



DOCUMENT TYPE: Strategy		UNIQUE IDENTIFIER: RMS-01	
DOCUMENT TITLE: Risk Management Strategy 2018/2019		VERSION NUMBER: 9	
SCOPE: Trust Wide		STATUS: Ratified	
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REPLACES: RMS-01 Risk Management Strategy 2016/17		HEAD OF DEPARTMENT: Christine Morris Interim Director of Governance	
VALIDATED BY: Christine Morris Interim, Director of Governance		DATE: 28 February 2018	
RATIFIED BY: Procedural Documents Ratification Group		DATE: 05 June 2018	
(NOTE: Review dates may alter if any significant changes are made).		REVIEW DATE: 05 June 2021	
WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and	√
6. The NHS is committed to providing best value for taxpayers' money.	√		
7. The NHS is accountable to the public, communities and patients that it serves.	√		

		<p>safer services for patients and their families.</p> <p>6. To have a process for staff to raise an internal grievance.</p> <p>7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.</p>	<p>√</p> <p>√</p>
<p>WHICH AIMS OF THE TRUST APPLY?</p> <p>Click here for Aims</p> <p>1. To offer excellent health care and treatment to our local communities. √</p> <p>2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria. √</p> <p>3. To drive innovation through world-class education, teaching and research. √</p>	<p>Tick those which apply</p>	<p>WHICH AMBITIONS OF THE TRUST APPLY?</p> <p>Click here for Ambitions</p> <p>1. Consistently deliver excellent care. √</p> <p>2. Great place to work. √</p> <p>3. Deliver value for money. √</p> <p>4. Fit for the future. √</p>	<p>Tick those which apply</p>
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1. SUMMARY

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

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

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

What's the ideal Risk Management Framework?

This relates to a working model in which:

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

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

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

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- The information mechanisms the Trust uses to identify Risk patterns.
- How the Trust learns lessons from themes identified from risks.

2. PURPOSE

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

The purpose of this strategy is to:

- Inform staff what risk and risk management is in the context of an NHS Foundation Trust.
- Inform staff regarding the committees and staff groups that have responsibility for the management and mitigation of risk.
- Set out how to provide assurances that effective risk management is being undertaken at all levels of the Trust.
- Inform staff regarding the role of Risk Registers.
- Inform staff regarding the role of the Board Assurance Framework.
- Inform staff about how risks are to be escalated through the organisation.
- Describe to staff the information mechanisms the Trust uses to identify Risk patterns.
- Describe how the Trust learns lessons from themes identified from risks.
- Ensure risk is managed whilst achieving the Trusts strategic objectives.

This Strategy will also assist the Trust to comply with the following Conditions and Standards:

- LTHTR NHS Improvement Licence Conditions G6 2(a) and G6 2(b)1 CQC Acute Hospital Provider Handbook 2

3. SCOPE

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

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4. STRATEGY

4.1 How the Trust sets its Strategic Objectives

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

4.1.1 LTHTR Strategic Aims

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

4.1.2 LTHTR's Ambitions

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

4.2 Duties / Roles

4.2.1 Board of Directors

The Board of Directors is responsible for:

- Providing the direction for effective risk management within the Trust.
- Reviewing the effectiveness of internal controls (its infrastructure) which includes; Workforce, Financial, Quality, Operational and Corporate Governance etc.
- Taking a pro-active lead in the communication of risk management duties.
- Ensuring that an appropriate Trust Committee Structure is in place to ensure that the Trusts Risk Management activity is subject to appropriate levels of oversight and scrutiny, the Trusts Committee structure is detailed in Appendix 2. These are supported by clear Terms of Reference.
- Overseeing and approving the Board Assurance Framework and the Corporate Risk Register, which will be undertaken on at least, a quarterly basis.
- Delegate's responsibility for the annual review of the Board Assurance Framework (Risk Register) to the Audit Committee.
- Producing statements of assurance that the Trust is making all "reasonable" efforts to manage risks to its activity in an efficient and effective manner.
- Ensuring that non-Executive Directors will act as scrutinisers, ensuring that Risk Management is properly addressed and that the processes to support the Board of Directors facing significant risk are robust.

4.2.2 Chief Executive

The Chief Executive has overall responsibility and accountability for the Risk

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Management activity within the Trust and provides clear visible leadership, ensuring that the implementation of Risk Management is delegated to the Executive Directors and Management structure of the Trust.

4.2.3 Director of Governance

The Director of Governance is the Director nominated as the Trust’s ‘Risk Champion’ with overall responsibility for the management of the Risk Management Framework. Their role provides leadership for the implementation of the Trust’s Risk Management Strategy, ensuring that the Trust consistently monitors and evaluates the effectiveness of its systems of internal control. The Director of Governance is responsible for approval of any risk Trust Wide Risks that are not rated as ‘High’. The Director of Governance works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Risk is undertaken.

4.2.4 Medical Director

The Medical Director is the joint executive lead (with the Nursing, Midwifery and AHP Director) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Medical Director works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Clinical Risk is undertaken. The Medical Director is the Trust’s Caldicott Guardian and has responsibility for Medicines Safety and Management and Mortality review.

4.2.5 Nursing, Midwifery and AHP Director

The Nursing, Midwifery and AHP Director is the joint executive lead (with the Medical Director) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Nursing, Midwifery and AHP Director works closely with the Chief Executive and other directors to ensure a whole systems approach to the management of the Clinical Risk is undertaken. In addition, the Nursing, Midwifery and AHP Director has responsibility for infection prevention and control, safeguarding (adults and children). The Nursing, Midwifery and AHP Director will also be the accountable Director in ensuring that lessons are learned and shared and communicated to staff when things go wrong.

4.2.6 Operations Director

The Operations Director is the executive lead for the management of risks to the Trust’s operational activity (Operational Risks). The Operations Director works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Operational Risk is undertaken.

4.2.7 Director of Finance

The Director of Finance is the Executive Director with overall accountability for the management of Financial Risk and as the Trust’s Senior Information Risk Owner (SIRO) is also responsible for the management of Information Governance and Security Risk. In addition to this, the Director of Finance is responsible for the

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identification, scoping definition and implementation of an Information Governance and Security Risk Programme.

4.2.8 Director of Workforce and Education

The Director of Workforce and Education is the executive lead for the management of risks to the Trust’s workforce activity. The Director of Workforce and Education works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Workforce Risk is undertaken.

4.2.9 Company Secretary

The Company Secretary has responsibility for coordinating the development of the Board Assurance Framework, which involves liaising with the Executive Directors with lead responsibility to ensure the Board Assurance Framework reflects the principal strategic risks associated with failure of the organisation to meet its corporate objectives and the actions being taken by the Trust to mitigate such risks. The Company Secretary will hold and maintain the Trust’s Register of Assurances, which underpins the evaluation of effectiveness of the Trust’s internal control functions.

