Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number:	FOI202324//053
From:	Private Individual
Date:	02 May 2023
Subject:	Details of the Trust's risk management procedure

Q1 Your organization's current risk management policy (or nearest equivalent, e.g., risk evaluation, risk reduction, risk assessment Policy, etc.)

A1 See attachment - *Risk Management Policy*

Q2 The organization's current risk management procedures (or nearest equivalent, e.g., risk assessment procedures, risk evaluation procedures, risk control, etc.).

A2 This information is provided as part of the Risk management policy - as per A1

Q3 Risk Evaluation and Risk Control Guidance provided to employees (or any other related guidance that exists)

A3 This information is provided as part of the Risk management policy - as per A1

Q4 Any procedure or guidance or related document existing about how to decide if a risk needs to be reduced or not.

A4 This information is provided as part of the Risk management policy - as per A1

Q5 Any procedure or guidance or related document existing about how to evaluate if your organization is obliged by the regulations to reduce the identified risk to a lower level or not. In this case, if you use a specific tool like "cost-benefit analysis" or any other tools, it would be truly appreciated to provide those documents as well.

A5 This information is provided as part of the Risk management policy - as per A1

Q6 Any procedure, guidance, formula, guideline, instruction, direction, prescription, method, or process through which your organization decides if your organization is going to implement a measure to reduce risk, or, you will not implement more risk reduction measures; and in case of not implementing more risk reduction measure, how you justify that risks are reduced to a level As Low As Reasonably Practicable"

A6 This information is provided as part of the Risk management policy - as per A1

Risk Management

Policy

For completion by Author			
Author(s) Name and Title:	Karan Wheatcroft, Director of Risk and Improvement		
Scope:	Trust Wide	Classification:	Non Clinical
Version Number:	4.0	Review Date:	July 2025
Replaces:	Risk Management Policy v3		
To be read in conjunction with the following documents:	Board Assurance Framework BAF Policy Incident Reporting Policy Raising Concerns Policy Liverpool CCG for SUI Reporting Essential Standards for Quality and Safety Policy Terms of Reference for the Assurance Committees Terms of Reference for The Divisional Governance Committees		
Document for public display:	Yes		
Executive Lead	Karan Wheatcroft, Director of Risk and Improvement		

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Contents

Key Points for Staff

Risk is the effect of uncertainty on the delivery of objectives and refers to any variation on the expected or desired objective or outcome. For example, we have an objective to keep patients and staff safe at all times, risk is therefore anything that could stop us from keeping people safe whilst in our care. The primary purpose of risk management is to:

- Reduce harm for patients, staff, visitors or contractors;
- Promote the success of Liverpool Heart and Chest Hospitals NHS Foundation Trust
- Protect everything of value to the Trust (such as reputation, market share, exemplary clinical outcomes); and
- Continuously improve patient experience, safety and quality performance

When identifying risk we anticipate what could stop us from achieving our objectives or goals. To help identify areas of risk we look at our historical performance and trends, previous events, current challenges, and needs of people who use our services as well as thinking about future scenarios or potential outcomes that could help or hinder the delivery of our plan. We are all required to be open, honest, think ahead and take an active part in identifying risk.

