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AMENDMENT HISTORY				
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Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
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CONTENTS

1. SUMMARY

Risk management is an integral part of Lancashire Teaching Hospitals NHS Foundation Trusts' management activity and is a fundamental pillar in embedding high quality, sustainable services for the people who access its services. As a large and complex organisation delivering a range of services in a challenging operational and financial environment, the organisation accepts that risks are an inherent part of the day-to-day life of the Trust. Through a systematic approach to assessing, recording and managing risks the Trust fosters both a proactive and responsive culture in mitigating threats to its business, and in doing so, working towards the achievement of its strategic objectives.

The Trust understands that it must have in place robust and effective controls to mitigate the inherent risks involved in delivering healthcare, whether they be clinical or non-clinical. The Trust has in place a framework that allows the Trust to plan effectively to mitigate risks that may present themselves over time but that also enables the Trust to be agile in mitigating emergent risks that present themselves through the course of the Trusts' day-to-day operation.

The Board of Directors intends to use the risk management processes outlined within this Strategy as a means to lead the organisation forward to deliver a quality service and achieve excellent results. The Board of Directors is committed to ensuring that risks are managed appropriately in line with the strategy, the Trusts' risk appetite statement and mandatory and best or good practice requirements. The purpose of the Risk Management Strategy is to create a culture that supports and encourages employees to effectively manage risk.

1.1 The Ideal Risk Management Framework

This relates to a working model in which:

- The organisations' management understand the risks to which it is exposed and deals with them in an informed, proactive manner;
- Required risk management practices are an accepted and natural part of the way in which the organisation operates.

This strategy sets out in detail the framework the Trust has in place and the steps staff should take to identify, assess, record and manage the risks that present themselves and in doing so working towards the delivery of strategic objectives. In particular, the strategy sets out the following:

- The Risk Management Process – How risks are identified, managed, controlled and reviewed at each level of the organisation (departmental, divisional, corporate and strategic).
- How the Board receives assurances that Risks are being identified, managed, controlled and reviewed effectively.
- Those in the Trust with key roles and responsibilities for co-ordinating and undertaking Risk Management activities.

- The role of the Board Assurance Framework.
- The role of Risk Registers.
- How Risks are managed, monitored and escalated.
- The information mechanisms the Trust uses to identify Risk patterns.
- How the Trust learns lessons from themes identified from risks.

2. PURPOSE

Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) Risk Management Strategy has been produced to assist all members of the organisation in understanding how the Trust manages risk, both strategically and operationally and serves as a practical guide to advise staff in the identification, control and reduction of the risks associated with providing healthcare at all levels of the Trust. Furthermore, the strategy has been produced to outline how the Trust takes an integrated, whole-system approach to managing risks which is not separate to, or in addition to, the day-to-day management of the Trust.

The purpose of this strategy is to provide a framework through which LTH can:

- Ensure staff understand what risk and risk management is, in the context of an NHS Foundation Trust.
- Ensure staff understands the purpose of the operational and strategic risk registers and their role in the context of the Board Assurance Framework.
- Embed a positive risk management culture throughout the Trust that supports and encourages employees to effectively manage risk.
- Ensure that there are effective and comprehensive risk management systems and processes in place to identify, understand, monitor and address current and future risks and that these are continually reviewed, scrutinised and monitored.
- Ensure staff are aware of their duties in relation to risk management, with clearly defined roles and responsibilities for individuals within the organisation in relation to identification, management, review, approval and escalation of risks.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement.
- Ensure staff are aware of the systems and processes for the management of risk at local, divisional and organisational level along with the committee structures in place to support effective risk management throughout the Trust.
- Set out how to provide assurances that effective risk management is being undertaken at all levels of the Trust.
- Ensure staff understands how Risks are to be escalated through the organisation.
- Describe to staff the information mechanisms the Trust uses to identify Risk patterns.
- Describe how the Trust learns lessons from themes identified from Risks
- Ensure Risk is managed in line with the Risk Appetite Statement in order for the Trust to meet its strategic objectives.

- Ensure continued compliance with current and future standards and legislation.

3. SCOPE

This document applies to all employees of the Trust. It will be led by managers at all levels to ensure that risk management is a fundamental consideration of the Trusts' approach to Workforce, Financial, Safety, Quality, Performance, Education, Research and Corporate Governance.

4. STRATERGY

4.1 How the Trust sets its Strategic Objectives

Each year as part of its Annual Planning process the Board of Directors meets to agree the Trusts' aims to achieve in the coming year in line with its ambition, vision and values and in line with the requirements set out by the Department of Health, NHS England and the Trusts' Regulatory Bodies (such as NHS Improvement and the Care Quality Commission). This process results in the Trusts' Annual Operational Plan being produced which details the Trusts' Strategic Objectives.

4.1.1 LTH Strategic Aims

A copy of LTH's three Strategic Aims is available on the Intranet with links included in this document template.

4.1.2 LTH Ambitions

A copy of LTH's four Ambitions is available on the Intranet with links included in this document template.

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4.2 Duties/Roles

4.2.1 Board of Directors

The Board of Directors is responsible for:

- Providing leadership and direction for effective risk management within the Trust.
- Reviewing the effectiveness of internal controls (its infrastructure) which includes; Workforce, Financial, Safety, Quality, Performance, Education, Research and Corporate Governance etc.
- Setting the Strategic Objectives and Risk Appetite.
- Taking a pro-active lead in the communication of risk management duties.
- Ensuring that an appropriate Trust Committee Structure is in place to ensure that the Trusts Risk Management activity is subject to appropriate levels of oversight and scrutiny, the Trusts' Committee structure is detailed in Appendix 1. These are supported by clear Terms of Reference.

- Overseeing and approving the Board Assurance Framework which comprises of the Strategic and Operational Risk Registers, on at least, a quarterly basis.
- Delegates' responsibility for the annual review of the Board Assurance Framework (Risk Register) to the Audit Committee.
- Producing statements of assurance that the Trust is making all "reasonable" efforts to manage risks to its activity in an efficient and effective manner.
- Ensuring that non-Executive Directors will act as scrutinisers, ensuring that Risk Management is properly addressed and that the processes to support the Board of Directors facing significant risk are robust.

4.2.2 Chief Executive

The Chief Executive has overall responsibility and accountability for the Risk Management activity within the Trust and provides clear visible leadership, ensuring that the implementation of Risk Management is delegated to the Executive Directors and Management structure of the Trust.

4.2.3 Director of Governance

The Director of Governance is the Director nominated as the Trusts' 'Risk Champion' with overall responsibility for the management of the Risk Management Framework. The Director of Governance reports into the Executive Nursing, Midwifery & AHP Director. Their role provides leadership for the implementation of the Trusts' Risk Management Strategy, ensuring that the Trust consistently monitors and evaluates the effectiveness of its systems of internal control. The Director of Governance works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Risk is undertaken. In addition to this the Director of Governance is responsible for the oversight of delivery of Governance Key Performance Indicators and the oversight of the Health and Safety portfolio as delegated to do so by the Finance Director.

4.2.4 Medical Director

The Executive Medical Director is the joint Executive lead (with the Nursing, Midwifery and AHP Director) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Medical Director works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Clinical Risk is undertaken. The Medical Director is the responsible officer for medical staffing in the organisation and is responsible for the professional leadership of Clinical Scientists, Pharmacists and Psychology. The Medical Director is the Trusts' Caldicott Guardian and has responsibility for Medicines Safety and Management, Mortality and Radiation. In addition to these responsibilities the Medical Director is responsible for the development and deployment of the Clinical strategy.

4.2.5 Nursing, Midwifery and AHP Director

The Executive Nursing, Midwifery and AHP Director is the joint Executive lead (with the Medical Director) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Nursing, Midwifery and AHP Director works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of the Clinical Risk is undertaken. In addition, the Nursing, Midwifery and AHP Director has responsibility for the professional leadership of the Nursing, Midwifery & AHP workforce, Infection Prevention and Control, Safeguarding (adults and children), Maternity and Children's services alongside the lead for clinical service regulatory inspections. The Nursing, Midwifery and AHP Director is also the accountable Director in ensuring that lessons are learned and shared and communicated to staff when things go wrong.

4.2.6 Chief Operating Officer

The Executive Chief Operating Officer is the Executive lead for the management of risks to the Trusts' operational activity and performance (Performance Risks). The Chief Operating Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Operational and Performance Risks are undertaken. In addition the Chief Operating Officer is responsible for operational delivery of the Clinical Services, Emergency Preparedness and the management of the Divisional Improvement and Accountability processes.

4.2.7 Finance Director

The Executive Finance Director is the Executive Director with overall accountability for the management of financial governance and risk and as the Trusts' Senior Information Risk Owner (SIRO) is also responsible for the management of Information Governance and Security Risk and Capital and Estates. In addition to this, the Finance Director is responsible for the identification, scoping definition and implementation of an Information Governance and Security Risk Programme, the management of Health and Safety within the organisation and lead for use of resources regulatory inspections.

4.2.8 Strategy, Workforce and Education Director

The Strategy, Workforce and Education Director is the executive lead for the management of risks to the Trusts' strategy, workforce, education and research activity. The Strategy, Workforce and Education Director works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Workforce, Education and Research Risks is undertaken. In addition to this the Strategy, Workforce and Education Director is responsible for Equality, Diversity and Inclusion, Freedom to Speak up arrangements and Well Led, education and research regulatory inspections.

4.2.9 Head of Corporate Affairs (incorporating role of Company Secretary)

The Head of Corporate Affairs has responsibility for co-ordinating the development of the Board Assurance Framework, which involves liaising with the Executive Directors with lead responsibility to ensure the Board Assurance Framework reflects the principal strategic risks associated with failure of the organisation to meet its corporate objectives and the actions being taken by the Trust to mitigate such risks. In addition to this the Head of Corporate Affairs is responsible for the overall corporate governance and legal arrangements that underpin effective risk management across the organisation.

4.2.10 Associate Director of Governance (reports to the Director of Governance)

The Associate Director of Governance is responsible for the overall management of the Governance and Risk Manager and provides support to the Director of Governance in co-ordinating the Trusts' Risk Management Framework, Risk Management Strategy and the operational activities that underpin them. They will achieve this by:

- Operationally support the implementation of the Risk Management Strategy.
- Professional leadership to the Divisional Operational Governance Leads.
- Providing co-ordination and oversight for the Trusts' Risk Registers.
- Supporting the Company Secretary in the maintenance of the Board Assurance Framework.
- Championing a whole systems approach to Risk Management.
- Providing advisory support to the Trusts' Divisional Management Team and Divisional Governance Leads Teams in the identification of Divisional Risks and the management of Divisional Risk Registers.
- Provide Quality Assurance Guidance to Divisional Governance Leads.
- Maintaining the Trusts' electronic Risk Management System (DATIX).
- Producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.
- Providing support, advice and training to the Divisions in the principles of risk.
- Being responsible for supporting the Director of Governance on reviewing and monitoring trends in the Trusts' NHS Resolution and Clinical Negligence Scheme for Trusts' (CNST) premiums and Care Quality Commission (CQC) standards relating to the management of Risk.
- Ensure the quality of risk management meets the required expectations.