4.2.10 Governance and Risk Lead (reports to the Director of Governance)

The Governance and Risk Lead provides support to the Director of Governance and nominated Deputy in coordinating the Trust’s Risk Management Framework, Risk Management Strategy and the operational activities that underpin them. They will achieve this by:

- Operationally support the implementation of the Risk Management Strategy,
- Providing co-ordination and oversight for the Trust’s Risk Registers
- Supporting the Company Secretary in the maintenance of the Board Assurance Framework
- Championing a whole systems approach to Risk Management
- Providing advisory support to the Trust’s Divisional Management Team and Divisional Governance Leads Teams in the identification of Divisional Risks and the management of Divisional Risk Registers
- Provide Quality Assurance Guidance to Divisional Governance Leads
- Maintaining the Trust’s electronic Risk Management System (DATIX).
- Producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.
- Providing support, advice and training to the Divisions in the principles of risk

- Being responsible for supporting the Director of Governance on reviewing and monitoring trends in the Trust’s NHS Resolution and Clinical Negligence Scheme for Trust’s (CNST) premiums and Care Quality Commission (CQC) standards relating to the management of Risk.

4.2.11 Risk Team

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The Risk Team provides operational support to the Governance and Risk Lead by:

- Supporting the Divisional Management Teams in validating the Risk Registers, including the adequacy of risk descriptions, the adequacy of controls and assurances and justification of risk scoring.
- Maintaining the Trust’s electronic Risk Management System (DATIX Module).
- Producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.
- Providing support, advice and training to the Divisions in the principles of risk.

4.2.12 Director of Estates and Facilities

The Director of Estates and Facilities advises on health and safety, security, fire safety, environmental management, medical devices management and all aspects of emergency planning and business continuity.

- Supporting Managers and staff with the identification and management of Health and Safety risks.
- Liaising with the Trust’s Governance and Risk Lead in the identification and management of Health and Safety risks.

4.2.13 Divisional Leadership Team Divisional Directors, Divisional Medical Directors, Divisional Nursing Directors, AHP Director, Head of Midwifery

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

- Providing leadership for Risk Management activities in their Division.
- Promoting and supporting the implementation of the Risk Management Strategy.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy.
- Monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Ensuring that Divisional Risk Management activity is discussed and reviewed at relevant Divisional meetings (Divisional Governance meeting, Divisional Management Team, and Divisional Board).
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to Risk Management activities.
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for Risk Management.
- Informing the Trust Management Board of Risks that are being escalated to the Corporate Risk Register, where required.
- Presenting Risk Management reports to the Trust Management Board and Trust Committees, where required.
- Management of the identified risks within their Division/Department, including the escalation of risks, where appropriate.
- To promote and embed an ‘open’ and ‘just’ culture.
- Monitoring that all relevant Risk Assessments are undertaken, reviewed and

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documented appropriately.

4.2.14 Divisional Governance Lead

All Divisional Governance Leads have responsibility for supporting their Division in the management of their risks including:

- Providing support for Risk Management Activities in their Division.
- Promoting and supporting the implementation of the Risk Management Strategy.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy.
- Monitoring, and where appropriate, challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Undertaking Quality Assurance checks in accordance with guidance provided by the Director of Governance.
- Ensuring that Divisional Risk Management activity is discussed and reviewed at relevant Divisional meetings Divisional Governance Meetings, Divisional Management Board (DMB), Divisional Management Team (DMT).
- Undertaking Divisional Administration on their Divisional Risk Register in Datix producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.

4.2.15 Managers

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

- Providing support for Risk Management activities in their Division.
- Promoting and supporting the implementation of the Risk Management Strategy.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy.
- Monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Ensuring that Divisional Risk Management activity is discussed and reviewed at the relevant Divisional Governance Meetings and the Divisional Management Board (DMB) meetings.

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

- To support the delivery of the Trust Risk Management Strategy in accordance with their role.
- Monitoring activities within their Service, Ward/Department to ensure

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- compliance with all Trust Strategies and policies.
- To promote and embed an open and ‘just’ culture.
- Awareness of the Trust’s infrastructure for the management and mitigation of risk.
- Monitoring activities within their Service, Ward/Department to ensure risks are identified, assessed and entered onto the Trust Risk Register.
- Monitoring the Risk Mitigation activities within their Service, Ward/Department Area to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Strategy.
- Ensuring that Service, Ward/Department Area of Risk Management Activity is discussed and reviewed at relevant meetings.
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to risk management activities
- Providing information to the Divisional Governance meetings on the identified risks within their Service, Ward/Department.
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for risk management.
- Informing the Divisional Management team of Risks that are being escalated to the Divisional Risk Register, where required.

4.2.17 All Employees

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

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

4.2.18 Staff Side Representatives

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

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

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

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

The Corporate Committee Structure detailing all those committees/sub- committees and groups which have some responsibility for risk and help manage the delegated responsibility for implementing risk management systems within the Trust is explained below. These are supported by clear Terms of Reference.

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

4.3.1.1 Board of Directors

The Board of Directors is responsible for ensuring the effectiveness of the Trust’s infrastructure and has overarching responsibility for the Risk Management Framework.

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

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

The Board has responsibility for producing an Annual Governance Statement, which provides evidence of the robustness of the Trust’s system of internal control. This will be informed by the Head of Internal Audit Opinion and will be subject to scrutiny by external auditors.

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

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Operationally the Board of Directors is responsible for Approving the addition or removal of risks to the Board Assurance Framework.

If the Board of Directors needs to be made aware of an emergent serious risk, the risk assessment can be fast-tracked. In this scenario, the risk assessment must be forwarded to the Director of Governance, who will facilitate inclusion on the Board of Directors agenda.

The Trust Risk Register is made up of two parts; Part A and Part B.

Part A: Board Assurance Framework

4.3.1.2 Risk Management Committee

The Risk Management Committee is the high level risk committee which reviews and monitors the Board Assurance Framework, the Corporate and Divisional Risk Registers. Each Division is scheduled to present their Risk Register according to the Committee's Schedule of Business. This is an operational Committee, not a Board Committee.

The Risk Management Committee will provide the interface between the Board and the rest of the organisation. It has a key role in managing the assurance process; one of its key roles is defining the criteria for admission of risks into the Corporate Risk Register and the Board Assurance Framework.

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

The minutes of the Risk Management Committee must identify the specific Board Assurance Framework/Corporate Risk number that has been removed and placed on the Divisional Risk Register, including the documented evidence in place to ensure actions have been completed for this risk, and the name of the Division who will then be responsible for managing and reviewing this risk on the relevant Divisional Risk Register.

All high and significant risks that score 15 and above will be reviewed by the Risk Management Committee to assess the need for inclusion on the Corporate Risk Register or the Board Assurance Framework.

