Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI2021/493
From: Other

Date: 04 March 2022

Subject: Copies of Risk Management Documents

Q1 Please provide a copy of your organisations Risk Management Strategy

A1 Information not held – the Trust does not have a Risk Management Strategy, this is part of the Risk Management Policy.

Q2 Please provide a copy of your organisations Risk Management Policy if this is a separate document to the Strategy

A2 Please see attached – *Risk Management Policy*

Q3 Please provide your organisations Risk Appetite Statement

A3 Risk Appetite Statement is included at Appendix 5 in the Risk Management Policy, as per A2

Q4 Please provide your organisations approach to risk tolerance

A4 Approach to risk tolerance is included in the Risk Management Policy, as per A2

Q5 Please provide the minutes and any associated papers from the last meeting where your Board of Directors reviewed the Trust's risk appetite statement and setting the risk tolerance levels within the organisation

A5 Risk appetite was discussed in the Private Board meeting (30th March 2021) with the relevant extract rating to this agenda item provided below:

4.1 Strategic Risk Review – Progress and Update
The Director of Corporate Affairs updated the Board on progress with the strategic risk review following the Board workshop held on 3rd March 2021. The Board considered the final iteration of the Risk Appetite Statement derived from the Board risk survey and subsequent discussions, along with the 7 strategic risk themes that the Board had identified. The risk tolerance for each strategic theme was considered along with the 13 principal risks, assigned risk owners and inherent risk scores.

The Board supported each of these outputs and approved the proposed changes to the Risk Management and Board Assurance Framework Policies.

The Board noted the further work in train which would support the population of the 2021/22 Board Assurance Framework for Board approval in April.

Other work in progress included the review of the KPI dashboard for Audit Committee which was designed to provide assurance on the effective operation of risk management processes.

There was a plan in place to transfer responsibility for management of clinical and corporate risk to the Directors of Nursing and Corporate Affairs respectively from 1st April 2021. As a result, the Risk Management Committee's terms of reference would be reframed along with a review and tailoring of risk reports to meet the individual needs of the various forums. This work would be progressed throughout Quarter 1.

The Director of Corporate Affairs thanked Board colleagues for their input and engagement in this work which had enabled the review of strategic risk to be co-developed and completed at pace.

The extract of the paper relating to risk appetite and setting risk tolerance is attached – *LHCHFT Principal Risks 21/22*

Q6 Please provide a copy of your organisations latest Corporate Risk Register Report

A6 The High Risk Register is our Corporate Risk Register, which is reported to the private board. Please see attached – *High Risk Report.*

Some information from this report has been redacted. The requested information is held by the Trust however disclosure is being exempted under Section 38: Health and Safety, specifically S38(b) disclosure would or could be likely to endanger the safety of any individual.

We have assessed the public interest in disclosure and believe the only factor for release would be openness and transparency, outweighed by the factors against release. Release could cause harm to the mental health of patients or potential patients of the Trust and may have an adverse impact on public health because patients may delay or cancel their treatment with the Trust.

Q7 Please provide a copy of your organisations latest Board Assurance Framework

A7 The Board Assurance Framework is reported to the private board. Please see attached – *Board Assurance Framework Policy.*

Q8 Please provide a copy of your latest Risk Management Internal Audit report

A8 The latest risk management internal audit report was the Assurance Framework Opinion February 2022. Please see attached – *Assurance Framework Review*

Some information has been redacted under Section 40: Personal Data

Q9 Please confirm how your organisation records risk – do you use a system, if so which system e.g. in house, Ulysses, Datix, Radar etc, or do you use excel spreadsheets?

A9 We use a bespoke in-house system called Athena to record risk.

Q10 Please provide the risk management role structure within your organisation including the Banding of these roles

A10 Please see attached – *Risk Organisational Structure*

To: Karan Wheatcroft – Interim Chief Governance Officer

From: [redacted] – Senior Internal Audit Manager, MIAA

Date: 1ST February 2022

Re: Assurance Framework Review

1 Introduction and Background

An efficient and effective Assurance Framework (AF) is a fundamental component of good governance, providing a tool for the Board to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to organisational success.

This AF review is a key piece of evidence to support your annual governance statement (AGS), and the Board's conclusions on the effectiveness of their internal control systems.

2 Objectives & Scope

The overall objective was to assess the approach to which the organisation has maintained and uses the AF to support the overall assessment of governance, risk management and internal control.

The review consisted of the following sub-objectives:

- The structure of the AF meets the NHS requirements;
- There has been Board engagement in the review and use of the AF throughout the financial year; and,
- The quality of the content of the AF demonstrates clear connectivity with the Board agenda and external environment.

Limitation to Scope: The review focused on the elements described above and therefore did not include review/ confirmation of the controls or actual assurances received.

