

## Risk Management Policy

Applicable to (please mark with an X)					
Group-wide	x	LUHFT-wide		Liverpool Women's	
Aintree Hospital		Broadgreen Hospital		Royal Liverpool Hospital	
			LCL		

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<b>Department/Division:</b>	Governance
<b>Version:</b>	1
<b>Approving Committee or Group:</b>	Board of Directors
<b>Date Approved:</b>	May 2025
<b>Date for Review:</b>	May 2028 (This document will be reviewed every 3 years or as and when changes or legislation which affects the document are introduced)
<b>Target Audience:</b>	All staff, including contractors and agency staff
<b>Key Words/Tags:</b>	Appetite Tolerance BAF Register
<b>Consulted with:</b>	Governance teams across both trusts and all hospitals Corporate Governance Hospital Leadership Teams Transformation Delivery Unit Pharmacy
<b>Associated Documents:</b>	Risk Management Strategy Risk Management Guidance Documents
<b>Access to Information:</b>	To access this document in another language or format please email <a href="mailto:ITS@liverpoolft.nhs.uk">ITS@liverpoolft.nhs.uk</a>

### What is new in this version?

Latest Version	Page	Changes Made	Date
1	All	New Group-wide Policy utilising best practice nationally and from previous Liverpool Women's Hospital and University Hospitals Liverpool policies	May-2025

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## 1.0 Introduction, Purpose and Risk Management Statement

### 1.1 Introduction and purpose

Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Liverpool Women's Hospital NHS Foundation Trust (LWH) have come together to form NHS University Hospitals of Liverpool Group (UHLG). Coming together under a group model has been a natural progression for the individual Trusts that make up the Group. It enables us to build upon existing leadership arrangements and operate as a stronger organisation with greater oversight of risks and issues, whilst maximising opportunities to manage our resources, retain talent and attract research income.

The Group's Risk Management Policy sets out the corporate framework and processes required for successful delivery of the Board's risk management statement. The Policy will be supported by a Group Risk Management Strategy and is underpinned by risk management processes that set out the specific activities required to implement the policy and evolve each Trusts' risk management systems, processes, culture and competencies.

This document provides the framework for all staff to understand their responsibilities and, alongside the more detailed processes, the specific methodology that should be followed to ensure a consistent approach to risk management across the Group. The guidance and the methodology are built upon the values of each Trust.

This document describes the context of the organisation which can be characterised as complex and evolving. The Group Risk Management Strategy sets out in greater detail the strategic direction, which is driven by a need to transform healthcare provision locally and nationally to provide a high-quality care, sustainable, patient-focused service, underpinned by seamless care pathways across the health economy.

### 1.2 Risk management statement

The Group's Risk Management Strategy sets out the context in which we operate, why it is important for us to manage our risks and the benefits of doing this. The Group believes that effective risk management will enhance our strategic planning and prioritisation, assist in achieving objectives and strengthen our ability to be agile to respond to the challenges faced. This will also provide greater public accountability in the way we deliver the healthcare services required by our local population.

The Group recognises that healthcare organisations cannot be risk averse and be successful. Risk is inherent in everything we do to deliver high-quality services. This policy therefore encourages appropriate risk taking. Effective and meaningful risk management in healthcare remains as important as ever in taking a balanced view to managing opportunity and risk. It must be an integral part of informed decision-making; from inception through implementation to the delivery of services.

At its most effective, risk management is about evaluating the uncertainties and implications within options as well as managing impacts once choices are made. It is about being realistic in the assessment of any risk to the Group's objectives and in the consideration of the effectiveness of the actions taken to manage these risks.

As with all aspects of good governance, the effectiveness of risk management depends on the individuals responsible for operating the systems put in place. The Group is therefore committed to working in partnership with staff to make risk management a core organisational process, and to ensure that it becomes an integral part of the Group's philosophy and activities. Our risk culture will embrace openness, support transparency, welcome constructive challenge and promote collaboration, consultation and co-operation. We will invite scrutiny and embrace expertise to inform decision-making. We will also invest in the necessary capabilities and seek to continually learn from experience.

## 2.0 Scope

This policy sets out the direction for the components of the risk management framework that supports and sustains risk management throughout the Group.

The Board of Directors has overall responsibility for the governance of risk management in the Group, with identified committees and groups having delegated responsibilities. Each of the Hospital Leadership Teams has responsibility for embedding the process within their site.

The Corporate Governance function supports the Board in achieving its objectives to provide proactive leadership within a framework of prudent and effective controls. The Quality Governance function is responsible for implementing the policy at an operational level, ensuring policies and Standard Operating Procedures are in place to enable the wider organisation to manage operational risk effectively.

All members of staff are responsible for making sure that risks associated with the activities and assets they are responsible for, are identified, assessed and managed, in accordance with the Group's risk management systems and processes.

This policy applies to the management of all risks within the Group's associated services, operations and business. This includes aspects of the Group's work that sit outside of a "business as usual" environment, such as projects and programmes, change management, research and innovation.

## 3.0 Key Principles

### 3.1 Good governance

Governance is the system by which an organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity and openness. Risk Management is a component of good governance. Risk management shall be an essential part of governance and leadership, and fundamental to how the Group is directed, managed and controlled at all levels.

The Group has adopted an integrated governance approach, which ensures that the Board and its Committees have appropriate visibility of all aspects of governance, including safety, effectiveness, performance and finance. Integrated governance is defined as: -

*“The systems, process and behaviours by which we lead, direct and control our functions in order to achieve our organisational objectives and the safety, quality and values for money of services as they relate to patients and carers, the wider community and partner organisations”*

The Group is required to demonstrate that it is doing “it’s reasonable best to manage risk”. In practice this means having systems and processes in place to identify, assess, evaluate and assign responsibilities to manage risk within the Group. Oversight of risk is incorporated into the Group’s assurance and escalation processes and structures.

### **3.2 Group objectives**

The assessment and management of opportunity and risk will be an embedded part of, and not separate from:

- setting strategy and plans
- evaluating options and delivering programmes or projects
- prioritising resources
- supporting safe, efficient and effective operations
- managing performance
- delivering improved outcomes

The Board and senior managers will use horizon scanning and scenario planning collectively and collaboratively to identify and consider the nature of emerging risks, threats and trends that have the potential to impact on delivery of the Group objectives.