4.3.1.3 The Audit Committee

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

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4.3.1.4 The Safety and Quality Committee

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

- Reviewing Safety & Quality Risks on at least a quarterly basis to facilitate a Trust-wide approach to mitigations.
- Identify any deficiencies in the identification and management of Safety & Quality Risks and to raise these concerns with the relevant Divisional Management Team.
- Delegate the responsibility for Safety & Quality Risks that fall within the remit of one of the Safety and Quality Committee's Sub-Committees to the relevant Sub-

Committee, the Sub- Committees are;

- Risk management committee.
 - Clinical governance committee.
 - Safeguarding board.
 - Infection prevention and control.
- Receive Assurance from the relevant Sub-Committees that risks within their remit have been appropriately scrutinised and that concerns are escalated to the Safety & Quality Committee.
 - Provide assurance to the Board of Directors that Safety & Quality Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Safety & Quality Risks.

4.3.1.5 The Workforce Committee

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

- Reviewing Workforce Risks on at least a quarterly basis to facilitate a Trust-wide approach to mitigations.
- Identify any deficiencies in the identification and management of Workforce Risks and to raise these concerns with the relevant Divisional Triumvirate.
- Provide assurance to the Board of Directors that Workforce Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Workforce Risks.

4.3.1.6 The Finance and Investment Committee

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

- Reviewing Finance Risks on at least a quarterly basis to facilitate a Trust-wide approach to mitigations.
- Identify any deficiencies in the identification and management of Finance Risks and to raise these concerns with the relevant Divisional Triumvirate.
- Provide assurance to the Board of Directors that Finance Risks have been

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appropriately scrutinised and to escalate any concerns regarding the identification and management of Finance Risks.

4.3.1.7 Approved Terms of Reference

The approved Terms of Reference for the Trust's Committees is held by the Company Secretary's Office.

4.3.1.7 The Education, Training and Research Committee

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

- Reviewing Education, Training or Research risks on a quarterly basis to facilitate a Trust wide approach to mitigation
- Identify any deficiencies in the identification and management of Education, Training or Research risks and to raise these concerns with the relevant Divisional Triumvirate.
- Provide assurance to the Board of Directors that Education, Training and Research risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Education, Training or Research risks.

4.4 Risk Register Systems and Software

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

The nominated individuals within each Division that have access to add and edit risks within their Divisional risk register, will normally include, but is not limited to:

- Divisional Management team members
- Senior Clinicians
- Matrons
- Ward Managers/Sisters
- Clinical Leads
- Clinical Business Managers/Service Business Managers
- Divisional Governance Lead

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

- Risk Description and Assessment.
- Risk Grading / Scoring.
- Current and Target Risk scores.
- Risk Controls and Assurances.
- Remedial Action Plans.
- Risk Review.
- Recording of supporting evidence.

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- Production of risk registers reports.
- Archiving of closed risks.

As such the Risk module serves as the Trust’s Risk Register and contains the following:

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

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

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

4.5 What is Risk and Risk Management

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

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

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

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In simple terms, Risk Management Process is the activity required to proactively and responsively identify, assess and manage threats to achieving objectives. At a very top level, the Trust’s Board is responsible for putting in place the necessary infrastructure to enable the Trust to achieve its strategic objectives. As the infrastructures in place at Acute NHS Foundation Trusts are largely the same from Trust to Trust, and have been in place for a long period of time, they are ingrained in the operational activity of Trusts; as such, the infrastructure isn’t always recognised by staff as being key to the management of risk and in delivering strategic objectives. At LTHTR, the Trust has in place a whole systems approach to Risk Management which is articulated in Figure 2 above; each of the steps in the Risk Management process is articulated in detail in Appendix 3 and 4.

4.6 Risk Management: Two Key Approaches

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

Top Down (Strategic Risks) – The Trust undertakes strategic Risk Management through Executive Management and Committee structure that enable the identification, assessment and recording of strategic risks and the implementation and monitoring of controls and mitigating actions. Strategic Risks may be identified through the monitoring and reporting of Operations risks. Strategic Risks are identified, managed, monitored and reported through the Trust’s Board Assurance Framework.

Bottom Up (Operational Risks) – The Trust undertakes operational Risk Management activity through staff working in adherence to the Trust’s Risk Management Strategy. Operational Risks may present themselves, which may impact on the Trusts ability to meet its objectives and targets. Operational Risks are identified, managed, monitored and reported through the Trust’s Risk Register.

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Figure 3 – Risk Management Activity – Top down and Bottom up approach

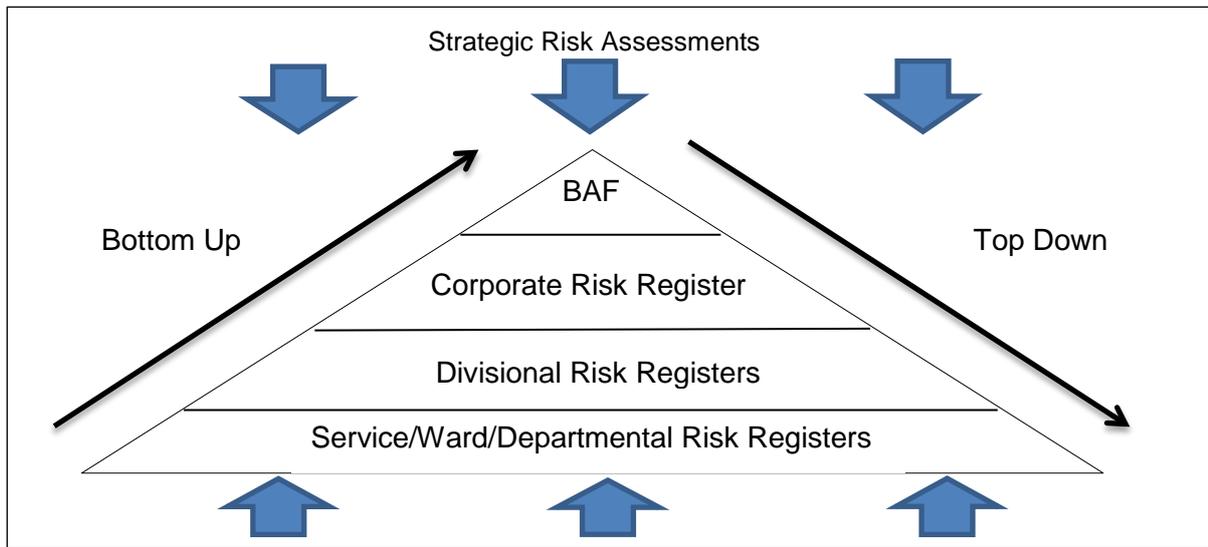


Illustration courtesy of University Hospitals of Morecambe Bay NHS Foundation Trust.
Operational Risk Assessment

4.7 Risk Appetite Statement

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

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

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

In response to these factors the Trust will seek to manage risks in accordance with the well-established ALARP principle - As Low As Reasonably Practicable, with priority being placed upon maintaining or improving Patient Safety ahead of any other aim or objective. All identified Risks will be allocated a Risk Mitigation score that ensures compliance with the ALARP Principle.