3 Objectives & Assurance Statement

Opinion

Structure	**The organisation's AF is structured to meet the NHS requirements.**
Engagement	**The AF is visibly used by the organisation.**
Quality & Alignment	**The AF clearly reflects the risks discussed by the Board.**

4 Detailed Assessment

4.1 Structure

Desktop review of the Assurance Framework (Date on AF provided: 27th July 2021 (Q1 Update), 30th November 2021(Q2 Update))

Requirement	Conclusion	Wider Commentary
4.1.1 The structure of the AF meets the NHS requirements in respect of defining objectives, risks, controls, assurances and gaps.	The structure of the AF does meet the NHS requirements. In particular, the Trust has updated the format of the AF for 2021/22 which includes a very clear layout showing the transition from inherent risk to target risk scores coupled with detailing controls and actions at the appropriate point in the layout.	• The organisation's AF includes consideration of risk appetite and target risk score evidenced on the July and November 2021/22 BAF. • The organisation's AF does provide updates of progress against actions. • The organisation's AF does use tables and graphs to provide visual overviews.
4.1.2 The objectives within the AF align with those in the strategic plan.	The strategic objectives within the AF do align with those in the 'About us' section on the Trust's external website.	
4.1.3 The AF includes risk scoring, i.e. initial, current and target risk scores.	The organisation's AF does include reference to the movement of risks under the 'Principal risks in relation to Strategic Objectives' section within the November 2021 BAF Summary Report.	
4.1.4 The format of the AF provides an action plan to address the gaps.	The AF includes actions to address gaps.	

4.2. Engagement

Review of Board minutes for April 2021 and July 2021 (Dates on meetings when the AF was presented: 27th July 2021 (Q1 Update), 30th November 2021(Q2 Update))

Requirement	Conclusion	Wider Commentary
4.2.1 The AF is regularly presented to the Board.	The AF was presented to the private Board meetings on a quarterly basis as per the 2021/22 Board of Directors Business Cycle.	Although the Private Board formally review the BAF completeness on a quarterly basis, the Public Board meeting Agenda does not include a standing Agenda item to formally consider 'Review of risk impacts of items discussed'. This is also the case for Board sub-committees as evidenced by our review of the People Committee Agenda for December 2021. Although no formal recommendation has been made, the Trust may wish to consider including such an agenda item on Board and sub-committee Agendas.
4.2.2 The minutes of the Board clearly demonstrate discussion, review and update of the AF.	The Private Board minutes clearly demonstrate discussion and update of the AF.	
4.2.3 The AF is regularly presented to the relevant committees of Board. **4.2.4 The minutes of Board Committees clearly demonstrate consideration of the AF and associated risks.**	The People Committee regularly see relevant extracts from the AF. During the financial year, processes have been developed to also include relevant extracts from the AF being presented to the Quality Committee and the Integrated Performance Committee. The Trust are currently formalising a plan to submit the remaining AF risks to the relevant forum. (see 4.4 Trust – Action Plan) Cover sheets on papers submitted to sub-committees show linkage to the BAF risks. Discussions highlighted that, on a quarterly basis, the Interim Chief Governance Officer meets with each Executive Director to update on progress against actions in the AF and the AF is tabled at a full meeting of the Executive Directors before submission to the Private Board meeting. In addition, all members of Committees of the Board are also members of the Trust Board so review the full AF quarterly at the Private Board meeting.	

4.3. Quality and Alignment

Review against Board minutes (Dates of the two Public Board meetings reviewed: 28th September 2021, 30th November 2021; Dates of AF Papers to Private Board meetings reviewed: 27th April 2021, 27th July 2021, 30th November 2021).

Requirement	Conclusion	Wider Commentary
4.3.1 The risks within the AF are visible on the Board agenda.	The risks within the AF were visible on the Board agenda through reference to relevant BAF risks on report cover sheets and by means of a column on the Board of Director Business Cycle 2021/22 to indicate agenda items relevant to the BAF.	The AF includes a wide range of risks reflective of the NHS and external environment with consideration of recovery from Covid-19 pressures. There is evidence of the Board connecting BAF risks to reports through the 'BAF Reference' and 'Impact on BAF' sections on the report cover sheets within the Trust Board meeting packs. Although the Business Cycle 2021/22 document includes a column to indicate which Agenda items relate to the BAF, there were relatively few Agenda items flagged in this column. (see 4.4 Trust – Action Plan)
4.3.2 The risks identified within the Board minutes are reflected in the AF.	Risks identified by the Board were reflected in the AF.	
4.3.3 Board assurances are clearly identified within the AF.	Assurances were clearly identified.	
4.3.4 Controls are clearly defined within the AF.	Controls were clearly defined.	
4.3.5 Gaps are clearly identified within the AF and actions detailed.	Gaps were clearly identified and mitigating actions were in place	

4.4. Trusts - Action Plan:

No	Recommendation	Management Response / Responsibility for Action / Date
1.	The process to roll out submission of BAF extracts to Board sub-committees and other forums should be completed as planned.	Agreed. Action by: Interim Chief Governance Officer Target date: end April 2022
2.	Ensure that a reference to the relevant BAF risk is fully completed on the Business Cycle document for 2022/23.	Agreed. Action by: Interim Chief Governance Officer Target date: end April 2022

Board Assurance Framework

Policy

For completion by Author			
Author(s) Name and Title:	Lucy Lavan, Director of Corporate Affairs		
Scope:	Trust Wide	Classification:	Non-Clinical
Version Number:	9.0	Review Date:	25 July 2022
Replaces:	Board Assurance Framework Policy 8.3		
To be read in conjunction with the following documents:	Board Assurance Framework and supporting document describing key controls and assurances NHSI Risk Assessment Framework Board Committee Structure Board of Directors-Annual Work Plan; Risk Management Policy Operational Plan and Strategic Objectives; Board Dashboard		
Document for public display:	Yes		
Executive Lead	Lucy Lavan, Director of Corporate Affairs		

