Lincolnshire Community Health Services NHS Trust

Risk Management Strategy

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Lincolnshire Community Health Services
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Version Control

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1		New Policy - amalgamation of the reviewed Risk Management Strategy (RM002a), Risk Management Procedure9 (RM006a) and Risk Register Guidance (G_RM_01).	December 2012	Trust Board Secretary / Corporate Assurance Manager
2		Full review and update – incorporating change in process and other minor amendments	January 2014	Trust Board Secretary / Corporate Assurance Manager
2.1		Update of footers and extension to March 2015 agreed at Audit Committee December 2014	December 2014	Trust Board Secretary / Corporate Assurance Manager
3	Full Review	General formatting and administrative updates, inclusion of reference to Strategic and Corporate Risk Profile and Board Assurance framework	January 2015	Trust Board Secretary / Corporate Assurance Manager
3.1		Update to footers and extension to May 2016 to allow for changes to RM process to be completed	February 2016	Trust Board Secretary/ Corporate Assurance Manager
4		General formatting and administrative updates, inclusion of reference to Corporate Risk Register and Board Assurance Framework	February 2016	Trust Board Secretary/ Corporate Assurance Manager
4.1	Page 17	Inclusion of a new 'Data Quality' paragraph	September 2016	Trust Board Secretary/ Corporate Assurance Manager
4.2		Minor amendments accepted and extension approved	April 2017	Trust Board Secretary/Corporate Assurance Manager
5		Full review – general administrative and process updates, inclusion of risk appetite statement, inclusion of reference to BS 310000	November 2017	Trust Board Secretary/Corporate Assurance Manager

6		Rewrite of the strategy to update and bring in line with revised processes	February 2018	Interim Board Business Manager
7	Whole document	Review of strategy and process. Provide clarity about what is the strategy and what the process is for the management of risks	December 2018	Interim Head of Corporate Governance
8	Whole document	Review of strategy overall, removal of Treatment Plan and creation of Corporate Services Operational Risk Register and associated management, updating of responsibilities Merged with G_RM_01 – Process for Identifying and Managing Risk	November 2019	Head of Corporate Governance
9	Whole document	Full review of strategy, appendices and associated documentation, such as risk assessment form.	December 2020/ January 2021	Deputy Director of Corporate Governance

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Contents

1. Introduction

1.1 Lincolnshire Community Health Services ('LCHS' or 'the Trust') is committed to implementing the principles of good governance, defined as the system by which the organisation is directed and controlled at its most senior levels, to achieve its objectives and meet best practice standards in accountability, probity and openness. The Trust recognises that the principles of governance must be supported by an effective risk management system.

1.2 Risk management is an inherent part of the delivery of healthcare by LCHS and supports the effective running of the organisation. This Risk Management Strategy outlines the Trust's approach to risk management and the process in place to identify, manage and escalate risks.

1.2 This strategy identifies the accountability arrangements in place and provides guidance on what may be regarded as acceptable risk in consideration of the strategic context, appetite, tolerance and aims of the Trust.

1.3 Effective risk and issue management involves:

- Identifying and assessing risks;
- Taking action to anticipate, manage and mitigate risks;
- Monitoring risks and reviewing progress in order to establish further actions;
- Ensuring effective contingency plans are in place.

1.4 The Trust recognises that risk management forms an integral part of its philosophy, practices and the business planning cycle. The Trust Board must be able to assure itself that the organisation is operating effectively and meeting key aims, goals and principal strategic objectives.

2. Purpose

2.1 The purpose of the Risk Management Strategy is to provide a framework to ensure that risks to the achievement of the Trust's strategic aims and objectives are identified and managed in a consistent manner, appropriate to the level of risk in order to reduce the risk.

2.2 The Trust's approach to risk management aims to be forward looking, innovative, comprehensive and to make the effective management of risk an integral part of everyday practice. It also aims to support a culture which encourages continuous improvement and development, considered decision-making and a focus on proactive rather than reactive risk management in line with the Trust's risk appetite and tolerance level for each strategic aim.

2.3 This strategy outlines the Trust's vision for managing risks and issues. Through the management of risks and issues the Trust seeks to minimise, though not necessarily eliminate, threats and maximise opportunities.

3. Scope

3.1 The Trust recognises that it has a legal and moral obligation to safeguard staff, patients and members of the public. Failure to manage risks effectively can lead to avoidable harm, loss or damage in terms of personal injury as well as loss or damage to the Trust's reputation, financial loss and potential for complaints, litigation and adverse or unwanted publicity.