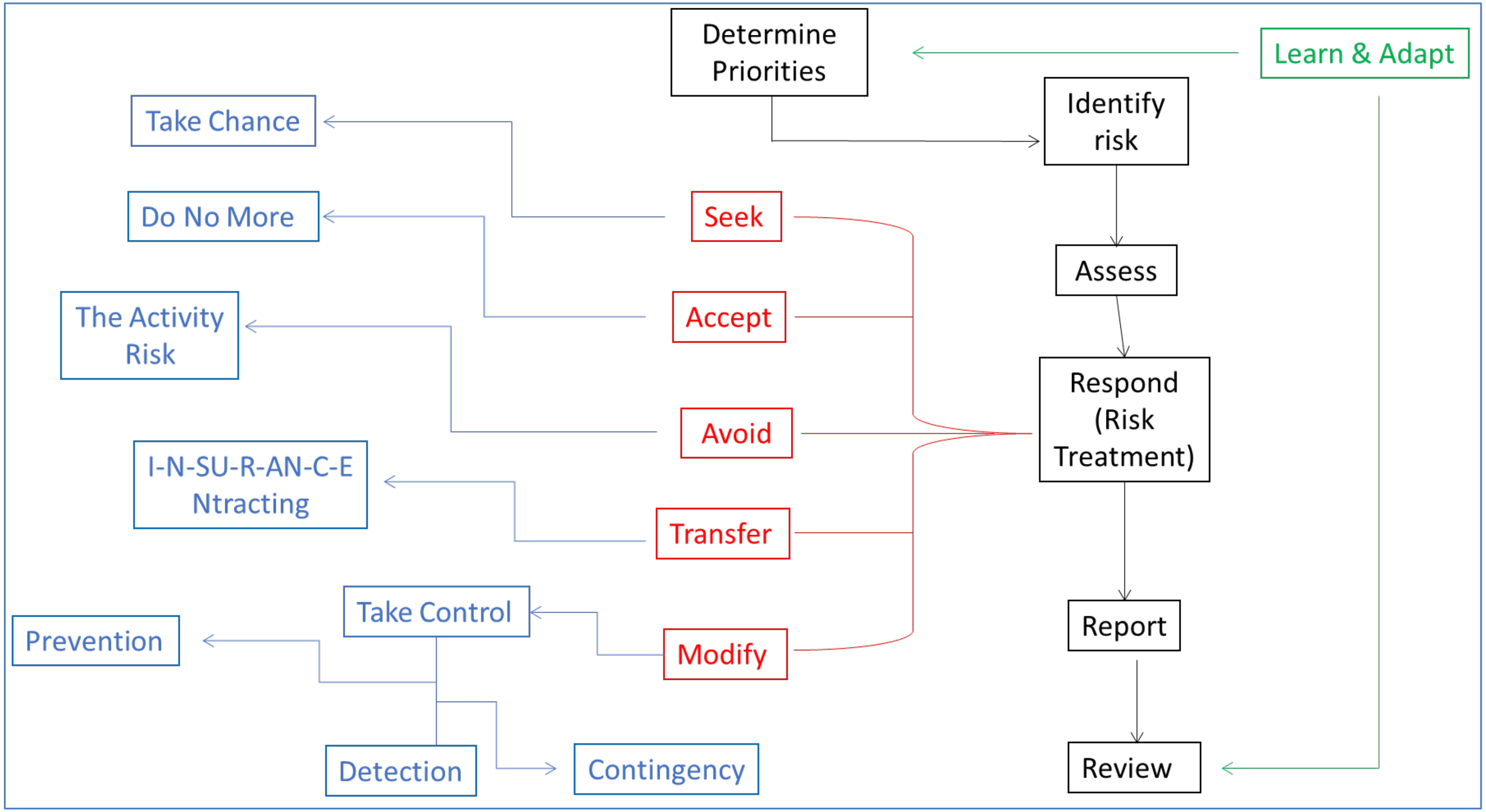
Risk analysis involves estimating the severity (the impact the risk has on the Trust, colleagues and people in our care) and likelihood (the probability or chances of the risk occurring). The scores are multiplied to give an overall risk rating. The risk rating is used to determine risk management priorities and monitor acceptable amounts of risk. Colleagues are required to challenge constructively any assumptions made regarding severity and likelihood, and to strive to ensure risk is kept within agreed tolerance.

Risk is treated proactively using a combination of prevention, detection and contingency controls. **Prevention / Treatment** controls help to stop risks becoming reality or worsening through ensuring activities are performed in a certain way. They are typically policies, clinical or operational procedures, guidelines, training or computer systems. **Detection** controls alert management to any deficiencies preventing risk and typically involves performance monitoring, audits, alarms or tests. **Contingency** controls are designed to allow the Trust to recover from a failure to manage risk and allow the Trust to continue to function albeit in a modified way. Colleagues are required to understand and implement all controls designed to manage risk at the Trust.

Organisational learning is reflected in the Trust's ability to continuously reduce the frequency of the same adverse event (near miss, incident, complaint or claim) occurring, and continuously improve performance. Controls are monitored and continuously improved as part of an open and learning culture.

Risk management is everyone's responsibility. This policy applies to all Trust employees, contractors or volunteers working at the Trust.

At a Glance: The Risk Management Process



1. Introduction

1.1 This document is the policy for the management of risk at Liverpool Heart and Chest Hospitals NHS Foundation Trust. Risk management is an integral component of the Trust's Corporate and Quality Governance Frameworks. By complying with the organisational arrangements described in this document, services will ensure the effective identification, assessment and control of risk thereby promoting and supporting the achievement of objectives.

1.2 The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Uncertainty of outcome helps to define risk. Risk management includes identifying and assessing risks, and responding to them in an effective and resilient manner.

1.3 At all times the Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

1.4 The Trust's governance framework shall be supported by an effective risk management system that delivers continuous improvements in safety and quality and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish. This supports the Trust's vision to "be the best".

2. Objective

2.1 The overall purpose of risk management at the Trust is to:

a) **Reduce the level of exposure to harm for patients, colleagues or visitors** by proactively identifying and managing personal risk to a level as low as reasonably practicable
b) **Promote success and protect everything of value** to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income
c) **Continuously learn and improve performance** by proactively adapting, remaining resilient to changing circumstances or events, and learning.

2.2 The Trust will establish an effective risk management system which ensures that:

- All risks that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust are proactively identified and managed well
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff
- Effective controls are put in place to manage risks, and treating (reducing) risks is understood by those expected to apply control
- All staff have a responsibility to comply with controls, whilst the operation of controls is monitored by management
- Gaps in control are identified and rectified by management are held to account for the effective operation of controls
- Assurances are reviewed regularly and acted on (frequency depending on severity of risk)
- Staff continuously learn and adapt to improve safety, quality and performance
- Risk management systems and processes are embedded locally across Divisional teams and in corporate services including business planning, service development, financial planning, project and

programme management and education

2.3 The Trust shall achieve this by:

- Developing and driving a clear strategy to meet the needs of the patients and the wider public
- Actively engaging openly with patients and the public, colleagues and stakeholders
- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process
- Regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations
- Providing training to keep risk under prudent control
- Investigating thoroughly, learning and acting on defects in care
- Liaising with enforcing authorities, regulators and assessors
- Effective oversight of risk management through team and committee structures
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings
- Effective reporting and arrangements to hold staff to account
- Defining the Trust appetite for risk which can then be used by staff to set targets to the management of risk

3. Scope of Policy

3.1 **Risk management is everyone's responsibility**. This Policy applies to all employees, contractors and volunteers. All employees are required to co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised under specific and generic responsibilities on pages 10-11.