4.2.11 Corporate Governance & Risk Team

The Corporate Governance & Risk Team provides operational support to the Governance and Risk Manager by:

- Supporting the Divisional Management Teams in validating the Risk Registers, including the adequacy of risk descriptions, the adequacy of controls and assurances and justification of risk scoring.'
- Maintaining the Trusts' electronic Risk Management System (DATIX Module).

- Producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.'
- Providing support, advice and training to the Divisions in the principles of risk.

4.2.12 Divisional Director of Estates and Facilities

The Divisional Director of Estates and Facilities is responsible for ensuring the safe maintenance of property and services in line with statutory estate compliance including pre-planned maintenance of the health and safety portfolio relating to security, fire safety, environmental management, medical devices management, facilities provision and all aspects of estate and facilities business continuity.

The Divisional Director will:

- Supporting Managers and staff with the identification and management of estate related Health and Safety risks.
- Liaising with the Trusts' Governance and Risk Lead in the identification and management of estate Health and Safety risks.

4.2.13 Divisional Leadership Team - Divisional Directors, Divisional Medical Directors, Divisional Nursing, Midwifery & AHP Directors

All Divisional Leadership Team members have responsibility for the risk management activity in their Division, including:

- Providing leadership for Risk Management activities in their Division.
- Promoting and supporting the implementation of the Risk Management Strategy.
- Delivery of Governance key performance indicators contained within the Governance dashboard.
- Setting relevant and effective Divisional Objectives, which collectively ensure the delivery of Trusts' Strategic Objectives as set out in the Trusts' annual plan.
- Identifying principal operational risks which threaten the delivery of Divisional Objectives and establishing the Divisional Risk Register.
- Safeguarding the Divisional Risk Register and escalating any divisional risks scoring 15 and above to the Executive Management Group.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy.
- Quality assuring, monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Ensuring that Divisional Risk Management activity is owned; discussed and reviewed at relevant Divisional meetings. At a minimum this should take place at divisional board level; however this should be woven through each divisional forum. Ensuring that staff are given necessary information, instruction, training and supervision in relation to Risk Management activities.

- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for Risk Management.
- Ensure staff are aware of their duties in relation to risk management identification, management, review and escalation of risks.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement.
- Presenting Risk Management reports to the Trust Management Board and Trust Committees and Executive Management Group where required
- Management of the identified risks within their Division/Department, including the escalation of risks, where appropriate.
- Promoting and embedding an 'open' and 'just' culture.
- Monitoring that all relevant Risk Assessments are undertaken, reviewed and documented appropriately.
- Monitoring Divisional risk management activity against Key Performance Indicators.

4.2.14 Divisional Governance Lead

All Divisional Governance Leads have responsibility to facilitate the section 4.2.13 above and in addition to this facilitate for the division:

- Identifying any operational risks that exist within the Division that threaten the achievement of Divisional and Strategic Principal Objectives as set out in the annual plan.
- Providing support, advice and training in relation to Risk Management Activities in their Division.
- Promoting and supporting the implementation of the Risk Management Strategy.
- Ensure staff are aware of their duties in relation to risk management identification, management, review and escalation of risks.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy
- Quality assuring, monitoring, and where appropriate, challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Undertaking Quality Assurance checks in accordance with guidance provided by the Director of Governance.
- Promoting and embedding an 'open' and 'just' culture.
- Ensuring that Divisional Risk Management activity is discussed and reviewed at relevant Divisional meetings (Divisional Governance Meetings, Divisional Workforce meeting, Divisional Finance and Performance meeting. Divisional Board, Divisional Team Meeting).
- Undertaking Divisional Administration on their Divisional Risk Register in Datix producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.

4.2.15 Managers

Associate Divisional Medical Directors, Clinical Directors, Clinical Business Unit Managers, Speciality Business Managers, Matrons, Professional Leads. The Senior Managers have responsibility for supporting their Division in the management of their risks including:

- Identifying any operational risks that exist within the Specialty, Clinical Business Unit and/or Division that threaten the achievement of Divisional and Strategic Principal Objectives as set out in the annual plan.
- Providing support, advice and training in relation to Risk Management activities in their Specialty, Clinical Business Unit and/or Division.
- Promoting and supporting the implementation of the Risk Management Strategy.
- Ensure staff are aware of their duties in relation to risk management identification, management, review and escalation of risks.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy.
- Quality assuring, monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Promoting and embedding an open and 'just' culture.
- Presenting Risk Management reports to Specialty and Divisional Meetings where required.
- Ensuring that Divisional Risk Management activity is discussed and reviewed at relevant Speciality Governance Meetings, Divisional Governance Meetings and the Divisional Board meetings.

4.2.16 All Ward, Department Managers and Clinicians have responsibility for supporting their Division in the management of their risks including:

- Identifying any operational risks that exist within the Ward/Department that threaten the achievement of Divisional and Strategic Principal Objectives as set out in the annual plan.
- To support the delivery of the Trust Risk Management Strategy in accordance with their role.
- Monitoring activities within their Speciality, Service, Ward/Department to ensure compliance with all Trust Strategies and policies.
- Promoting and embedding an open and 'just' culture.
- Awareness of the Trusts' infrastructure for the management and mitigation of risk.
- Monitoring activities within their Specialty, Service, Ward/Department to ensure risks are identified, assessed and entered onto the Trust Risk Register.

- Monitoring the Risk Mitigation activities within their Specialty, Service, Ward/Department Area to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy.
- Ensuring that Specialty, Service, Ward/Department Area of Risk Management Activity is discussed and reviewed at relevant meetings.
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to risk management activities.
- Providing information to the Divisional Governance meetings on the identified risks within their Specialty, Service, Ward/Department.
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for risk management.
- Informing the Divisional Management team of Risks that are being escalated to the Divisional Risk Register, where required.

4.2.17 All Employees

All Employees have responsibility for supporting their Division in the management of their risks including:

- Reporting incidents and near misses using the Datix Incident Reporting System. The Trust accepts that the reporting of adverse events or near misses is on an 'open' and 'just' culture basis.
- Complying with the Trust Induction and Mandatory Training Programmes.
- Complying with the Trust Guidance and Instructions to protect the health, safety and welfare of anyone affected by the Trusts' business.
- To support the delivery of the Trust Risk Management Strategy in accordance with their role.
- Awareness of the Trusts' Risk Management systems and processes.
- Reporting identified risks to the relevant Senior Managers, Service, Ward/Departmental Managers and Clinicians to ensure risks are identified, assessed and entered onto the Trust Risk Register.
- Undertaking and completing any Risk Mitigation activities that are assigned to them.
- Ensuring that they obtain the necessary information, instruction, training and supervision in relation to risk management activities.
- Ensuring they are aware of risks within their work environment and of their personal responsibilities for risk management.
- Acceptance of personal responsibilities for maintaining a safe environment. Awareness of local emergency procedures, systems and processes.
- Provision of safe practice in their relevant specialty/role.
- Taking reasonable care of their personal and colleagues' safety.

4.2.18 Staff Side Representatives

- To work in collaboration with Managers to promote risk management reporting.

4.3 Corporate Governance Committee Structure to Support the Risk Management Reporting Processes

The Trust will ensure that an appropriate Trust Committee Structure is in place to ensure that the Trusts' Risk Management activity is subject to appropriate levels of oversight and scrutiny.

A Risk Management Organisational Structure is in place, which supports the accountability arrangements within the Trust for Risk Management and ensures that all risks are properly considered and escalated to the Board as required. Through this structure, the Board of Directors ensures that adequate resources and support systems are in place to enable the Trust to effectively manage threats to its business objectives.

The Corporate Committee Structure detailing all those committees and groups which have responsibility for risk and facilitates the management and delegated responsibility for implementing risk management systems within the Trust is explained below. These are supported by clear Terms of Reference. The approved Terms of Reference for the Trusts' Committees is held by the Company Secretary's Office.

4.3.1 How the Board or High Level Risk Committees Review the Organisation Wide Risk Register

4.3.1.1 Board of Directors

The Board of Directors is responsible for ensuring the effectiveness of the Trusts' infrastructure and has overarching responsibility for the Risk Management Framework.

The Board works actively to promote and demonstrate the values and behaviours which underpin the delivery of good governance and pro-active risk management, including being open and transparent.

The Board is accountable for all aspects of its business (i.e. workforce, finance, safety, quality, performance and corporate governance) and will systematically engage with patients, the public, staff and stakeholders on its objectives and plans, including hearing patient stories at Board meetings, undertaking patient safety walk rounds by members of the Board and wider communication events.

The Board is responsible for producing an Annual Governance Statement, which provides evidence of the robustness of the Trusts' system of internal control. This will be informed by the Head of Internal Audit Opinion and will be subject to scrutiny by external auditors.

The Board has delegated aspects of the delivery of its functions to Board Committees and designated staff. These are described in Standing Orders and the Scheme of Reservation and Delegation. The Board, however, retains accountability

and receives assurance on the delivery of its functions through the Board Committees and designated staff.

The Board of Directors is responsible for approving the addition or removal of risks to the Board Assurance Framework.

If the Board of Directors needs to be made aware of an emergent serious risk, the risk assessment may then be fast-tracked for consideration at Board or the appropriate Committee of the Board. In this scenario, the risk assessment must be approved by the Chief Executive and the Director of Governance, who will facilitate inclusion on the Board of Directors or Committee of the Board agenda.

4.3.1.2 Executive Management Group

The Executive Management Group is the high level risk group which receives details of all high operational risks (15 and above) for escalation from Divisional Boards. Each Division is scheduled to present their Risk Register according to the Committee's Schedule of Business. This is an operational Committee, not a Board Committee.

The Executive Management Group will provide the interface between the Board and the rest of the organisation. It has a key role in managing the assurance process; one of its key roles is defining the criteria for admission of risks onto the Board Assurance Framework by rejecting those high scoring risks through effectively challenging the risk content and/or score or by accepting those high scoring risks which warrant further oversight through escalation to the relevant committees of the Board.

The Trust Board must also ensure that any operational risks that are on the Board Assurance Framework are reviewed at least quarterly. Risks recorded on the Board Assurance Framework that are well managed and have adequate controls may move back to the appropriate Operational Risk Register, as long as there is documented evidence that the risk will continue to be actively managed and monitored at Divisional Level.

The minutes of the Executive Management Group must identify the specific Operational Risk number that has been rejected and for management and monitoring at Divisional level or escalated for oversight at the relevant committees of the Board.

4.3.1.3 The Audit Committee

The Audit Committee is responsible for monitoring the effectiveness of the Trusts' infrastructure and internal control system, including Risk Management and is responsible for providing assurance to the Board that this structure and these processes are appropriate and effective. This includes the formal approval of the Trusts' Annual Governance Statement. The lead Executive for Audit Committee is the Finance Director.

4.3.1.4 The Safety and Quality Committee

The Safety and Quality Committee is responsible for the following Risk Management Activities:

- Reviewing Safety & Quality Risks on at least a quarterly basis to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Safety & Quality Risks and to raise these concerns with the relevant Divisional Management Team.
- Delegating responsibility for Safety & Quality Risks that fall within the remit of one of the Safety and Quality Committee's Sub-Groups to the relevant Sub-Group.
- Receive Assurance from the relevant Sub-Groups that risks within their remit have been appropriately scrutinised and that concerns are escalated to the Safety & Quality Committee.
- Review and accept or reject escalated operational risks. Where a risk is accepted, the Committee will provide assurance to the Board the controls are adequate for the risk. The minutes will identify the specific Operational Risk number that has been accepted or rejected for management and monitoring at Executive Management Group or Divisional level or escalated for oversight at Board.
- Identifying, managing and monitoring Strategic Risks aligned to the Safety and Quality Committee.
- Provide assurance to the Board of Directors that Safety & Quality Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Safety & Quality Risks.
- The lead Executive for Safety & Quality Committee is the Nursing, Midwifery & AHP Director.