For completion by Approving Committee			
Equality Impact Analysis Completed:		NA	
Endorsement Completed:	Yes	Record of Changes	Yes
Authorised by:	Board of Directors	Authorisation date:	27/07/2021

For Corporate Governance Manual documents			
CGM Reference	B2	CGM Review date:	29/07/2022
Authorised by:	Board of Directors	Authorisation date:	27/07/2021

For completion by Document Control					
Unique ID No:	NCP0I47	Issue Status:	Approved	Issue Date:	25/08/2021
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	IG and Document Control Facilitator				

Contents

Document Statement

The Board Assurance Framework (BAF) is determined by the Board of Directors. It is the means by which the Board holds itself to account and identifies the principal risks that would prevent achievement of the Trust's strategic goals; or threaten safe Board self- certification of the Corporate Governance Statement and other Provider Licence provisions. It also provides a structure for the evidence to support the Annual Governance Statement (AGS).

The BAF maps out the control systems in place to mitigate these risks and confirms the assurances (internal and external) that the Board wishes to receive directly to evidence the effective operation of these controls. Gaps in controls or assurances are noted along with actions required to close the gap / mitigate the risk and each principal risk is RAG rated according to likelihood and impact using a 5x5 risk scoring matrix. Movements in principal risk scores will be tracked throughout the year and reviewed in the context of the trust's appetite for risk.

An assessment of the likelihood and impact of each strategic risk will generate a RAG rating which the Board will assign to each BAF entry

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

1. Roles and Responsibilities

The following roles and responsibilities support the BAF but do not in any way dilute the accountability of individual directors.

1.1 Board of Directors

It is the responsibility of the Board of Directors to define the structure of the BAF to meet its assurance requirements and to populate the BAF such that it describes the system of internal control and the assurances it requires.

The Board must clearly define the role of its Assurance Committees as these operate on behalf of the Board with responsibility for the systems of internal control and integrity of data relating to quality and integrated performance. The Board defines the role of the Assurance Committees by determining the Terms of Reference and ensuring that adequate controls are in place to ensure that these are being discharged effectively. The Board will routinely receive the minutes and BAF Key Issues reports in addition to an annual report which will include an evaluation of the effectiveness of the Committee and a review of its terms of reference.

The Board will formally review and evaluate the BAF quarterly; the Board action log will be the key vehicle for tracking the actions that the Board identifies to close gaps in controls and assurances.
Executive Directors will ensure that reports and assurances brought to the Board are referenced to the BAF and provide clarity around risks to either the delivery of the Trust's strategic objectives or regulatory compliance.

1.2 Assurance Committees

The Quality Committee has responsibility to provide the Board with assurances in respect of quality governance.

The Integrated Performance Committee has responsibility to provide the Board with assurances in respect of the Trust's current and forecast performance and its operations in relation to compliance with the licence, regulatory requirements and statutory obligations.

The People Committee has responsibility to provide the Board with assurances in respect of workforce governance.

The Non-executive Committee Chairs (each supported by a designated Executive Lead) of each of the Assurance Committees are responsible for compiling a business cycle and annual work plan that meets the committee's terms of reference. They must ensure the effective operation of their Committee and produce an accurate record of each meeting, BAF key issues reports and an annual report for the Board of Directors. The effectiveness of the Assurance Committees will be reviewed annually by the Audit Committee.

1.3 Non-Executive Directors

The Non-Executive Directors (NEDs) are particularly responsible for constructively challenging the executive directors in decision making and on the Trust's strategy, but they are collectively accountable with the executive directors for the exercise of their powers and for the performance of the Trust.

The Assurance Committees are Non-executive Committees comprising three nominated NEDs, one of whom is the designated Chair and one the Deputy Chair. A named lead Executive Director will support the Chair of each Committee and be responsible for the timeliness and quality of documentation. The role of the NED is to provide effective scrutiny and challenge to the work of the Committee; to contribute to agenda setting and to the identification and reporting of BAF key issues to the Board; to identify and refer issues to the Audit Committee for more detailed review; to enrich their understanding of systems of internal control and data quality within their Committee's remit in order to bring constructive challenge and debate to Board and Audit Committee meetings.

1.4 Executive Directors

The executive directors are responsible in their executive role for managing the organisation, and as Board members, for the leadership and direction of the Trust.

Where executive directors are designated attendees of Assurance Committees, they have a responsibility to contribute actively to the work of the Committee as directed by the Committee Chair and will be held to account for the relevant aspects of the Committee's work. The designated lead Executive Director will ensure the production of good quality papers that are compliant with this policy (refer Appendix 2 for Guidance, Appendix 3 for reporting template) and support the effective escalation and reporting of assurances to the Board of Directors (Refer Appendix 1).

1.5 Executive Team

The Executive team has the following responsibilities**:**

- To advise the Board on strategy
- To develop the capability & capacity of the Trust with respect to delivery of the Trust's strategic objectives
- To deliver the Annual Operational and Strategic Plan
- To support the development & effectiveness of executive directors

The Chief Executive will chair meetings and be responsible to the Board for the effective running of the team. The accountability of individual directors to the Board is unaffected by their inclusion in the executive team.

The team will communicate its major decisions and deliberations through normal channels.