3.2 Effective employee engagement is vital to our success and vision to provide care all of us would recommend to family and friends. Our values and behaviours set out "the way we do things around here" and these guide our work patients, colleagues and stakeholders. Our guiding values and behaviours are:

- **I**nclusion-We will create an environment where everyone is treated with dignity and respect and where the talents and skills of different groups are valued

Make a Difference-We will ensure what we do contributes to providing outstanding care to our patients

- **P**erson Centred - Value each person as an individual; our patients, their families, each other and our communities
- **A**ccountability - Every member of staff takes personal responsibility for the services they provide, taking **pride** in the work they do.
- **C**ontinuous Improvement - We will deliver the best care for our patients through continuously improving what we do and how we do it
- **T**eamwork - We work **Together** as one whole team to achieve our vision" **To be The Best"**

These values and behaviours are recognised by staff by the acronym "IMPACT".

3.3 By wholeheartedly embracing our values and behaviours in all risk management activity, this policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation.

4. Policy

The Risk Management Process

4.1 Step 1: Determine Priorities

Risk is defined as the effect of uncertainty on the objective[1]; or in other words it is anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful (for a summary of key terms used in this document see Appendix 1). The Board of Directors and Senior Management will be clear about objectives. These will be expressed in the form of an annual plan in specific, measurable, achievable ways with clear timescales for delivery. These are shared with staff and publicly available.

4.2 Step 2: Identify Risk

Evaluating what is stopping, or anticipating what could prevent, the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The identification of risk is an on-going process and is never static, but is particularly aligned to the annual planning process and compliance requirements. Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive. In order to do this the Board of Directors, senior leaders and divisional teams should identify what is uncertain; consider how it may be caused and what impact it may have on the objective and service.

4.3 Step 3: Assess Risk

Estimate the magnitude of a risk by multiplying the severity of impact by the likelihood of the risk occurring. Be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to risk scoring and grading is provided in appendices 2 and 3.

4.4 Step 4: Respond to the Risk

There are a number of different options for responding to a risk[1]. These options are referred to as risk treatment strategies. The main options most likely to be used include:

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk*. For example, the Board may approve the investment of significant time and resources to evaluate a new business opportunity when there is no certainty the opportunity may come to LHCH.
- **Accept** - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- **Avoid** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co- production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer arrangement*.
- **Modify** - this strategy involves specific controls designed to change the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:

There are three types of control used to modify risk and comprise of:

i) **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre- procedure checks etc.
ii) **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits
iii) **Recovery** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Recovery controls are designed to maintain resilience.

A combination of all 3 types of control is usually required to keep risk under prudent control

4.5 Step 5: Report Risk

All risks shall be recorded on the Trusts Risk Registers. Key outputs from the risk management system shall be reported to relevant staff/committees depending on the residual risk score as follows (**see appendix 4**):

≥15 – each formal meeting of the Board of Directors
≥12 – each meeting of the Operational Board
≥12 – Risk Management Committee as part of the Committee's annual work plan
≥8 – Specialty/Divisional /Departmental Governance meeting at twice per year
≤6 – Ward/Departmental Management at least annually

The **Board of Directors** shall receive summary reports at each formal meeting to inform the Board of all material risks(≥15).

The **Quality Committee**, **People Committee** and the **Integrated Performance Committee** are the assurance committees of the Board. Their oversight and assurance role in relation to risk management is set out in paragraph 4.7. Reports to these Committees support the discharge of these duties.

The **Operational Board** receive a formal regular update on risks scoring ≥12 from the Risk Management via the Corporate Risk Report.

The **Risk Management Committee** is a sub-committee of the Operational Board. It will receive reports to monitor the quality, completeness and utilization of risk registers, and also to oversee the distribution of risk across the Trust. Reports will cover the risk description, the residual risk (exposure after control), main controls, date of review and risk owner.

The Board of Directors Committee structure is shown in appendix 4.

Divisions and Corporate Functions will have access to DATIX (the Trust's incident management and alert system) and receive system generated specific reports in order to review the identification of risks within their wards, departments and specialties, and check that adequate controls are in place and actions are being implemented.

Additionally, they will also have access to ATHENA, which is the Trust's risk register database for maintaining a record of all risks threatening the achievement of objectives. All risk assessments must be entered onto this electronic system. In order to fit in with the monthly reporting cycle, the risk register should be reviewed monthly and updated accordingly. This should occur at least one week ahead of the meeting of the Operational Board to allow the latest risks and scores to be included in the Corporate and Divisional reports.