4.3.1.5 The Workforce Committee

The Workforce Committee is responsible for the following Risk Management Activities:

- Reviewing Workforce Risks on at least a quarterly basis to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Workforce Risks and to raise these concerns with the relevant Divisional Management Team.
- Delegating responsibility for Workforce Risks that fall within the remit of one of the Workforce Committee's Sub-Groups to the relevant Sub-Group.
- Receive Assurance from the relevant Sub-Groups that risks within their remit have been appropriately scrutinised and that concerns are escalated to the Workforce Committee.
- Review and accept or reject escalated operational risks. Where a risk is accepted, the Committee will provide assurance to the Board the controls are adequate for the risk. The minutes will identify the specific Operational Risk

number that has been rejected for management and monitoring at Executive Management Group or Divisional level or escalated for oversight at Board
- Identifying, managing and monitoring Strategic Risks aligned to the Workforce Committee.
- Providing assurance to the Board of Directors that Workforce Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Workforce Risks.
- The lead Executive for Workforce Committee is the Strategy, Education and Workforce Director.

4.3.1.6 The Finance and Performance Committee

The Finance and Performance Committee is responsible for the following Risk Management Activities:

- Reviewing Finance Risks on at least a quarterly basis to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Finance Risks and to raise these concerns with the relevant Divisional Triumvirate.
- Delegating responsibility for Finance and Performance Risks that fall within the remit of one of the Finance and Performance Committee's Sub-Groups to the relevant Sub-Group.
- Receive Assurance from the relevant Sub-Groups that risks within their remit have been appropriately scrutinised and that concerns are escalated to the Finance and Performance Committee.
- Review and accept or reject escalated operational risks. Where a risk is accepted, the Committee will provide assurance to the Board the controls are adequate for the risk. The minutes will identify the specific Operational Risk number that has been rejected for management and monitoring at Executive Management Group or Divisional level or escalated for oversight at Board.
- Identifying, managing and monitoring Strategic Risks aligned to the Finance and Performance Committee.
- Providing assurance to the Board of Directors that Finance and Performance Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Finance and Performance Risks.
- The lead Executive for Finance Committee is the Finance Director.

4.3.1.7 The Education, Training and Research Committee

The Education, Training and Research Committee are responsible for the following risk management activities:

- Reviewing Education, Training or Research risks on a quarterly basis to facilitate a Trust wide approach to mitigation.
- Identifying any deficiencies in the identification and management of Education, Training or Research risks and to raise these concerns with the relevant Divisional Triumvirate.

- Delegating responsibility for Education, Training and Research Risks that fall within the remit of one of the Education, Training and Research Committee's Sub-Groups to the relevant Sub-Group.
- Receive Assurance from the relevant Sub-Groups that risks within their remit have been appropriately scrutinised and that concerns are escalated to the Education, Training and Research Committee.
- Review and accept or reject escalated operational risks. Where a risk is accepted, the Committee will provide assurance to the Board the controls are adequate for the risk. The minutes will identify the specific Operational Risk number that has been rejected for management and monitoring at Executive Management Group or Divisional level or escalated for oversight at Board.
- Identifying, managing and monitoring Strategic Risks aligned to the Education, Training and Research Committee.
- Providing assurance to the Board of Directors that Education, Training and Research risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Education, Training or Research risks.
- The Executive Lead for Education, Training and Research Committee is the Strategy, Workforce and Education Committee.

4.3.1.8 The Council of Governors

The Council of Governors is responsible for the following risk management activities:

CoG members play a key role in holding the Non-Executive Directors to account and to raise issues and concerns in a constructive manner. Their level of involvement and influence is a critical element to an effective risk management framework due to their experience and knowledge. This strategy will continue to build the role of the CoG going forward as part of the assurance framework on quality governance and to report back to the CoG improvements made to service delivery based on their input. The CoG have a pivotal role in approving the Trusts Auditors and being a critical friend on patient experience via the CoG sub groups set up.

4.4 Risk Register Systems and Software

The Trust uses the Risk module of the Datix System. This is a system that is well established and is in wide spread use with the NHS and the wider Health Economy.

The Risk Register module is available to all staff across the Trust who have a user account on Datix. The full risk register is accessible to allow cross-Divisional or Departmental working on risk mitigation and to promote transparency of the Risk Register.

The Risk module of the Datix System includes the below functionality which is utilised by the Trust:

- Risk Description and Assessment.
- Risk Grading / Scoring.

- Current and Target Risk scores.
- Risk Controls and Assurances.
- Mitigating Action Plans.
- Risk Review.
- Recording of supporting evidence.
- Alignment to the Trusts' Strategic Ambitions.
- Production of risk registers reports and dashboards.
- Archiving of controlled risks.

As such the Risk module serves as the Trusts' Risk Register and contains the following:

- Corporate Department Risk Registers.
- Committee Risk Registers.
- Divisional Risk Registers.
- Specialty Risk Registers.
- Service/Ward/Departmental Risk Registers.

The benefit of using a single system is that it ensures a single source of the truth for Risk Register information, guarantees that appropriate standards are maintained and improves oversight of risk within the Trust.

Where a member of staff does not normally have access to a computer, but has requested to 'view' the Risk Register, this should be facilitated by their line manager or supervisor at the earliest opportunity.

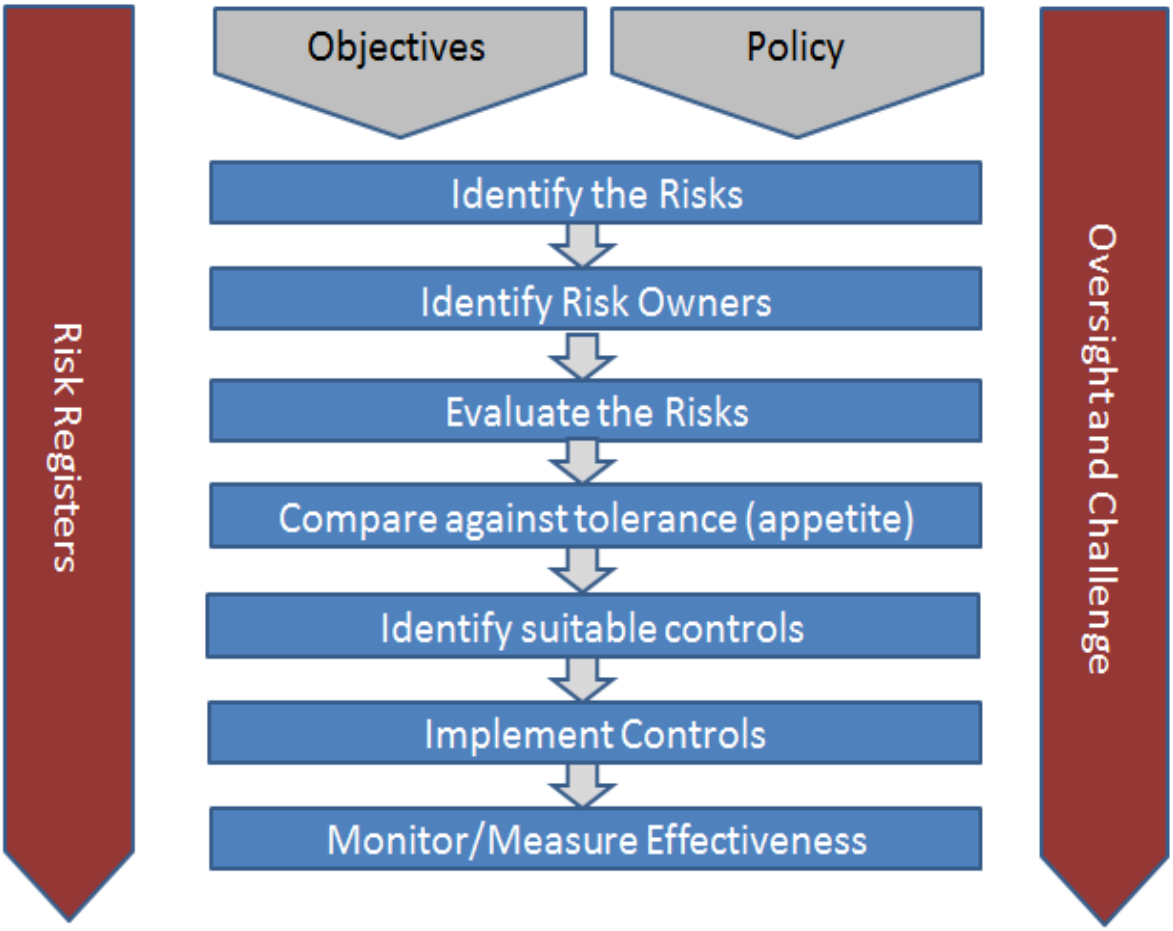
4.5 What is Risk and Risk Management?

A Risk: is an uncertain event or set of events which, should it occur, will have an effect upon the achievement of objectives. This consists of a combination of: the level or scale of impact should the event occur, and the likelihood of the event occurring which can be evaluated via a risk assessment being undertaken.

A Risk Assessment: is the evaluation of an uncertain event that can interfere with the delivery of a Trust objective.

Risk Management: is in simple terms, the activity required to identify, assess and manage threats to achieving objectives. The Trusts' Board is responsible for putting in place the necessary infrastructure to enable the Trust to achieve its strategic objectives.

Figure 1 – Whole System Approach to Risk and Risk Management



In simple terms, Risk Management Process is the activity required to proactively and responsively identify, assess and manage threats to achieving objectives. At a very top level, the Trusts' Board is responsible for putting in place the necessary infrastructure to enable the Trust to achieve its strategic objectives. As the infrastructures in place at Acute NHS Foundation Trusts are largely the same from Trust to Trust, and have been in place for a long period of time, they are ingrained in the operational activity of Trusts; as such, the infrastructure is not always recognised by staff as being key to the management of risk and in delivering strategic objectives. At LTH, the Trust has in place a whole systems approach to Risk Management which is articulated in Figure 1 above; each of the steps in the Risk Management process is articulated in detail in Appendix 2 and 3.