### **3.3 Risk appetite**

The Board will determine and assess the nature and extent of the principal risks that the organisation is willing to take to achieve its objectives – its “risk appetite” – and ensure that planning and decision-making appropriately reflect this assessment. This will take place as part of the process of setting the strategic direction for the organisation at least annually.

The Group recognises that it is impossible and not always appropriate to eliminate all risks. Systems of control must be balanced in order that innovation and the use of limited resources are supported when applied to healthcare. The Group may be willing to accept a certain level of risk when the cost of treating the risk is disproportionately high in comparison to potential impact and the likelihood of it occurring.

### **3.4 Risk tolerance**

Risk tolerance represents the practical application of risk appetite and is utilised by the Group to consider the levels that are considered acceptable to achieve specific objectives or gain identified benefits. The Group’s risk tolerance is the specific maximum risk that the organisation is willing to take regarding each relevant risk. To reduce its exposure to unacceptable risk the Group will consider risk in a controlled manner.

### **3.5 Key risk indicators**

The Group sees the integration of performance indicators within the risk framework as an essential element in effective risk management. The use of data analysis routinely will make risks and their mitigation visible.

Key Risk Indicators (KRIs) will be used to assist in defining risks. The following are examples: -

- Sickness absence levels
- Staff survey results
- Clinical audit outcomes
- Information governance incidents
- Referral to Treatment (RTT) performance
- A&E performance
- Financial forecast
- Internal audit findings
- Patient safety incidents
- Business continuity events

### 3.6 Controls

Controls are a dynamic and iterative framework of processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risk. Controls permeate and are inherent in the way the organisation operates and are affected by cultural and behavioural factors.

Where additional action is required to bring the levels of risk within the nature and extent that the Group is willing to take to achieve its objectives, managers should select, develop and implement options for addressing risk through preventive, directive, detective, and/or corrective controls that manage risks to an acceptable level. These might be manual or automated. This involves an iterative process of:

- planning and implementing controls
- assessing the effectiveness of controls
- deciding whether the nature and extent of the remaining risk after the implementation of controls is acceptable
- if not acceptable, reassessing options and taking further action where appropriate

The Group places such importance on the effectiveness of controls that it has adapted its risk scoring methodology to reflect this. Further operational detail is given within accompanying guidance, available on the Risk Management Knowledge base.

### 3.7 Assurance

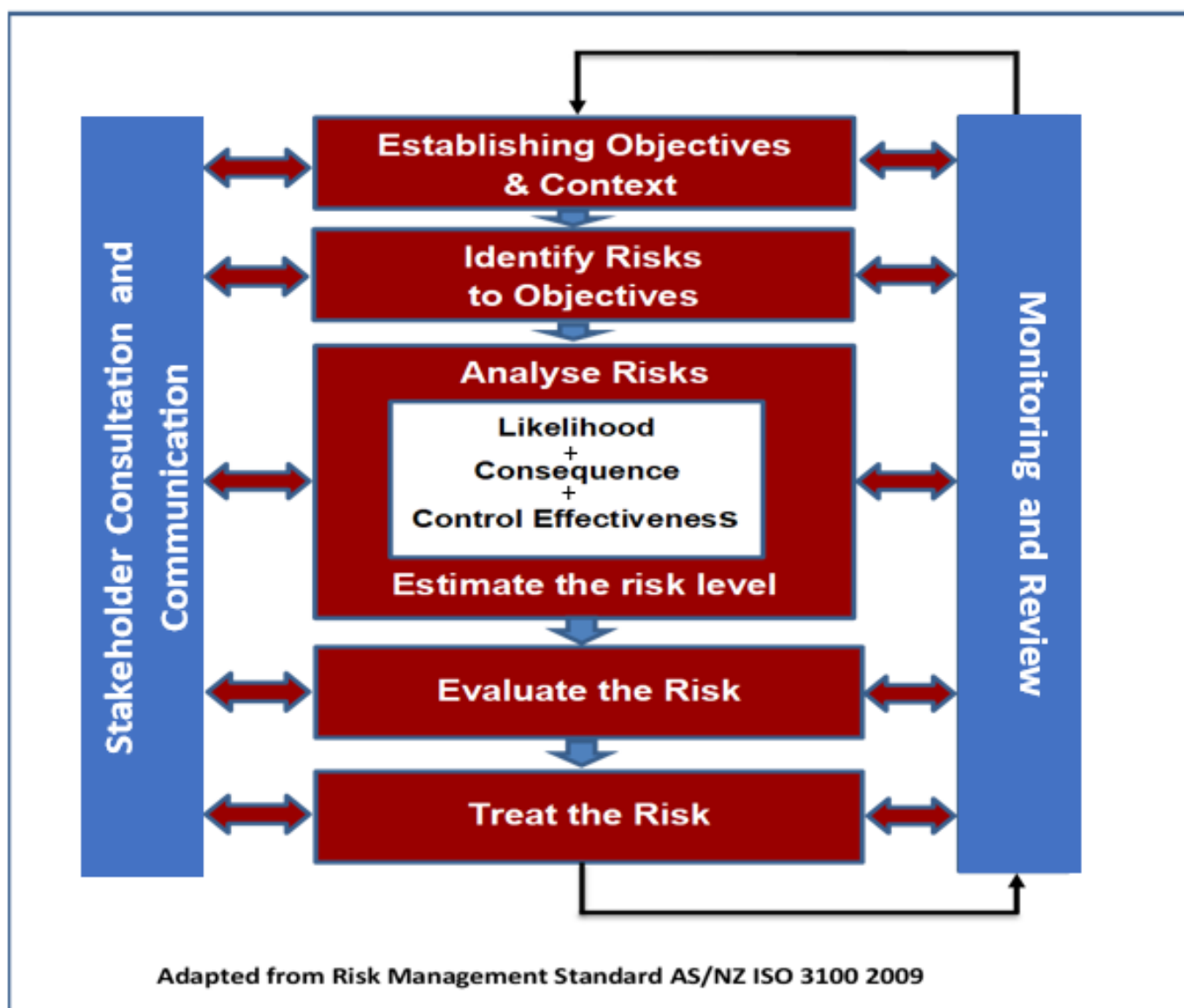
Assurance is a general term for the confidence that can be derived from objective information over the successful conduct of activities, the efficient and effective design and operation of internal control, compliance with internal and external requirements, and the production of insightful and credible information to support decision making. Confidence diminishes when there are uncertainties around the integrity of information or of underlying processes.

The Group has adopted the “three lines model”, which sets out how these aspects should operate in an integrated way to manage risks, design and implement internal control and provide assurance through ongoing, regular, periodic and ad-hoc monitoring and review. Further operational detail is given within accompanying guidance, available on the Risk Management Knowledge base.

## 4.0 Policy Statement

### 4.1 Risk management process

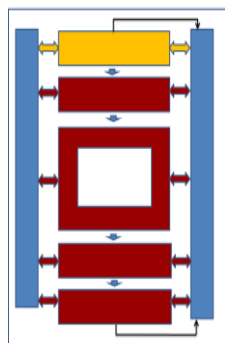
Effective risk management processes ensure a continual, systematic approach to risk identification, assessment, treatment and reporting throughout an organisation. The Group's risk management processes are adapted from Risk Management Standard AS/NZ ISO 3100 2009 and can be summarised in the following flowchart:



The key principles of each of stage within the flowchart are described in this Policy. Further enhanced guidance is provided for each stage within the Risk Management Knowledge base. There is an accompanying training package to provide practical examples.



## 4.2 Establishing objectives and context



Risk is the effect of uncertainty on the Group's objectives. Effective Risk Management is the co-ordinated activities designed and operated to manage risk and exercise internal control. Risk management therefore requires a thorough understanding of the context in which the Group, its hospitals, its divisions and its services operate. The analysis of this operating environment enables managers to define the parameters within which the risks to their outputs need to be managed.

To understand whether something constitutes a risk it must first be understood what the objectives / desired outcomes are.

**Strategic or corporate objectives** - as part of the establishment of NHS University Hospitals of Liverpool Group (UHLG), we are working to develop a new Group strategy, alongside Group vision and values. In the interim, the Group has put in place a clear Improvement Plan for the organisation.

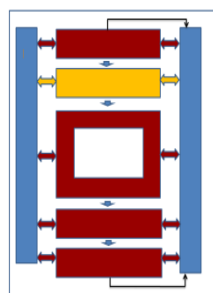
To identify and clarify which Group strategic or corporate objective is relevant to the hospital, division or service staff should refer to the emerging strategy and the improvement plans. If this step is missed or omitted, then the risk register will be neither relevant nor effective.

**Local objectives** should also be considered. By clarifying objectives, it can be identified whether there is a risk to manage. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the delivery of the Group's objectives.

**Context** - The context sets the scope for the risk management process. The context includes strategic, organisational and risk management considerations. Strategic context defines the relationship between the organisation and its environment. Factors that influence the relationship include financial, operational, competitive, political (public perceptions / image), social, client, cultural and legal. The definition of the relationships is usually communicated through analysis frameworks such as the SWOT (Organisational Strengths, Weaknesses, Opportunities and Threats) and PESTEL (Political, Economic, Social, Technological, Environmental and Legal). Other tools can also be used.

## 4.3 Identifying risks to objectives

Risk identification activities should produce an integrated and holistic view of risks. Risk identification involves examining all sources of potential risk that the Group may be exposed to from the perspective of all stakeholders throughout the organisation. When identifying potential risk, there are two key approaches: top-down and bottom-up.



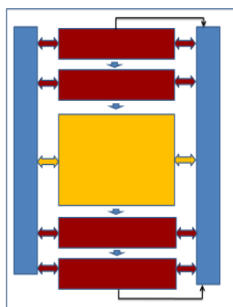
**Identifying strategic risk (Top down)** – Strategic risk management is undertaken through Executive Management and Committee structures and enables the identification assessment and recording of strategic risks which threatened the achievement of the Group's objectives.

**Identifying operational risk (Bottom up)** – Operational risk management activity is supported by staff working in adherence to organisation's policies and



procedures. Operational risks may present themselves via incidents, complaints, claims, patient feedback, safety inspections, external review and ad hoc assessments.

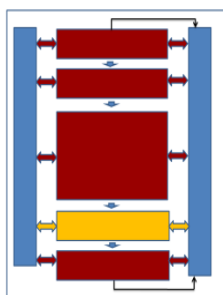
#### 4.4 Analysing the risk and defining and recording risks



While each risk identified may be important, some form of measurement is necessary to evaluate their significance to support decision-making. Without a standard for comparison, it is not possible to compare and aggregate risks across the organisation. This prioritisation is supported by risk assessment, which incorporates risk analysis and subsequently risk evaluation.

First, identify the controls (currently in place) that deal with the identified risks and assess their effectiveness. Based on this assessment, analyse the risks in terms of likelihood and consequence. Refer to the Group Risk Matrix to assist you in determining the level of likelihood, consequence and effectiveness of controls, and the current risk level (a combination of likelihood, consequence and the effectiveness of controls).

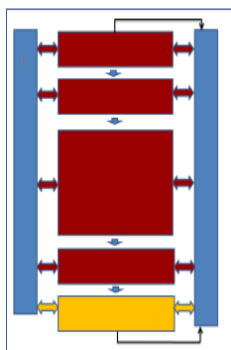
#### 4.5 Evaluate the risk



This stage of the risk assessment process determines whether the risks are acceptable or unacceptable. This decision is made by the person with the appropriate authority. A risk that is determined as acceptable should be monitored and periodically reviewed to ensure it remains acceptable.

A risk deemed unacceptable should be treated (see below). In all cases the reasons for the assessment should be documented within the Risk Management System to provide a record of the thinking that led to the decisions. Such documentation will provide a useful context for future risk assessment.

#### 4.6 Determine the Treatment for the Risk



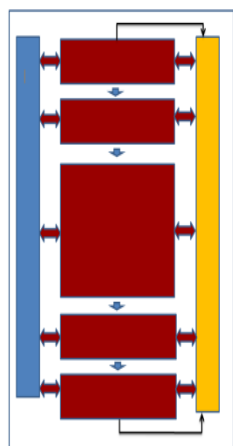
The range of risk treatment options or combination of risk treatments will vary dependent upon each risk and the costs and benefits applied to each option

The 5T's provide an easy list of treatment options available to anyone considering how to manage (control) risk:-

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted.
- **Treat** – work carried out to reduce the likelihood or consequence of the risk (this is the most common action).
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party.
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity.
- **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

Potential mitigation options are developed according to the selected treatment strategy. The selection of the preferred mitigation options takes into account factors such as the costs and effectiveness. The determination of the preferred treatments also includes the documentation of implementation details (e.g. responsibilities, a timetable for implementation and monitoring requirements). The intention of these risk treatments is to reduce the risk level of unacceptable risks to an acceptable level (i.e.: the target risk level).

## 4.7 Monitor and report on the effectiveness of treatment



Managers are required to monitor the effectiveness of risk treatment and have the responsibility to identify new risks as they arise and treat them accordingly. Managers are required to report on the progress of risk mitigation at regular intervals. The person who has the responsibility for risk mitigation is expected to provide feedback to the risk owner on progress being made. Monitoring should take into account the potential effect of the implementation of mitigation and any potential cause and effect obstacles.

### 4.7.1 Board Assurance Framework

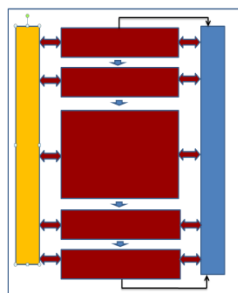
The BAF is an important component of the Group's corporate governance and risk management framework. It is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Group's risk profile and key controls. It aids transparency and can be used to inform the Annual Governance Statement as a means of monitoring the robustness of the systems of internal control. A properly used BAF will also drive the forward work plan and agendas for the Board and its Committees.

The risks contained within the BAF are those that are deemed to have a Group-wide impact with potential to affect one or more strategic objectives. They are agreed annually by the Board and kept under regular review. The information mapped through the BAF allows the Board to question the evidence about the effectiveness of the Group's key controls.

### 4.7.2 Operational risk

The Group has segmented its risk register into two levels: Board Assurance Framework (BAF), and operational (Datix / Ulysses). This enables the Board to take a holistic view of the Group's risk profile through assessment of risk across the Group as well as taking a 'bottom-up' perspective from local operational areas. Through the scoring methodology set out in section 7 of this Policy, and detailed in the supporting guidance, the Board is able to prioritise its attention on those risks that have the greatest potential to impact the Group's strategic direction.

#### 4.8 Stakeholder consultation / communication



Involving key individuals and groups that may be affected by the risk can help with gaining an understanding of their perspective and ensure commitment and buy-in to changes that may be required for treatment. Communication may occur at any phase of the process and particularly when authority for decisions is required.

### 5.0 Exceptions (if applicable)

There are no exceptions to this policy.

### 6.0 Embedding risk management and training our staff

#### 6.1 Training

The Risk Management Strategy for 2025-28 outlines the intention to deliver a more comprehensive Risk Management training programme for the organisation.

Using a modified assessment framework, based on the ALARM National Risk Management performance model, we will monitor and evaluate performance in a systematic and structured way. The provision of Risk Management training is key to progressing through a number of the elements within the maturity matrix.

The training will be delivered in a tiered approach as follows:-

Audience	Aim and content	Frequency
Executives and Non-Executives	<p>Executives and non-executives will be provided with training on key strategic context in relation to risk management. This includes details of the ALARM National Risk Management performance model and the regulatory and legislative framework that supports risk management for large Acute providers.</p> <p>Content will include the Board Assurance Framework, what constitutes good quality assurance, the operational risk register process and how this all aligns with the Group's current governance framework.</p> <p>Key terminology, including controls, assurance and mitigations are discussed in the context of the Group's longer term objectives. The importance of the management of risk in support of the Risk Management Strategy is emphasised.</p>	One off on appointment as an Executive or Non-Executive with refresher updates as required

Hospital leaders and aspiring leaders	<p>This course intends to provide the senior operational detail that supports the oversight and management of risk at hospital and divisional level. There is therefore a short explanation of the role of the executives and non-executives and other Tier 1 content. This is followed by more operational detail of the Group's policies and procedures with a focus on the specific roles and responsibilities for Directors.</p> <p>Content will include the requirements placed on senior managers for the promotion of good quality risk management and consistency of approach throughout their area of responsibility. There will be a focus on assurance versus reassurance, escalation and oversight of risk, treatment options and ensuring there is a collaborative approach to introducing strong controls and actions.</p> <p>The course also provides attendees with advice and guidance on testing assurance and horizon scanning for risks that may prevent them achieving their objectives. The importance of viewing risk alongside performance, incident reporting, audit activity and strategy will be introduced as appropriate. There will also be advice on risk appetite and pursuing risk within the tolerances set by the Board.</p>	One off on appointment to a leadership role, with refresher updates by request
All Staff	<p>This course is part of the Group's mandatory training programme. It provides attendees with details of what a risk is and focusses on good reporting principles. An overview of the Group's expectations and documentation is provided.</p> <p>Content includes an overview of key safety concepts, how risks are identified and some dos and don'ts based on previous staff feedback. Details of safety culture are provided along with an explanation of incident reporting principles</p>	This course must be completed once on appointment
Risk owners and teams of staff	<p>Bespoke courses will be delivered to provide teams with detail of the Group's policies and procedures with a focus on their specific roles and responsibilities. To ensure attendees are aware of the wider context the session will commence with a brief overview of the Tier 1 and Tier 2 content.</p> <p>Content will include how to add a risk to the risk management system. There will be training provided on the key principles of risk management and the techniques that should be applied. The importance of understanding your objective and of differentiating between cause and consequence will be emphasised.</p> <p>The course will also cover the requirements placed on local managers to ensure they are escalating risk with options for</p>	This course is available by request. It is neither mandatory or essential but is provided to ensure there is a bespoke offer to teams of staff or individual groups with a specific role (eg. governance leads, audit leads etc.)

	<p>senior managers on how to treat the risk. There will also be advice on risk appetite and pursuing risk within the tolerances set by the Board</p> <p>Rather than individuals or groups attending training where some content is not as applicable to their role, the programme targets training at specific responsibilities. This allows for a more focused training methodology with enhanced learning outcomes.</p>	
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## 6.2 Embedding Risk Management at all Levels of the Organisation

As previously described, the Group has a fully integrated Board Assurance Framework and operational risk register system. The Board Assurance Framework summarises how the Group Board knows that the controls it has in place are effectively managing the principle risks, together with reference to documentary evidence/assurance and current mitigation action plans.

The Group Board will maintain the Board Assurance Framework for the organisation, with the Hospital and Corporate management teams having responsibility for maintenance of their operational risks. Through this process the risk management activities of the Group are prioritised and managed. Principle risks to the delivery of the Group and Hospital principal objectives, along with and key operational risks are monitored and managed via committee and group led assurance and governance arrangements. These arrangements will ensure consistently designed risk registers, risk escalation and audit throughout the Group.

Risk Management activities will be managed as part of the normal business and monitored via Hospital and Divisional risk registers. To provide oversight and scrutiny of risk management activities, the Group has clear expectations at all levels of the organisation. These are outlined below, within the roles and responsibilities of individuals and in the Terms of Reference for the Group's Boards, Committees and Groups.

To ensure the Group realises its vision and fulfils its statutory duties the Group's Executive team identify principal objectives which must be achieved within the business year. These principal objectives are consolidated into Hospital and Corporate function operational plans which are rigorously monitored via the organisation's governance committee arrangements through the year of delivery. The operational plans are comprehensive in nature and fully detail the steps to be taken in year to achieve the principal objectives. The Board Assurance Framework and operational risk register accounts for the key controls in place to deliver the annual plans and details any further action required where gaps are identified.

The contents of the operational plans are influenced by a number of factors including national mandatory standards such as the NHS Performance Assessment Framework, NHS Quality and Outcome Framework and Care Quality Commission Registration Standards alongside local priorities identified via Hospital and Divisional governance processes and by the partners and stakeholders such as the local Integrated Care Board and patient advisory groups such as Healthwatch.

## The Group

The Board Assurance Framework (BAF) and the operational risk register are a mechanism through which the Chief Executive provides assurance to the Group Board in relation to the delivery of the principal objectives, with focus on principal risks. The BAF and the operational risk register maps the systems of internal control in place to manage the Group's principal objectives and map the assurances that give confidence that it is operating effectively. Where further action is needed BAF and the operational risk register includes detail of any further actions being undertaken to mitigate the principal risks.

**Hospital Leadership Team** responsibilities in relation to risk assurance include:-

- Local deployment and management of governance process set by the Group in relation to Risk Management
- Set relevant and effective objectives in a Hospital annual plan.
- Establish significant risks to the achievement of the Hospital objectives, escalating risks with a risk profile score of 12 or greater to the Board of Directors.
- Ensure that within the Hospital there are robust processes in place in to effectively escalate, approve and manage risks appropriately through the agreed Group governance structure
- Quality assuring risk assessments and oversee operational risks which are identified within Divisions and services, in line with the requirements set within the associate guidance.
- Establish a Hospital Management Board to monitor the effectiveness of risk management processes within the hospital, ensuring all relevant information is escalated to the Board of Directors.
- Monitor risk management activities against the Key Performance Indicators described in this document.

**Divisional Management Team** responsibilities in relation to risk assurance include:-

- Local deployment and management of governance process set by the Group in relation to risk management.
- Setting relevant and effective objectives, which collectively contribute to the delivery of the Hospital annual plan.
- Ensure all Divisional level operational risks are appropriately assessed and reported onto the risk management system.
- Establish processes to monitor the effectiveness of risk management processes within the Division, ensuring all relevant information is escalated to the Hospital Management Board.
- Quality assuring risk assessments and oversee operational risks which are identified within services, in line with the requirements set within the associated guidance.
- Monitor risk management activities against the Key Performance Indicators described in this document.

**Local Management Teams** responsibilities in relation to risk assurance include:-

- Local deployment and management of governance process set by the Group in relation to risk management.
- Setting relevant and effective objectives, which collectively contribute to the delivery of the Hospital annual plan.



- Ensure all local, operational risks are appropriately assessed and reported onto the risk management system.
- Establish a local meeting to monitor the effectiveness of risk management processes within the service, ensuring all relevant information is escalated to the appropriate Divisional Group.
- Quality assuring risk assessments and de-escalating/approving operational risks which are identified locally, in line with the requirements set out within the associated guidance.
- Monitoring risk management activities against the Key Performance Indicators described in this document.

**Corporate Services** responsibilities in relation to risk and assurance include:-

- Identify any operational risks that exist within their service that threaten the achievement of the Group's Principal Objectives as set out in the annual plan.
- Ensure all operational risks are appropriately assessed and reported onto the risk management system.
- Develop and maintain a risk register which reflects the risks relevant to the service.
- Ensure that a robust system is in place for the approving, escalating and managing risk within the service that reflects the requirements set out in within the associated guidance.
- Monitoring risk management activity against the Key Performance Indicators described in this document

**Programme Management and Project Leads**, responsibilities in relation to risk and assurance include:

- Identify any operational and project risks that exist within their programme/project, that threaten the achievement of the project/programme's aims, and ensure they are linked to the Group's principle objectives.
- Ensure all project risks are appropriately assessed and reported onto the risk management system.
- Follow the associated guidance on the management of risk within projects.
- Develop and maintain a risk register which reflects the risks relevant to the project.
- Ensure that a robust system is in place for approving, escalating and managing risk to the project or programme that reflects the requirements set out within the associated guidance.
- Monitoring risk management activity against the Key Performance Indicators described in this document

**Shared Risks:**

- It is acknowledged that risk management often requires a co-ordinated cross divisional / department / hospital approach to achieve effective mitigation. The associated guidance sets out a framework for the management of shared risk within the Group.



## 7.0 Roles and Responsibilities

### 7.1 Board, Committees and Groups

The Board of Directors is ultimately accountable for ensuring that the Group is complying with the terms of its Provider Licence, which includes its arrangements for integrated governance and effective risk management. The Chair and Non-Executive Directors exercise a key role for the promotion of risk management through participation in the Board and its Committees. They are responsible for scrutinising systems of governance and for ensuring that the Chief Executive and Executive Directors are held to account for their risk management responsibilities.

The Group operates a risk monitoring and reporting system to ensure that there is clear ownership of risk at the appropriate hierarchical levels and robust scrutiny and oversight of how risks are managed. The Corporate Governance Framework Manual references the delegated responsibility from the Board to its Committees, which is reflected in their terms of reference. The responsibilities in relation to risk management for the respective Board Committees and Groups are outlined in the table below.

Title	Responsibilities
<b>Board of Directors / Assurance and Risk Committee</b>	The Board of Directors provide a holistic approach to the management of risk and ensure that a comprehensive Assurance Framework is maintained. The Board of Directors receive assurance reports with escalated risks from the Hospital Management Boards and the Group Senior Management Board at the Assurance and Risk Committee.
<b>Audit Committees</b>	The primary function of the Audit Committee is to assess the adequacy and effectiveness of the Trust's systems of integrated governance, the internal control environment and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
<b>Remuneration and Nominations Group</b>	The Remuneration and Nominations Committee is responsible for a range of duties relating to Board appointments, remuneration, appraisal and succession planning. The Committee appraises the Board of any risks relating to the recruitment and employment of senior staff, as well as the structure, size and composition of the Board.
<b>Charitable Funds</b>	Delegated authority from the Board of Directors to oversee that the Charity is administered effectively and its spending is in accordance with the objectives set by the Board.
<b>Hospital Management Boards</b>	<p>The Hospital Management Boards are responsible for managing key risks (those with a score of 10+) across all areas of the site, ensuring that the risks are being managed and minimised through the application of the Group's risk management system.</p> <p>This will include, but not be restricted to the consideration of significant risks to the delivery of the Hospital annual plan, through review of risks alongside the relevant risks from the Board Assurance Framework. The Hospital Management Board is also responsible for the escalation of risks scoring 12 or greater to the Board of Directors at the Assurance and Risk Committee.</p>
<b>Group Senior Management Board</b>	The Senior Management Board is responsible for managing corporate and Group-wide risks (those with a score of 10+), ensuring that the risks are

	<p>being managed and minimised through the application of the Group's risk management system.</p> <p>This will include, but not be restricted to the consideration of significant risks to the delivery of the Group's annual plan, through review of risks alongside the relevant risks from the Board Assurance Framework in accordance with the Risk Management Policy. Senior Management Board is also responsible for the escalation of risks scoring 12+ to the Board of Directors at the Assurance and Risk Committee.</p>
<b>Hospital Quality and Safety Groups</b>	<p>The Hospital Quality and Safety Groups are responsible for providing the Hospital Management Boards with assurance on the standards of quality and safety for clinical care and patient experience, and the implementation of the Group's Risk Management Policy in relation to those areas.</p> <p>The Group oversees and monitors each Hospital's compliance with all legal, regulatory and other obligations such as the Group's/Hospitals compliance with CQC standards.</p>
<b>Hospital Clinical Effectiveness, Research and Innovation Groups</b>	<p>The Hospital Clinical Effectiveness Groups are responsible for providing the Hospital Management Boards with assurance that the Hospital has implemented sound systems to ensure the Hospital has the highest standards of clinical effectiveness. The Hospital Group will ensure that risks relating to the Hospital's clinical effectiveness and its capacity and capability to deliver the Group's and Hospitals objectives are monitored and managed appropriately.</p>
<b>Hospital Finance and Performance Group</b>	<p>The Hospital Finance and Performance Group are responsible for the oversight of operational performance and oversight of financial expenditure against planned budgets and the implementation of digital strategy within each Hospital. The Hospital Groups will ensure all risks related to operational performance financial expenditure against planned budgets are properly scrutinised and to give oversight to the development of appropriate assurance mechanisms.</p>
<b>Hospital People and Organisational Development Groups</b>	<p>The Hospital People and Organisational Development Groups are responsible for providing assurance to the Hospital Management Board in relation to the delivery of the Group's Workforce Strategy and Plan at a Hospital Level, ensuring delivery of statutory objectives and compliance with legislation. The Groups will ensure that risks relating to the Hospitals workforce and its capacity and capability to deliver the Group's and Hospitals objectives are monitored and managed appropriately.</p>
<b>Research, Development and Innovation</b>	<p>The Research, Development and Innovation Committee will advise on and direct the implementation of the Group's Research Development and Innovation Strategy. The Committee will ensure that risk management is properly integrated through these work streams, and that there is appropriate oversight of risks relating to Research, Development and Innovation activities.</p>
<b>Strategy and Partnership Committee</b>	<p>The Group Strategy and Partnership Committee will advise on and direct the implementation of the Group's Strategy and Work with Our partners to gain insight into the systemic risks within the provision of care within Cheshire and Merseyside</p>

The responsibilities in relation to escalation, action, assurance and oversight differ depending on the residual risk score. These are set out in detail in the associated guidance and are summarised below: -

Residual Risk Score	Escalation and Action
<b>Significant Risks</b> between 12 and 15	All new or escalated risks (residual risk $\geq 12$ or warrant inclusion due to impact) are evaluated by the Hospital Leadership Team and a decision is made as to whether the scoring is aligned to the wider risk profile and what additional action or support may be required.
<b>Serious</b> between 10 and 11	Risks are evaluated by the Divisional Leadership Team and a decision is made as to whether the scoring is aligned to the wider risk profile and what additional action or support may be required.
<b>Moderate</b> between 6 and 9	Risks are actioned locally. Any risks that the Department cannot adequately mitigate are escalated with a clear request on what support from the Divisional Leadership Team may be required.
<b>Low</b> between 3 and 5	

Residual Risk Score	Ownership and Oversight
<b>Significant Risk</b> between 12 and 15	<b>Owned:</b> Hospital Leadership Team / Corporate Leadership Team <b>Oversight by:</b> Executive Director <b>Monitored by:</b> Board of Directors / Assurance & Risk Committee, Hospital Management Board, Senior Management Board, Hospital Leadership Team Groups <b>Reviewed:</b> Every month
<b>Serious</b> between 10 and 11	<b>Owned:</b> Divisional Management Team (or similar corporate role) <b>Oversight by:</b> Hospital Management Board, Senior Management Board, Hospital Leadership Team Groups, Assistant Director/Head of Hospital Governance <b>Monitored by:</b> Hospital Leadership Team Groups, Senior Management Team Meetings <b>Reviewed:</b> Every month
<b>Moderate</b> between 6 and 9	<b>Owned:</b> Local Management Team <b>Oversight by:</b> Divisional Leadership Team, Divisional Governance Lead. <b>Monitored by:</b> Specialty/Care Group/ Appropriate Senior Manager <b>Reviewed:</b> every 3 months for Moderate and 6 months for Low
<b>Low</b> between 3 and 5	

## 8.2 Management and Staff Roles and Responsibilities

**Chief Executive** is responsible for ensuring that the group has in place the required systems and processes that support risk management across the organisation and these systems and processes are approved and monitored by the Board.

**Non-Executive Directors** are responsible for providing independent judgement in relation to risk management issues and satisfying themselves that the Group's systems of risk management are robust and defensible.

**Chief Nursing Officer** is the joint executive lead (with the Chief Medical Officer) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Chief Nurse works closely with the Chief Executive and other Executive Directors to ensure a whole systems approach to the management of Clinical Risk. The Chief Nurse is accountable to the Chief Executive for risks arising from areas linked to their executive responsibilities.

**The Chief Medical Officer** is the joint executive lead (with the Chief Nurse) for the mitigation of risk that relates to the delivery of clinical activities. The Chief Medical Officer works closely with the Chief Executive and other Executives to ensure a whole system approach to the management of Clinical Risks. The Chief Medical Officer is accountable to the Chief Executive for risks arising from areas linked to their executive responsibilities.

**Chief Finance Officer** is accountable to the Chief Executive for risks arising from areas linked to their executive responsibility.

**Chief Operating Officer** is accountable to the Chief Executive for risks arising from areas linked to their executive responsibility.

**Chief People Officer** is accountable to the Chief Executive for risks arising from areas linked to their executive responsibility

**Executive Managing Directors** are accountable to the Chief Executive for risks arising from areas linked to their executive responsibility.

**Director of Quality Governance** has delegated responsibility for:-

- Ensuring the developing and implementation of a risk management strategy and risk management policy for the Group.
- Ensuring the risk management systems in use effectively support the risk management requirements of the Group as set out in the Strategy and Policy.
- Ensuring appropriate monitoring of compliance with Strategy/Policy across the Group.
- Ensuring adequate training in risk management is provided for staff across the Group.

**Chief Corporate Affairs Officer / Company Secretary** is responsible for working with the Executive Team in order to produce the Board Assurance Framework and ensuring it is reviewed by the Board.

**Chief Pharmacist** is responsible for working with the Executive Team to identify and manage risks regarding staff and medicines being managed in line with relevant legislation and regulations, and national and professional guidance on medicines governance.

**Director of Estates and Facilities** is responsible for working with the Executive Team to identify and manage risks regarding the safety and functionality of Group buildings and infrastructure.

**Executive Managing Director / Hospital Leadership Team** are responsible for:-

- Local deployment and management of governance process set by the Group in relation to Risk Management
- Set relevant and effective objectives in a Hospital annual plan.
- Establish significant risks to the achievement of the Hospital objectives, escalating risks with a risk profile score of 12 or greater to the Board of Directors.
- Ensure that within the Hospital there are robust processes in place in to effectively escalate, approve and manage risks appropriately through the agreed Group governance structure in line with the requirements set out in section 5.5.4
- Quality assuring risk assessments and oversee operational risks which are identified within Divisions and services, in line with the requirements set within the associated guidance.
- Establish a Hospital Management Board to monitor the effectiveness of risk management processes within the hospital, ensuring all relevant information is escalated to the Board of Directors.
- Monitor risk management activities against the Key Performance Indicators described in Section 9.1 of this document.

**Divisional Management Team** are responsible for:-

- Local deployment and management of governance process set by the Group in relation to risk management.
- Setting relevant and effective objectives, which collectively contribute to the delivery of the Hospital annual plan.
- Ensure all Divisional level operational risks are appropriately assessed and reported onto the risk management system.
- Establish processes to monitor the effectiveness of risk management processes within the Division, ensuring all relevant information is escalated to the Hospital Management Board.
- Quality assuring risk assessments and oversee operational risks which are identified within services, in line with the requirements set within the associated guidance.
- Monitor risk management activities against the Key Performance Indicators described in this document.

**Local Management Teams** are responsible for:-

- Local deployment and management of governance process set by the Group in relation to risk management.
- Setting relevant and effective objectives, which collectively contribute to the delivery of the Hospital annual plan.
- Ensure all local, operational risks are appropriately assessed and reported onto the risk management system.
- Establish a local meeting to monitor the effectiveness of risk management processes within the service, ensuring all relevant information is escalated to the appropriate Divisional Group.
- Quality assuring risk assessments and de-escalating/approving operational risks which are identified locally.
- Monitoring risk management activities against the Key Performance Indicators described in this document.



Risk owners are responsible for: ensuring that the risk is managed, including the on-going monitoring of the risk, ensuring controls and further actions are in place to mitigate the risk and reporting on the overall status of the risk in line with the processes outlined in the document.

**Hospital Governance Teams** are responsible for:

- Working with the Deputy Director of Quality Governance to ensure that the Risk Management Strategy and Policy is effectively conveyed to all staff and is translated into operational practice.
- Supporting Hospital and Divisional Directors in maintaining an operational risk register that accurately reflects risks and is up to date.
- Providing governance reports for divisional and directorate groups and forums, collating risks to support assurance mechanisms and demonstrate compliance with key standards.
- Regularly review risk owners and director leads to ensure named leads are still in an applicable post, re-assigning the risks as required.
- Responsible for ensuring data quality within the risk module for their area of responsibility.
- Ensure all risks are appropriately managed within their area of responsibility.

**Quality Governance Team** is responsible for:

- Maintaining the risk management system and ensuring that it supports the management of risk across the organisation in line with the Risk Management Strategy and Policy.
- Supporting all staff to assess and report risks in line with the Risk Management Strategy and Policy.
- Providing support in development and management of risks.
- Maintain the Risk Management Knowledge Centre
- Develop and deliver the Group's risk management training programme.

**All employees and volunteers** have a responsibility to:

- Take reasonable care for the health, safety and welfare of themselves and others.
- Report any incidents and identify and escalate any risks they feel exist within their department/area or during the delivery of their services.
- Ensure that they comply with all organisation strategies, policies and procedures.
- Undertake mandatory training and other relevant training appropriate to their role.

**All clinicians employed by the Group** have a responsibility to:

- Practice within the standards of their professional bodies, any other national standards and any locally determined clinical policies and guidelines to ensure their practice is as risk free as possible.
- Be risk aware and report through their own department's self-assessment process and line management arrangements, any risks they feel exist within the service and their practice.
- To actively participate with the service to implement any actions.
- Be aware that failure to adhere to the standards set by the Group for the management and investigation of incidents and complaints may result in disciplinary investigation and subsequent action.

### 8.3 Third Party Organisations

Risk management will be integral in governance arrangements set in place for all partnerships with other organisations. Relevant risks identified by the Group will be documented and shared with partner organisations. Likewise, the Group expects that any relevant risks identified by partners will be shared with the Group.

## 8.0 Monitoring Effectiveness

The Group will undertake a regular risk maturity assessment to obtain a structured view of the adequacy of the components of its Risk Management Framework. The risk maturity assessment utilised will be based on the ALARM National Performance Model for Risk Management in Public Services. This will inform the setting of future goals for evolving the Group's risk management arrangements and improving consistency of practice across all areas. The Audit Committee has responsibility for overseeing actions arising out of the risk maturity review.

### 8.1 Audit of Compliance with Policy

The Director of Quality Governance and Deputy Director of Quality Governance (supported by the central Risk Management Team) will ensure that the processes described in this document are being applied throughout the organisation.

All levels of the organisation will be expected to measure their risk activity against the following Key Performance Indicators (KPIs):

- Percentage of approved and unapproved risks which are not moved to approved within 2 months
- Percentage of significant and serious risks reviewed, and progress notes completed in time
- Percentage of risks with review overdue
- Percentage of risks with open actions
- Percentage of risks with gaps in control
- Percentage of open actions beyond target date

Appropriate meetings will receive regular reports on performance against these standards. The risk management department will undertake regular independent compliance checks against these KPIs.

The Group can monitor the effectiveness of its risk management controls in a number of additional ways:

- Annual Governance Statement (AGS) – Each year the Chief Executive, on behalf of the Board of Directors, must sign a statement on the effectiveness of the systems of internal controls and detail any weaknesses identified. This is also independently verified by Internal Audit
- Care Quality Commission and other regulators – The Group is regularly reviewed by external assessors, each with their own set of performance and control standards against which it is measured.
- Hospital Management Boards, and their sub-groups, are essential to the monitoring of compliance of the Risk Management Policy.

The Risk Management Strategy and Policy will be reviewed every three years or sooner if circumstances dictate. Updates will take into account progress to enhance risk maturity. Analysis



of the risk registers will be used to evaluate how risks have been managed across the Group and understand how effectively current risk management arrangements have been implemented. Feedback from risk practitioners will be sought to update guidance for staff and to inform future training plans.

## 9.0 Equality, Diversity and Human Rights Statement

The Group is committed to an environment that promotes equality and embraces diversity in its performance both as a service provider and employer. It will adhere to legal and performance requirements and will mainstream Equality, Diversity and Human Rights principles through its policies, procedures, service development and engagement processes. This document should be implemented with due regard to the commitment.

## Appendix One: Equality Impact Assessment

### 1. Possible Negative Impacts

Protected Characteristic	Possible Impact	Action/Mitigation	
Age	Neutral		
Disability	Neutral		
Ethnicity	Neutral		
Gender	Neutral		
Marriage/Civil Partnership	Neutral		
Pregnancy/Maternity	Neutral		
Religion and Belief	Neutral		
Sexual Orientation	Neutral		
Trans	Neutral		
Other Under Served Communities (Including Carers, Low Income, Veterans)	Neutral		

### 2. Possible Opportunity for Positive Impacts

Protected Characteristic	Possible Impact	Action/Mitigation	
Age	Neutral		
Disability	Neutral		
Ethnicity	Neutral		
Gender	Neutral		
Marriage/Civil Partnership	Neutral		
Pregnancy/Maternity	Neutral		
Religion and Belief	Neutral		
Sexual Orientation	Neutral		
Trans	Neutral		
Other Under Served Communities (Including Carers, Low Income, Veterans)	Neutral		

### 3. Combined Action Plan

Action (List all actions and mitigation below)	Due Date	Lead (Name and Job Role)	From Negative or Positive Impact?
N/a			

**4. Information Consulted and Evidence Base (Including any consultation)**

Protected Characteristic	Name of Source	Summary of Areas Covered	Web link/contact info
Age	N/a		
Disability	N/a		
Ethnicity	N/a		
Gender	N/a		
Marriage/Civil Partnership	N/a		
Pregnancy/Maternity	N/a		
Religion & Belief	N/a		
Sexual Orientation	N/a		
Trans	N/a		
Other Under Served Communities (Including Carers, Low Income, Veterans)	N/a		

**5. EIA Update Log**

Date of Update	Author of Update	Change Made
April 2025	G. Hope	Initial review and assessment

**6. Have all of the negative impacts you have considered been fully mitigated or resolved?**

**7. Please explain how you have considered the duties under the accessible information standard if your document relates to patients?** N/a

**8. Equality Impact Assessment completed and signed off**

**Name:** G. Hope

**Date:** April 2025

**Last Appendix: Document History and Version Control**

Version	Date	Comments
1.0	May 2025	New Policy