The Executive Team will be informed by the Director of Risk and Improvement of any new significant risk arising at the first meeting opportunity.

The Audit Committee will scrutinise assurances on the entire risk management system to ensure it remains fit for purpose and, at the Committee's discretion, will examine assurances on the operation of controls for all significant risk exposures or any other risk of interest to the Committee.

Urgent Escalation - in the event of a significant risk arising out with meetings of the above, the risk will be thoroughly assessed, reviewed by the relevant Associate Medical Director, Head of Nursing, Divisional Head of Operations and Executive Director and reported to the Chief Executive (or their deputy) within 24 hours of becoming aware of the risk. The Chief Executive Officer, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive Officer will assign responsibility to a relevant Executive Director for the management of the risk and the development of mitigation plans. Progress will be formally reviewed by the Executive Team at their next weekly meeting.

4.6 Step 6: Review Risk

Review risk at a frequency proportional to the residual risk. Discretion regarding the frequency of review is permitted. As a guideline it is suggested, as a minimum, risk is reviewed as follows (**appendix 4**):

≥15 – at least monthly
>12 – at least monthly
≥8 – at least quarterly
≤6 – annually.

Risk should be reviewed against the Board's expressed appetite for risk. If the residual risk exceeds the appetite threshold (appendix 6), additional or strengthened controls should be implemented.

4.6 The Committees of the Board

The totality of the Trust's risk governance infrastructure includes the oversight provided by Board committees in their risk-related roles. Committees of the Board of Directors play a vital role in effective risk management and shall apply the following principles to enable the Board to keep risk under prudent control at all times:

a) oversee and advise the Board on current risk exposures and future risks to the Trust's strategy;
b) oversee risk appetite and tolerance for those areas under the Committee's purview.
c) address risk and strategy simultaneously taking into account assurance on the operation of control, the current and prospective macro-economic, public policy and financial environment;
d) receive assurances against the risks within their remit
e) challenge the Trust's analysis and assessment of risk;
f) advise the Board on risk treatment and strategy;
g) oversee due diligence appraisal of any proposed strategic transactions involving acquisition, merger or disposal;
h) evaluate risk management capability;
i) examine risks associated with emerging regulatory, corporate governance and industry best practices; and
j) Consult experts to optimise risk treatment where necessary.

5. Roles and Responsibilities

In order to achieve the aims of the Risk Management Policy the following roles, accountabilities and responsibilities apply:

Specific Duties & Responsibilities

5.1 **Chief Executive Officer**, as Accounting Officer, has overall accountability to the Board of Directors for effective risk management. The Chief Executive Officer is responsible for ensuring priorities are determined and communicated, risk is identified and managed in accordance with the Board's appetite for taking risk.

5.2 **Director of Risk and Improvement** behalf of the Chief Executive Officer is the Board lead for risk management processes across the Trust. They shall, on behalf of the Board, implement and maintain an effective system of risk management. The Director of Risk and Improvement is responsible for: (i) risk management policy development; (ii) developing and communicating the Board's appetite for taking risk; (iii) establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these; and (iv) monitoring the management of risk across Divisions. In the event of unsatisfactory compliance with the risk management process or unacceptable risk exposure, the Director of Risk and Improvement shall escalate the matter to a relevant Executive Director for their immediate attention and action. They shall ensure the maintaining of effective arrangements for emergency planning and response; and business continuity. They shall ensure that the risk register is updated and maintained by the Risk Management Team and that timely and tailored risk reports (including integrated reports on complaints, claims and incidents) are generated for review as required by the Board, Assurance Committees, Operational Board and Executive Team. The **Director of Risk and Improvement** – is also the lead officer for the Board Assurance Framework (BAF) supported by the executive directors. The BAF is the tool that the Board uses to monitor the Trust's principal risks in relation to strategic objectives (see separate policy). The Director of Risk and Improvement is responsible for the co-ordination and the updating of the BAF, ensuring that the information is reported appropriately.

5.3 **Other Managers** must ensure that they apply the risk management process within the teams they are responsible for.

5.4 **All Employees**, **including Clinicians** must follow the risk management process, and accept ownership of risks allocated to them for control, and improvement.

5.5 **Head of Risk Management -** has day-to-day responsibility for risk management process, quality governance and safety management. They shall report to the Director of Risk and Improvementfor:

(i) the implementation of risk management policy;
(ii) administration of risk management systems;
(iii) oversight of risk exposures facing the business;
(iv) provision of risk management training and support to Divisions; and
(v) the maintenance of the corporate risk/safety management plan.

They shall be responsible for the maintenance and reporting of the Corporate Risk Register and carry out sufficient checks within and across Divisions to monitor the management of risk alongside the Board's appetite for taking risk. They shall be responsible for the effectiveness of the DATIX system, a governance system on which the Board depend, taking whatever action is necessary with colleagues, or the system Vendor, to ensure its effectiveness, validity, data quality and data completeness. The

Head of Risk Management shall take the lead in triangulating lessons for learning ensuring defective arrangements, alerts or changes in practice are conveyed to front line teams promptly and acted upon. They will also work closely with the Director of Nursing, Quality and Risk in terms of management and reporting of clinical risk.