Minutes are not taken but an action log is maintained and monitored.

The executive team has no greater or lesser authority than that assigned to each team member as detailed in the Trust's Scheme of Reservation and Delegation.

1.6 Operational Board

The Operational Board has responsibility for the oversight of implementation of the Trust's operational strategies and objectives, providing assurance to the Board of Directors on execution of strategy and operational performance. The Divisional Governance Committees report to the Operational Board.

1.7 Divisional Governance Meetings

Divisional Governance Committees have defined responsibilities and authority levels assigned to them by the Operational Board in relation to all aspects of service delivery relating to the annual plan and ensuring compliance with relevant targets, CQC standards and management of risk in accordance with the Risk Management Strategy.

1.8 Audit Committee

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical, organisational and financial) and ensuring the provision of effective independent assurance via internal audit, external audit and legal / other professional advice from either internal or external sources.

The Audit Committee will report to the Board annually on its work in support of the Annual Governance Statement (AGS), specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embedding of risk management in the Trust and the integration of governance arrangements.

The Audit Committee's business cycle will incorporate a review of each Assurance Committee in order to test:

i) and the effectiveness of the ToR and work plan in meeting the requirements of the Board;
ii) the effectiveness of the Assurance Committee in discharging its responsibilities.

1.9 Council of Governors

The Council of Governors has a duty to hold the Non-executive Directors, individually and collectively to account for the performance of the Board of Directors and will independently review performance data and the work of the Audit committee on a quarterly basis. In holding the Board to account, the Council of Governors will represent the interests of members and of the public.

1.10 Chair

The Chair undertakes the dual role as Chair of the Board of Directors and Chair of the Council of Governors and must ensure that both bodies work together effectively and that each receives accurate, timely and clear information that is appropriate for their respective duties.

1.11 Director of Corporate Affairs

The Director of Corporate Affairs will maintain the BAF on behalf of the Board and will recommend amendments to the BAF in respect of any changes to the compliance regime or other factors.

The Director of Corporate Affairs will maintain the Board action log, ensuring that requests for further assurances arising at Board meetings are recorded and followed through.

2. Protocol

2.1 The Board of Directors will schedule time at the start of each financial year to review and update the structure and content of the BAF, ensuring that it is aligned to strategic goals and the latest compliance and regulatory requirements. Each principal risk will be aligned to the Trust's strategic objectives and / or to the requirements of the regulators and a lead executive director is assigned with responsibility for reducing any gaps in controls or assurances.

2.2 The Board of Directors will approve the BAF for the forthcoming year. The Trust's risk appetite is indicated on a thematic basis as determined from the risk appetite statement set by the Board of Directors (Refer Risk Management Policy). For each principal risk the Board will assign a risk score and associated priority rating and determine the actions required to close any control and assurance gaps in order to manage each risk to an acceptable level.
The risk ratings will be reviewed at least quarterly. The BAF will include an overview of the movement of risks, set against the Board's risk appetite, which will enable the Board to track its risk profile and to regularly test its appetite for risk.

2.3 The Board of Directors will review the level of assurance provided for controls included within the BAF. Assurance may be 'Acceptable' (green), 'Partial' (amber) or 'Low' (red) Where assurance is rated low an improvement plan should be in place to strengthen controls.

2.4 Board members will utilise the BAF throughout the year, in preparing for Board meetings and ensuring that assurances received are timely and robust.

2.5 The Director Corporate Affairs will maintain a Board Action log that will record any additional assurances required and any updates to be made to the BAF itself.

2.6 The Director Corporate Affairs will advise the Board of any changes that need to be made to the BAF in respect of new regulatory or compliance requirements. Executive Directors will advise the Board on any new or emerging risks and how these might impact upon the BAF.

2.7 The Director Corporate Affairs will work with the Chairman and Chief Executive to populate and maintain a Board business cycle and work plan for the year ahead – this will include receipt of all assurances described in the BAF and as required to evidence regulatory compliance.

2.8 The Director Corporate Affairs will prepare each Board agenda according to the plan, highlighting any variances to the Chairman.

2.9 The Executive Directors are responsible for the content, timeliness and accuracy of their respective Board reports and will ensure that these are referenced to the BAF and highlight any proposed changes to the risk assessment of each principal risk.

2.10 The Board of Directors will determine the Board Committee structure and set out the terms of reference of each assurance Committee and will review these annually to ensure consistency with any revisions to the BAF.

2.11 Committee Chairs, with Executive Leads will prepare a Committee work plan at the start of each year that meets the objectives of the committee and delivers the assurances required.

2.12 Committee Chairs, with Executive Leads, will be responsible for setting meeting agendas aligned to the work plan, for ensuring that meetings are properly recorded and for providing a BAF key issues report to the Board following each meeting. The BAF key issues report will follow the format determined by the Board (Appendix 1).

2.13 Following each Committee meeting, the most recent approved minutes and BAF key issues report will be presented to the next meeting of the Board of Directors. Where any new or emerging risk is raised, the Board will consider whether or not the BAF should be updated in respect of the risk rating or actions to strengthen controls or add to the assurance requirements.

2.14 The Committee Chair will maintain an oversight of the planning and reporting process and highlight any issues of concern to the Board or Audit Committee.

2.15 The Committee Chair will present to the Board an annual review of the effectiveness of the committee in terms of meeting its terms of reference.

2.16 The Audit Committee Chair will ensure Audit Committee review of the effectiveness of the Assurance Committees and seek assurance that the work plan and conduct of the Committee is meeting the terms of reference set by the Board.

3. Policy Implementation Plan

3.1 The Director Corporate Affairs will oversee the implementation of this policy.

3.2 Each Committee Chair, with Executive Leads will provide an induction to any new committee members or regular attendees outlining the requirements and expectations of their role on the Assurance Committee.

3.3 The Director Corporate Affairs will provide ongoing advice and support as required in relation to the running of the Committee and to report authors and attendees in respect of report writing and presenting of reports to Committees. This may be either by self-referral or referral by the Committee Chair or Executive Lead.

4. Monitoring Compliance

4.1 The Board of Directors will review the BAF quarterly and BAF policy at least as required, but at durations of no less than 3 years.

4.2 The Audit Committee will review any concerns as they arise and will undertake an annual review of the assurance process.

5. Appendices

Appendix 1 - Template for BAF Key Issues Report to Board of Directors

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors (in Public)
Item

Subject:
Date of Meeting:
Prepared by:
Presented by:
Meeting Held:
Purpose of Report:

Agenda Item	Lead Exec	Assurance Received	New/Emerging Risks	Actions/Comments

Appendix 2 – Guidance for Report to Board of Directors

Name of Board/Committee

Item

Subject:
Date of Meeting:
Prepared by:
Presented by:
Purpose of Report: For Approval / Decision / Note (delete as appropriate)

BAF Reference	Impact on BAF
Insert Risk Reference	*Proposed change to assigned risk rating in BAF – rationale for change to be explained in the paper and clear recommendation made to BoD / Committee in order that change to risk rating can be escalated to BoD and with reasons documented.*

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
☐	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary:
Purpose of the paper / what outcome (decision / action / assurance) is being sought? Brief overview of the problem / opportunity / issue in context of BAF – i.e. impact succinct summary of conclusion / recommendation on delivery strategic objective or regulatory compliance. Succinct summary of conclusion / recommendation.

2. Background:
Brief reference to any earlier work, published guidance and context of the report.

3.Main body of report – choose a header and sub-headings to best structure and describe the issues

Insert a paragraph on each key issue and how it relates to delivery strategic objectives or regulatory compliance – highlight any risks and or / extent to which assurance has been provided to close the gaps in controls and assurances. Consider any resourcing implications. Use appendices (referenced in the narrative) to add any supporting detail.

4. Conclusion:
What is the conclusion of the data / information presented? I.e. impact on delivery strategic objective or regulatory compliance. Should the BAF risk rating / gaps in controls or assurances be changed in light of this?

5. Recommendations:
What action is to be taken?
What is the Board / Committee being asked to do?
How will the information / assurance presented impact on the BAF? – note any recommendations for updating BAF re gaps in controls / assurances (or closure) or BAF risk rating.

Note:
Do not use names or identify individual patients or employees. Do not include information that is **Commercially sensitive.**

Your paper will be in the public domain unless there is a clear reason for the Board to consider the item in private.

Appendix 3 – Template for Report to Board of Directors

Name of Board/Committee (In Public/Private)
Item

Subject:
Date of Meeting:
Prepared by:
Presented by:
Purpose of Report: **For Approval / Decision / Note (delete as appropriate)**

BAF Reference	Impact on BAF

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
☐	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. **Executive Summary**

2. **Background**

3. ***Main Body of Report***

4. **Conclusion**

5. **Recommendations**

6. Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Lucy Lavan	Director of Corporate Affairs	March 2021

7. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason
Appendices	9.0	March 2021	Updated templates contained within appendices	N/A	N/A	Strategic Review in collaboration with Kirkby House Consultancy

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors (in Private)

Item 4.6

Subject: High Risk Report
Date of meeting: Tuesday 29th March 2022
Prepared by: Helen Martin, Risk and Safety Lead
Presented by: Karan Wheatcroft, Interim Chief Governance Officer
Purpose of report: To Note

BAF Reference	Impact on BAF
All	The report includes high level risks which continue to be considered in respect of any implications for the BAF.

Level of assurance (please tick one) *To be used when the content of the report provides evidence of assurance*					
☑	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

The Corporate Risk Register contains significant risks identified as having potential impact on the trust corporate objectives, including risks identified and escalated by Divisions. Risks are reviewed monthly at each Divisional Governance meeting and quarterly by the Risk Management Committee.

This report provides an update of risks with residual scores of 15 or higher along with the action plans in place to control and/or mitigate them. These relate to:

- Statutory waiting times (Risk score: 20)
- Lost to follow up (Risk score: 16)
- 5 year capital plan (Risk score: 16)

There is also an escalating risk to bring to the attention of the Board regarding the availability of theatre stock (current residual risk score of 12). Mitigations and action plans are in place, and these are being closely monitored.

2. Key Issues

For the benefit of this report, risks that are of similar nature have been pooled together under the same narrative, resulting in a total of **3 risks with a score of 15.**

For risks with a residual score of 15 or higher there are:

- 2 risks with static score of >15
- 1 new risk with a score that has increased to >15

Appendix 1 includes the details of each risk: date of identification, original score, mitigations and controls, residual score and date of review, and target score. It is accurate as of the updated date above, with any changes made after this date reflected in subsequent reports.

3. Recommendation

The Board are asked to note the content of this report and be assured the Trust has systems and processes in place for the identification, management and escalation of risks.

Appendix 1 – Risks > 15

Risk ID	Risk Owner	Date	Original Score	Review Date	Residual Score	Target Score
C10538	Chief Operating Officer	Sep 2020	[redacted]	Feb 2022	[redacted]	6
[redacted]						
C11629	Chief Finance Officer	Apr 2021	[redacted]	March 2022	[redacted]	12
[redacted]						
C11636	Chief Operating Officer	Apr 2021	[redacted]	Feb 2022	[redacted]	6
[redacted]						

KEY: ⇔ Static score ⇧ Increasing score ⇩ Decreasing score NEW risk

KIRKBY HOUSE
Consultancy Services

Principal Risks 2021/22

Liverpool Heart and Chest Hospital NHS FT

March 2021

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 more open attitude to risk in relation to Operational Effectiveness, our Workforce and Finance.

We acknowledge that restoration of services may be challenging as capacity continues to be prioritised across out healthcare system and as we adapt our models of working to the 'new normal'. Our strategic plans are underpinned by improvement and additions to our estate and we accept that investing 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 will support our people to adapt and thrive during change.

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, System Working and Digital.

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.

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

Risk appetite by risk theme

Quality & Patient Experience	Operational Effectiveness	Workforce	Finance	Innovation	System Working	Digital
Risk appetite: <u>Minimalist</u> Upper tolerance limit 6	**Risk appetite: <u>Open</u> Upper tolerance limit 12**	**Risk appetite: <u>Open</u> Upper tolerance limit 12**	**Risk appetite: <u>Open</u> Upper tolerance limit 12**	**Risk appetite: <u>Seek</u> Upper tolerance limit 16**	**Risk appetite: <u>Seek</u> Upper tolerance limit 16**	**Risk appetite: <u>Seek</u> Upper tolerance limit 16**
During this time of change and uncertainty we will continue to protect the quality and safety of care and minimise risks that would affect the patient and family experience.	We acknowledge that restoration of services may be challenging as capacity continues to be prioritised across out healthcare system and we adapt our models of working to the 'new normal'. Our strategic plans are underpinned by improvement and additions to our estate and we accept that investing 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 will support our people to adapt and thrive during change.	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.	Clinical research and innovation is vital to our position as a world class specialist healthcare provider and we accept that such pursuits carry a higher level of inherent risk.	Healthcare systems are subject to reform at national and local levels and 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.	The digital agenda will underpin clinical innovation and the transformation of services to become more efficient and effective. While we are prepared to accept higher levels of risk to implement changes for longer term benefit, we will ensure that data protection is a priority.

Risk Management

Policy

For completion by Author				
Author(s) Name and Title:	Lucy Lavan, Director of Corporate Affairs			
Scope:	Trust Wide	Classification:	Non Clinical	
Version Number:	3.0	Review Date:	01/07/2022	
Replaces:	Risk Management Policy 2.1			
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	Lucy Lavan, Director of Corporate Affairs			

For completion by Approving Committee				
Equality Impact Analysis Completed:			NA	
Endorsement Completed:		NA	Record of Changes	
Authorised by:	Board of Directors		Authorisation date:	30/03/2021

For completion by Document Control					
Unique ID No:	TT02(08)	Issue Status:	Approved	Issue Date:	09/04/2021
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	IG and Document Control Facilitator				

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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.

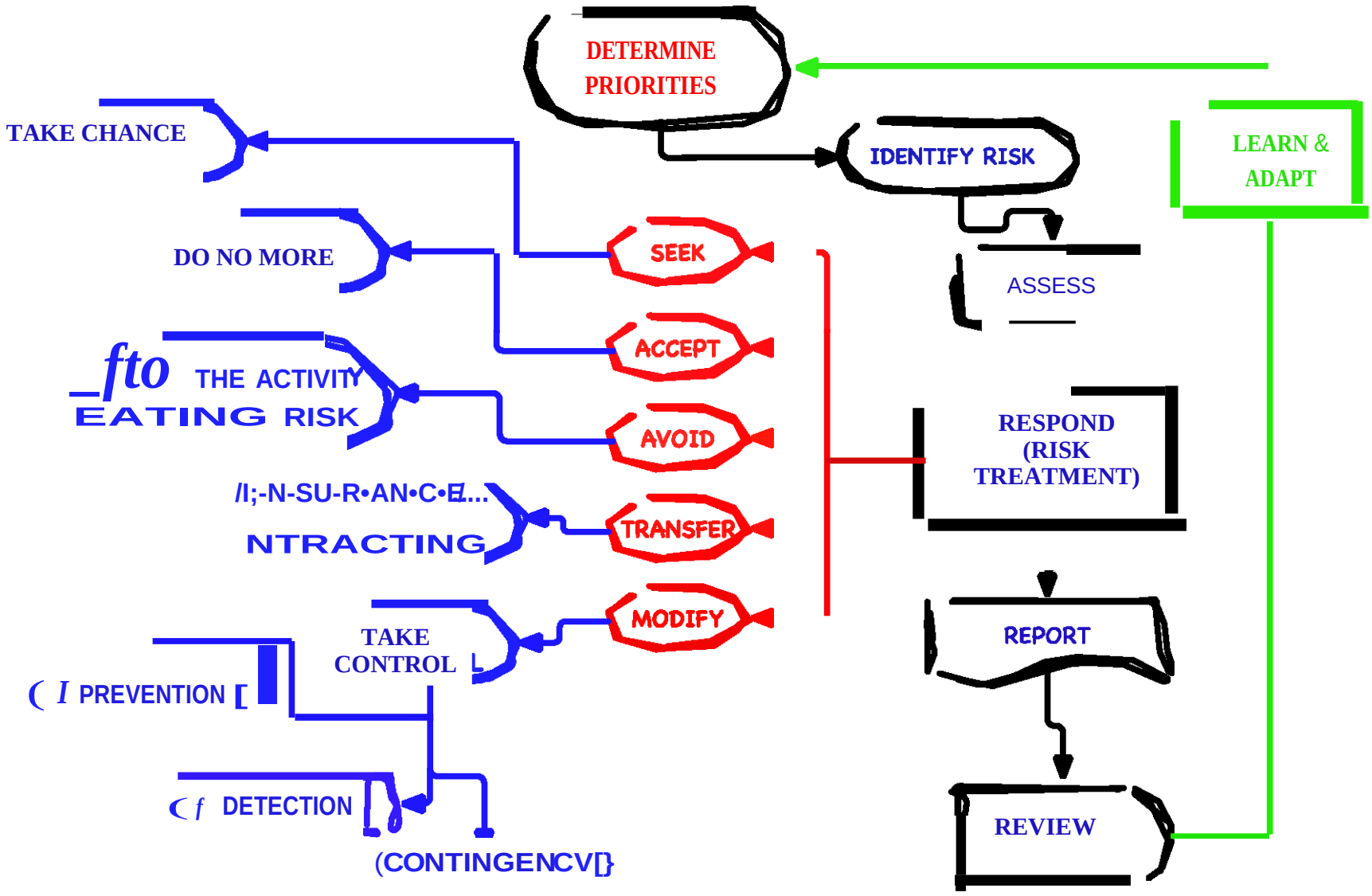
Risk analysis involves estimating the severity (the impact the risk has on the Trust and people in our care) and likelihood (the probability or chances of the risk occurring). The scores are multiplied to give an overall risk rating. The risk rating is used to determine risk management priorities and 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 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
- 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:

- **P**atient & Family Centred - **Excellent**, **Compassionate** and **Safe** care for every patient, every day
- **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 our services and are passionate about **research** and **education**
- **T**eamwork - We work **Together** as one whole team to support our Hospital in being **The Best**

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

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 each year through the Executive Road shows.

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) **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency 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
≥10 – Risk Management Committee as part of the Committee's annual work plan
≥8 – Specialty/Divisional /Departmental Governance meeting at least quarterly
≤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. The top scoring risks (≥15) shall be set out within the Chief Executive's report.

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 **Operations Board** receive a formal regular update on risks scoring ≥12 from the Risk Management via the Corporate Risk Register.

The **Risk Management Committee** is a sub-committee of the Operations 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 Corporate Affairs 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, 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, 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 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
≥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.

4.7 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) challenge the Trust's analysis and assessment of risk;
e) advise the Board on risk treatment and strategy;
f) oversee due diligence appraisal of any proposed strategic transactions involving acquisition, merger or disposal;
g) evaluate risk management capability;
h) examine risks associated with emerging regulatory, corporate governance and industry best practices; and
i) 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**, as Accounting Officer, has overall accountability to the Board of Directors for effective risk management. The Chief Executive 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 Corporate Affairs** on behalf of the Chief Executive 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 Chief Risk Officer 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 Chief Risk Officer shall escalate the matter to a relevant Executive Director for their immediate attention and action.

5.3 **Director of Nursing, Quality & Safety** on behalf of the Chief Executive shall monitor and report upon clinical risks and lead the risk management team in the monitoring and reporting of all incidents, complaints and claims; maintaining 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.

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

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

5.6 **Risk Manager** - has day-to-day responsibility for risk management process, quality governance and safety management. They shall report to the Director of Nursing, Quality and Safety for:

(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 Risk Manager 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.

5.7 **Director of Corporate Affairs** – is 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 Corporate Affairs is responsible for the co-ordination and the updating of the BAF, ensuring that the information is reported appropriately.

6. Generic Duties and Responsibilities

Main Duties	Board of Directors	Executive Director	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 decisions which keep risk under prudent control	• 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 across divisions or Divisions so that risk is managed in accordance with the Board's risk appetite.	• 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 govern the management of risk locally	• 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
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	• Determine Audit	• Assist Internal Audit wher	• Cooperate fully	• Cooperate with

	priorities using a risk-based approach • Take account of reports from the Audit Committee	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	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	and assist Internal Audit, • Challenge recommendations if they are not agreed • Develop and implement changes in practice within the timescales agreed • Report when concluded.	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 (http://lhch- dw01/ReportServer/Pages/ReportViewer.aspx?%2fATHENA+REPORTING+SUITE%2fATHENA+MAIN+MENU&rs:Command=Render). 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 Risk Manager. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

ii) All staff shall receive an introduction to the Risk Management Process briefing as part of the Corporate Induction programme.

Iii) Additional training will be provided through an e-learning programme which will be made available during 2015/16.