4.8 Risk Management Framework

4.8.1 Trust Wide Strategic Risks and the Board Assurance Framework

As part of the Annual Planning process, following the establishment of the Trust’s Strategic Objectives, the Board will identify any organisation wide strategic risks that may threaten the achievement of the Trust’s Strategic Objectives. The Board, supported by the Company Secretary will establish what the strategic risks are and identify and review the controls and systems the Trust has in place to mitigate these risks.

Through the Board Assurance Framework the Trust will document all of its Strategic Risks, the key controls that are in place to manage and mitigate these strategic risks

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and which Executive Director is leading on the mitigation. The Board Assurance Framework will be monitored on at least a quarterly basis at the Board of Directors meetings, where the Trust's Executive and Non-Executive Directors review and challenge the levels of assurance offered within the Board Assurance Framework. Should a gap be identified in the control management and mitigation of the risk, the gap will be managed operationally through the creation of a new operational risk on the Trust Risk Register.

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

The Board will undertake the final validation of and new Risk Assessments and agree inclusion of new risks on the BAF.

It is reviewed and revised a minimum of 10 times per year at the Executive Team meeting by the Company Secretary and the Executive Directors.

Changes to High and Significant risks are reported to Risk Management Committee a minimum of 5 times per year and to the Board of Directors on a monthly basis by the Company Secretary in report format.

The updated Board Assurance Framework is presented to the Risk Management Committee a minimum of 5 times per year by the Company Secretary and is presented to the board at each meeting. Additionally, risks on the board assurance framework are aligned to responsible committees and these are routinely reviewed at each meeting of the committee.

4.8.2 Operational Risks and the Trust Risk Register System

To provide oversight and scrutiny of the Operational Risk Management Activity, the Trust produces Risk Registers at a Corporate, Committee, Divisional Specialty and Ward/Departmental level.

4.8.3 Risk Register

All operational risks that have been rated as 'High' (Risk Score of 15 to 25) are allocated to the Corporate Risk Register and are monitored at the Trust Management Board and subsequently reported to the Board of Directors meeting on at least a quarterly basis. Risks are scored in line with the NPSA scoring matrix found in Appendix 9.

4.8.4 Assurance Committee Risk Registers

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

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4.3.

4.8.5 Divisional Risk Registers

All operational risk are allocated to the relevant Trust Division Risk Register and are monitored through the reporting of risks to the Divisional Management Meetings (DGM, DMT, DMB) on at least a quarterly basis and through Clinical Directors performance reports to the Divisional Performance meetings and the Trust Management Board on at least a quarterly basis.

4.8.6 Specialty Risk Registers

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

4.8.7 Ward/Departmental Risk Registers

When relevant some operational risk are allocated to the relevant Trust Ward/Departmental Risk Register and are monitored through the reporting of risks to the Ward/Departmental 'Governance' Meeting on at least a quarterly basis, with exceptions being reported to the Specialty 'Governance' Meeting and/or the Divisional Governance meeting (DGM).

4.8.8 Commissioner Related Risks

Are monitored through the reporting of risks that are identified as being 'Commissioner Related' to the Quality Assurance meeting on at least a quarterly basis. The Quality Assurance meeting is joint meeting between the Trust and its Commissioners.

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

4.8.9 Risk Register Format

The Risk Registers are recorded into the Datix System using a standard template and the severity of each risk is rated according to the impact/likelihood Risk Assessment Matrix from the National Patient Safety Agency 8. The Data fields included in the standard template are detailed in Appendix 6.

The operational risk registers identify and record the following:

- The Location of the risk (Site, Division, Specialty and Department)
- The Risk Assessor and Risk Manager
- The date the risk was identified
- The description of the Risk
- The Risk Group, Risk Type and the Source of risk

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- If the Risk is ‘Commissioner Related’
- The Trust Wide Board Assurance Framework strategic that are affected by this risk
- The Trust Assurance Committee that will monitor this risk
- Key Performance Indicators (KPI’s) that are at risk
- The controls that are in place to assist in securing delivery of the objectives or KPIs
- The assurances that enable evidence to be gained that our controls are effective
- The current risk rating - the risk rating with the current controls in place
- The mitigation strategy for the Risk
- The Mitigating Actions that are being taken to reduce the risk that will improve the level of control and assurance on the risk
- The target risk rating - the risk rating with the mitigating actions are completed
- The Review Frequency and Date of next review
- The Review history
- Any supporting documents or evidence attached to the Risk

4.9 Operational Risk Levels, Management, Monitoring and Escalation

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

To deliver this the Trust allocates each risk to one of four risk levels which reflect how the risk is impacting on the Trust and who is likely to be responsible for the operational management of the risk, the Risk levels are;

- 1 Ward/ Department
- 2 Specialty
- 3 Divisional
- 4 Trust Wide

The allocation of risks between the risk levels is not based on the Risk Score or Risk Rating. As such there will be some higher scoring risks allocated as Departmental, Specialty and Divisional level risks that will continue to appear in the Corporate Risk Register (any risk that scores 15-25) and there will also be a number of low scoring risks that are in the ‘Trust Wide’ Level that will not appear in the Corporate Risk Register.

The frequency at which a risk should be reviewed is determined by the risk score with higher scoring risks requiring more frequent review. Any risk rated as ‘High’ or ‘Significant’ (risk score 8-25) must be reviewed on at least a quarterly basis. Risk Review frequency guidance is included in Appendix 7.

The robust and overlapping monitoring and escalation processes will ensure that risks are not managed by Clinicians or Managers without sufficient authority, experience and knowledge to mitigate the risk and that significant and serious risks are identified and escalated as quickly as possible. Figure 3 contains an overview of these processes.

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Figure 3: Overview of Risk Levels, Management, Monitoring and Escalation

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

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4.10 The Risk Management Process

The Risk Management process is the activities required to identify, assess and manage risks to achieving objectives. A Risk Assessment and Management Guidance and Flow Chart are included in Appendix 4 and 5.

4.11 How Operational Risks are added to the Trust Risk Register

All Trust Staff with 'Add/Edit' Access rights can add a new risk to the Risk Register. There are specified Mandatory Data items that must be completed before a new risk can be saved; this is to ensure that minimum data requirements are achieved.

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

The ability to release an approved risk from the Pending Tray into the live risk register is limited to those users with Admin access rights, so it is not possible for the vast majority of system users to approve their own risk. The decision to approve or decline a Divisional Risk from the Pending Tray will be taken at the Divisional Governance Meeting. The decision and the reasons for doing so will be recorded in the Divisional Governance Meeting minutes.

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

The approval by a Divisional Governance meeting of any Divisional, Specialty or Ward/Departmental risks with a risk rating of 'High' (risk score of 15-25) is notified to the Director of Governance.

Any Risk that has a risk level of 'Trust Wide' and a risk rating of 'Low', 'Moderate' or 'Significant' (risk score of 1-12) must be approved by the Director of Governance.

Any Risk that has a risk level of 'Trust Wide' and a risk rating of 'High' (risk score of 15-25) must be approved at a meeting of the Executive Directors Group, or by two or more Executive Directors if urgent approval is required.

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

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

- Changes in Risk Ratings
- Summary of Risks by Division
- Summary of Risks by Category
- Summary of changes in Risks and Risk scores

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- Themes and Profiles
- Risk Register report

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

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

The approved format for the Risk Register Report is detailed in Appendix 8.

4.12 Risk Closure

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

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

The decision to approve or to decline the closure request, and the reason for doing so, will be recorded in the Divisional Governance meeting minutes.

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

The ability to change the status of risk from 'Active' to 'Closed' in the risk register is limited to those users with Admin access rights, so it is not possible for the vast majority of system users to close their own risk.

4.13 Reporting on the Triangulation of Risk Information and Risk Themes

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

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

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4.14 Risk Management Training

The Trust has an agreed Training Needs Analysis (TNA) for all staff groups that includes Risk Management topics. All training will be delivered in line with the training needs analysis.

4.15 Internal and External Audit and Assurance

4.15.1 Independent External Assurance

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

- Care Quality Commission visits/inspections.
- National Audits.
- Reviews of external independent reports.
- Serious Incident Panel.
- Quality Risk Profile.
- Health and Safety Inspections.
- External Audit Reports.
- Annual Audit Letter.
- National Staff Surveys.
- NHSLA Reports.
- National Patient Satisfaction Surveys.
- Patient Led Assessments of the Care Environment (PLACE) Inspections.

4.15.2 Internal Assurance

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

- Trust Board Integrated Performance Report.
- Risk Management Annual Report.
- Performance Reviews.
- Key Performance Indicators including internal standards.
- Minutes.
- Committee Reports.
- Divisional Management Board Reports.
- Annual Quality Accounts.
- Development and review of Risk Registers.
- Compliance levels within the CQC Assessments, Board Assurance. Framework/Corporate Risk Register.
- Accreditation levels achieved within NHSLA Risk Management standards.
- The Annual Governance Statement.
- Benchmarking activity.

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- Compliance with mandatory induction and training standards.
- Response to Medical Devices Alert (MDA)/National Patient Safety Audit (NPSA)/Estates and Facilities (EFA) alerts and hazard notices.
- Incident investigations.
- Incident, claims and complaints trends.
- Patient and staff attitude surveys.
- Corporate Quality Reviews.
- Walkabouts.

4.15.3 Key Stakeholders Assurance

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

These include:

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

4.16 Other Risk Assessments

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

4.16.1 Patient Risk Assessments

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

4.16.2 Safety Incident Reporting

Specific detail regarding the Safety Incident risk assessment process can be found in the Trust's 'Policy for the Reporting and Management of Incidents including Serious Incidents'.

4.16.3 Complaints

Specific detail regarding the Complaints risk assessment processes can be found in the Trust's Management Procedure for the Investigation and Resolution of Complaints.

4.16.4 Litigation

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Specific detail regarding the Litigation risk assessment processes can be found in the Trust's Claims Management Procedure.

4.16.5 Workplace, Environment, Health and Safety and Security Assessments

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

4.16.6 Clinical Audit

Specific detail regarding the Clinical Audit risk assessment processes can be found in the Trust's Clinical and Non-Clinical Audit Procedure and Clinical Audit Strategy.

4.16.7 NICE Guidance and Standards

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

4.16.8 Project Risk Assessments

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

4.16.9 Internal and External Reviews/Reports

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

4.17 Dissemination and Implementation

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

5. AUDIT AND MONITORING

How the Organisation Monitors Compliance with the Risk Management Strategy
Monitoring of this strategy will be done via the following mechanisms:
The Board of Directors will receive the following via the Audit Committee:

An Annual Risk Management Report covering all aspects of Risk to be submitted to the Trust Board. An Annual Report on the effectiveness of the organisation's Risk Management Processes from the Audit Committee. Arrangements will be made as part of the Annual Internal Audit Plan agreed by the Audit Committee, for periodic audits to be carried out to provide assurances to the Board that the Risk Management System in place conforms to the requirements of the Divisional Measurable Objectives (Appendix 9) and CQC standards.

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6. TRAINING

To ensure the successful implementation and maintenance of Risk Management within the organisation, all employees (including members of the Board, Clinicians, Managers, Bank, Locum and Agency Staff) will have their responsibilities for risk identified within their job descriptions and job plans. Staff will be trained in carrying out risk identification, assessment and treatment specific to their role.

7 ATTACHMENTS	
Appendix Number	Title
Appendix 1	Equality, Diversity & Inclusion Impact Assessment Form
Appendix 2	Trust Corporate Governance Committee Structure
Appendix 3	The Risk Assessment and Management Process Guidance
Appendix 4	Risk Assessment and Risk Management Process Flow Chart
Appendix 5	Summary of the Risk Register Data Fields
Appendix 6	Risk Review Frequency Guidance
Appendix 7	Risk Register Report Template
Appendix 8	NPSA Scoring Matrix
Appendix 9	Divisional Measurable Objectives

6 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
RMP-HS-102	Risk Assessment and the Process for Use of Risk Registers and Associated Guidance
TP-27	Policy and Procedure for handling Clinical Negligence, Personal Injury, Property Expense Claims and Personal Property Losses
TP-24	Complaints Policy and Procedure Listening, Learning, Improving
TP-113	Clinical Audit Policy and Procedure
RMP-C-98	Implementation of NICE Guidance and Quality Standards
RMP-HS-113	Reporting and Investigation of Incidents including Serious Incidents
TP-16	Health and Safety Policy
TP-149	Duty of Candor (being open) policy and procedure

7 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS		
References in full		
Number	References	
1	Lancashire Teaching Hospitals NHS Foundation Trust Licence	
2	Care Quality Commission (CQC) (2015) Acute Hospitals: provider handbook. Available at: http://www.cqc.org.uk/content/provider-handbooks (accessed 02/02/2017)	
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3	Department of Health (DOH) website. Available at: https://www.gov.uk/government/organisations/department-of-health (accessed 02/02/2017))
4	NHS England website. Available at: https://www.england.nhs.uk/ (accessed 02/02/2017))
5	NHS Litigation Authority website. Available at: http://www.nhs.uk/clinical-claims (accessed 02/02/2017)
6	NHS Litigation Authority. Clinical Claims Available at: http://www.nhs.uk/clinical-claims (accessed 02/02/2017)
7	Care Quality Commission (CQC) The Fundamental Standards. Available at: (accessed 02/02/2017)
8	National Patient Safety Agency (NPSA) (2008) A risk matrix for risk managers(Available at: http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/ (accessed 02/02/2017)

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NHS Litigation Authority (2013) NHSLA Risk Management Standards 2013-14. Available at:
<http://www.nhs.uk/clinical-claims>

Health and Safety Executive (HSE) (1999) Management of health and safety at work. Available at: <http://www.hse.gov.uk/pUbns/books/l21.htm>

National Patient Safety Agency (NPSA) (2004) Seven Steps to patient safety. Available at: <http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787> (accessed 02/02/2017)

National Patient Safety Agency (NSPA) (2009) Being Open Framework. Available at: <http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=83726> (accessed 02/02/2017)

Health and Safety Executive (HSE) Controlling the risks in the workplace. Available at: <http://www.hse.gov.uk/risk/controlling-risks.htm> (accessed)

8 DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
ALARP	As Low As Reasonably Practicable
BAF	Board Assurance Framework
CQC	Care Quality Commission
DGAG	Divisional Governance Assurance Group
DMB	Divisional Management Board
DMT	Divisional Management Team
HSE	Health and Safety Executive
MHRA	Medicines and Healthcare Products Regulatory Agency
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence

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NPSA	National Patient Safety Agency
TNA	Training Needs Analysis
TMB	Trust Management Board

9 CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
Christine Morris	Interim Director Governance	Feb 2018
Phebe Hemmings	Company Secretary	Feb 2018

10 DISTRIBUTION PLAN

Dissemination lead:	Phebe Hemmings
Previous document already being used?	Yes
If yes, in what format and where?	Electronic on Procedural Document Library Heritage
Proposed action to retrieve out-of-date copies of the document:	Trust Policy Administrator to arrange for replacement on Procedural Document Library (Heritage)
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date

Appendix 1



Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Governance
Lead Assessor	Interim Director of Governance
What is being assessed?	Equity in application of Risk Management Strategy

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Date of assessment	12.2.2018			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	<input type="checkbox"/>	Staff Side Colleagues	<input type="checkbox"/>
	Service Users	<input type="checkbox"/>	Staff Inclusion Network/s	<input type="checkbox"/>
	Personal Fair Diverse Champions	<input type="checkbox"/>	Other (Inc. external orgs)	<input type="checkbox"/>
	Governance and Company Secretary			

1) What is the impact on the following equality groups?

Positive:		Negative:	Neutral:
<ul style="list-style-type: none"> ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups 		<ul style="list-style-type: none"> ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups 	<ul style="list-style-type: none"> ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	Impact (Positive / Negative / Neutral)	Comments:	
		<ul style="list-style-type: none"> ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal? 	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		
Marriage and Civil Partnership	Neutral		
Pregnancy and maternity	Neutral		
Other (e.g. caring, human rights, social)	Neutral		

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	Promotes safe care for all patients, staff and users of our services.
--	---

3) If your assessment identifies a negative impact on Equality Groups you must develop an

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action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

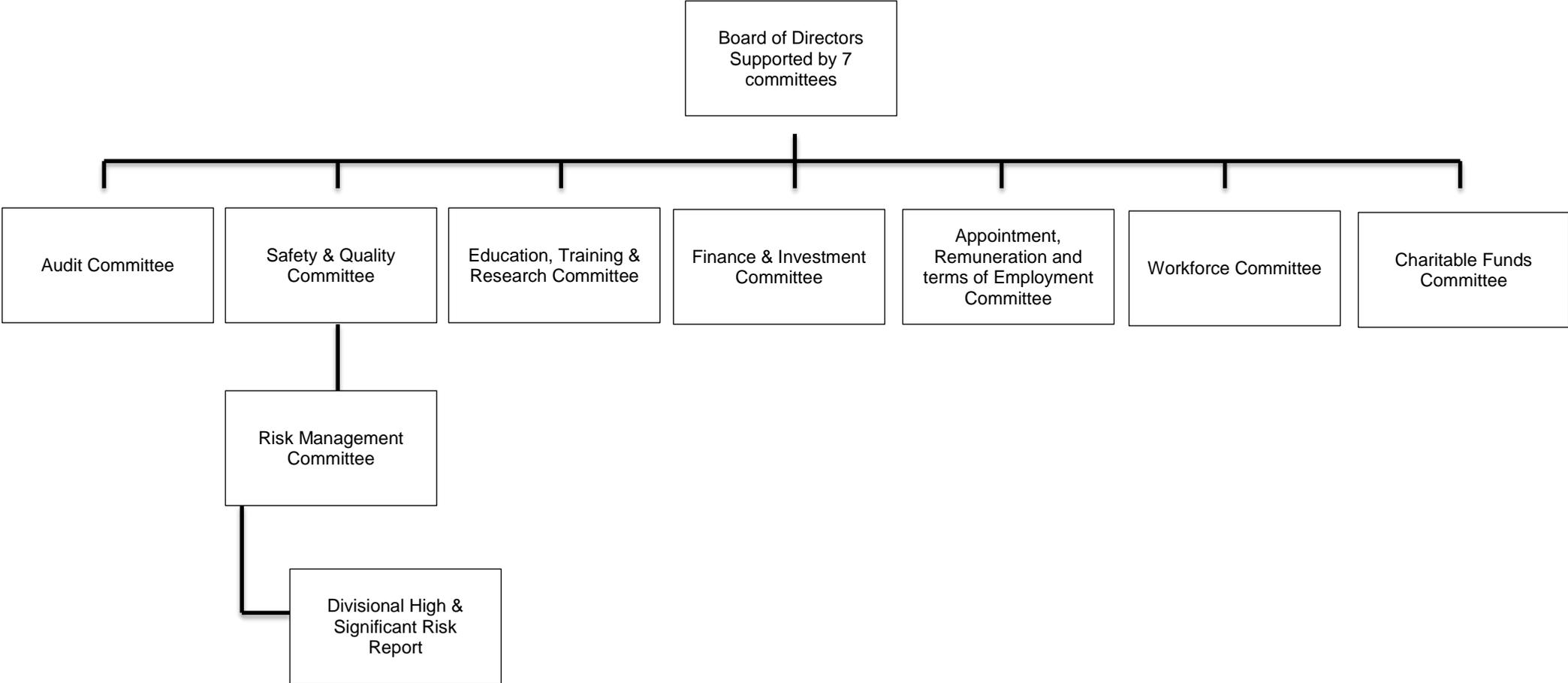
- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale

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Appendix 2 Trust Corporate Governance Committee Structure



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Appendix 3 RISK MANAGEMENT REPORTING ARRANGEMENTS

Document	Presented to	Frequency	By
Board assurance	Board of Directors	At each meeting	Company Secretary
Board Assurance	Exec Team	A minimum of 10 x per year	Company Secretary
Board Assurance	Risk Management Committee	At each meeting	Company Secretary
Board Assurance	Audit Committee	At each meeting	Company Secretary
Operational Risk Register	Risk Management Committee	At each meeting	Nursing Director
Risk Management Strategy	Board of Directors	Annually	Nursing Director
RMC Minutes	Safety & Quality	After each meeting	Committee Secretary
Annual Risk Management Report	Audit Committee	Annually	Company Secretary/ Nursing Director / Associate Director Patient Safety and Governance
Divisional Reports	Risk Management Committee	At each meeting	Divisional Head of Nursing
Women's Health Service review	Risk Management Committee	A minimum of three times a year	Head of Midwifery
Information Governance Sub-Committee Report	Risk Management Committee	Annually	Director of Finance
Clinical service strategy	Board of Directors	Monitored through board workshops	Medical Director

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Appendix 4 – The Risk Assessment and Management Process Guidance

Identifying the Risks to Objectives:

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

Proactive Processes:

- Planning Processes
- General Observations
- Internal/External Audits

Reactive processes:

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

Risk Assessor and Risk Manager:

When a risk is identified, a Risk Assessor and Risk Manager must be assigned to take responsibility for the assessment and ongoing management of the risk and the actions to mitigate the risk.

The Risk Assessor: should be the person that will have 'day-to-day' responsibility for the assessment and management of the risk, as such Risk Assessors must have the requisite authority to make the required decisions.

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

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

Nursing	Risk Assessor	Risk Manager
Intra-Divisional	Ward Manager/Sister	Matron
	Matron	Assistant Chief Nurse
Extra-Divisional	DND	DND
	Nurse Director	Nurse Director

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Medical	Risk Assessor	Risk Manager
Intra-Divisional Escalation	Junior Doctor	Consultant/Clinical Lead
	Consultant	Clinical Lead
	Consultant/Clinical Lead	Clinical Director
Extra-Divisional Escalation	Clinical Director	Deputy Medical Director
	Deputy Medical Director	Medical Director

Service Management	Risk Assessor	Risk Manager
Intra-Divisional Escalation	Department/Unit/Ward Manager	Service Manager
	Service Manager	Divisional General Manager
Extra-Divisional Escalation	Divisional General Manager	Deputy Chief Operating
	Deputy Chief Operating Officer	Chief Operating Officer

Risk Assessments and Systematic Approach

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

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

All Risk Assessments must include the following:

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

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

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

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

Description of the risk and the consequences of the risk occurring

It is important that Risk Descriptions are both concise and contain sufficient information to allow a reader to understand the risk. The Risk description should include; a summary of the cause and nature of the risk (the 'If'), the circumstances in which the risk may occur or worsen (the 'Then'), a statement of the plausible reasonably impacts (the 'So').

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

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

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

Do include objective statements and facts.

Do not include subjective personal opinions and views.

Do not include abbreviations and acronyms, unless they are in very common usage e.g. NHS

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Do not include Personal Identifiable Data of Patients or Visitors in the Risk Description. Do not include Personal Identifiable Data of colleagues in the Risk Description, unless it is directly relevant to the Risk.

Controlling Risks

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

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

Record each control individually and identify if there are any gaps in the control and the effectiveness of that Control. Identify and record any internal or external sources of assurance which are already in place e.g. performance monitoring reports, audits, reviews, incident reports, committee/group minutes etc. and any gaps in these assurances.

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

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

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			proactively address them
Adequacy of Assurance	Significant Assurance	Limited Assurance	Limited Assurance

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

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

- Fully Adequate
- Mostly Adequate
- Partly Adequate
- No Controls in Place

Risk Mitigation Strategy

In accordance with the Trust Risk Appetite statement all identified risks will be allocated a Risk Mitigation Strategy, this will define how the Trust will approach the management of the risk. The four Risk Mitigation Strategies are detailed in the below table:

Strategy	Explanation
Tolerate	Accept the risk
Treat	Take cost effective actions to reduce the risk
Transfer	Let someone else take the risk (e.g. by passing responsibility to CCG/different organisation/contract)
Terminate	Agree that the risk is too high and do not proceed with the project or activity.

The Current Risk score

Utilise the NPSA Risk Scoring Matrix and guidance to quantify the risk in terms of its current impact of the risk arising and the current likelihood of the risk arising. The matrix is in Appendix 8 of the Trust Risk Management Strategy.

Mitigating Action Plans

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

Section	Explanation
Action Type	Staff training – selected from a drop down list
Action Priority	Low, Medium or High
Action Title	Training Plan

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

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

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

Overdue progress updates can be escalated to:

- Divisional Governance Meetings
- Director of Clinical Governance
- Committees

Commissioner Related Risks

If a Risk that is affecting the Trust is also directly relevant to our Commissioners this can be recorded in the risk register, e.g. the performance of another Trust that also has services commissioned by our Commissioners, such Mental Health Trusts. This means the Trust can identify such Risks and then include them in reports to the Quality Assurance Meeting that is held with Commissioners. This will ensure that Commissioners are aware of this risk and can take further remedial action themselves, if practicable.

Target Risk Rating

Utilise the NPSA Risk Scoring Matrix and guidance to quantify the risk in terms of its target impact of the risk arising and the target likelihood of the risk, after the completion of the remedial action plan.

The matrix is in Appendix 8 of the Trust Risk Management Strategy and is also available in the Datix system.

Risk Monitoring and Review

It is mandatory that all risks have a defined review frequency and scheduled review date that is compliant with the guidance detailed in Appendix 6.

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Any Risk that has been given a Risk rating of ‘Significant’ or ‘High’ must be reviewed on at least a quarterly basis. Significant or High risks that are not reviewed on this basis will be escalated to the Director of Governance for resolution.

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

- Review Date
- Reviewed By
- Details of Review

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

Overdue Risk reviews are escalated to:

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

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

Risk Archiving and Record Management

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

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

- Pending – The risk is in ‘pending’ tray and is still under assessment
- Open– The risk is ‘assigned’ to an ‘Assessor’ and ‘Manager’ and its being actively mitigated
- Closed – The risk has appropriately mitigated and has been closed and archived

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

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Appendix 5 - Risk Assessment and Risk Management Process Flow Chart

Risk Management – Trust Risk Register, Life Cycle and Process

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

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

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

Risk Closure

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

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

Risk Review Process	
Automated Process Manual Checks	All Risks have a specified Risk Review Date that is compliant with the review frequency. Reminder email issued 7 days before review date, on review date and each 7 days after review date. Month end report of all risk reviews that are more than 7 days overdue issued to Divisional Governance Leads for chasing and escalation as appropriate.
Reviewers	Risk Assessors should review and update the Action Plan and Control Status of the Risk. Risk Managers should review and challenge the information provided by the Risk Assessor.
Quality Assurance	Divisional Governance Lead (or Corporate Governance team) assess the quality of the reviews undertaken by the Risk Assessor and Manager and provide feedback and advice as required.
Reporting: Oversight and scrutiny	Oversight and Scrutiny of the Risk Register is carried out from 'Ward to Board'. Multiple oversights for higher scoring Risks are provided at Divisional, Committee and Board Level. Some Committees monitor all risks that are within its remit e.g. Safeguarding Board.