6. Generic Duties and Responsibilities

Main Duties	Board of Directors	Executive Director	Divisional Head of Operations, AMDs, Clinical Leads, Heads of Nursing & Heads of Departments/Wards	Other Managers	All Employees
Strategy & Policy	• Determine the Trust's vision, mission and values • Set corporate strategy • Provide leadership	• Develop and oversee the implementation of strategic plans • Develop and communicate corporate objectives • Proactively anticipate risk • Provide leadership and guidance to employees, business partners and stakeholders	• Develop and Implement Clinical Strategy • Alignment of divisional objectives to Trust strategy	• Alignment of team/personal objectives to Trust strategy	• Deliver personal objectives • Abide by ***Trust values and behaviours***
Organise	• Establish an effective risk management system • Establish and keep under review the Board's appetite for taking risk • Focus on material risk and proactive anticipation of future risk	• Develop & apply Risk Management Process • Accept and allocate ownership for risk • Share ownership for cross-enterprise risk	• Apply Risk Management Process • Accept and allocate ownership for risk • Proactively anticipate risk • Provide leadership and guidance	• Apply Risk Management Process • Accept and allocate ownership for risk • Proactively anticipate risk • Provide leadership and guidance	• Follow Risk Management Process • Accept ownership for risk
Plan & Control	• Decide what opportunities, present or future, the Board wants to pursue and what risks it is willing to take in developing the opportunities selected Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks • Decide whether or not a risk can be accepted • Simultaneously drive the business forward whilst making	• Design, apply and monitor the operation of controls to ensure the achievement of objectives and promote organisational success • Ensure failure does not disable – contingencies are in place and tested for all reasonably foreseeable situations • Allocate structure and prioritise resources within and	• Design and apply controls to manage risk in line with the Board's appetite for taking risk • Prepare risk management mitigation plans • Ensure adequate emergency preparedness and contingencies for foreseeable disruptive events • Manage resources to optimum effect • Develop policies, guidelines, procedures and standards to	• Design and apply controls to manage risk in line with the Board's appetite for taking risk • Remain alert to risk • Manage resources to optimum effect • Develop and implement risk management plans	• Undertake and keep up to date with mandatory training and other relevant training • Follow policies, clinical standards and relevant procedures • Act on lessons for learning

	decisions which keep risk under prudent control	across divisions or Divisions so that risk is managed in accordance with the Board's risk appetite.	govern the management of risk locally		
Monitor	• Keep under review material risk exposures that are not accepted by the Board at each formal meeting	• Challenge, support, supervise and hold colleagues to account for performance and continuous improvement	• Monitor the operation of controls and address identified gaps in control	• Supervise the work of others to ensure controls are applied correctly	• Report concerns, defects, adverse events or failures to contain risk adequately.
Audit	• Determine Audit priorities using a risk-based approach • Take account of reports from the Audit Committee	• Determine Audit Priorities using a risk-based approach • Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues • Account for control of risk to the Audit Committee where required	• Assist Internal Audit when required and ensure recommendations are acted upon by relevant colleagues • Account for control of risk to the Audit Committee where required • Undertake appropriate inspection/checks of controls for safety critical procedures	• Cooperate fully and assist Internal Audit, • Challenge recommendations if they are not agreed • Develop and implement changes in practice within the timescales agreed • Report when concluded.	• Cooperate with Internal Audit and act on their findings • Carry out instructions based on agreed audit recommendations
Review	• Effectively hold those responsible for managing risk to account for performance and continuous improvement. • Take decisions	• Report to the Board all material risks and significant gaps in control	• Report to the Board all material risks and significant gaps in control • Escalate risk in accordance with this Policy • Ensure all risks are reviewed correctly		

7. Associated Documentation and References

- Moore P., A. (2013) *Countering the Biggest Risk Of All: attempting to govern uncertainty in healthcare management*. London. Good Governance Institute
- Chapman R., J. (2012) *Simple tools and techniques for enterprise risk management (2nd Edition)*. London. Wiley Finance
- Audit Commission (2009) *Taking it on Trust: a review of how boards of NHS Trusts get their assurance*. London. Audit Commission
- BSI (2008) *Risk Management - Code of Practice*. BS 31100:2008. London. British Standard International
- NPSA (2004) *Seven Steps to Patient Safety*. London. NPSA
- DH (2003) *Building the Assurance Framework: A Practical Guide for NHS Boards*. London. Department of Health
- DH (2000) *An Organisation with a Memory*. London. HSMO

8. Training and Resources

Risks may be identified proactively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

a) Risk Register

The Risk Register will be recorded via the ATHENA information reporting portal
(A template for the risk registers is shown as appendix 7. This provides an effective mechanism for recording details of each risk within a database so that risk records can be analysed to facilitate effective oversight of risk management at all levels.

b) Risk Management Training

This document recognises that training will be required to effectively manage risks in line with the process set out above. Details of all trust training programmes are set out in the Training Needs Analysis which can be found in the Mandatory Training Policy and associated documents.

i) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Medical Directors, Divisional Heads of Operations, Heads of Nursing, Clinical Leads) will receive training and/or briefings on the risk management process by the Head of Risk Management. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

ii) All staff have access to the Risk Management Policy through the Trust intranet.