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 ≥10):
    - 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 Risk Manager, reviewed by Director of Corporate Affairs 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.

11. 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

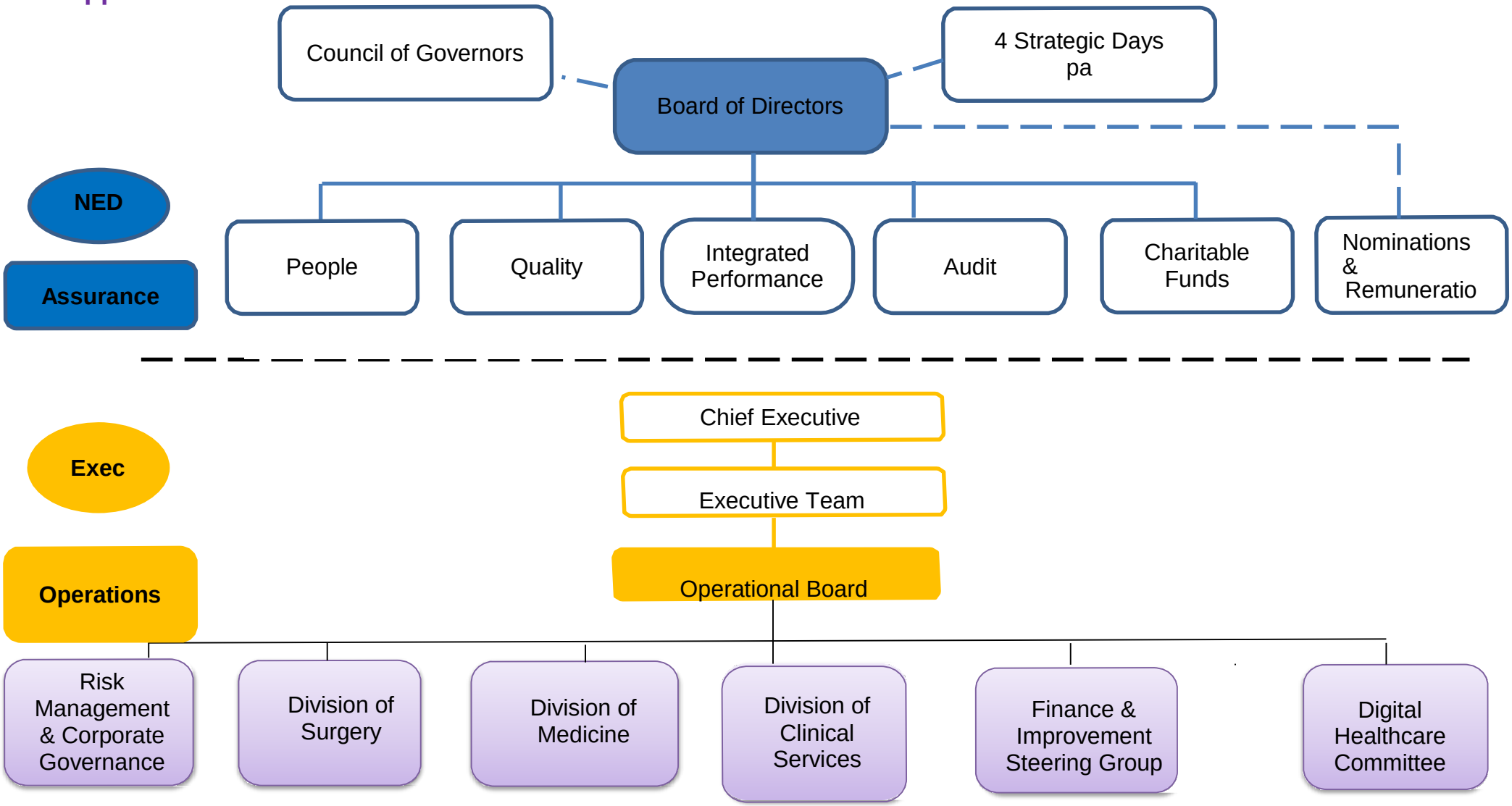
Score	Incident/Risk Grade (NPSA Cat.)	Level of Risk	Communicate to and Overseen by	Investigation Level (in the event of risk occurrence, i.e. an incident)
15-25	Catastrophic	SIGNIFICANT	Alert Director of Corporate Affairs or Manager Reported to Board of Directors	Executive Analysis – 28 days SI Procedures as needed RCA as needed – 45 days
10-14	Major	HIGH	Alert Divisional Management Team Reported to Risk Management & Corporate Governance 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

Board Committee Structure 2020

Appendix 4: Board Committee Structure



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

Board of Directors approved Risk Appetite Statement 2021/22

"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 more open attitude to risk in relation to Operational Effectiveness, our Workforce and Finance. We acknowledge that restoration of services may be challenging as capacity continues to be prioritised across out healthcare system and as we adapt our models of working to the 'new normal'. Our strategic plans are underpinned by improvement and additions to our estate and we accept that investing 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 will support our people to adapt and thrive during change.

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, System Working and Digital. 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. The digital agenda will underpin clinical innovation and the transformation of services to become more efficient and effective. While we are prepared to accept higher levels 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 & Corporate Governance Committee

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

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

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

12. Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

13. Record of Changes

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

Risk Organisational Structure – Aug 21