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Appendix 6 – Summary of the Risk Register Data Fields

Orange denotes mandatory fields, grey denotes system generated fields.

Section	Data Item	Section	Data Item	
System Data	Risk Number	Current Risk Assessment	Current Risk Severity Score	
	Version		Current Risk Likelihood Score	
	Risk Level		Current Risk NPSA Rating	
	Current Status		Risk Group	
Location Details	Division		Risk Type	Source of Risk
	Site		Commissioner related	Action Priority
	Department		Action Plans	Action Title / Summary
	Specialty			Action Detail
Manager Details	Risk Assessor			Action Owner
	Risk Manager			Person Responsible
Link to Objectives	Trust Objectives	Start Date		
	Sub Objectives	Target Date		
	KPI Details	Reminder Date		
	Oversight Committee	New Progress		
Risk Details	Date Identified	Progress History		
	Risk Title	Action Status		
	Risk Description	Action Completed date		
	Additional	Target Risk Levels		
Existing Controls in Place	Control Type	Target Date		
	Details of Control	Target Risk Severity Score		
	Gaps in Control	Target Risk Likelihood Score		
	Effectiveness of Control	Target Risk NPSA		
	Assurance – Internal	Risk Review	Review Frequency	
	Assurance - External		Next Review Date	
	Gaps in Assurance		Review Date	
	Adequacy of Assurance		Reviewed By	
	Overall Control Effectiveness		Details of Review	
	Risk Mitigation Strategy		Supporting Documentation	
		Any Items of Supporting Documentation that have been added		

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Appendix 7 – Risk Review Frequency Guidance

Risk Review Frequency Guidance

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

Table of Suggested Risk Review Frequency

Total Risk Score	Risk Rating	Minimum Frequency	Maximum Frequency	Range of Review Frequencies
1 - 3	Low risk	Annual	Quarterly	Annual, Six Monthly, Quarterly
4 - 6	Moderate risk	Quarterly	Bi-Monthly,	Quarterly, Bi-Monthly,
8 - 12	Significant risk	Quarterly	Monthly	Quarterly, Bi-Monthly, Monthly
15 - 25	High risk	Monthly	Daily	Monthly, Bi- Weekly, Weekly, Daily

NPSA Risk Matrix – for reference

Consequence Score	Likelihood Score				
	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 Negligible	1	2	3	4	5

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Appendix 8 – Risk Register Report Template

Title of Report e.g. Corporate Risk Register Report									Trust Logo	
No.	Division	Date Identified	Manager	Type of Risk	Description	Current Score	Overall Control Effectiveness	Mitigation Strategy	Target Score	Target Date
1234	A Division	DD/MM/YYYY	A Manager	Risk Type	A description of the Risk	25	Fully Effective	Eliminate	1	DD/MM/YYYY
							Mostly Effective	Reduce		
							Partly Effective	Accept		
							No Controls in Place	Tolerate		
Control Type		Details of Current Controls						Effectiveness of Control	Level of Assurance	
A Control Type		Details of the Control						Fully Effective	Fully Assurance	
A Control Type		Details of the Control						Mostly Effective	Significant Assurance	
A Control Type		Details of the Control						Partly Effective	Limited Assurance	
A Control Type		Details of the Control						No Controls in Place	No Assurance	
Action Type		Details of Mitigating Actions						Person Responsible	Target Date	
An Action Type		Details of the Action						A Manager	DD/MM/YYYY	
An Action Type		Details of the Action						A Manager	DD/MM/YYYY	
Details of Last Risk Review										
Last Review Date:		DD/MM/YYYY								
Next Review Date:		DD/MM/YYYY								
Reviewed By:		A Manager								
Last Review Progress Update:		Details of the last review or progress update								

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

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Appendix 9 – NPSA SCORING MATRIX

Table 1 Consequence scores (Impact or severity)

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

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to avoidable death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

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Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved	Treatment or service has significantly y reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

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Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendation s/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media Coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget (<£0.62M) Claim less than £10,000	Loss of 0.25–0.5 per cent of budget (£0.62-1.25M) Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget (£1.25-2.5M) Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget (£ 2.5m) Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

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Service/business interruption Environmental impact	Loss/interrupt on of >1 hour Minimal or	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
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Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

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

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

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

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

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

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Appendix 10 - DIVISIONAL MEASURABLE OBJECTIVES

Objective	Action
1. To ensure all staff are aware of the Trust Risk Management Strategy where appropriate.	The strategy will be introduced at the Corporate and local induction and reinforced at annual risk management training.
Process for Monitoring: Annual Audit	
Objective	Action
2. To ensure all staff are aware of the process for assessing all types of risk.	<p>Ward/Departmental managers will ensure staff use the Trust standardised risk assessment form for the appropriate types of risk for completion of risk assessments for the following:</p> <ul style="list-style-type: none"> • Health and Safety risk assessments • Environmental risk assessments • Infection control risk assessments • Moving and handling of objects risk assessments • Moving and handling of patients risk assessments • Physical security of premises and assets risk assessments • Slips, trips and falls for staff and others risk assessments • Violence and aggression risk assessments
Process for Monitoring: Annual Audit	
Objective	Action
<p>3. Ensure staff is aware of the process for the management of risk locally.</p> <p>Ensure Ward/Departmental Managers manage and monitor risks by way of a Risk Register.</p> <p>Ensure staff manage and monitor risks by way of a Divisional Risk Register.</p>	<p>A Ward/Departmental Risk Register Folder will be developed by the Ward/Departmental Manager and Risk Assessments will be undertaken in accordance with the Trust Risk Management Strategy.</p> <p>A Divisional Risk Register will be formulated by the nominated professional leads and monitored by the Divisional Governance Meeting at least on a quarterly basis and by the Trust Management Board on a quarterly basis.</p>

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Process for Monitoring: Annual Audit	
Objective	Action
4. Ensure staff is aware of the process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation.	Demonstrate the escalation of risks from the Ward/Department (Risk > 8) are escalated onto the Divisional Risk Register and (Risks > 15) are escalated onto the Corporate Risk Register and/or Board Assurance Framework.
Process for Monitoring: Annual Audit	
Objective	Action
5. Ensure those with a responsibility for risk; attend the Divisional Governance and Assurance Group and other risk related meetings as defined in the Terms of Reference.	Record attendance of Committee Members and deputies in minutes. Ensure monitoring attendance sheets are maintained. Terms of Reference must define lines of communication.

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