Iii) Additional training is provided by the Head of Risk Management as required.

iv) General, Ward and Departmental Managers together with the Heads of Nursing will receive further more detailed risk management process training.

v) Staff designated to regularly undertake Root Cause Analysis will have the opportunity to undertake Root Cause Analysis training.

9. Monitoring and Audit

The following indicators shall form the Key Performance Indicators by which the effectiveness of the Risk Management Process shall be evaluated:-

- All verified significant (>=15) risks are reported to the Board of Directors at each formal meeting of the Board
- The risk profiles (for risks ≥12):
    - Risks reviewed by the Risk Management Committee, at a frequency determined by them, as part of a rolling programme of reviews
- Local risk registers are in place, maintained and available for inspection at
- ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and ≥95% of risks are within review date and none are overdue for review by 6 or more months.
- The no harm to harm incident ratio

Compliance with the above will be monitored by the Head of Risk Management, reviewed by Director of Risk and Improvement with an annual report from the Risk Management Committee provided to Operational Board

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

- Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting
- Evidence of review of significant risk exposure by the Risk Management Committee at each formal meeting of the committee
- Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and reviews)

10. Equality & Diversity

Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, Braille, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements

10.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

Appendices

Appendix 1: Glossary of Terms used within Policy

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	A document setting out material risk and assurances on the operation of controls to manage those risks	**Risk**	Effect of uncertainty on objectives
Control	An intervention used to manage risk	**Risk Acceptance**	Informed decision to take a particular risk
Exposure	Extent to which the organisation is subject to an event	**Risk Aggregation**	Process to combine individual risks to obtain more complete understanding of risk
Hazard	Anything that has potential for harm	**Risk Analysis**	Process to comprehend the nature of risk and to determine the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	**Risk Appetite**	Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate
Inherent Risk	Exposure arising from a specific risk before any intervention to manage it	**Risk Assessment**	Overall process of risk identification, risk analysis and risk evaluation
Level of Risk	Overall magnitude of a risk. It can be significant, high, moderate, low or very low	**Risk Avoidance**	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Material Risk	Most significant risks or those on which the Board or equivalent focuses	**Risk Management**	Coordinated activities to direct and control the organisation with regard to risk
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	**Risk Owner**	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Operational Risk	The risk of loss or gain, resulting from internal processes, people and systems or from external events	**Risk Register**	A record of information about identified risks.
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	**Target Risk**	A level of risk being planned for
Residual Risk	Current Risk. The risk remaining after risk treatment		

Appendix 2: Calculating Risk Scores

This section describes how to score risks by estimating the severity of impact should a risk occur and the likelihood of the risk occurring. An overall risk rating is derived by multiplying the impact and the likelihood scores together, which aids the prioritisation of risks.

The Trust uses a 5x 5 scoring matrix set out below:

IMPACT (CONSEQUENCES) INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	Almost Certain	5	No effective control; Consequence will undoubtedly happen / recur frequently, at least daily or > 50% of the time
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	Likely	4	Weak control; Consequence will probably happen / recur but not persistently, occurring perhaps weekly or 10% to 50% of the time
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Divisions; Service closure	Possible	3	Limited effective control; Consequence might happen or recur occasionally, occurring perhaps monthly or 1% to 10% of the time
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	Unlikely	2	Good control; Consequence not expected to happen but it is possible it may do so, occurring perhaps annually or 0.1% to 1% of the time
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	Rare	1	Very good control; Consequence will probably never happen / recur. If it did, there would be periods of years between them, occurring less than 0.1% of the time

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Impact or Consequences
Impact is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of impact looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood
Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represent a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate**.

Inherent, residual and target risk
In order to determine the effectiveness of the risk response three levels of risk score are used.

- **Inherent risk** refers to the status of the risk before controls are applied – this helps establish the baseline.

- **Residual risk** refers to the remaining risk as controls are applied. The residual risk score reflects the current status of the risk and should change over time to reflect progress in implementing the risk response.
- **Target risk** is amount of risk that is predicted to remain once the full risk response plan has been implemented – this is the forecast future state.

Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register**.