4.6 Risk Management: Two Key Approaches

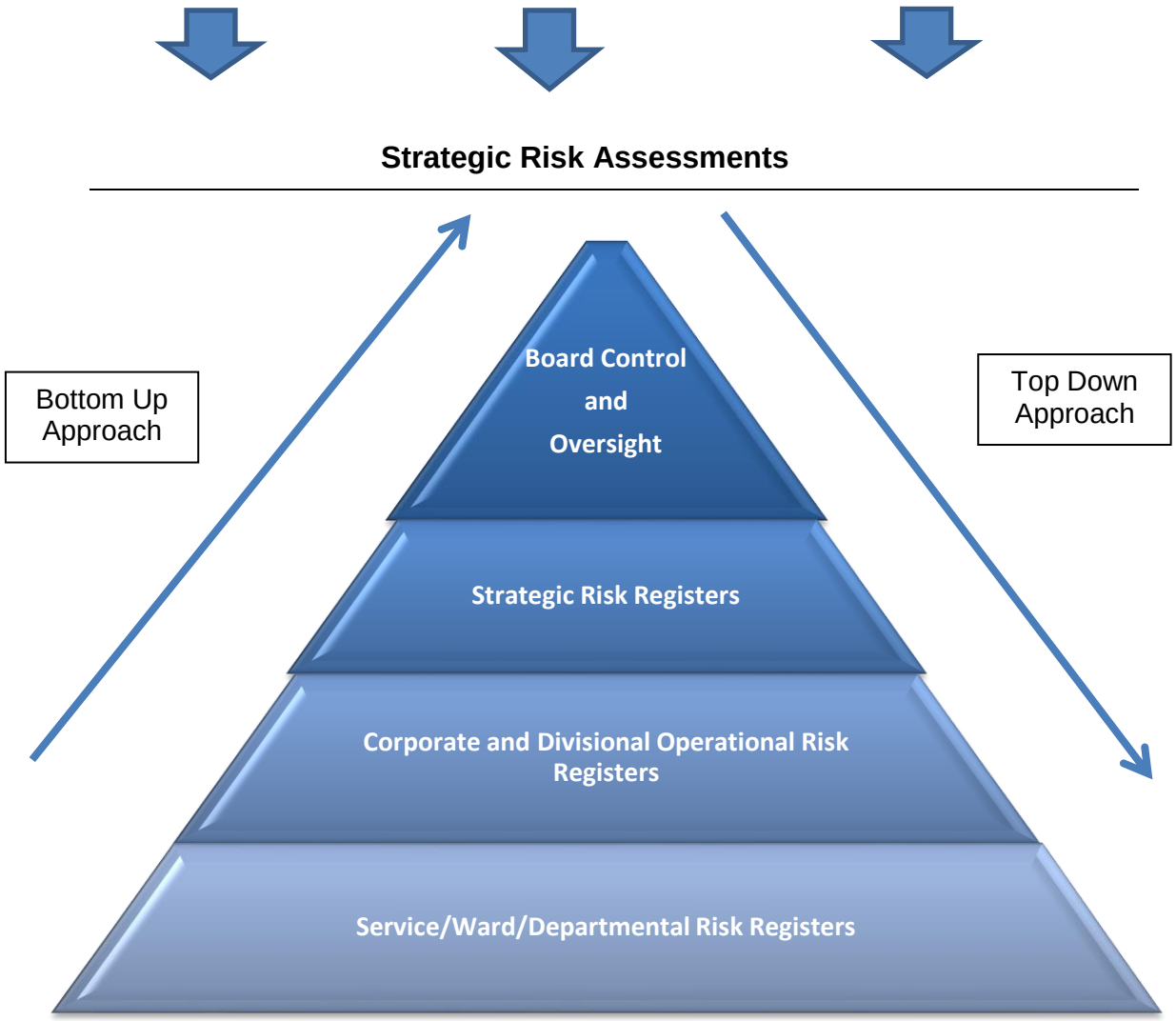
In undertaking Risk Management activity there are two key approaches that the Trust takes: the top down and the bottom up approach.

Top Down (Identifying Strategic Risks) – The Trust undertakes Strategic Risk Management through Executive Management and Committee structures that enables the identification, assessment and recording of strategic risks which threaten the achievement of the Trusts' Strategic Objectives. The management of Strategic

Risks also consider the implementation and monitoring of controls and mitigating actions. (Strategic Risks may also be identified through the monitoring and reporting of Operations risks).

Bottom Up (Identifying Operational Risks) – The Trust undertakes operational Risk Management activity through staff working in adherence to the Trusts' Risk Management Strategy. Operational Risks may present themselves via incidents, complaints, claims, patient feedback, safety inspections, external review, ad hoc assessments etc., which may impact on the Trusts ability to meet its objectives and targets.

Figure 2 – Risk Management Activity – Top down and Bottom up approach



4.7 Risk Appetite Statement

The Trust recognises that it is operating in a competitive healthcare economy where patient safety, quality of service and organisational viability are vitally important.

The Trust also recognises that there is always a level of inherent risk in the provision of acute healthcare which must be accepted or tolerated, but which must also be actively and robustly monitored, controlled and scrutinised.

The Trust also recognises that it has finite resources in terms of staff, equipment and finances available to it in the delivery of healthcare services.

In response to these factors the Trust will seek to manage risks in accordance with the following Risk Appetite Statement set by the Board.

The Trust has a low appetite for risk in relation to its strategic aim to **Consistently Deliver Excellent Care**, only being prepared to adopt safe delivery options. However, the Trust has an open appetite for risk in relation to its strategic aims to be **Fit for the Future** and to **Deliver Value for Money**, so that the Trust embraces change and employs innovative approaches to the way services are provided. The Trust has a moderate appetite for risk in its strategic aim to create a **Great Place to Work,** recognising the need for a strong and committed workforce might involve accepting some, but not significant risk.

All identified Risks will be allocated a Risk Mitigation score that ensures compliance with the ALARP Principle.

Table 1 – Outlines the Trusts' Strategic Ambitions and its associated target appetite and risk mitigation score.

Strategic Ambition	Target Risk Appetite	Target Score in line with Risk Appetite Statement
Consistently Deliver Excellent Care	Cautious to Risk - Willing to accept some low risk, whilst maintaining an overall preference of safe delivery options.	1-3
Great Place to Work	Moderate to Risk - Tending always towards exposure to only modest levels of risk in order to achieve acceptable but possibly unambitious outcomes.	4-6
Deliver Value for Money	Open to Risk - Prepared to consider all delivery options and select those with the highest probability of productive	8-12

	outcomes, even when there are elevated levels of associated risk.	
Fit for the Future	Open to Risk - Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.	8-12

4.8 Risk Management Framework (including Board Assurance Framework, Strategic Risk Registers and Operational Risk Registers)

4.8.1 The Board Assurance Framework

The **Board Assurance Framework** provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trusts' high level strategic objectives and is made up of two parts The **Strategic Risk Register** and the **Operational Risk Register**.

- **Strategic Risks** are those risks that threaten the delivery of the strategic objectives and are not likely to change over time.
- **Operational Risks** are those that sit on the divisional and corporate risk registers and may affect and relate to the day to day running of the organisation. They mainly affect internal functioning and delivery and are managed at the appropriate level within the organisation.

4.8.2 Trust Wide Strategic Risks

As part of the Annual Planning process, following the establishment of the Trusts' Strategic Objectives and Ambitions, the Board will identify any organisation wide strategic risks that may threaten the achievement of the Trusts' Strategic Objectives and Ambitions. The Board, supported by the Strategy, Workforce and Education Director and Head of Corporate Affairs will establish what the strategic risks are and identify and review the controls and systems the Trust has in place to mitigate these risks. The Big plan is the strategic planning framework that is in place to deliver the Trusts ambitions.

Through the Board Assurance Framework the Trust will document all of its Strategic Risks, the key controls that are in place to manage and mitigate these strategic risks and which Executive Director is leading on the mitigation. The Board Assurance Framework will be monitored on at least a quarterly basis at the Board of Directors meetings, where the Trusts' Executive and Non-Executive Directors review and challenge the levels of assurance offered within the Board Assurance Framework. Should a gap be identified in the control management and mitigation of the risk, the gap will be managed operationally through the creation of a new operational risk on the Trust Risk Register.

The Board Assurance Framework (BAF) records organisation wide strategic risks that include risks identified in relation to the Business objectives, corporate objectives and the Care Quality Commission Standards. The BAF enables the Board to demonstrate how it has identified and met its assurance needs. Every risk on the BAF is assigned to an Executive Director who will be responsible for reporting on progress to the Board of Directors via the Trust Management Board on a quarterly basis.

The Board will undertake the final validation of any new Strategic Risk Assessments and agree inclusion of new risks on the Strategic Risk Register. It is reviewed and revised monthly by Executive Directors.

Changes to High - risks are reported to the Executive Management Group monthly and to the Board of Directors on a bi-monthly basis by the Head of Corporate Affairs in report format.

The updated Board Assurance Framework is presented to the Executive Management Group on a quarterly basis is presented to the Board at each meeting. Additionally, operational risks on the Board Assurance Framework are aligned to responsible committees and these are routinely reviewed at each meeting of the committee.

4.8.3 Operational Risks and the Trust Risk Register System

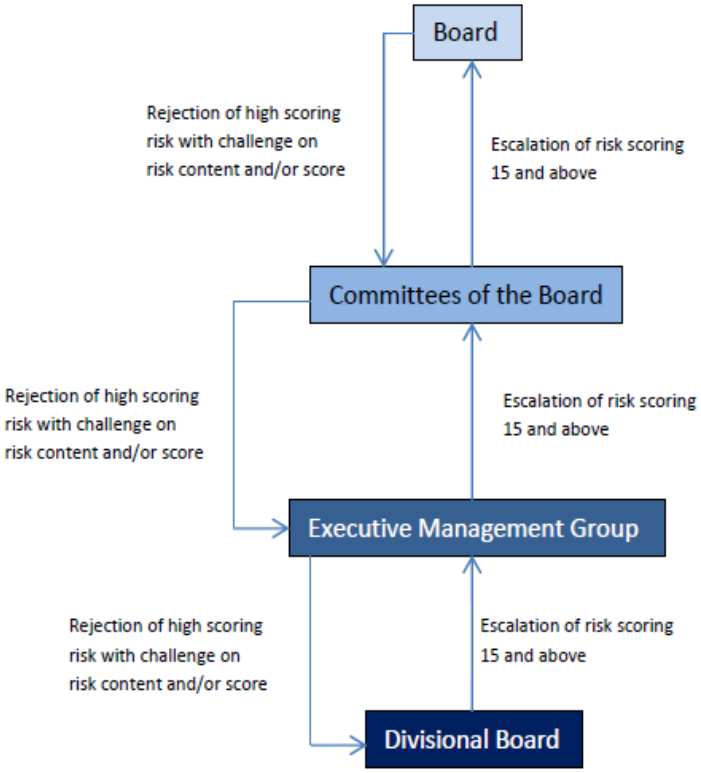
To provide oversight and scrutiny of the Operational Risk Management Activity, the Trust produces Risk Registers at a Corporate, Committee, Divisional, Specialty and Ward/Departmental level. To ensure oversight of this management, Governance and Risk dashboards are in place that are included in the Divisional Improvement Forums and a formal cycle of business scheduled for review at the Executive Management Group.

4.8.4 Operational Risk Register

All operational risks that have been rated as 'High' (Risk Score of 15 to 25) are maintained on Divisional Risk Registers and escalated via Divisional Boards to the Executive Management Group and subsequently to the Board via Committees of the Board. Having a formal process in place allows for control around the risk details and allows for appropriate challenge of the information prior to Board receiving the details as part of the Board Assurance Framework. Operational Risks are scored in line with the NPSA scoring matrix found in Appendix 8.

Through reviewing and monitoring Operational Risk Registers through its Board, Committee, Divisional Specialty and Ward/Departmental structures, the Trust gains assurance as to the appropriateness and effectiveness of Risk Management activity at all levels of the Trust.

Figure 3 – Escalation of High (15-25) Operational Risks



4.8.5 Assurance Committee Risk Registers

All operational risks are allocated to the relevant Trust Assurance Committee Risk Register and are monitored at the Committee meetings on at least a quarterly basis. The Assurance Committees that receive Risk Register Reports are detailed in Section 4.3.

4.8.6 Divisional Risk Registers

All operational risk are allocated to the relevant Trust Division Risk Register and are monitored through the reporting of risks to the Divisional Management Meetings on at least a quarterly basis and through Clinical Directors performance reports to the Divisional Performance meetings and the Executive Management Group on at least a quarterly basis.

4.8.7 Specialty/Clinical Business Unit Risk Registers

When relevant, some operational risks are allocated to the relevant Specialty Risk Register and are monitored through the reporting of risks to the Specialty Governance Meetings on at least a quarterly basis, with exceptions being reported to the Divisional Governance meeting.

4.8.8 Ward/Departmental Risk Registers

Ward/Department managers will identify risks and ensure these risks are considered on the agenda of the specialty business meetings. As detailed in section 4.8.6. The Ward/Department manager should discuss risks as part of the ward/department meetings and feedback to staff the actions being taken to control or mitigate risks raised or identified.

4.8.9 Risk Register Format

The Risk Registers are recorded into the Datix System using a standard template and the severity of each risk is rated according to the consequence/likelihood Risk Assessment Matrix from the National Patient Safety Agency 8. The Data fields included in the standard template are detailed in Appendix 5.

The operational risk registers identify and record the following:

- The Location of the Risk (Site, Division, Specialty and Department).
- The Risk Handler and Risk Owner.
- The date the Risk was identified.
- The description of the Risk.
- The Source of Risk.
- The principle Trust Ambition the risk impacts upon the Trust Assurance Committee that will monitor this risk.
- Key Performance Indicators that are at risk.
- The controls that are in place to assist in securing delivery of the objectives or Key Performance Indicators.
- The assurances that enable evidence to be gained that our controls are effective.
- The current Risk rating - the Risk rating with the current controls in place.
- The mitigation strategy for the Risk.
- The Mitigating Actions that are being taken to reduce the risk that will improve the level of control and assurance on the risk.
- The target Risk rating - the Risk rating with the mitigating actions are completed in line with the Trust Risk Appetite Statement.
- The review frequency and date of next review.
- The review history.
- Any supporting documents or evidence attached to the Risk.

4.9 Operational Risk Levels, Management, Monitoring and Escalation

As a ‘Clinically Led Organisation’ the Trust believes that operational risks are best managed by the Clinicians and Managers that are directly affected by that risk. These Clinicians and Managers should also receive appropriate and robust guidance, support and oversight from the Divisional and Trust Management teams, Assurance Committees and functional experts.

The frequency at which a Risk should be reviewed is determined by the risk score with higher scoring risks requiring more frequent review. Any risk rated as 'High' (15-25) must be reviewed monthly and any risk rated as 'Significant' (risk score 8-12) must be reviewed on at least a quarterly basis. Risk Review frequency guidance is included in Appendix 6.

The robust and overlapping monitoring and escalation processes will ensure that risks are not managed by Clinicians or Managers without sufficient authority, experience and knowledge to mitigate the risk and that significant and serious risks are identified and escalated as quickly as possible. Figure 4 contains an overview of these processes.

Figure 4: Overview of Risk Levels, Management, Monitoring and Escalation

Risk Level	Impact / Management	Monitoring	Escalation
1 Service/ Ward/ Department	Impacts on a single ward/department on a site. Managed by a Ward/Department Lead Clinician or Manager.	Ward/Departmental 'Governance' meetings. Relevant Assurance Committee.	Specialty Governance meetings/ Divisional DGAG Meeting
2 Speciality	Impacts on multiple wards/departments or sites within a speciality. Managed by a Speciality Lead Clinician or Manager	Specialty' Governance' meetings. Relevant Assurance Committee.	Divisional DGAG Meeting.
3 Divisional	Impacts on multiple Specialities within a Division. Normally managed by a member of the Divisional Triumvirate	Divisional DGAG Meeting. Relevant Assurance Committee.	Divisional Performance Review Meeting.
4 Trust Wide	Impacts on multiple Divisions or all Divisions. Managed by the relevant Lead Clinician or Manager.	Departmental 'Governance' meetings. Divisional DGAG Meetings. Relevant Assurance Committee.	Divisional Performance Review Meeting. Director of Governance. Executive Directors Group Meeting.

4.10 The Risk Management Process

The Risk Management process is the activity required to identify, assess and manage risks in order to achieve its objectives. A Risk Assessment and Management Guidance and Flow Chart are included in Appendix 3 and 4.

4.11 How Operational Risks are added to the Trust Risk Register

All Trust Staff with a Datix user account can add a new risk to the Risk Register. There are specified Mandatory Data items must be completed before a new risk can be saved; this is to ensure that minimum data requirements are achieved. Staff who do not have a password should speak to the Ward/Department Manager to raise risk matters. The Ward/Department Manager has a responsibility to respond to any risk identified to them.

All newly created risks are held in a 'Pending Tray' until they have been subjected to; a Quality Assurance check by the Divisional Governance Lead, and a check and challenge process at the Divisional Governance meeting. The purpose of the 'pending Tray' is to prevent the inadvertent addition of duplicate or near duplicates of existing risks and to ensure that risk assessments have been completed to the standard required by this Policy.

The decision to approve or decline a Divisional Risk from the Pending Tray will be taken at the Divisional Governance Meeting. The decision and the reasons for doing so will be recorded in the Divisional Governance Meeting minutes and in the Datix system.

If a Risk requires urgent approval it can be approved by the Director of Governance. In such cases, the relevant Divisional Governance meeting will be informed of the urgent approval and the reason for the urgent approval.

The following types of standardised Risk reports will be produced at Board of Directors Level:

- Board Assurance Framework detailing those strategic and operational risks that may compromise the achievement of the Trusts' Objectives.

The following types of standardised Risk reports will be produced at Committee Level:

Summary Position and Exceptions which will include, but is not limited to:

- Changes in Risk Ratings.
- Themes and Profiles.
- Content of Strategic Risks.
- Details of operational high risks aligned to the relevant assurance committee.

The following types of standardised Risk reports will be produced at Divisional Level:

- Changes in Risk Ratings.
- Risk Performance Key Performance Indicators.
- Risks pending approval decision.
- Risks that have been controlled.
- Risks overdue for review.
- Risks that have 'No Controls in Place'.
- Risks with 'No Open actions in place'.
- Open mitigating actions with no progress recorded.
- Themes and Profiles.
- Risk Register report.

The approved format for the Risk Register Report is detailed in Appendix 7.

4.12 Controlling Risks on the Trust Risk Register

When a Risk Handler or Owner believes that a risk has been suitably mitigated and can now be closed, they must submit a risk control request through Datix to the Divisional Governance Meeting. The risk will then be subject to a Quality Assurance check by the Divisional Governance Lead, and a Check and Challenge process at the Divisional Governance meeting.

This is to ensure that all action plans have been completed, the appropriate and effective controls in place and that the risk is at an inherent level that can be managed through the Trusts normal operational activities and procedures.

The decision to approve or to decline the control request, and the reason for doing so, will be recorded in the Divisional Governance meeting minutes and should also be detailed on the Notepad section of the risk record on Datix prior to placing into the "Controlled Risks" approval status.

Risks that are rated as High are not eligible for control under any circumstances.

4.13 Risk Management Training

The Trust has an agreed Training Needs Analysis (TNA) delivered through the risk maturity plan. This will be extended each year to strengthen training around risk management topics.

To ensure the successful implementation and maintenance of Risk Management within the organisation, all employees (including members of the Board, Clinicians, Managers, Bank, Locum and Agency Staff) will have their responsibilities for risk identified within their job descriptions and job plans.

4.14 Reporting on the Triangulation of Risk Information and Risk Themes

Where possible the Trust will seek to triangulate information, especially thematic profiles and trend analysis, with similar information that is produced in respect of; Complaints, Incident Management, Audit, Mandatory Training, NICE Guideline compliance.

The purpose of this is to act as an 'Early Warning System' to enable the early identification of potential problems so that early action can be taken to reduce or remove these problems.

4.15 Assurance (including Internal and External Audit)

The Trust Board via the Audit Committee will receive assurances on the effectiveness of the risk management framework annually be receiving the Head of Internal Audit Opinion following the Internal Audit reviews undertaken throughout the year and reported to the Audit Committee.

4.15.2 Benefits of an Assurance System

An assurance system achieves a number of benefits:

- Provides confidence in the operational working of the Trust.
- Maximises the use of resources available in terms of audit planning, avoiding duplication of effort.
- Ensures assurances are appropriately gathered, reported and that the governance structure is working as intended.
- Identifies any potential gaps in assurances relating to key risks and key controls, and that these are understood and accepted or addressed as necessary.
- Supports the preparation of the Annual Governance Statement and regular assurance reports.

4.15.3 Types, Sources and Levels of Assurance

There are three types of assurance, which are referred to as the three lines of defence:

Level 1 - Departmental Assurance

- Local Management Oversight – direct management assurances.

Level 2 - Corporate Assurance

- Corporate Oversight – internal assurance sources (including assurance committees), independent from direct management assurance sources.

Level 3 - Independent Assurance

- Independent Oversight – External Auditors, Internal Auditors, Regulators, External Benchmarking etc.

4.15.4 Assurance Values

- Independent assurance is used to confirm management assertions and is often seen as of highest value. This is however dependent on many other factors as noted below including: Age – the time elapsed since assurance was obtained, this may erode the value of assurance.
- Durability – whether it endures as a permanent assurance on an historical matter e.g. Auditors Report on Financial Statements, or loses relevance over passage of time e.g. clinical audit.
- Relevance – the degree to which assurances align to specific areas or objectives 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.

4.15.5 Independent External Assurance

The Board receives Independent assurance(s) that a Risk Management System is in place that meets with the requirements of the Risk Management Standards through the process of internal and external audit and from external assessments, reviews and benchmarking, for example:

- Care Quality Commission visits/inspections.
- National Audits.
- Reviews of external independent reports.
- CCG Serious Incident Panel.
- Quality Risk Profile.
- Health and Safety Inspections.
- External Audit Reports.
- Internal Audit reports from externally appointed 3rd party.
- Royal College reviews.
- Annual Audit Letter.
- National Staff Surveys.
- NHSLA Reports.
- National Patient Satisfaction Surveys.
- Patient Led Assessments of the Care Environment (PLACE) Inspections.

4.15.6 Internal Assurance

The Trust will seek assurance that risks are being appropriately identified and managed through the following:

- Trust Board Integrated Performance Report.
- Risk Management Annual Report.
- Performance Reviews.
- Key Performance Indicators including internal standards.
- Minutes.

- Committee Reports.
- Divisional Management Board Reports.
- Annual Quality Accounts and Clinical audits.
- Development and review of Risk Registers.
- Compliance levels within the CQC Assessments, Board Assurance. Framework/Corporate Risk Register.
- Accreditation levels achieved within NHSLA Risk Management standards.
- The Annual Governance Statement.
- Benchmarking activity.
- Compliance with mandatory induction and training standards.
- Response to Medical Devices Alert (MDA)/National Patient Safety Audit (NPSA)/Estates and Facilities (EFA) alerts and hazard notices.
- Incident investigations.
- Incident, claims and complaints trends.
- Patient and staff attitude surveys.
- Corporate Quality Reviews.
- Walkabouts.
- STAR ensures that suitable evidence exists to support adherence with regulatory and accreditation standards. The STAR Team provides support for such reviews.

4.15.7 Key Stakeholders Assurance

In addition to the internal routes for raising concerns and risk, there are formal mechanisms by which our key stakeholders can raise risk concerns.

These include:

- Regular contract and performance review meetings with Clinical Commissioning Group (CCG), County Councils, City Council, District Council and Borough Council.
- Incident and Serious Incident process.
- Complaints process.
- Claims process.
- Regulators.

4.16 Other Risk Assessments

A wide variety of ‘Risks Assessments’ are systematically identified and reported throughout the Trust. In most cases it is not appropriate that these ‘Risk Assessments’ are entered into the Trust Risk Register as ‘Risks’. Detailed below are some of the most common of these ‘Risks Assessments’.

4.16.1 Patient Risk Assessments

A wide variety of Patient-related Risk Assessments may take place including; Bed Rails, Falls, Hydration, Nutrition and Tissue Viability etc. These risk assessments should be recorded within the Patient's individual record.

4.16.2 Safety Incident Reporting

Specific detail regarding the Safety Incident risk assessment process can be found in the Trusts 'Adverse Incident Reporting, Management and Investigation Policy and Procedure'.

4.16.3 Complaints

Specific detail regarding the Complaints risk assessment processes can be found in the Trusts 'Customer Care and PALS Policy and Procedure'.

4.16.4 Litigation

Specific detail regarding the Litigation risk assessment processes can be found in the Trusts 'Policy and Procedure for handling Clinical Negligence, Personal Injury, Property Expense Claims and Personal Property Losses'.

4.16.5 Workplace, Environment, Health and Safety and Security Assessments

Specific detail regarding the Workplace, Environment, Health and Safety and Security risk assessment processes can be found in the Trusts' Health and Safety Policy.

4.16.6 Clinical Audit

Specific detail regarding the Clinical Audit risk assessment processes can be found in the Trusts' Clinical Audit Policy and Procedure. Clinical Audit is a key component of the assurance framework, as such, regular clinical audit performance activity reports as presented to the Audit Committee for oversight and coordination with the Internal Audit plan.

4.16.7 NICE Guidance and Standards

Specific detail regarding the NICE publications and Quality Standards risk assessment processes can be found in the Trusts' Implementation of NICE publications and Quality Standards Procedure.

4.16.8 Project Risk Assessments

Specific detail regarding the risk assessment processes for project risks can be found in the project documentation.

4.16.9 Internal and External Reviews/Reports

Risks that are identified from internal and external audit reports and other reviews, assessments and accreditation, would need to be carefully assessed by the relevant Clinician or Manager to ascertain if the risk should also be placed on to the Trust Risk Register.

4.17 Dissemination and Implementation

This strategy will be distributed and communicated as outlined in the Distribution Plan section.

5. AUDIT AND MONITORING

How the Organisation Monitors Compliance with the Risk Management Strategy Monitoring of this strategy will be done via the following mechanisms:

The Board of Directors will receive:

- An Annual Risk Management Report covering all aspects of Risk to be submitted to the Trust Board.
- An Annual Report on the effectiveness of the organisation's Risk Management Processes from the Audit Committee.

Arrangements will also be made as part of the Annual Internal Audit Plan agreed by the Audit Committee, for periodic audits to be carried out to provide assurances to the Board that the Risk Management System in place conforms to the requirements of the Divisional Measurable Objectives (Appendix 8) and CQC standards.

6. TRAINING

TRAINING Is training required to be given due to the introduction of this policy? No		
Action by	**Action required**	**Implementation Date**

7. DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
Appendix 1	Trust Corporate Governance Committee Structure
Appendix 2	Risk management reporting arrangements
Appendix 3	The Risk Assessment and Management Process Guidance
Appendix 4	Risk Assessment and Risk Management Process Flow Chart

Appendix 5	Summary of the Risk Register Data Fields
Appendix 6	Risk Review Report Template
Appendix 7	NPSA Scoring Matrix
Appendix 8	Divisional Measurable Objectives
Appendix 9	Equality and Diversity Impact Assessment Tool

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
RMP-HS-102	Risk Assessment and the Process for Use of Risk Registers
TP-27	Policy and Procedure for Handling Clinical Negligence, Personal Injury, Property Expense Claims and Personal Property Losses
TP-24	Customer Care and PALS policy and procedure
TP-113	Clinical Audit Policy and Procedure
RMP-C-98	Implementation and Management of NICE Guidance
RMP HS 114	Adverse Incident Reporting, Management and Investigation Policy and Procedure
TP-16	Health and Safety Policy
TP-149	Duty of Candour

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full** **References checked by library 22/09/2020**	
Number	References
1	Lancashire Teaching Hospitals NHS Foundation Trust Licence
2	Care Quality Commission (2015) Acute hospitals: provider handbook
3	Department of Health & Social Care website https://www.gov.uk/government/organisations/department-of-health
4	NHS England website https://www.england.nhs.uk/
5	NHS Resolution website https://resolution.nhs.uk/
6	Care Quality Commission - The Fundamental Standards https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards
7	National Patient Safety Agency (2008) *A risk matrix for risk managers*. London, NPSA.
Bibliography	
NHS Commissioning Board (2013) *Reservation of Powers to the Board & Delegation of Powers.*	
NHS Litigation Authority (2013) *NHSLA Risk Management Standards 2013-14.* London, NHSLA.	
The Management of Health and Safety at Work Regulations 1999 https://www.legislation.gov.uk/uksi/1999/3242/contents/made	
National Patient Safety Agency (2004) *Seven Steps to Patient Safety: the Full*	

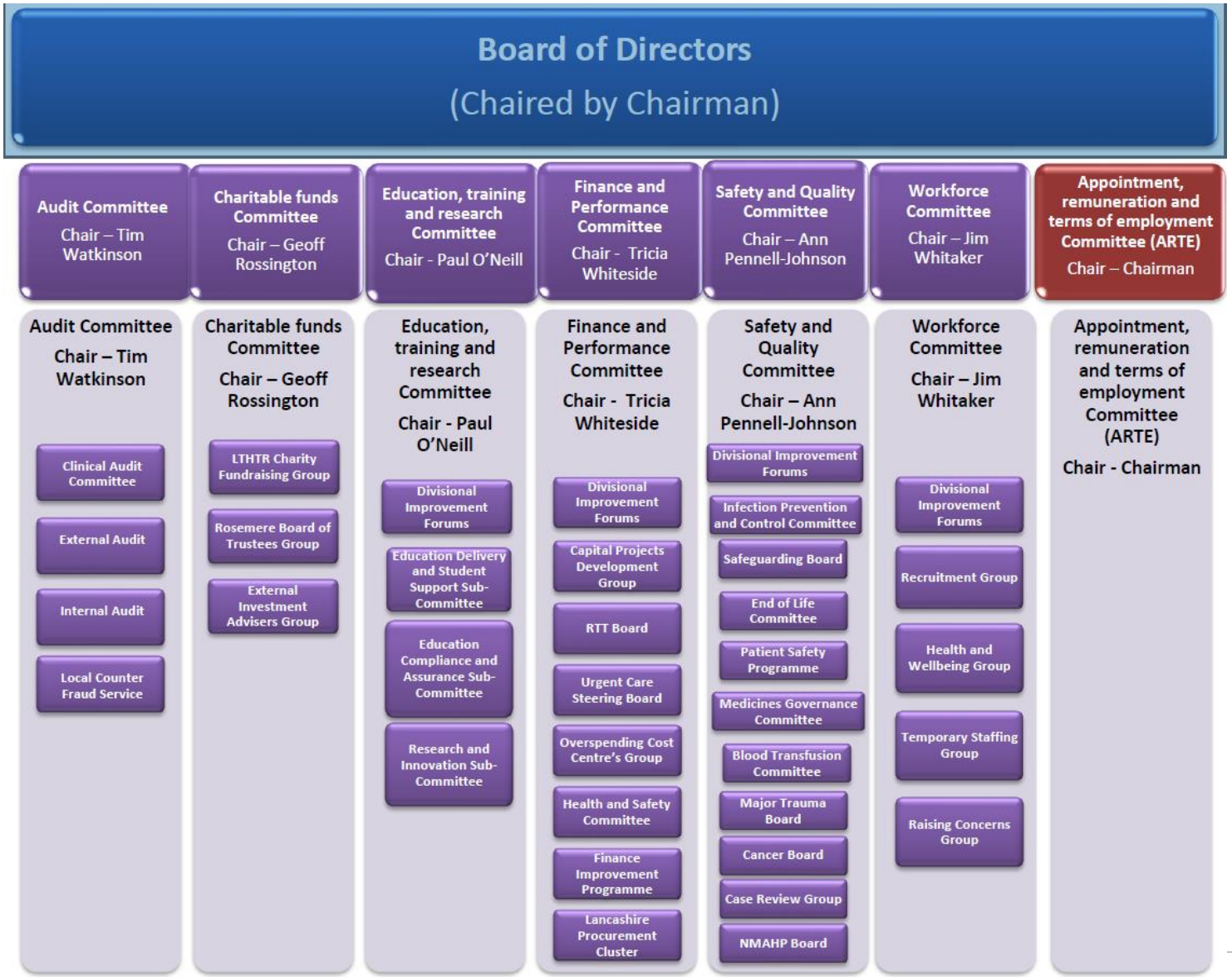
Reference Guide. London, NPSA.
National Patient Safety Agency (2009) *Being Open Framework*. London, NPSA.

DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
ALARP	As Low As Reasonably Practicable
BAF	Board Assurance Framework
CQC	Care Quality Commission
DGAG	Divisional Governance Assurance Group
DMB	Divisional Management Board
DMT	Divisional Management Team
HSE	Health and Safety Executive
MHRA	Medicines and Healthcare Products Regulatory Agency
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
TNA	Training Needs Analysis
TMB	Trust Management Board

CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
Executive Management Team		June 2020
Board of Directors		June 2020

DISTRIBUTION PLAN	
Dissemination lead:	Hajara Ugradar
Previous document already being used?	Yes
If yes, in what format and where?	Electronic, heritage library system, hard copy
Proposed action to retrieve out-of-date copies of the document:	Knowledge and library to replace with updated version. Any paper copies to be removed and placed in confidential waste.
To be disseminated to:	Trust wide
Document Library	Heritage
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

Appendix 1 Trust Corporate Governance Committee Structure



Appendix 2

RISK MANAGEMENT REPORTING ARRANGEMENTS

Document	Presented to	Frequency	By
Board Assurance Framework	Board of Directors and Committees of the Board	At each meeting	Director of Governance
Board Assurance Framework	Exec Management Group	Quarterly	Director of Governance
Board Assurance Framework	Audit Committee	At each meeting	Director of Governance
Operational High Risk Register	Executive Management Group	At each meeting	Director of Governance
Risk Management Strategy	Board of Directors	Annually	Director of Governance
Executive Management Group Escalation Report	Board of Directors	After each meeting	Head of Corporate Affairs
Annual Risk Management Report	Audit Committee	Annually	Head of Corporate Affairs, Director of Nursing, Midwifery and AHP r / Director of Governance
Divisional Reports	Executive Management Group	Quarterly	Divisional Management Team

Appendix 3

The Risk Assessment and Management Process Guidance

Identifying the Risks to Objectives:

Risks can be identified from a variety of different sources through the operation of the Trusts' business; these sources can include, but are not limited to:

Proactive Processes:

- Planning Processes
- General Observations
- Internal/External Audits

Reactive processes:

- Incidents
- Complaints
- Claims
- Inspections/Assessments/Accreditations/Reviews
- Regulatory Assessments

Types of Risk

Risks to Safety:

- Risks that could result in accidental death, disability or severe distress to patients, visitors, contractors and/or staff
- Risks that could result in unintentional harm
- Risks that may be less serious but are more frequent or could affect a large number of patients/staff

Risks to Reputation:

- Risks that could lead to adverse publicity or affect the reputation of the Trust
- Risks that could lead to litigation or may be the cause of a formal complaint
- Risks that could affect the Division / CO or Group in meeting corporate objectives (e.g. failure to meet service delivery targets / operational loss or delay / national requirements)

Risks to Resources:

- Risks that could result in financial loss to the Trust
- Risks to service provision
- Risks to equipment / buildings
- Risks to staff retention

Risk Handler Assessor and Risk Owner:

When a risk is identified, a Risk Handler and Risk Owner must be assigned to take responsibility for the assessment and ongoing management of the risk and the actions to mitigate the risk.
The Risk Handler: should be the person that will have 'day-to-day' responsibility for the assessment and management of the risk, as such Risk Assessors must have the requisite authority to make the required decisions.

The Risk Owner: should be the person that will have 'managerial' responsibility for the oversight of the risk. They will also provide direction and management support where appropriate to the Risk Handler; as such Risk Owners must have the requisite authority to make the required decisions.

Below is simplified example of the types of Risk Handlers and Owners that might occur in a nursing, medical and service management context.

Nursing	Risk Handler	Risk Owner
Intra-Divisional	Ward Manager/Sister	Matron
	Matron	Deputy Nursing, Midwifery & AHP Director
Extra-Divisional Escalation	Divisional Nurse Director	Divisional Nurse Director
	Deputy Nursing Midwifery & AHP Director	Deputy Nursing Midwifery & AHP Director
Medical	**Risk Handler**	**Risk Owner**
Intra-Divisional Escalation	Junior Doctor	Consultant/Clinical Lead
	Consultant	Clinical Lead
	Consultant/Clinical Lead	Clinical Director
Extra-Divisional Escalation	Clinical Director	Deputy Medical Director
	Deputy Medical Director	Medical Director

Service Management	Risk Handler	Risk Owner
Intra-Divisional Escalation	Department/Unit/Ward Manager	Specialty Business Manager
	Specialty Business Manager	Divisional Director
Extra-Divisional Escalation	Divisional Director	Deputy Chief Operating Officer
	Deputy Chief Operating Officer	Chief Operating Officer

Risk Assessments and Systematic Approach

A Risk Assessment is the evaluation of any risk that has been identified that can interfere with the achievement of a Trust objective. These assessments are a vital part of identifying what is being done to mitigate risks, how effective this mitigation is in practice and what further mitigation is required.

Upon completion of a Risk Assessment, it is the responsibility of the either the Risk Handler or Risk Owner to record the Risk Assessment on Datix. Where possible risk assessments can and should be directly entered into the Datix system to avoid unnecessary duplication of effort.

All Risk Assessments must include the following:

- The Location of the risk (Division, Department, Specialty and Site)
- The Risk Handler and Risk Owner
- The Trust Ambition that is at risk
- The date the risk was identified
- The risk title and description of the Risk
- The source of the risk i.e. how the risk has come to be identified
- The controls that are in place to assist in securing delivery of the objectives or Key Performance Indicators
- The assurances that enable evidence to be gained that our controls are effective
- The mitigation or control strategy for the Risk
- The current risk rating - the risk rating with the current controls in place
- The Source of risk
- The Mitigating Actions that are being taken to reduce the risk that will improve the level of control and assurance on the risk
- The target residual risk rating - the risk rating with the mitigating actions are completed
- The Review Frequency and Date of next review
- The Review history
- Any supporting documents or evidence attached to the Risk

All new risks are held in Pending 'Pending Tray' until they have been subjected to:

- A Quality Assurance check by the Divisional Governance Lead, and a check and challenge process at the Divisional Governance meeting.

The purpose of the 'Pending Tray' is to prevent the inadvertent addition of duplicate or near duplicates of existing risks and to ensure that risk assessments have been completed to the standard required by this Policy.

Risk Title

Risks must be titled in a clear and concise way and localised as much as possible to avoid confusion with similar risks across the organisation E.g. [Brief Description] at [localised name] e.g. Staffing levels on Ward 12.

Description of the risk and the consequences of the risk occurring

It is important that Risk Descriptions are both concise and contain sufficient information to allow a reader to understand the risk. The Risk description should

include; a summary of the cause and nature of the risk (the 'If'), the circumstances in which the risk may occur or worsen (the 'Then'), a statement of the plausible reasonably impacts (the 'So').

Some examples of 'If, Then, So' risk descriptions are detailed in the table below:

If	Then	So
In the current financial climate,	Failing to maintain appropriate staffing levels,	Resulting in poor service delivery/increased complaints.
Due to ineffective maintenance/failure to recognise wear and tear,	Key equipment breakdowns will increase,	Resulting in cancellation of lists.
Due to lack of leadership opportunities,	Failing to develop skills of existing staff,	Resulting in a lack of staff incentive to be retained/seek promotion.
Due to system failures,	Non availability of patient notes,	Leading to patient treatment being delayed, unsafe or cancelled.
Due to difficulties in recruiting,	Insufficient consultant staff to fulfil rota,	Resulting in rota being covered by staff working longer hours, which may adversely affect decision making ability.

IMPORTANT Do's and Don'ts when writing a risk description:

- **Do** include objective statements and facts
- **Do not** include subjective personal opinions and views
- **Do not** include abbreviations and acronyms, unless they are in very common usage e.g. NHS
- **Do not** include Personal Identifiable Data of Patients or Visitors in the Risk Description. Do not include Personal Identifiable Data of colleagues in the Risk Description, unless it is directly relevant to the Risk.

Controlling Risks

The existing controls that are in place for the risk need to be detailed. It is worth taking some time with this section and perhaps consulting with colleagues to ensure that all relevant controls have been identified and documented.

Describe what controls are currently in place to control the risk, typically these include, policies, procedures, guidelines, training, formal structures and organisational arrangements, etc.

Record each control individually and identify if there are any gaps in the control and the effectiveness of that Control. Identify and record any internal or external sources of assurance which are already in place e.g. performance monitoring reports, audits,

reviews, incident reports, committee/group minutes etc. and any gaps in these assurances.

Below are some examples of controls and the information that should be recorded:

Control Type	Trust Procedure	Capital Bid Request	Managerial Oversight
Control	An agreement is in place with rent-a-radiographer agency to provide appropriately qualified x-ray staff	Capital Bid for replacement Radiography equipment	Manager oversight of staffing rota
Gap in Control	Agency requires 7 days' notice to provide suitable staff	Capital Bid may not be successful	Cannot ensure availability of staff at short notice
Effectiveness of Control	Mostly Adequate	Partly Adequate	Partly Adequate
Assurance - Internal	Monitoring of performance against agreement	Capital Bid requests subject to approval by Finance Committee	Verbal report to senior manager
Assurance - External		External Audit of Capital bid requests	
Gaps in Assurance	None identified	None identified	Assurance can only reactively identify problems not proactively address them
Adequacy of Assurance	Significant Assurance	Limited Assurance	Limited Assurance

Where a significant 'Gap in Control' has been identified that Control must be given an Effectiveness of Control rating of 'Partly Adequate'

The overall effectiveness of all the controls that are in place should be determined and recorded in the Risk Register, the four levels of control effectiveness are:

- Fully Controlled
- Partly Controlled
- No Controls in Place

The Current Risk score

Utilise the NPSA Risk Scoring Matrix and guidance to quantify the risk in terms of its current impact of the risk arising and the current likelihood of the risk arising. The matrix is in Appendix 7 of the Trust Risk Management Strategy.

Mitigating Action Plans

The Mitigating Action Plan will detail how the Risk will be mitigated and managed to reduce the risk that will improve the level of control and assurance on the risk.
All active risks should have at least one active mitigating action plan in progress. Each Mitigating Action should include the items detailed in the below table:

Section	Explanation
Action Type	Staff training – selected from a drop down list
Action Title	Training Plan
Action Owner	Normally but not always this is the 'Risk Assessor' e.g. Relevant Ward Manager
Person Responsible	This is the person who will complete the action e.g. relevant Practice Educator
Start Date	The date the action will start on
Reminder Date	The date on which a reminder for the action to be completed should be issued, normally this would be a week or a month before target date, this date can be changed if required
Target Date	The date the action should be completed by, this date can be changed in required
Action Status	Ongoing, Closed, Removed - selected from a drop down list
Action Completed Date	The date the action was completed upon

The 'Person Responsible' for the completion of the action should record progress towards completion on a regular basis, preferably as the progress occurs.

The 'Action Owner' should scrutinise the progress reported by the 'Person Responsible' to ensure it is of sufficient quality and to ensure that regular progress is being recorded.

Overdue progress updates can be escalated to:

- Divisional Governance Meetings.
- Director of Clinical Governance.
- Committees.

Key aspects to consider when developing an action plan in order to mitigate/reduce the risk are summarised below.

- What are the existing controls?
- Are there any gaps?

- What further controls are practical and sustainable? (Check with staff who work in the area).
- Is the design of the control right? Is it helping you achieve your objectives?
- What further actions are needed to manage the risk?
- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

Action Plans should be focused on gaps in controls and should include the following:

- A list any actions that are needed to manage the risk indicating the agreed time scale for each action;
- A designated person must be identified to take responsibility for each action on the list.
- Each action identified should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely).
- Action plans must be appropriate to the level of the current risk.
- Action target dates and risk review dates should be set in accordance with the level of risk, and compliance with these must be monitored appropriately through the relevant committee.

Target Risk Rating

This is the score that is intended after the action plan has been fully implemented and aligned to the organisations risk appetite. See below.

Strategic Ambition	Target Risk Appetite	Target Score in line with Risk Appetite Statement
Consistently Deliver Excellent Care	Cautious to Risk - Willing to accept some low risk, whilst maintaining an overall preference of safe delivery options.	1-3
Great Place to Work	Moderate to Risk - Tending always towards exposure to only modest levels of risk in order to achieve acceptable but possibly unambitious outcomes.	4-6
Deliver Value for Money	Open to Risk - Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.	8-12
Fit for the Future	Open to Risk - Prepared to consider all delivery options	8-12

	and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.	

Risk Monitoring and Review

It is mandatory that all risks have a defined review frequency and scheduled review date that is compliant with the guidance detailed in Appendix 4.

When a Risk review is due the Risk Handler is expected to undertake a review of the Risk and its associate actions to ensure that appropriate mitigation action is in progress and that the Risk is updated accordingly. They should then record this by adding a new 'Risk Review', which has the following mandatory items:

- Review Date.
- Reviewed By.
- Details of Review.

The Risk Owner is expected to provide appropriate oversight and scrutiny over the work undertaken by the Risk Handler. The Divisional Governance meetings are also expected to provide appropriate oversight and scrutiny over their Divisional risks, especially risks that are rated as 'High'.

Overdue Risk reviews are escalated to:

- Divisional Governance Meetings.
- Nominated Deputy to Director of Clinical Governance.
- Director of Governance.

The Datix system stores all previous Risk reviews as evidence to show the progress taken in updating and mitigating this Risk.

Risk Archiving and Record Management

The record of a Risk, including all its previous versions, from its creation through the period of its 'active' management, then into its 'inactive' archive retention is fully maintained within the Datix system. This includes all risks that have been added to Datix system since it went "live". All these records are available within the Datix system and can be immediately accessed if required.

To ensure the easy identification and reporting of 'active' risks, all Risks in the Datix system are assigned one of the following statuses as is appropriate:

- Pending – The risk is in 'pending' tray and is still under assessment.
- Active – The risk is 'assigned' to a 'Handler' and 'Owner' and it's being actively mitigated.

- Controlled– The risk has appropriately mitigated and has been controlled and archived.

The Trust Risk Register can be ‘filtered’ to show all of the risks that are allocated each of the above statuses. ‘Assigned’ risks can also be ‘filtered’ by the Division or the Site they have been allocated to.

Appendix 4

Risk Assessment and Risk Management Process Flow Chart

Risk Management – Trust Risk Register, Life Cycle and Process

Ongoing Risk Register Processes: Risk Review, Quality Assurance and Reporting (Oversight and Scrutiny)			
Risk	Risk Review	Quality Assurance	Reporting: Oversight and Scrutiny

Risk Identification Assessment and Acceptance	
Risk Identification	Local Level: Variety of means and methods staff are encouraged to identify and report risks
Entry on to Risk Register	Local Level: Risk Identifier, Risk Assessor or Risk Manager
Quality Assurance Check	Divisional Governance Lead and/or Corporate Governance team, ensures appropriate standards
Acceptance	Divisional Governance Meeting and/or Corporate Governance Team

	Assessor	Manager	Gov Lead	Corp .Go	Dept/Ward	Divisional	Committee	Trust Board
Low Risk Score 1-3	Yes	Yes	Periodic Assessment depends on size of Division	Periodic Assessment as Required / Identified	Yes	Periodic Reporting depends on the size of the Division		
Moderate Risk Score 4-6	Yes	Yes	Periodic Assessment depends on size of Division	Periodic Assessment as Required / Identified	Yes	Periodic Reporting depends on the size of the Division		
Significant Risk Score 8-12	Yes	Yes	Yes	Periodic Assessment as Required / Identified	Variable depends on the nature of Risk	Periodic Reporting depends on the size of the Division		Yes 12 only Clinical Director Report
High Risk Score 15-25	Yes	Yes	Yes	Yes	Variable depends on the nature of Risk	Yes		Yes Corporate Risk Register Report Clinical Director Report

Risk Closure	
Risk Closure Request	Local Level: Risk Assessor or Risk Manager
Quality Assurance Check	Divisional Governance Lead and or Corporate Governance Team, ensures appropriate standards.
Closure Decision	Divisional Governance Meeting and/or Corporate Governance team

Risk Review Frequency Guidance

The frequency of review for a Risk should be based upon the profile and seriousness of that Risk. The below table provides guidance on normally appropriate review frequencies based upon the Risk Rating of the Risk.

Risk review Frequency			
Risk Rating / Score	**Minimum Frequency**	**Maximum frequency**	**Range or Review Frequencies**
Low Risk 1- 3	Annual	Quarterly	Annual, Six Monthly, Quarterly
Moderate 4- 6	Quarterly	Bi - Monthly	Quarterly, Monthly
Significant 8-12	Quarterly	Monthly	Quarterly, Monthly
High Risk 15-25	Monthly	Daily	Monthly, Bi-weekly, Weekly

NPSA Risk Matrix – for reference

	Likelihood Score				
Consequence Score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Review Process	
Automated Process Manual Checks	All Risks have a specified Risk Review Date that is compliant with the review frequency. Reminder email issued 7 days before review date, on review date and each 7 days after review date. Month end report of all risk reviews that are more than 7 days overdue issued to Divisional Governance Leads for chasing and escalation as appropriate.
Reviewers	Risk Assessors should review and update the Action Plan and Control Status of the Risk. Risk Managers should review and challenge the information provided by the Risk Assessor.
Quality Assurance	Divisional Governance Lead (or Corporate Governance team) assess the quality of the reviews undertaken by the Risk

	Assessor and Manager and provide feedback and advice as required.
Reporting: Oversight and scrutiny	Oversight and Scrutiny of the Risk Register is carried out from 'Ward to Board'. Multiple oversights for higher scoring Risks are provided at Divisional, Committee and Board Level. Some Committees monitor all risks that are within its remit e.g. Safeguarding Board.

Appendix 5 – Summary of the Risk Register Data Fields

Orange denotes mandatory fields, grey denotes system generated fields.

Section	Data Item
System Data	Risk Number
	Version
	Risk Level
	Current Status
Location Details	Division
	Site
	Department
	Specialty
Manager Details	Risk Assessor
	Risk Manager
Link to Objectives	Trust Objectives
	Sub Objectives
	KPI Details
	Oversight Committee
Risk Details	Date Identified
	Risk Title
	Risk Description
	Additional
Existing Controls in Place	Control Type
	Details of Control
	Gaps in Control
	Effectiveness of Control
	Assurance – Internal
	Assurance - External
	Gaps in Assurance
	Adequacy of Assurance
	Overall Control Effectiveness
	Risk Mitigation Strategy

Section	Data Item
Current Risk Assessment	Current Risk Severity Score
	Current Risk Likelihood Score
	Current Risk NPSA Rating
	Risk Group
	Risk Type
	Source of Risk
	Commissioner related
Action Plans	Action Priority
	Action Title / Summary
	Action Detail
	Action Owner
	Person Responsible
	Start Date
	Target Date
	Reminder Date
	New Progress
	Progress History
	Action Status
	Action Completed date
Target Risk Levels	Target Date
	Target Risk Severity Score
	Target Risk Likelihood Score
	Target Risk NPSA
Risk Review	Review Frequency
	Next Review Date
	Review Date
	Reviewed By
	Details of Review
Supporting Documentation	Any Items of Supporting Documentation that have been added

Appendix 6

Risk Register Report Template

Title of Report e.g. Corporate Risk Register Report									Trust Logo	
No.	Division	Date Identified	Manager	Type of Risk	Description	Current Score	Overall Control Effectiveness	Mitigation Strategy	Target Score	Target Date
1234	A Division	DD/MM/YYYY	A Manager	Risk Type	A description of the Risk	25	Fully Effective Mostly Effective Partly Effective No Controls in Place	Eliminate Reduce Accept Tolerate	1	DD/MM/YYYY

Control Type	Details of Current Controls	Effectiveness of Control	Level of Assurance
A Control Type	Details of the Control	Fully Effective	Fully Assurance
A Control Type	Details of the Control	Mostly Effective	Significant Assurance
A Control Type	Details of the Control	Partly Effective	Limited Assurance
A Control Type	Details of the Control	No Controls in Place	No Assurance
Action Type	**Details of Mitigating Actions**	**Person Responsible**	**Target Date**
An Action Type	Details of the Action	A Manager	DD/MM/YYYY
An Action Type	Details of the Action	A Manager	DD/MM/YYYY

Details of Last Risk Review	
Last Review Date:	DD/MM/YYYY
Next Review Date:	DD/MM/YYYY
Reviewed By:	A Manager
Last Review Progress Update:	Details of the last review or progress update

N.B. The report format produced from Datix will include all of the above data fields but will have a slightly different structure, due to the technical parameters of the reporting function within Datix.

Appendix 7 – NPSA SCORING MATRIX

Table 1 Consequence scores (Impact or severity)
Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Other domains should be considered to determine if there are any other consequences which could influence the severity.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological l harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional l intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which	Major injury leading to long-term incapacity/disabil ity Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to avoidable death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved	Treatment or service has significantly y reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media Coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget (<£0.62M) Claim less than £10,000	Loss of 0.25–0.5 per cent of budget (£0.62-1.25M) Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget (£1.25-2.5M) Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget (£ 2.5m) Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interrupt on of >1 hour Minimal or	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/ interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

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

	Likelihood				
Likelihood	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15

2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Table 3 Risk scoring = consequence x likelihood (C x L)

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	Significant risk
15 - 25	High risk

Appendix 8 - DIVISIONAL MEASURABLE OBJECTIVES

Objective	Action
1. To ensure all staff are aware of the Trust Risk Management Strategy where appropriate.	The strategy will be introduced at the Corporate and local induction and reinforced at annual risk management training.
Process for Monitoring: Annual Audit	
Objective	**Action**
2. To ensure all staff are aware of the process for assessing all types of risk.	Ward/Departmental managers will ensure staff use the Trust standardised risk assessment form for the appropriate types of risk for completion of risk assessments for the following: • Health and Safety risk assessments • Environmental risk assessments • Infection control risk assessments • Moving and handling of objects risk assessments • Moving and handling of patients risk assessments • Physical security of premises and assets risk assessments • Slips, trips and falls for staff and others risk assessments • Violence and aggression risk assessments
Process for Monitoring: Annual Audit	
Objective	**Action**
3. Ensure staff are aware of the process for the management of risk locally. Ensure Ward/Departmental Managers manage and monitor risks by way of a Risk Register. Ensure staff manage and monitor risks by way of a Divisional Risk Register.	A Ward/Departmental Risk Register Folder will be developed by the Ward/Departmental Manager and Risk Assessments will be undertaken in accordance with the Trust Risk Management Strategy. Divisional Risk Register will be monitored at monthly Divisional Governance and Speciality Governance Meetings and any high risks at committees of the Board as per the Cycle of Business basis.

Process for Monitoring: Annual Audit	
Objective	**Action**
4. Ensure staff is aware of the process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation.	Demonstrate the escalation of risks from the Ward/Department to Divisional level and (Risks > 15) are escalated up to the Board via EMG and committees of the Board

Process for Monitoring: Annual Audit	
Objective	**Action**
5. Ensure those with a responsibility for risk; attend the Divisional Governance and other risk related meetings as defined in the Terms of Reference.	Record attendance of Committee Members and deputies in minutes. Ensure monitoring attendance sheets are maintained. Terms of Reference must define lines of communication.

Appendix 9

Lancashire Teaching Hospitals NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Governance			
Lead Assessor	David Pilsbury			
What is being assessed?	Risk Management Strategy – 2020/21			
Date of assessment	29.7.2020			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Governance and Interim Head of Corporate Affairs. Board of Directors and Executive Management Group			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		
Marriage and Civil Partnership	Neutral		

Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	The policy sets out a clear standardised process on the management of risk that aims to reduce any risk of inequality in the management of risk.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	√
6. The NHS is committed to providing best value for taxpayers' money.	√	6. To have a process for staff to raise an internal grievance.	√
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	√

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	√	3. Deliver value for money.	√
		4. Fit for the future.	√