3.2 This strategy applies to all employees, including contractors and agency staff, and to all areas of the Trust and to all types of risk, both clinical and non-clinical. Effective delivery of risk management is everyone's responsibility. Ensuring that every member of the Trust is responsible for raising risks for their area of work well help to minimise risks and issues and protect our patients, staff, resources, reputation and embed the risk management culture as described by the LCHS Way.

3.3 The strategy and process is accessible to all employees on commencement of employment as part of their induction and via the Trust website. All managers have a responsibility to ensure that staff are made aware of what a risk is and how to manage risks.

3.5 Throughout this document risk terms have been used, a definition table of terms can be found at appendix 1.

4. Objectives of the Strategy

4.1 The objectives of this Risk Management Strategy are as follows:

- To set out the Trust's approach to risks and issues, provide a framework and clear process for robust risk and issue management at all levels within LCHS;
- To outline the framework to provide assurance and meet regulatory requirements that risks at all levels of the Trust are being appropriately identified, assessed, prioritised, addressed, monitored and reviewed;
- To detail expectations, roles and responsibilities of all staff in order to embed the process of risk identification, risk assessment, risk management and risk accountability into the day to day working practices of LCHS;
- To support and promote on-going training and development as a learning organisation;
- To demonstrate the organisational-wide accountability;
- To ensure decision-making, routine actions, incidents, complaints and claims are considered in terms of risk and issue management.

5. Approach to Risk Management

5.1 The Trust recognises the importance of having effective systems and processes in place to ensure identified risks are mitigated against and that new

or emergent risks are proactively scoped, assessed, monitored and controlled to reduce the potential that a risk will become an issue.

5.2 The Trust has adopted the following principles of Risk Management and applies them as appropriate:

- Commitment and ownership - ensuring the commitment to and ownership of risk management practice is demonstrated by the Board, Chief Executive, all senior managers and embedded throughout the Trust.
- Active Involvement - everyone at every level of the organisation is responsible for managing risk.
- Staff training – staff should receive relevant risk management training relevant to their role throughout their employment with the Trust.
- Communication - throughout the organisation, with patients and partner agencies, communication must be constant and through effective channels.
- Information – accurate, intelligent and timely information collection is essential to monitor progress and mitigate risks.
- Learning - learn from the information about incidents, claims and complaints to understand the problem rather than attributing blame and share learning across the organisation.
- Action - act on information gathered in a planned, consultative and timely way
- Controls – ensure effective systems of control are scoped and adopted that address the cause not the symptoms.
- Balance - in assessing risks and weighing the cost of mitigating risk, in opportunity or resources, against the achievable risk management.
- Feedback - ensure learning is incorporated into training programmes and disseminated to staff.

5.3 The Trust has a robust process to identify, assess, record, manage and monitor risks, and issues, as outlined in Appendix 3. Each individual and team is responsible for identifying, scoring and recording relevant risks which are entered onto the risk register. Risks are rated on a scale of 1-5 for both impact and likelihood and multiplied together to provide an overall risk rating as illustrated in the Risk Management Matrix in Appendix 4.

6. Risk Culture

6.1 The Trust is committed to having a risk management culture that underpins and supports the business of the Trust and the LCHS Way. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

6.2 LCHS is a creative and innovative Trust that is keen to work with partners to develop and grow our services and business for the benefit of the Lincolnshire community and to improve population health. Business and commercial risks of this nature can be embraced and explored within the risk management framework provided by this strategy to enable opportunities to be fully exercised.

6.3 Considered risk taking is encouraged together with experimentation and innovation within authorised and defined limits and Trust tolerance levels. The priority is to reduce risks that impact on safety and reduce our financial, operational and reputational risks.

6.4 Senior leaders will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

6.5 Managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

6.6 All staff have a responsibility to ensure they are aware of and understand the potential risks that could occur in their day to day area of work. Trust mandatory training provides an overview of how to manage risk appropriate to their work.

6.7 All staff are able to access comprehensive risk guidance and advice with additional training, development and support being provided to staff with additional accountability for risk management.

7. Training and Development

7.1 All employees will be connected to this strategy as they join the Trust through the Trust induction programme.

7.2 LCHS will further develop knowledge, competence and ownership of the risk process and increase the quality and responsiveness to risk reporting and mitigation activities. This will be implemented through a revised training programme that will be rolled out to all employees, as appropriate for their level of responsibility and accountability.

8. Risk Appetite Statement

8.1 The Trust recognises that there is always a level of inherent risk in the provision of healthcare which must be accepted or tolerated in addition to being actively and robustly monitored, controlled and action taken to mitigate.

8.2 LCHS has finite resources in terms of staff, equipment and finances available in the delivery of healthcare services.

8.3 In response to these factors the Trust will seek to manage risks in accordance with the well-established principle of ensuring the risk is mitigated as far as possible with priority being placed upon maintaining or improving patient safety ahead of any other aim or objective.

8.4 The Trust Board has approved a risk appetite statement that reflects the tolerance level of risk the organisation is willing to accept against each strategic aims and key elements of risk. The full Risk Appetite Statement is available on

the Trust's website at LCHS_Risk_Appetite_Statement_2021-22.pdf (lincolnshirecommunityhealthservices.nhs.uk)

9. Definitions of Risk

9.1 Different types of risk will originate from different situations. Various risks originate due to the uncertainty arising out of various factors that influence a situation. Risk implies future uncertainty and possible deviation from an expected outcome. Risk measures the uncertainty that an organisation is willing to take.

9.2 The definition of risk is the threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. A risk describes something that may or may not happen or crystallise. It is measured in terms of likelihood and consequence.

9.3 Risk can relate to either a threat – probability of damage, harm, injury, liability, loss, or any other negative occurrence that is caused by external or internal vulnerabilities and that may be avoided through preemptive action – and an opportunity – where there are risks attached to opportunities to obtain a benefit, innovate, grow or improve.

9.4 If a risk crystallises it ceases to be a risk and instead is called an issue. An issue can be defined as an unplanned event that has happened, which requires actions. The aim of programme risk and issue management is to support better decision-making through a good understanding of risks and issues and their likely impact. LCHS issues are managed using the same scoring matrix and process for risk management to identify, assess, record, manage and monitor the issue until it can be closed.

10. Business development and risk assessment

10.1 Any new business development opportunity should be considered from a risk perspective. The business case and proposal documents should include a risk assessment that identifies the risks that the Trust could be exposed to. Those risks should be considered against the Risk Appetite Statement.

11. Duties/Responsibilities

Trust Board

11.1 The Trust Board is collectively responsible for risk management and setting the Trust risk appetite and tolerance levels, although, as Accountable Officer the Chief Executive holds overall responsibility for risk management.

11.2 The Trust Board is responsible for the Board Assurance Framework and Corporate Risk Register.

11.3 The Trust Board is responsible for approving the movement of risks on and off the Board Assurance Framework and the Corporate Risk Register. The Trust Board will have sight of the full Board Assurance Framework and Corporate Risk Register on a bi-monthly basis.

Board Committees

11.4 The Board Committees will review the Corporate Risk Register and Board Assurance Framework as part of the agenda of the monthly meeting.

11.5 The Board Committees will seek assurance that the risks are being properly addressed by the leaders in the Trust.

Trust Leadership Team (TLT)

11.6 TLT is responsible for managing risks included on the Corporate Services Operational Risk Register (CSORR), including proposals to move risks between the Corporate Risk Register and the CSORR.

11.7 TLT will be responsible for ensuring the appropriateness of arrangements for additional operational risk registers in consideration of advice from the relevant Executive Directors and the Deputy Director of Corporate Governance.

Executive-led groups

11.8 Each meeting of Executive-led groups will review relevant parts of the Corporate Risk Register and Operational Risk Registers as part of the agenda and provide any updates to the Director responsible for the service.

The Chief Executive

11.9 The Chief Executive holds overall responsibility for risk management. The Chief Executive is also accountable for the implementation of risk management and controls assurance.

Executive Directors

11.10 The Executive Director remains responsible for the risk score and has the final decision as to what the score should be in consideration of advice from specialists and Executive-led groups.

11.11 The Executive Director may delegate operational monthly review and management to Deputy Directors. Executive and Deputy Directors shall provide updates to TLT, Board Committees and Trust Board on changes to risk registers via the regular risk report prepared by the Deputy Director of Corporate Governance.

Deputy Director of Corporate Governance

11.12 The Deputy Director of Corporate Governance is responsible for advising on and co-ordinating risk management activities including maintenance of the Corporate Risk Register and CSORR. The Deputy Director of Corporate Governance consults with the Chief Executive, Executive Directors and Deputy Directors on the strategic direction of all risk activities.

11.13 Detailed roles and responsibilities of staff are included in Appendix 2.

Leaders and Line Managers

11.14 All leaders and line managers within the Trust have a responsibility to ensure that they and their staff fulfil their responsibilities for risk management by identifying, reporting, monitoring, reviewing and managing risk in line with this and other associated policies;

11.15 It is important to ensure that appropriate and effective governance processes are in place to proactively identify assess and manage risk within their designated area and scope of responsibility.

11.16 Leaders and line managers should also ensure that identified risks are recorded, properly assessed, escalated, communicated and managed effectively and appropriately in line with this strategy and guidance within their area of responsibility so that the consequences of a risk – patient harm, financial loss, reputational damage, etc. are minimised.

All staff

11.17 Staff should ensure they know how to identify, whether clinical, non-clinical or both environments apply, risks that exist or emerge within the area in which they work and the escalation of these identified risks to managers, risk leads or senior management as appropriate.

11.18 Across the Trust staff should undertake working practices that comply with all policies, regulations, procedures and specific safe systems of work.

11.19 Staff should act in a manner which is safe and secure for themselves, colleagues, patients, visitors and others who may be affected by their actions, being aware they have a duty to take reasonable care for their own safety and the safety of others who may be affected by their acts or omissions.

11.20 Any hazardous situations and accidents/ near-misses/ incidents should be reported to the relevant manager(s) as soon as possible and through the appropriate systems, utilising Datix as necessary to report incidents.

12. Risk Management Review

12.1 The Risk Management Strategy and process for identifying, assessing, managing and monitoring a risk and the Risk Appetite Statement are reviewed every year.

13. System Risks

13.1 LCHS risks and issues are identified, raised, escalated and monitored as outlined in appendix 3.

13.2 Risks that are identified as their scope extending to be system-wide are escalated to the Lincolnshire NHS System Leaders Board (SLB) risk register for monitoring and management.

14. Board Assurance Framework

14.1 The Trust Board agrees the strategic aims and objectives for the forthcoming financial year on an annual basis. The strategic aims and objectives are reflected in the Board Assurance Framework which is reviewed by Board Committees on a monthly basis and the Trust Board bi-monthly. Each strategic aim and objective is owned by an Executive Director who is responsible for its delivery. Overall responsibility for delivery of the Board Assurance Framework is held by the Chief Executive.

14.2 An update report detailing changes and movement to the Board Assurance Framework is presented for review to Board Committees and Trust Board at each meeting.

15. Corporate Risk Register

15.1 The Corporate Risk Register provides senior leaders with a clear understanding of the current active risks that have been identified and are being managed by the Trust for risks that have an overall score rating of 12 or above.

15.2 The Corporate Risk Register underpins the Board Assurance Framework and is supported by the operational risk registers. The Corporate Risk Register is reviewed by all Deputy Directors on a monthly basis. At each meeting the Deputy Director considers the risks and will provide details on any additional updates or adjustments, liaising with their Executive Director as necessary.

15.3 The updated Corporate Risk Register is presented to Board Committees at every meeting and to each Public Trust Board, identifying changes proposed for approval.

15. 4 If a risk materialises into an issue this should be moved onto the issue register within the corporate risk register, actions noted and the issue managed according to the Trust process for risk and issue management.

16. Operational Risk Registers

16.1 Risks that are assessed to have an overall score rating below 12 will be noted on an operational risk register, which provides the basis for the hierarchy of risk. Each operational area has a local log where local risks are recorded. Risks are discussed at local governance groups and are escalated as appropriate within the LCHS governance structure and their Head of Service, dependent on the overall score. Risks which it is considered merit escalation shall be discussed with the appropriate Deputy Director by the register manager.

16.2 If a risk materialises into an issue this should be moved onto the issue register within the CSORR, actions noted and the issue managed according to the Trust process for risk and issue management.

16.3 Local clinical risk logs are managed by Quality Assurance Managers and escalated via agreement with the relevant head of service for discussion at the Clinical Safety and Effectiveness Group (CSEG).

16. 4 The CSORR is updated by Deputy Directors and overseen and managed by the Deputy Director of Corporate Governance.

17. Closed Registers

17.1 The closed register records all the risks and issues that have been considered by the Trust where the risk or issue no longer exists. Risks are closed primarily, but not exclusively, due to a significant change to the initial risk; the risk has been managed and mitigating actions fully implemented reducing the risk to the target rating; the Trust has ceased undertaking the activity that gave rise to the risk; or the risk has materialised into an issue. The Corporate Services Operational Risk Register and the Corporate Risk Register each have a closed register sitting within the excel spreadsheet.

17.2 The closed risk register shall be archived annually with a new closed risk register commenced for each new financial year.

18. Annual Governance Statement

18.1 The Annual Governance Statement is an annual statement prepared by the Trust which provides assurance on the internal controls in place across the organisation during the year. It includes detail of the risk management systems, how the Trust’s capacity to manage risk is addressed and a summary of key risks. The statement is prepared by the Deputy Director of Corporate Governance on behalf of the Chief Executive and approved by the Trust Board.

Appendix 1- Definition of terms

Term	Description
Action	is the work that is undertaken to address the risk, however, may not result in a control being put in place to manage the risk in the future.
Assurance	Internal and external evidence that risks are being effectively managed
Control(s)	Outcomes of work that has been undertaken that help the risk be mitigated and prevented from reoccurring.
Consequence	The potential consequence if the adverse effect occurs as a result of the hazard
Internal control	A method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control
Inherent/ initial risk	The level of risk before any control activities are applied.
Likelihood	The chance or possibility of something happening.
QAM	Quality Assurance Manager
Target risk score	The risk score which it is expected the mitigating actions will achieve once fully implemented.
Current risk	The current risk 'left over' after controls, actions or contingency plans have been put in place.
Risk	The threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. It is measured in terms of likelihood and consequence.
Risk Appetite	The amount and type of risk the Trust is prepared to accept or be exposed to at any point in time.
Risk Capacity	The amount or type of risk which the organisation is able to be exposed to whilst having regard to the resources available.
Risk Management	All the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress'.
Risk Maturity	The overall quality of the risk management framework.
Risk Owner	The individual who is responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation to risks (or a given level of the organisation).
Risk Rating/ overall risk score	The total risk score worked out by identifying the consequence and likelihood scores and cross referencing the scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans to mitigate and reduce risks.
Risk Tolerance	The boundaries of risk outside of which the organisation is not prepared to venture in the pursuit of its objectives.

Appendix 2 - Roles and Responsibilities
The following table describes the responsibilities for employees, groups committees and Trust Board for risk management.