Appendix 3: Risk Grading

Risk grading applies to all risks; inherent, residual and target

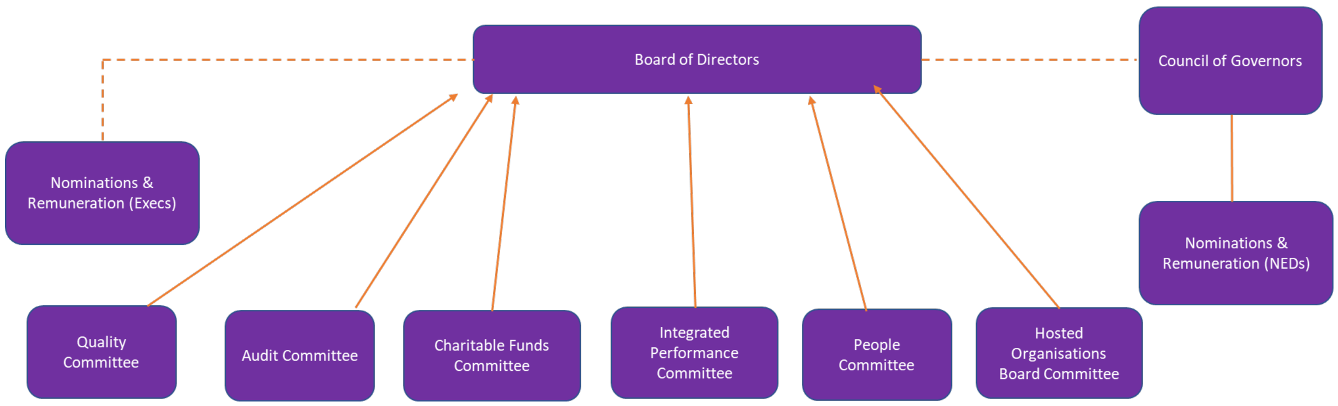
Score	Incident/Risk Grade (NPSA Cat.)	Level of Risk	Communicate to and Overseen by	Investigation Level (in the event of risk occurrence, i.e. an incident)
15-25	Catastrophic	SIGNIFICANT	Alert Director of Risk and Improvement or Manager Reported to Board of Directors	Executive Analysis – 28 days SI Procedures as needed RCA as needed – 45 days
10-14	Major	HIGH	Alert Divisional Management Team Reported to Risk Management Committee	Divisional Analysis– 28 days
8-9	Moderate	MEDIUM	Inform Divisional Manager Overseen at Divisional Level	Divisional Analysis– 28 days
4-6	Minor	LOW	Inform Ward/Departmental Manager Oversee at Ward/Departmental Level	Ward/Department Analysis – 10 Days
1-3	Negligible	VERY LOW	Ward/Departmental Management	Ward/Department Analysis – 10 Days

5x5 Matrix

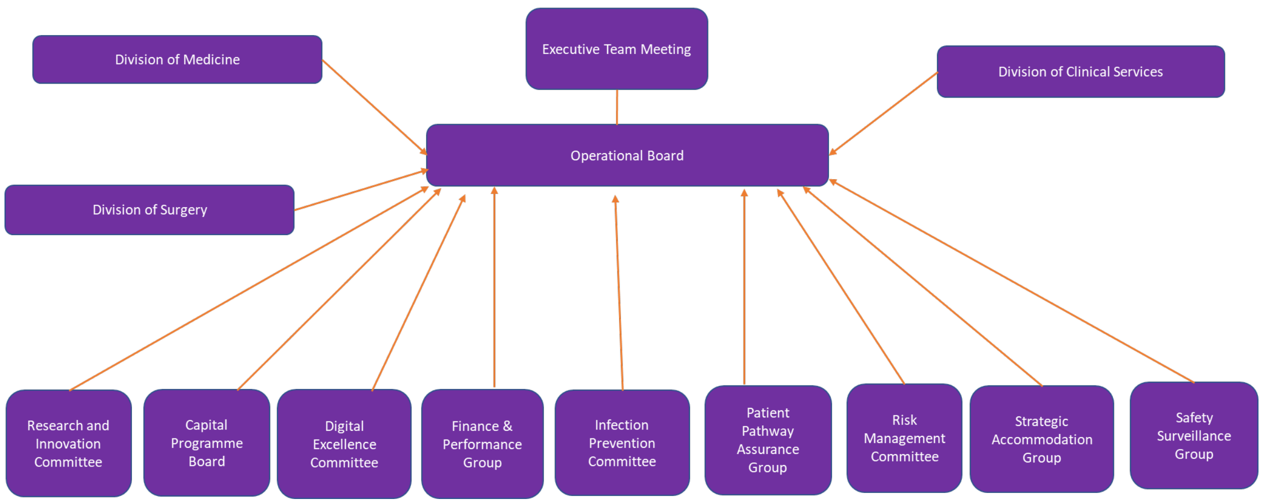
X	LIKELIHOOD					
IMPACT / CONSEQUENCE		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligable	1	2	3	4	5

Appendix 4: Board Committee Structure

Assurance Committee Organogram



Executive Committee Organogram



Appendix 5: Risk Appetite and Tolerance Levels

The Trust recognises that its long term success depends upon the delivery of its strategic objectives. To be successful, the Trust must take risks, but in a managed way and to a level which is deemed acceptable. The Risk Appetite levels are categorized as:

Appetite level	Averse	Minimalist	Cautious	Open	Seek
Description	Avoidance of risk and uncertainty	Preference for ultra-safe delivery options that have a low degree of inherent risk and only have potential for limited reward	Preference for safe delivery options that have a moderate degree of inherent risk and may have limited potential for reward	Willing to consider all potential delivery options and choose the ones most likely to result in successful delivery while also taking some risks whilst providing an acceptable level of reward	Eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk
Tolerance	**Max score 3**	**Max score 6**	**Max score 9**	**Max score 12**	**Max score 16**

The Board sets out its attitude to risk to in an annual statement.

