
- Residual risk score;
- Mitigating actions;
- Date of assessment and date for review.

Risk Prioritisation

A standardised approach to risk prioritisation is essential as it provides a consistent determination of what constitutes an acceptable or significant risk and for directing staff action. The use of a risk categorisation matrix to score the likelihood and consequence of risks allows all staff to consider severity and to take a managed approach to risk decisions and further actions. Consideration must also be given to any funding required to implement controls and the overall ability to manage the risk locally.

The grade assigned to risks on the risk register must be reviewed/confirmed by management at the level it is assigned (Division/Directorate – NB risk registers are reviewed at least quarterly). Where the grade is confirmed at 12 or above the risk

escalation process below will apply. To ensure consistent prioritisation of risks that trigger escalation, the central governance team conducts regular checks of the risk recording system in order to identify trigger grades and validate scores. Bespoke training is available to staff where grading inconsistencies are identified.

Risk Escalation

Risks that require escalation through the Trust structure are determined by the likelihood and impact if realised. All risks categorised as grade 12 or above on the categorisation matrix must be escalated to Trust risk register following local agreement. Risks identified at each level (Division/Directorate/ward or department) must be reviewed with a view to further escalation, downgrade or local management.

The Board Assurance Framework (BAF)

The BAF details the principal risks to meeting Trust strategic objectives, sets out controls to mitigate these risks and details assurances on the effectiveness of these controls. The BAF provides a starting point for the Trust Board to record risks affecting strategic objectives that then interfaces with the Trust risk register and local risk registers. Related risks or elements of a risk may be delegated for local management/monitoring on Divisional/Directorate risk registers. This cascade approach ensures management alignment with the BAF risks and the strategic objectives they support.

The BAF provides a control structure to support the Annual Governance statement.

The BAF is reviewed regularly by the Trust Board and delegated Committees.

Trust Risk Register (TRR)

The TRR is the corporate record of high level operational risks escalated from service areas as well as risks delegated from the strategic objectives for local/operational management. It provides the link between local risk management processes and board level review of operational risk. The Trust risk register will automatically include all risks graded at score 12 and above using the categorisation matrix and will include risk mitigation/ control actions. Equally the identified causes of BAF risks can be transferred to the TRR. Used correctly the TRR demonstrates an effective risk management and escalation approach operates within corporate and operational levels of the Trust. The TRR is reviewed regularly by the Trust Board and delegated Committees.

Local Risk Registers (Divisional and Directorate registers)

Each Division and Directorate manages a risk register and operates the risk escalation process. Local risk registers will be regularly reviewed and all risks graded at 12 or above will be escalated (once agreed by the Division/Directorate) to the Trust risk register for the attention of Directors. The Division/Directorate will ensure it has a system for approving and reviewing risks including controls and action monitoring. Division must have oversight of Directorate risks ensuring that risks highlighted or escalated through the risk register hierarchy are considered in the context of other risks already on the register in other areas or at other levels.

Appendix 2 illustrates the Risk Assurance and Escalation framework.

5.2.3 Use of Risk Management to assure improvement

Sharing lessons

The Trust uses a multi-pronged approach to lesson sharing which is detailed in OP10 (Risk management and patient safety reporting policy). The methods include

standardised reporting at local and Trust committee level, newsletter publication and a Complaints, Litigation, Incident and PALs group (CLIP) whose remit include the identification of learning and trends from incidents, complaints, claims or inquests in order to determine improvement actions/strategies. In addition the Trust uses learning and improvement alerts to enable more timely feedback where adverse incident findings or precautions need to be shared. The Trust sees the effective use of lessons for improvement as an area that requires continuous evolvement and challenge to have the desired effect. The Trust is developing a Learning strategy with a core focus on identifying and implementing learning, building experiential learning capability and measuring change/improvement resulting from the embedding of lessons learned and actions.

Action tracking

The organizationwill establish monitoring systems for the tracking of actions resulting from serious incident investigation, national compliance measures, national / internal audit or other sources where significant risks are identified. Action tracking will occur through local arrangements at operational level with local management having delegated accountability for assurance of closure. An oversight report for SUI, National Guidance including CQC compliance, Clinical Audit will be made to an appropriate Trust committee/group. Action tracking is recognised as vital to closing the loop and to ensure an improved outcome is achieved.

5.3 Monitoring of Quality and Compliance risk

The Trust will take a holistic and evidence based view of assurance using hard and soft evidence as pointers to monitor quality and safety and detect poor performance. Measures include:

- Performance indicators (i.e. Nurse/Quality metrics, CQC surveillance data)
- Incidents, complaints, claims trends
- CQC domains and Fundamental Standards assessment
- NHS Litigation Authority claims profile
- Health and Safety compliance
- Information Governance compliance
- Patient/staff feedback
- External assessment/Inspection
- Internal Quality review programme
- National benchmarks, Independent and external assurance used for triangulation

The review of the quality and compliance measures is assigned across the Trust committee/group structure within their terms of reference.

Monitoring of CQC Regulation - Compliance Risk

The Trust must maintain compliance with the Health and Social Care Act 2008 (Regulated activity) regulations 2014. The Care Quality Commission (CQC) will monitor compliance with the regulations through the new approach assessment and inspection regime and produce a rated report under the 5 Domains of Safe, Effective, Caring, Responsive and Well Led. The Trust has transitioned from a purely self-assessed approach to monitoring compliance against the new

regulations and Fundamental standards of Care, to one which includes measurement through specialist oversight, key performance indicators and observational peer review.

The Trust will develop performance indicators in line with the CQC Fundamental standards of care and key lines of inquiry (KLOE).

An Internal Quality review programme has been development using observational and peer review methods to monitor quality and safety of patient care in line with the new regulations and Fundamental Standards of Care.

The Trust uses a system (Health Assure) to capture compliance performance (eg. National guidance, NICE, CQC Fundamental Standards of Care) at Divisional and Trust levels. The system is subject to continuous development and upgrade to enhance user functionality and reporting.

The Risk management assurance system will use quality and compliance monitoring as an early warning alert to risk.

5.4 Monitoring Safeguarding Risk

Safeguarding arrangements are fully integrated into the Trust governance and risk management processes. Where appropriate arrangements have been aligned for both children and adults to improve consistency in safeguarding standards.

Assurance is provided by local referral monitoring, training, external audit, performance indicators derived from Trust policies and the Wolverhampton Safeguarding boards. Safeguarding activity and performance will report through the Quality Standards Action Group to inform the assurance framework.

5.5 Information management and reporting

In order to improve risk detection the Trust has strengthened the level and content of information reported to its sub-committees and groups by review of report templates, terms of reference and escalation mechanisms. Report content will be driven by:

- Trust Strategic objectives and identified risks;
- Key national priority indicators, standards and regulatory requirements;
- Selected metrics covering safety, clinical effectiveness and patient safety;
- Selected advance warning indicators;
- Adverse event priorities/patterns - from incident, complaint and claim;
- Harm reduction priorities;
- Qualitative descriptions to back up quantitative information.

Board information will be backed up by a pyramid of more granular reports reviewed by sub-committees, specialist groups, divisional/directorate management and specialist leads. New metrics will be developed to inform assurance where this is lacking.

The Trust will continue to improve on its efforts to provide timely and quality assured risk data.

During 2018/19 the Trust has embedded its revised reporting structure for quality, safety and risk through the function of two new groups (Quality and Safety Intelligence group QSIG and Compliance Oversight group COG). The QSIG takes a quality performance focus and COG focuses on oversight reporting by independent

leads for specialist groups and subjects. There is liason between COG to QSIG, where operational action is needed to redress compliance.

5.6 Policy Management and Risk Assurance

Policy implementation, audit and monitoring is a key part of the risk assurance process. The Trust operates a policy management system which ensures consistency in the minimum content, format, communication and review of Trust policies. A designated Policy group is assigned for review of Trust Policies. Each policy must identify the monitoring and audit requirements for key deliverables in order to inform assurance. Where compliance/quality risks are identified this must follow the standard process for escalation.

The integration of Community care (2011), transfer of services from Mid Staffordshire Foundation Trust (2014), launch of Vertical Integration (VI) (2016) and formation of the Black Country Pathology Service (2018) has further emphasised the importance of policy management prompting developments in the access to Trust policies on the intranet across the new sites.

The strengthening of governance arrangements for local procedural documents will remain a focus throughout the duration of this strategy.

Within the lifetime of this strategy the Trust will explore IT and other solutions to enhance the communication of essential policy content to appropriate staff as well as assurance of staff review of policies.

5.7 Monitoring Clinical Audit Risk

Clinical audit is delivered through a structured and risk-prioritised annual programme. An audit plan is agreed each year having regard to the Trust objectives and priorities, risk intelligence, Standard and Regulatory compliance status and local service demands. A subgroup (Clinical audit group) is responsible for monitoring delivery of the annual audit plan and to ensure that actions are disseminated for improvement.

The Trust participates in national audits and uses this benchmark to raise standards and improve effectiveness.

Divisions are to operate local systems which ensure that the outcomes of clinical audits are implemented, that actions are tracked and re-audits are undertaken where indicated.

Risks identified through audit must be reported and managed in accordance with the risk management process detailed in the Risk management reporting policy (OP10).

Areas such as the oversight and monitoring of completed audit actions will be undertaken by the central Governance Department.

5.8 Risk Management Assurance - Structure

5.8.1 Overview

The Trust Board has set in place a committee and management structure (Appendix 3) to manage internal controls and the Quality, Safety and business operations/risks to the Trust. It is principally important that this strategy makes clear the collective responsibility of committees / groups and the individual responsibility of managers and staff for ensuring the safety of patients, staff and visitors (refer section 5 Governance structure and section 6 roles and responsibilities).

A headline summary of the scope of each tier is provided below. The effective function of each tier is heavily reliant on the discharge of membership roles, behaviour and the culture within the Trust.

In monitoring risks, the Board, its sub committees, subgroups and specialist working groups will consider:

- Adequacy of existing controls to mitigate the risk, additional actions needed and by whom within reasonable timescales;
- Whether the risk score and current level is appropriate or requires upward escalation;
- Whether there are links between the identified risk which points to a broader corporate issue and appropriate next steps;
- Whether identified risks represent a threat to the Trust strategic aims and must therefore be escalated for consideration for the BAF;
- Whether to accept the risk with no further possible mitigation.

Tier 1 - Sub Board Committees (black boxes)

Beneath Trust Board are 6 sub–committees derived to provide assurance to the Board. The focus of a Committee is on assurance, challenge and triangulation. Each committee has terms of reference (agreed by the Trust Board) and a prescribed portfolio of work aligned to Corporate Objectives and to statutory/specialist necessities.

Committees may utilise a network of subgroups to lead on various segments or work and will review reports on performance/risk to inform overall assurance. This level of reporting and review will take the form of assurance and overview reports with exception reporting on triggered performance so as not to duplicate delegated responsibilities of subgroups. Deep dive reports or further assurance may be requested from subgroups or others in response to performance issues or for triangulation. In addition a programme of themed reviews can be scheduled as a proactive approach to assurance over the year. Sub-committees are to utilise multiple means of seeking/testing assurance. This may include traditional reports but will also extend to area visits by members with feedback, focal points via safety walkabouts/peer reviews, proactive audit assurance (internal and independent).

Tier 2 - Sub Groups (green boxes)

Subgroups are usually subject-specific or cohorted (e.g. Trustwide Patient Safety or Compliance Projects) to enable large and disparate areas of work to be co-ordinated and managed. The focus of a sub-group is on action delivery, monitoring and escalation. This level of review will be of more granular reports (per location) which underpin Trust level dashboard/overview reports. The expected remit for this group is the challenge of performance in specific areas and the review and monitoring of improvement actions.

Subgroups must only be established with official approval by a lead Director and once approved must report to a tier 1 Committee.

Tier 3 - Specialist Working Group (white boxes)

Specialist working groups are usually derived from professional/specialist guidance or best practice. They may be permanent or fixed term entities which contribute to assurance in a specific area. Upward reporting is made against derived measures agreed with the parent subgroup. Specialist subgroups are required to review Trust wide performance on a specialist subject (e.g. Medicines Management,

Resuscitation, Medical Devices etc.), establish and report on the impact of risks or gaps in Trust compliance and develop and monitor improvement plans.

Specialist working groups are listed in Appendix 3.

Tier 4 - Divisional Governance

A divisional governance document will outline the local structures and arrangements needed to deliver core functions of Governance, Risk management and Assurance at local level (e.g. NICE, national guidance, standard compliance, safety alerts, investigations, Information Governance, audit etc.). The requirements are defined at each level (Division/Directorate/Ward or Department). It includes detail such as meeting arrangements, a template governance agenda, terms of reference meeting frequency and reports produced, review requirements etc. Each operational area (i.e. division, directorate and department) will have standard governance/risk management systems and processes in operation to deliver the requirements outlined in this strategy and related policies.

Reporting within the structure

Reporting to the Board from committees and between subgroups and committees will be a combination of minutes, Chair's report (escalation/assurance reporting) and performance reports. Each committee and subgroup will identify core themes and measures to be reported. On agendas of committees and subgroups a standing item will exist for 'issues for escalation' and for 'evaluation of the meeting' to reflect on effectiveness.

At different levels focus will be placed towards assurance, escalation, challenge, monitoring and implementation and further described within terms of reference.

NB. The terms of reference includes the reported items and reporting groups for each meeting within the structure.

5.8.2 Trust Committee summary

Trust Board (TB)

The TB is accountable for assuring itself that systems and processes for governance and risk management (internal controls) are functioning effectively. Key responsibilities include:

- Set and monitor strategic objectives and direction for the organization;
- Review the effectiveness of the Trust internal controls supporting the Annual Governance statement and BAF;
- Oversee performance and risk assurance for the organizationensuring appropriate corrective action;
- Ensure financial stewardship;
- Ensure dialogue with external bodies and the local community.

The Management and Governance Committee structure helps to deliver the responsibilities for internal control. Trust Board has delegated responsibility for monitoring and managing risk across the organizationto:

Trust Management Committee

Audit Committee

Finance and Performance Committee

Quality Governance Assurance Committee

Remuneration Committee

Charity Committee

Specific responsibilities are delegated as follows (Terms of Reference can be obtained from the Trust Secretary/Governance department).

Trust Management Committee (TMC)

The Trust Management Committee has the responsibility for the development and delivery of the Trust business plan and the identification and control of operational risks to the delivery of that plan. Key responsibilities are:

- The identification and control of operational risks to the delivery of the Trust business plan;
- To review operational performance reports to include red incidents, complaints, risks, business case proposals and national compliance;
- To approve Trust policies and strategies for implementation;
- Manage delegated BAF risks, monitoring controls to provide assurance.

Audit Committee (AC)

The Audit Committee provides the Board with a means to undertake and obtain independent assurance through objective reviews and audits of strategic, operational and financial risks / systems and help ensure compliance with relevant law, guidance and codes of conduct. Key responsibilities include:

- To provide reasonable assurance for safeguarding of assets, for waste or inefficiency avoidance, and that best value for money is continuously sought;
- To obtain independent and objective reviews of key operational and financial systems / information;
- To advise the Board as to the nature of the Annual Governance Statement.

Finance and Performance (F&P)

The Finance and Performance Committee provides assurance to the Board on the effective delivery of financial and external performance targets of the organisation. It will also support the development, implementation and delivery of the Medium Term Financial Plan (MTFP) and the efficient use of financial resources. Key responsibilities include:

- Monitor income and expenditure against planned levels;
- Monitor and support the development of a Medium and Long Term Financial and investment Plan in relation to capital and revenue;
- Utilise the assurance reporting processes to inform the Trust Board of Finance, performance, investment related risk and redress actions;
- Manage delegated BAF risks, monitoring controls to provide assurance.

Quality Governance Assurance Committee (QGAC)

The QGAC has responsibility for scrutinising and gaining assurance in relation to management and control of clinical, non-clinical, and corporate risk. It is the main committee through which the organizationis assured that risks are mitigated through appropriate control and reduction mechanisms.

Key responsibilities include:

- Review and assure on indicators relating to patient experience, patient care and quality and patient safety;
- Monitor the BAF and Trust risk register management framework and where necessary make recommendations/challenges to assurances/updates provided;
- Monitor the operation and effectiveness of risk management through the Quality and Safety Intelligence group (QSIG) and Compliance Oversight group (COG);
- Utilise the assurance reporting processes to inform the Audit Committee and Trust Board on the management of risk;
- Receive and act upon any feedback / reports from the Audit Committee following their review of the internal audit plan;
- Review the Annual Governance Statement together with any accompanying Head of Internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- Provide reports to Trust Board via minutes and executive summary reports following every meeting;
- Provide minutes to the Audit Committee to inform on the adequacy of governance processes, corporate risk management and controls;
- Approve terms of reference and receive reports from key sub subgroups e.g. QSIG and COG;
- Manage delegated BAF risks, monitoring controls to provide assurance;
- Co-ordinate the identification of risks utilising the BAF/TRR framework to manage controls, assurances/gaps in assurance and further action.

NB. Specific subgroups supporting the function of QGAC is outlined in section 5.8.3 below.

Workforce and Organisation Development Committee (WODC)

The committee is established to:

- provide the Board with assurance on the delivery of the Organisational development and workforce strategy and key areas of workforce governance;
- to ensure the Board is meeting its legal and regulatory duties in relation to its employees;
- ensure processes are in place to support optimum employee performance and;
- ensure the management and control of human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives.

Remuneration Committee

The Remuneration Committee to agree and execute the framework by which the remuneration and conditions of the Chief Executive and other Executive Directors will be set.

Charity Committee

The Charity Committee is established to ensure the management and administration of the Royal Wolverhampton NHS Trust Charity, in accordance with the Charity's purposes, as set out in its Governing Documents.

5.8.3 Subgroups supporting the function of QGAC

Quality and Safety Intelligence Group

The Quality and Safety Intelligence Group is responsible for the review and oversight of quality and safety performance and outcomes within Divisions; to ensure they manage risk and improvement in quality and safety within service delivery. Where a specific compliance focus and improvement is needed, subject leads may report directly into QSIG where there is Divisional representation to monitor progress.

Compliance Oversight Group

The Compliance Oversight Group is responsible for the review of Trust compliance reported by service leads and/or independent sources. Reporting will include trust performance against regulatory and national standards, quality and safety outcome measures and risk related data. The group will use reported information and independent data to oversee safety systems, triangulate operational compliance, and strengthen Trust assurance. Compliance reports are also made available to Divisions for their attention and redress.

5.8.4 Role of Central Governance Team

To deliver bespoke elements of the strategy the Trust has identified central and divisional governance resource to facilitate:

- A standardised approach to process/outcome and assurance;
- Centrally managed governance and risk management systems and processes;
- Provision of assurance in the form of standard and exception reports (within the portfolio);
- And oversee controls e.g. risk registers, Investigations, Audit etc.

Portfolio includes:
Risk management (Incident and risk reporting, investigation and follow up)
Governance and risk management systems and processes
Trust Policy management
Clinical audit and effectiveness
Health and Safety
Standards Compliance management (CQC, NHSR, NICE, National guidance, Inquiries, Professional College reports etc.)
Litigation and Inquest management
Information Governance
Governance Informatics
Trust Committee and subgroup administration
Trust Registration/Licencing

6.0 Communication of Strategy

The strategy will be made available on the Trust intranet / website and will be cascaded via the management and governance lines of communication.

The strategy will also be communicated via training provided to staff. Risk Management training material will be reviewed regularly to remain in line with National guidance, best practice and Trust risk triggers. The following training applies:

- Governance and Risk Management - Induction – all new staff
- Risk Management training (e training) – all staff
- Risk Management (e training) – Senior Managers and the Board
- RCA Investigation Training – all staff with responsibility for incident investigation
- Being Open training (online, bespoke) – all staff with responsibility for incident communication (a minimum of Directorate management)
- Items of training falling from supporting policies include Clinical Audit training, Health and Safety, statement writing etc.

7.0 Evaluation and Review

Monitoring measures

- Progressive achievement of Trust strategic objective year on year;
- Monitoring of the Trust Strategic objectives and BAF progression;
- Evaluate Sign up to Safety objectives and risk priorities identified;
- Maintain registration and ongoing compliance with CQC regulation standards – without conditions or enforcements action;
- Maintain low risk rating on CQC Insight intelligence monitoring system (and any future ratings);
- Achieve and improve compliance scores against the Information Governance Toolkit.

The implementation of this strategy will be monitored in the following ways:

- Audit of high level indicators derived from this strategy and supporting policies (i.e. OP10, OP01, OP60, OP45, OP95 etc.);
- Monitoring objectives and other risk priorities e.g. Health and Safety outcomes, NHS Resolution risk profile, IG toolkit scores.

8.0 Equality Statement

The initial Equality Impact Assessment has identified a low impact affecting one PPC (Disability – visual impairment). To address this the strategy has included a standard statement within the document control sheet offering the document in larger print where necessary.

9.0 Resource assessment

It is anticipated that the strategy will be delivered within existing resources. Where new business priorities and additional resource is identified within the lifetime of this strategy, the Trust business planning process will be applied.

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No

3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

10.0 References

The development of this strategy is underpinned by the mandates of a number of external governance and risk management drivers:

- The National Patient Safety Agency (NPSA) combined with other emerging national safety organisations, has set out detailed standards it expects NHS organisations to achieve in their risk management arrangements.
- Care Quality Commission (CQC) is the regulator of adult health and social care in England and Wales. CQC collates quality, safety and risk information relating to the organizationin order determine compliance with the Fundamental Standards of Care. A risk profile is made for each organization(CQC Insight system) and used along with other intelligence to inform decisions for unplanned visits/inspections and/or enforcement action.
- NHS Improvement (combines NHSI & NHSE); a combined regulator with a focus on supporting providers to become more efficient as well as providing higher quality care. NHSI produces guidance for Boards of NHS Provider organisations which informs the Risk Management Assurance Strategy.
- Other external regulators and stakeholders include Health and Safety Executive (HSE), Department of Health (DoH), Clinical Commissioning groups (CCG) and Local Area Team (LAT), NHS Resolution (NHSR), Royal College and National guidance reports.
- Francis Reports 1 and 2 (2010 and 2013)
- Department of Health (2006) Integrated governance handbook. A handbook for executive and non executives in healthcare organisations. London. Available at: www.dh.gov.uk
- Monitor (2010) Quality Governance Framework. Available at: www.monitor-nhsft.gov.uk
- Monitor (2010) Compliance Framework 2010 / 11 London. Available at: www.monitor-nhsft.gov.uk
- Monitor (2010) The NHS Foundation Trust Code of governance. London. Available at: www.monitor-nhsft.gov.uk
- NHS Appointments Commission. [2009]. The Intelligent Board. London: NHS Appointments Commission. Available at: www.appointments.org.uk
- Board Assurance Frameworks – A simple rules guide for NHS – Good Governance Institute 2009

- Assurance Frameworks – HM Treasury 2012
- NHS Improvement Single Oversight Framework – September 2016

Further standards considered / adhered to when setting this strategy and with which all NHS Trusts are required to comply are set out in the following NHS documents:

- Taking it on Trust. Audit Commission – April 2009
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission Guidance about compliance with the Health and Social Care Act 2008 [Registration requirements] Regulations 2009
- Building a Safer NHS for Patients. Implementing an organizationwith a memory 2001
- National Guidance [National Institute for Health and Care Excellence, National Service Frameworks, National Confidential Enquiries and special enquiry reports]
- Professional reports and recommendations i.e. Royal College and Professionals Allied to Medicine
- NHS Resolution Extranet reports
- Health & Safety Executive regulations and directives
- Kirkup Report January 2018 (Report of the Liverpool Community Health Independent Review)

11.0 Appendices

Appendix 1 – Glossary and abbreviations

Appendix 2 - Risk Assurance and Escalation map

Appendix 3 - Trust Committee structure

<table>
<tr><td>Strategy Name:
Risk Management Assurance Strategy</td><td colspan="2">Version:
8.0 June 2018</td><td colspan="2">Status: Final</td><td>Author:
Head of Governance
Director Sponsor:
Chief Nurse Officer</td></tr>
<tr><td rowspan="7">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td colspan="2">Reason</td></tr>
<tr><td>2</td><td>March 08
(09/10)</td><td>Head of Governance and Legal Services</td><td colspan="2">Annual Review</td></tr>
<tr><td>3</td><td>March 09 (for 10/11)</td><td>Head of Governance and Legal Services</td><td colspan="2">Annual review</td></tr>
<tr><td>4</td><td>March 11 (for 11.12)</td><td>Head of Governance and Legal Services</td><td colspan="2">Annual review to incorporate acquisition of new services via TCS and Trust priorities for year ahead (including CQC ongoing monitoring, NHSLA assessment and internal audit recommendations)</td></tr>
<tr><td>5</td><td>Feb 2012 (for 12/13)</td><td>Head of Governance and Legal Services</td><td colspan="2">Routine update. Changes made to align with CQC regulatory requirements and to incorporate acquired Community services.</td></tr>
<tr><td>5</td><td>August 2012
[MinorAmendApp_PolCAug12]</td><td>Head of Governance and Legal Services</td><td colspan="2">Reference made to divisional governance strategy to demonstrate how risks are managed and reviewed locally. Audit section updated.</td></tr>
<tr><td>6</td><td>Mar 15</td><td>Head of Governance and Legal Services</td><td colspan="2">Full review</td></tr>
</table>

	6.1	Oct 15	Head of Governance and Legal Services	Update to Committee subgroups Appendix 3 and addition of an illustrative diagram showing committee reporting.
	7.0	April 17	Head of Governance and Legal Services	Full Review
	8.0	June 18	Head of Governance and Legal Services	Full Review
	9.0	June 19	Head of Governance	Full Review
Intended Recipients: All senior managers for cascade to all staff				
Consultation Group / Role titles and Date: Policy Group membership, Quality Governance Assurance Committee, Chief Nurse, Governance team members (Healthcare Governance Managers, Compliance managers).				

Name and date of Trust level committee where reviewed	Trust Policy Group – June 2019
Name and date of final approval committee	Trust Management Committee – June 2019
Date of Policy issue	June 2019
Review Date and Frequency [standard review frequency is 3 yearly unless otherwise indicated]	Annual review (June 2020)
Training and Dissemination: Ongoing Training programme in place	
To be read in conjunction with: Several policies support the implementation of this strategy please refer to the scope in section 2 below.	
Equality Impact [initial] Assessment [all policies]: **Completed Yes** **Full Equality Impact assessment [as required]:** **Completed No**	
If you require this document in an alternative format e.g. larger print please contact Central Governance Department on Ext 5114.	
Contact for Review	Head of Governance
Implementation plan / arrangements [Title	Implementation plan held separately. Lead is Head of Governance

of Implementation Lead]	
Monitoring arrangements and Committee	Quality Governance Assurance Committee
Document summary / key issues covered: **The strategy outlines the framework for delivery risk management internal controls and assurance. It includes:** – **the committee reporting structure** – **key roles and responsibilities for Risk management Assurance** – **Trust risk management and assurance process**	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

<table>
<tr><td>Strategy number and version V10 June 19</td><td colspan="2">Title of Strategy – Risk Management Assurance strategy</td><td></td></tr>
<tr><td>Reviewing Group</td><td colspan="2">Policy Group, QGAC</td><td>Date reviewed: June 2019</td></tr>
<tr><td colspan="4">Implementation lead: Print name and contact details</td></tr>
<tr><td colspan="2">Implementation Issue to be considered (add additional issues where necessary)</td><td>Action Summary</td><td>Action lead / s (Timescale for completion)</td></tr>
<tr><td colspan="2">Strategy; Consider (if appropriate)
1. Development of a pocket guide of strategy aims for staff
2. Include responsibilities of staff in relation to strategy in pocket guide.</td><td>E training for all staff and induction handouts in use.</td><td>NA</td></tr>
<tr><td colspan="2">Training; Consider
1. Mandatory training approval process
2. Completion of mandatory training form</td><td>Risk Management e training available.</td><td></td></tr>
<tr><td colspan="2">Development of Forms, leaflets etc; Consider
1. Any forms developed for use and retention within the clinical record MUST be approved by Health Records Group prior to roll out.
2. Type, quantity required, where they will be kept / accessed/stored when completed</td><td>Existing documents</td><td></td></tr>
<tr><td colspan="2">Strategy / Policy / Procedure communication; Consider
1. Key communication messages from the policy / procedure, who to and how?</td><td>SMB – policy communication
Local strategies outlines arrangements in Divisions
Awareness weeks held for specific subjects during the year</td><td></td></tr>
<tr><td colspan="2">Financial cost implementation
Consider Business case development</td><td>Existing resources</td><td></td></tr>
<tr><td colspan="2">Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation</td><td></td><td></td></tr>
</table>

Appendix 1

Glossary of Terms in use in this document are defined as follows:

Assessment – a review of evidence in order to form an opinion; this can be undertaken either internally in the form of a self-assessment or by a third party.

Assurance – 'confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved' (*Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health)*

Clinical audit - 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change'. *(Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence)*

Compliance – to act in accordance with requirements

Controls – actions to reduce likelihood and or consequence of a risk

Corporate Governance – the 'system by which organisations are directed and controlled in order to achieve their objectives and meet the necessary standards of accountability and probity' (*Department of Health)*. Corporate Governance refers to many areas including clinical, information, human resources etc.

Empirical – based on observation or experience

Escalation – the act of advancing an issue to the next appropriate management level for resolution, action or attention

Evidence – information that allows a conclusion to be reached

External Audit – the organizationappointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust

Internal Audit – the team, which may be part of the Trust or an outsourced provider, responsible for evaluating and forming an opinion of the robustness of the system of internal control

Internal Control – a method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control

Key Risk / Key Control – risk to the achievement of a strategic objective / control to mitigate key risks

Reasonable – based on sound judgement

Reassurance – the process of telling others that risks are controlled without providing reliable evidence in support of this assertion

Risk – the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events

Risk Management – the system for identifying, assessing and responding to risks

Risk Register – the tool for recording identified risks and monitoring actions and plans against them

Risk Tolerance – the level of risk the Trusts is prepared to accept, tolerate or be exposed to at any point in time

Sufficient – in relation to the definition of assurance given above sufficient is defined as whatever is adequate to provide the level of confidence required for the Trust Board

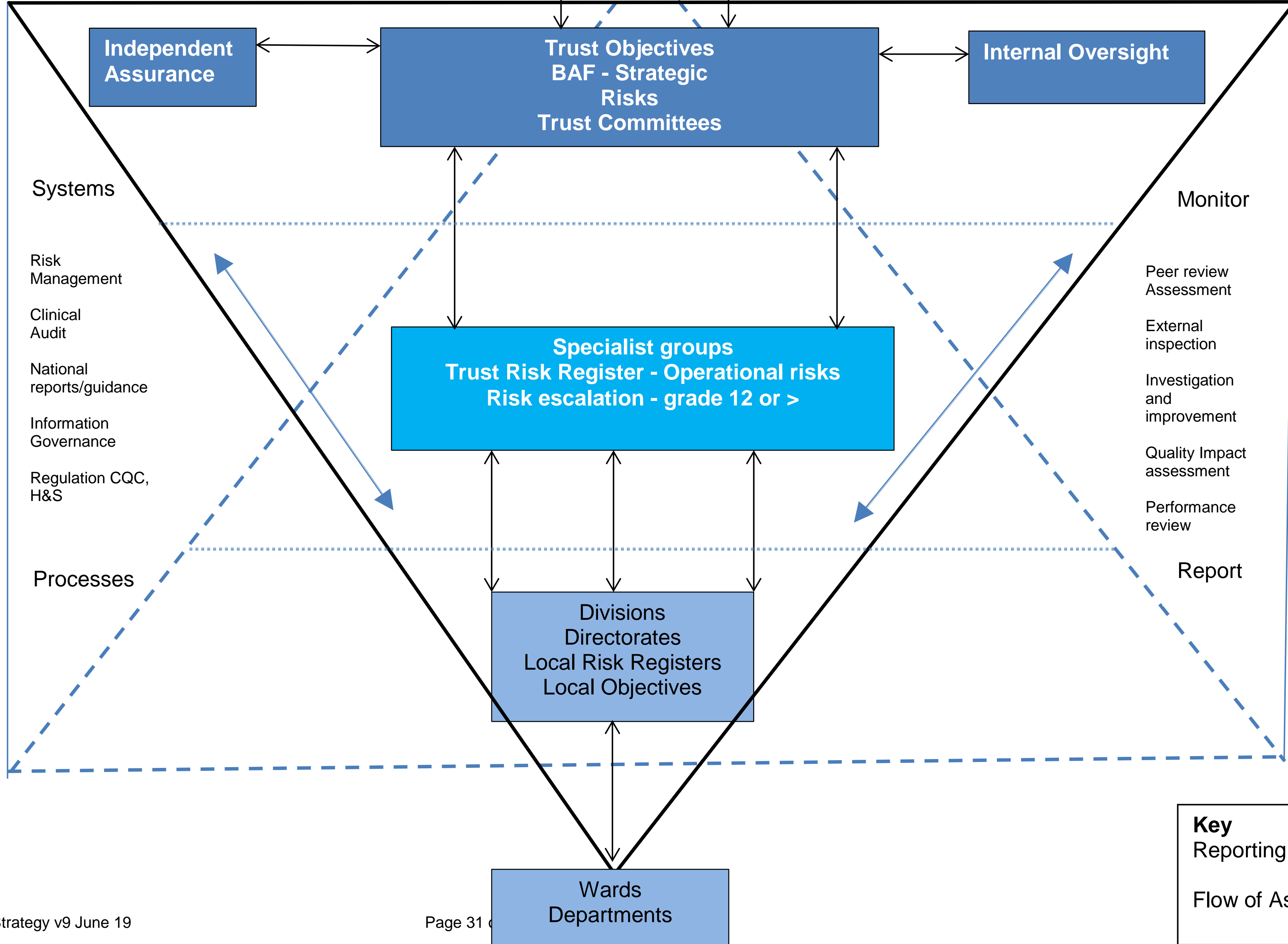
Abbreviation listing:

AC – Audit Committee
BAF – Board Assurance Framework
BCPS – Black Country Pathology Services
CCG – Clinical Commissioning groups
CQC – Care Quality Commission
CLIP – Complaints, Litigation, Incidents and PALs group
COG – Compliance Oversight group
CP – Clinical Policy
DoH – Department of Health
F&O – Finance and Performance Committee
HSE – Health and Safety Executive
HM – Her Majesty
ICT – Information Communication and Technology
IG – Information Governance
IMR – Intelligence monitoring report
KLOE – Key lines of enquiry
LAT – Local area team
MTFP – Medium term Financial plan
NHS – National Health Service
NHSI – NHS Improvement
NHSR – NHS Resolution
NICE – National Institute for Health and Care Excellence
NPSA – National Patient Safety Agency
OP – Operational Policy
PALs – Patient Advice and Liaison service
QSIG – Quality and Safety Intelligence Group
QGAC – Quality Governance Assurance Committee
TRR – Trust Risk Register
TB – Trust Board
TMC – Trust Management Committee
VI – Vertical Integration
WODC – Workforce and Organisational Development Committee

Risk Assurance and Escalation Framework

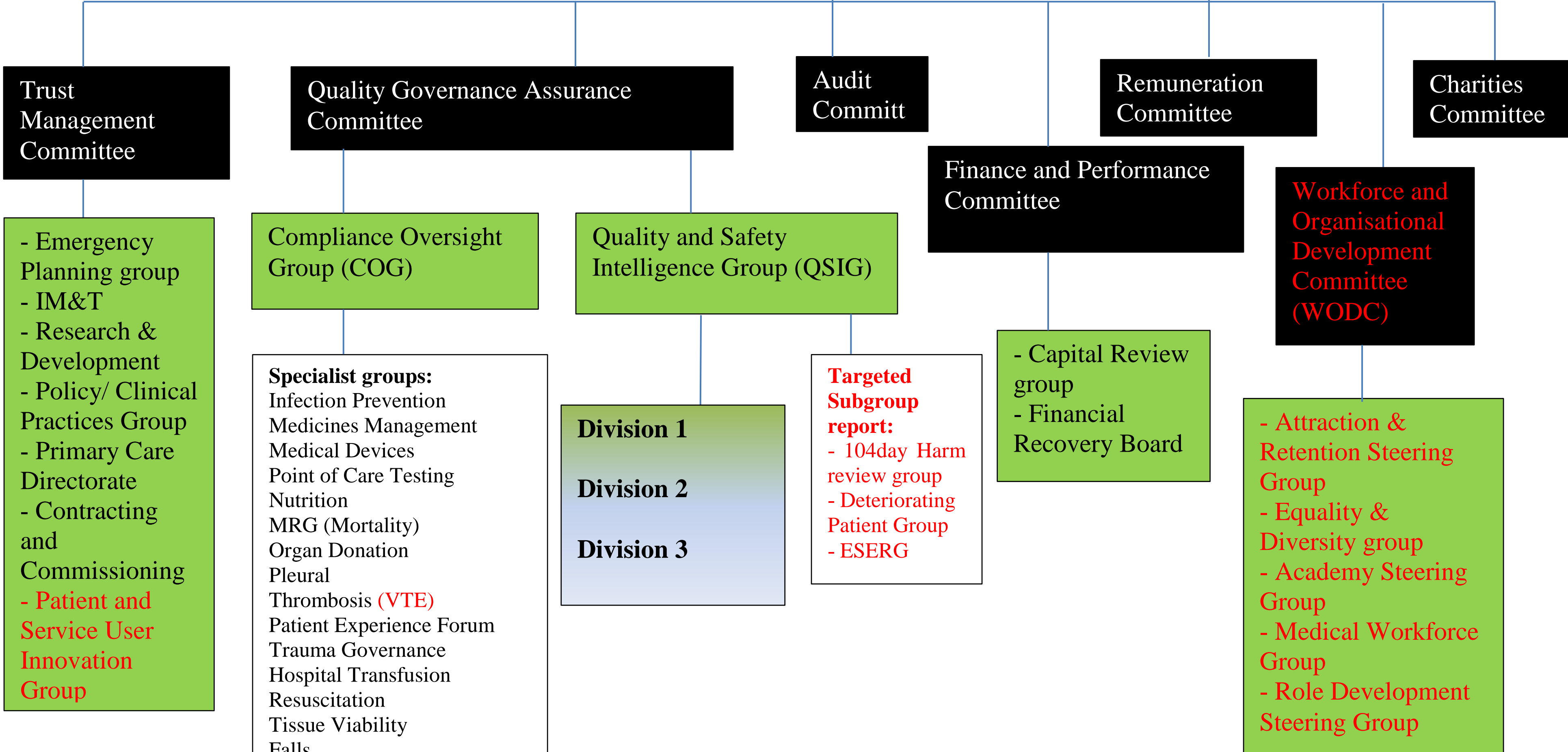
Appendix 2

Trust Board/Objectives/BAF



Key
Reporting to/from
Flow of Assurance

Appendix 3



Tier	Meeting	Purpose/Function
Tier 1	Sub board Committee	Assurance
Tier 2	Sub-group	Trust Oversight, Action monitoring
Tier 3	Specialist Working group	Specialist/Project implementation & monitoring
Tier 4	Division/Directorate (Div/Dir structure on separate chart)	Performance monitoring, oversight of controls outcomes and improvement.

The Royal Wolverhampton NHS
NHS Trust

Quality Governance Assurance Committee

To provide assurance to the Board that patient care is of the highest achievable standard and in accordance with all statutory and regulatory requirements. To provide assurance of proactive management and early detection of risks across the Trust.

Routine Reports:

- BAF / TRR
- Integrated Quality & Performance Report
- NRLS Reporting
- TOR
- AGS
- Internal Audit Opinion

Assurance Reports:

- External Reviews
- CQC Compliance
- H&S Assurance
- Clinical Audit
- Litigation & Inquest

Sub-Groups

- Quality and Safety Intelligence Group - Monthly
- Compliance Oversight Group - Monthly

Themed Reviews:

- Mortality
- Safeguarding

Compliance Oversight Group

The Compliance Oversight Group is responsible for the review of Trust compliance reported by service leads and/or independent sources. Reporting will include trust performance against regulatory and national standards, quality and safety outcome measures and risk related data. The group will use reported information and independent data to oversee safety systems, triangulate operational compliance, and strengthen Trust assurance.

Routine Reports:

- CQC (FSC), QRV's
- National Guidance
- External Visits / Inspections
- Quality Account

Sub-Group Reports

Sub-Group	Frequency
- Infection Prevention /Medical Device group/POCT/Organ Donation/Pleural Service Group/Hospital Transfusion/Resuscitation	6 Monthly
- Nutrition Support Group/MRG/Thrombosis Group/CIICG	Quarterly
- NICE Assurance Group	6 Monthly
- Health and Safety Steering Group	6 Monthly
- Clinical Audit	4 Monthly
- Information Governance	Quarterly
- Safeguarding Vulnerable Adults/ Safeguarding Children	4 Monthly
- Radiation Protection Group	6 Monthly
- Trauma Governance Committee	6 Monthly
- SWAN	Quarterly

Quality and Safety Intelligence Group

The Quality and Safety Intelligence Group is responsible for the review and oversight of quality and safety performance and outcomes within Divisions, to ensure they manage risk and improvement in quality and safety within service delivery.

Routine Reports:

- Divisional Quality and Safety Dashboard (incl Nursing and Quality metrics)
- Divisional Highlight report
- SUI
- WHO Safety Checklist
- New procedure applications
- NatSiPP Audits
- Mortality