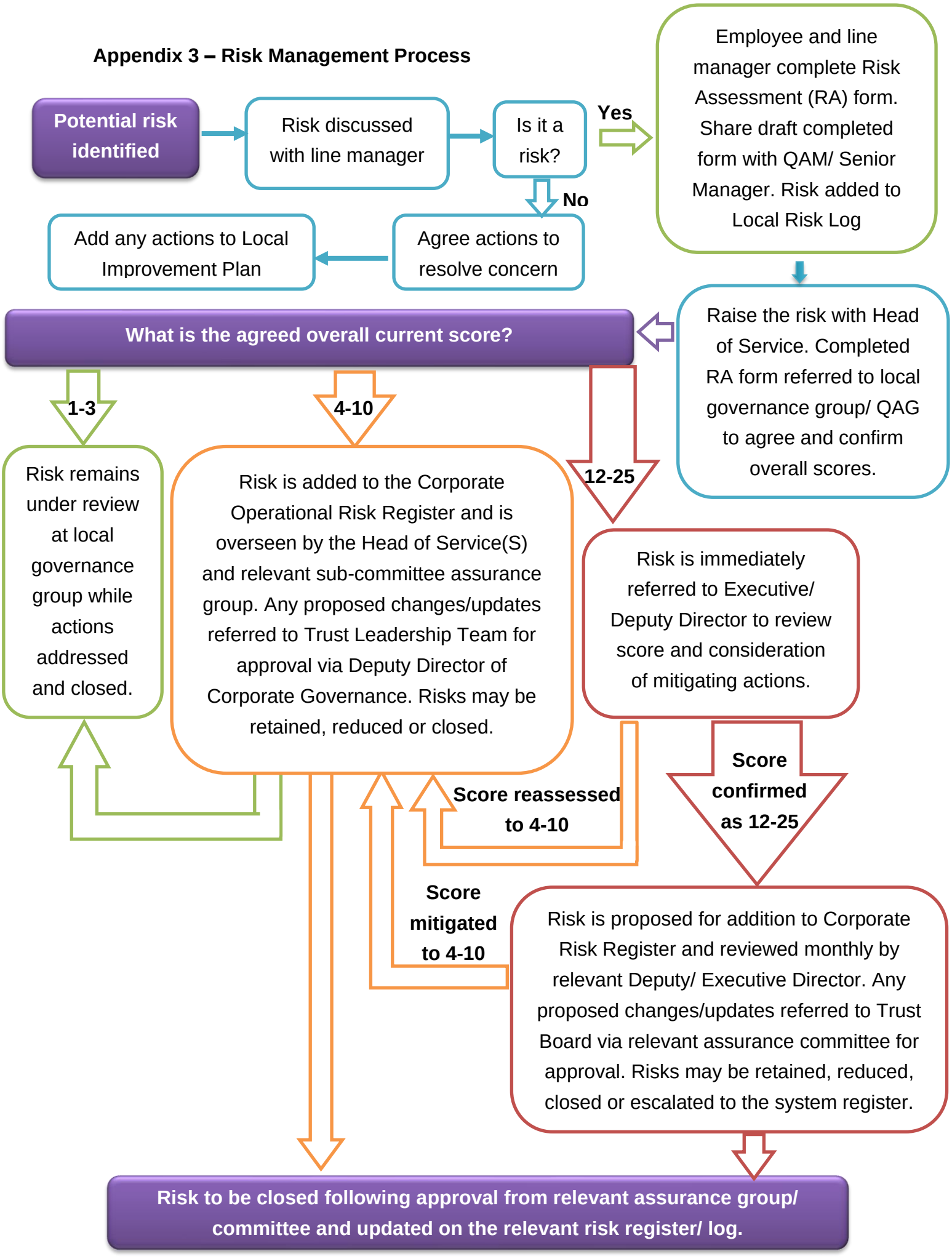
Title	Responsibilities
Chief Executive	• Overall accountability for maintaining a sound system of internal control and assurance that supports the achievement of the organisation's strategic aims and objectives; • Responsibility for ensuring full support and commitment is provided and maintained in every activity relating to risk management; • Responsibility for planning for adequate staffing, finances and other resources to ensure the management of those risks which may have an adverse impact on staff, finances or Trust stakeholders; • Signing the Trust's Annual Governance Statement and ensuring this adequately reflects the risk management journey within the Trust over the course of the financial year; • Delegating responsibility for the implementation of the Risk Management Strategy to other individuals as appropriate.
Director of Finance and Business Intelligence	• Responsibility for financial governance and associated financial risks, including those featuring on both the Corporate Risk Register and the CSORR.
Medical Director	• Responsibility for medical risks appearing on the Corporate Risk Register, CSORR and the local clinical risk logs or operational risk registers.
Director of Nursing, AHPs and Operations	• Responsibility for clinical and operational risks appearing on the Corporate Risk Register and CSORR; • Executive lead for Clinical Operational Risk Registers; • Deputisation for responsibilities detailed under Chief Executive as required. • As the Trust Accountable Emergency Officer and the Specialist Emergency Preparedness, Resilience and Response (EPRR) Officer to ensure appropriate leadership and models are in place to respond to unexpected circumstances.
Director of People and Innovation	• Responsibility for People and Innovation risks including those featuring on both the Corporate Risk Register and the CSORR.
All Executive Directors	• Ensure that, within their directorates, all risk management activities are coordinated, managed, monitored and reviewed: • Ensure the implementation of short, medium and long-term actions to tackle identified risks; • Recommending risk register changes or updates to the Trust Board.

Non-Executive Directors	• Providing challenge to the risk management and governance arrangements within the organisation. • Providing assurance of the robustness of these arrangements as part of their role as members of the Trust Board and its committees.
Deputy Director of Corporate Governance	• Operational management and oversight of the Corporate Risk Register and the CSORR; • Updating of this strategy and associated documentation; • Lead coordination through Chief Executive's Office for the timely review of risks by Executive and Deputy Directors; • Review and preparation of the Annual Governance Statement on behalf of the Chief Executive.
All Employees (including contracted personnel and agency staff)	• The identification of both clinical and non-clinical risks that exist or emerge within the area in which they work and the escalation of these identified risks to managers, risk leads or senior management as appropriate; • Undertaking working practices that comply with all policies, regulations, procedures and specific safe systems of work; • Ensuring they act in a manner which is safe and secure for themselves, colleagues, patients, visitors and others who may be affected by their actions, being aware they have a duty to take reasonable care for their own safety and the safety of others who may be affected by their acts or omissions; • Report any hazardous situations and accidents/ near-misses/ incidents to the relevant manager(s) as soon as possible and through the appropriate systems, utilising Datix as necessary to report incidents.
Senior/Line Managers	Ensuring that they and their staff fulfil their responsibilities for risk management by identifying, reporting, monitoring, reviewing and managing risk in line with this and other associated policies; Ensuring that appropriate and effective governance processes are in place to proactively identify assess and manage risk within their designated area and scope of responsibility; Ensure identified risks are recorded, properly assessed, escalated, communicated and managed effectively and appropriately in line with this strategy and guidance within their area of responsibility so that the consequences of a risk – patient harm, financial loss, reputational damage, etc. are minimised
Quality Assurance Managers (QAMs)	• Playing a key role in supporting the systems and processes for the review and recording of all risks within their operational areas; • Managing local clinical risk logs and clinical operational risk registers, as appropriate, within their areas of allocated responsibility; • Providing expert advice on the grading and escalation/de-escalation where appropriate. This will involve providing

	education and encouragement of how risk reporting improves patient safety, experience and the quality of services; • Providing support on the relationship between incidents, complaints, claims, compliments and the risk systems; • Supporting their area in the identification, assessment and reporting of risk.
Heads of Clinical Services (HOCS)	• Discussing existing and emerging risks within their environment with the Quality Assurance Mangers, Matrons and Clinical Team Leads; • Ensuring risk assessments are undertaken and an action plan is developed to mitigate the risk including any cost implications, reviews of risks and monitor progress of completion of mitigating actions; • Ensuring all risks and associated action plans are monitored and reviewed at each local governance meeting. Any risk scoring 8 or above should be included in the risk register for discussion at local groups and committees; • Ensuring all staff are aware of their responsibilities in relation to risks in their working environments; • Ensuring staff have been provided with the necessary information and training to enable them to work safely; • Discussing any new risks with the most appropriate Deputy Director. • Discussing existing and emerging risks with QAM, Matrons, Clinical Team Leads and Specialist EPRR Officer.
Chairs of all Trust meetings	• Ensuring all relevant risks are brought to the meeting on a regular basis for review to ensure they are up to date and being effectively managed. • Seeking assurance that appropriate action has been taken to mitigate the risk.
Trust Leadership Team	• The Trust Leadership Team (TLT) is responsible for all operational risk registers including directly reviewing the CSORR and receiving assurance as to the effectiveness of clinical operational risk registers; • The TLT will seek views from specialist groups as required; • The TLT will make recommendations to the Trust Board on the inclusion of risks on the Corporate Risk Register, either as TLT or via the Executive Directors who sit on Trust Board.
Audit Committee	• The Audit Committee will review the adequacy of the risk systems and provide assurance to the Trust Board that the systems are appropriate and provide the Trust with an appropriate risk management system. • The committee has responsibility for providing assurances to the Trust Board on the internal control systems and the process which are in place by the monitoring and validation through internal and external audit cycles.
Quality and Risk	The Quality and Risk Committee (Q&RC) will be responsible for overseeing the management of medical and clinical risks. It will seek

Committee	assurance that risks are being updated on a regular basis and triangulate the information report to the Committee with the Corporate Risk Register.
Finance, Performance and Investment Committee	The Finance, Performance and Investment Committee (FPIC) is responsible for overseeing the management of business risks. It will seek assurance that risks are being updated on a regular basis and triangulate the information report to the Committee with the Corporate Risk Register.
Senior Management Team	• The meeting is chaired by the Director of Nursing, AHP and Operations and is the point at which any risk escalated from the Safeguarding Group can be discussed with the senior management and the Director responsible for the service; • The meeting will review the risks and escalate any as appropriate.
Specialist Groups	• At each meeting specialist groups will include the Corporate Risk Register and Corporate Services Operational Risk Register and relevant suite of documents as part of the agenda and provide any updates to the Deputy Director responsible for the service. • The groups provide advice to the Deputy Directors and agree any update to the risk. The Deputy Director should update the register in line with the agreement made at the group. • Specialist Groups include, but are not limited to, Senior Management Team, Health and Safety Committee, People Executive Group, Safeguarding Group, Clinical Safety and Effectiveness Group, Fraud Risk Group, Emergency Planning Group.
The Trust Board	• Sharing the collective responsibility for the success of the Trust, including the effective management of risk and compliance with relevant legislation and providing the strategic direction and leadership to the Trust including: ▪ Protecting the reputation of the Trust; ▪ Providing leadership on the management of risk and ensuring the approach to risk management is consistently applied and determining the risk appetite for the Trust; • Ensuring all assurances demonstrate that the risk has been identified assessed and all reasonable steps have been taken to manage it effectively and appropriately. • Endorsing risk related disclosure documents. • Review the Risk Appetite Statement on an annual basis

Appendix 3 – Risk Management Process



Appendix 4: Risk management Matrix

Table 1: Consequence score (C)

Consequence score (severity levels) and examples of descriptors					
	1	2	3	4	5
Domains	**No harm**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	No harm 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 impacts on a small number of patients	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 death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	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 Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2: Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

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 frequently

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3: Overall risk score/ rating = consequence x likelihood (C x L)

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

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	High risk
15 - 25	Significant risk

Appendix 5: Risk Register Hierarchy

Appendix 6: Risk Assessment Form

To be completed in conjunction with the LCHS Risk Matrix Tool

Risk Title	
Location of Risk: e.g. specific service/countywide/corporate	
Date completed:	
Risk Owner: (responsible for updating risk weekly and notifying Head of Service/ Deputy Director for service)	
Job Role:	

Please choose one of the following:

New/Emerging Risk		**Update on existing risk**	

Description of Risk:		
What is the risk?	**What is happening?**	**What is the consequence? For? e.g. staff/patients**
There is a risk that:	**Caused by:**	**Resulting in:**

Details of existing controls currently in place, including immediate actions that have taken place

Controls:

1.
2.
3.

Immediate actions taken:

1.
2.
3.

Initial Mitigating Action Plan (What actions do you intend to implement to reduce the risk?):			
Action:	**Responsible Lead:**	**Due By:**	**Progress/Date completed:**
Planned Review Date/Frequency: (Reviews to be taken on a weekly basis as a minimum)			
Name of Assessor:			

(Use the Trust grading matrix)

Initial Risk Rating (On completion of assessment considering controls and mitigation in place)					
Date completed:					
Likelihood Score: (Highlight relevant box)	**1** **Rare**	**2** **Unlikely**	**3** **Possible**	**4** **Likely**	**5** **Almost certain**

Consequence: Please note the Trust grading matrix Click here. If a domain is not applicable please enter N/A. Please note that the consequence of the risk will not change. This score relates to LCHS's overall ability to respond to COVID_19	**Domain**	**Score**	**Descriptor**
	Impact on the safety of patients, staff or public (physical/psychological harm)		
	Quality/complaints/audit		
	Human resources/ organisational development/staffing/ competence		
	Statutory duty/ inspections		
	Adverse publicity/ reputation		
	Business objectives/ projects		
	Finance including claims		
	Service/business interruption Environmental impact		

Consequence Highest Score	
Initial / inherent Risk Rating - LxC (without controls/immediate actions in place)	
Risk Category:	
Current Risk Rating - LxC (With controls in place and immediate actions taken)	
Risk Category:	

Target Risk Rating - LxC **(What is the risk tolerance score?)**	
Risk Category:	

Updated Management of Risk Action Plan:				
Date of Update	**New/Revised Actions:**	**Responsible Lead:**	**Due By:**	**Progress/Date completed:**
Planned Review Date/Frequency:				
Name of Assessor:				

19. Appendix 7: Equality Analysis

NB - It is the responsibility of the author / reviewer of this document to complete / update the Equality Analysis each time it has a full review and to contact the Equality Diversity and Inclusion Lead if a full equality impact analysis is required

Equality Impact Analysis Screening Form

Title of activity	LCHS Risk Management Strategy		
Date form completed	08.01.2021	Name of lead for this activity	Catherine Leggett

Analysis undertaken by:		
Name(s)	Job role	Department
Catherine Leggett	Deputy Director of Corporate Governance	Chief Executive's Office

What is the aim or objective of this activity?	NHS Trusts are required by law to ensure a robust process is in place to assess, manage and to take proactive action to mitigate risks to patients, the public, employees and relevant stakeholders. LCHS is responsible for ensuring it operates within legal and regulatory parameters and in a safe manner.
Who will this activity impact on? *E.g. staff, patients, carers, visitors etc.*	Unlikely to impact.

Potential impacts on different equality groups:

Equality Group	Potential for **positive** impact	**Neutral** Impact	Potential for **negative** impact	Please provide details of how you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
Age	☐	☒	☐	
Disability	☐	☒	☐	
Gender reassignment	☐	☒	☐	

Marriage & civil partnerships	☐	☒	☐	
Pregnancy & maternity	☐	☒	☐	
Race	☐	☒	☐	
Religion or belief	☐	☒	☐	
Sex	☐	☒	☐	
Sexual Orientation	☐	☒	☐	
Additional Impacts ***(what other groups might this activity impact on? Carers, homeless, travelling communities etc.)***	☐	☒	☐	

If you have ticked one of the above equality groups please complete the following:

Level of impact

	Yes	No
Could this impact be considered direct or indirect discrimination?	☐	☐
If yes, how will you address this?		
N/A		

	High	Medium	Low
What level do you consider the potential negative impact would be?	☐	☐	☐

If the negative impact is high, a full equality impact analysis will be required.

Action Plan

How could you minimise or remove any negative impacts identified, even if this is rated low?
N/A
How will you monitor this impact or planned actions?
N/A
Future review date: January 2022