Board of Directors approved Risk Appetite Statement

"The risk appetite set by the Board of Liverpool Heart and Chest Hospital NHS Foundation Trust is necessarily more open than in previous years. This reflects the unprecedented challenges that the NHS has, and is, experiencing, the healthcare reforms taking place at national and local levels, and fast paced societal and technological changes.

During this time of change and uncertainty we will continue to protect the Quality and Safety of Care and minimise risks that may have a detrimental effect on the Patient and Family Experience.

We have a cautious attitude to risk in relation to Operational Effectiveness, with a more open attitude to Finance as we look to develop new opportunities to ensure future sustainability and investment. We acknowledge that restoration of services continues to be challenging across our healthcare system. Our strategic plans are underpinned by improvement and additions to our estate and we accept that finding ways to invest in and managing such programmes carries higher levels of risk.

Transforming services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We have a risk seeking approach to our workforce challenges as we look at new and innovative ways to recruit, retain and support our people to adapt and thrive.

Investment decisions will reflect our ambitions to be at the forefront of innovation and maintain a leading position in the delivery of world class specialist services.

To achieve our aims of providing world class care and leading in the diagnosis and treatment of cardiovascular disease, we have a risk-seeking approach to Innovation and System Working. Clinical research and innovation are vital to our position as a world class specialist healthcare provider and we accept that such pursuits carry a higher level of inherent risk. We will seek the opportunities that healthcare reform may present; we have a keen desire to take a leading role in the collaborative arena and implement new ways of working through a range of partnerships.

Our open attitude to the digital agenda will underpin clinical innovation and the transformation of services to become more efficient and effective. While we are prepared to accept some level of risk to implement changes for longer term benefit, we will ensure that data protection is a priority."

Making this Real for Staff

The following table shows the risk appetite level for each risk domain with the associated risk tolerance limits. This represents the maximum risk tolerance for each type of risk and provides guidance for Managers to use in managing their risks. It provides an easy way of conveying to the operational front line what the Board's appetite is for risk, and will provide a focus for targeting the review of risks outside of tolerance by the Risk Management Committee.

Risk domain	Risk appetite level	Risk score upper tolerance limit
Quality, Patient & Family Experience	Minimalist	6
Operational Effectiveness	Cautious	9
Workforce	Seek	16
Finance	Open	12
Innovation	Seek	16
System Working	Seek	16
Digital	Open	12

Appendix 6: Risk Register Structure

The Trust's Risk Register will adopt the following structure

Field Name	Description
Risk ID	Unique Reference Number
Risk Location	Ward or Department or Function
Risk Description	What is uncertain (the risk), what is its potential cause and what is the impact on objectives (the consequences)
Key Objective Affected	Quality, Patient & Family Experience Service & Innovation Finance & Value for Money Workforce Stakeholder Relationships
Date Risk Identified	
Date Risk Reviewed	
Risk Owner	Must be Executive Director, Divisional GM, AMD, Assistant Director or Nursing or Head of Department
Consequence	Scored using 5 x 5 matrix
Likelihood	Scored using 5 x 5 matrix
Risk Score	Consequence x Likelihood
Key Controls	Will likely be multiple controls to manage a risk
Control Type	Prevent / Treat, Detect, Contingency
Target Risk Score	Derived from risk appetite
Further Mitigating Actions	What more needs to be done to get risk score to target?
Internal Assurances	What reports or other evidence generated from within the organisation do we have that tells us how we are delivering the objective the risk is threatening the delivery of?
External Assurances	What reports or other evidence generated from outside the organisation do we have that tells us how we are delivering the objective the risk is threatening the delivery of?

Appendix 7: Version Control

Version	Date	Comments	Author(s)
1.0	April 2015	Adoption of Paul Moore's policy adapted for LHCH	Mark Jackson, Chief Risk Officer Helen Martin, Risk Manager
1.2	April 2015	Addition of risk appetite and flowcharts to improve utility	Mark Jackson, Chief Risk Officer Helen Martin, Risk Manager
1.3	March 2017	Minor editorial changes. Update of Finance risk appetite. Completeness of risk registers.	Mark Jackson, Chief Risk Officer Helen Martin, Risk Manager
1.5	June 2018	Minor editorial changes. Implementation of recommendations from the MIAA risk register review.	Mark Jackson, Chief Risk Officer
1.6	December 2018	Update of risk appetite statement and matrices follow Board of Directors workshop.	Mark Jackson, Chief Risk Officer
3.0	March 2021	Strategic Risk Review in collaboration with Kirkby House Consultancy	Lucy Lavan, Director of Corporate Affairs Gilly Conway, Kirkby House Consultancy
4.0	May 2022	Update of roles and risk appetite statement	Helen Martin , Head of Risk Management Karan Wheatcroft, Director of Risk and Improvement

Review Process Prior to Ratification

Name of Group/Department/Committee	Date
Risk Management & Corporate Governance Committee	April 2017
Audit Committee	May 2017
Board	June 2017
Board (re-ratification as part of Governance Manual)	July 2018
Board (re-ratification following Risk Appetite Workshop)	January 2019
Board of Directors	March 2021

11. Endorsed By:		
Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

12. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason