UNIQUE IDENTIFIER NO: G-101-2015
EQUIP-2017-060
Review Date: April 2019
Review Lead: Director of Nursing

Calderdale and Huddersfield
NHS Foundation Trust

Risk Management Policy

Version 3

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Document Summary Table		
Unique Identifier Number	G-101-2015	
Status	Ratified	
Version	3	
Implementation Date	July 2015	
Current/Last Review Dates	April 2017	
Next Formal Review	April 2019	
Sponsor	Director of Nursing	
Author	Head of Governance and Risk	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors		
Executive Board		6 July 2017
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Risk & Compliance Group	Director of Nursing	11 April 2017
Audit and Risk Committee / WEB	Non-Executive Director	19 July 2017
Other Stakeholders Consulted		
Clinical Governance Support Managers		
Does this document map to other Regulatory requirements?		
Regulator details	*Regulator standards/numbers etc*	
CQC	Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 17: Good Governance Regulation 19: Fit and Proper Persons	

Document Version Control	
Version No	
1	The Risk Management Strategy used to form part of the Trust's Governance Strategy. The Risk process has been removed from this to form its own policy.
2	Risk Management Policy review in line with scheduled review date
3	Alignment with Risk Management Strategy December 2016 and EQUIP policy.

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1. Introduction

Vision and Statement of Intent

The Trust's vision of this strategy is for risk management to be regarded as a highly valuable and useful tool to help the Trust achieve its objectives, with:

Risk management systems understood by staff
Risk management systems embedded into everyday working practice across all parts of the organisation
The Board and its committees assured that risks are managed to achieve the Trust's objectives

The Trust will aim continually to improve the content and maturity of the risk management framework which is a key part of the governance framework.

The Risk Management Policy applies to all categories of risk, both clinical and non-clinical risks. These include, though are not limited to:

Clinical quality / patient safety risks	**Operational / performance risks**	**Financial risks**
Health and Safety Risks	**Project Risks**	**Patient Experience Risks**
Business Risks	**Reputational Risk**	**Regulatory risks**
Governance risks	**Workforce Risks**	**Partnership risks**
Information risks	**External environment risks**	**Risks from political change / policy**

The Risk Management Strategy details the organisational structure for risk management, the roles and responsibilities of committees responsible for risk (see section 7) and accountabilities for risk management (see section 8).

Within the Risk Management Policy, key responsibilities for operational staff are given at section 4.

This policy should be read in conjunction with the risk management strategy which we aim to embed by the following:

2. Risk Management Objectives

The overall objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks which may adversely affect patients, staff, contractors, the public and the fabric of buildings, are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach thereby providing a safe environment in which patients can be cared for, staff can work and the public can visit

- Risks are managed to an acceptable level as defined in the Board's Trust risk appetite and staff have a clear understanding of exposure and the action being taken to manage significant risks

- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated, (a flowchart of risk escalation is given at section 9.4)

- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage and monitor risks effectively – see section 9 for further details

- All staff recognise their personal contribution to risk management

- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed

3. Scope of this Policy

Risk management is everyone's responsibility. This policy applies to all employees, contractors and volunteers. All employees will co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. Specific roles and responsibilities for risk management are summarised at Section 4 below.

4. Roles and Responsibilities

In order to achieve the aims of this policy the following roles, accountabilities and responsibilities apply at operational level:

Operational Staff Duties & Responsibilities

4.1 Clinical and Divisional Directors

Clinical and Divisional Directors have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities.

In addition to Divisional Directors and Clinical Directors the divisional management team includes an Associate Director of Nursing and Associate

Divisional Director.

They are responsible for demonstrating and providing leadership of risk management within their division, directorates and teams. They are accountable for:

- Pro-actively identifying, assess, managing and reporting risks in line with Trust processes
- Establishing and sustaining an environment of openness and learning from adverse events to prevent recurrence and creating a positive risk management culture
- Seeking assurance through their governance arrangements of the effectiveness of risk management
- Ensuring clinical risks, health and risks, emergency planning and business continuity risks, project and operational risks are identified and managed.
- That general managers, operational managers, matrons, ward managers, departmental team managers are responsible for ensuring effective systems of risk management and risks registers are in place at all levels.

4.2 All Staff

All staff will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks
- Identify, assess, manage and control risks in line with Trust policies and procedures
- Be familiar with local policies, procedures, guidance and safe systems of work
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, eg comply with incident and near miss reporting procedures
- Be responsible for attending mandatory and essential training and relevant educational events
- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been assessed

4.3 Contractors and Partners

It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of

Contractors policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of the Trust are fully conversant with CHFT's health and safety rules staff member responsible is fully aware of the contractors activity for which they are engaged and, if applicable, are in possession of the contractors risk assessment and method statement for their activity.

4.4 Risk Management Specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience so that competent advice is available to staff. As well as supporting staff manage risks, these specialists create, review and implement policies, procedures and guidelines for the effective control of risks. These include:

Role	Responsibility
Caldicott Guardian Senior Information Risk Owner (SIRO) Information Governance Manager	Information Governance Risks
Company Secretary	Strategic Risks Foundation Trust risks Central alert systems risks
Director of Nursing	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Emergency Preparedness	Emergency Planning and business continuity risks
Fire Safety Manager Health and Safety Advisor Local Security Management Specialist (LSMS) Director of Estates and Facilities Director of Security	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability Security Management
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Patient Experience lead	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Governance and Risk Team Assistant Director of Quality Head of Governance and Risk Risk Manager, Legal Services Manager Clinical Governance Support Managers / Quality and Safety lead	All risks and risk management tools, processes and training.
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

Further details on these roles can be found in Appendix 3 of the Risk Management Strategy.

5. Risk Management Process: Risk Registers

All areas assess record and manage risk within their own remit, reporting on the management of risks through the risk register, using the risk grading system detailed at Appendix 4. All risks are linked to strategic objectives.

A database is used to capture all risks to the organisation including clinical, organisational, health and safety, financial, business and reputational risks. A framework is in place for assessing, rating and managing risks throughout the Trust, ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, division, directorate and team. Further detail on the process for populating the risk register is given in the Risk Management Policy.
It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the High level risk register which is an integral part of the Trust's system of internal control.

The High level risk register includes those significant risks which may impact on the Trust's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed on a monthly basis by the Risk and Compliance Group and presented to the Board of Directors.

Divisional, directorate and team risk registers are managed and reviewed by the Divisions, with divisional risk registers reviewed on a regular basis by the Risk and Compliance Group. The performance framework for divisions also includes scrutiny of risks within divisions. The Risk Management Policy details the process for risk register reporting.

The diagram below depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout the Trust.

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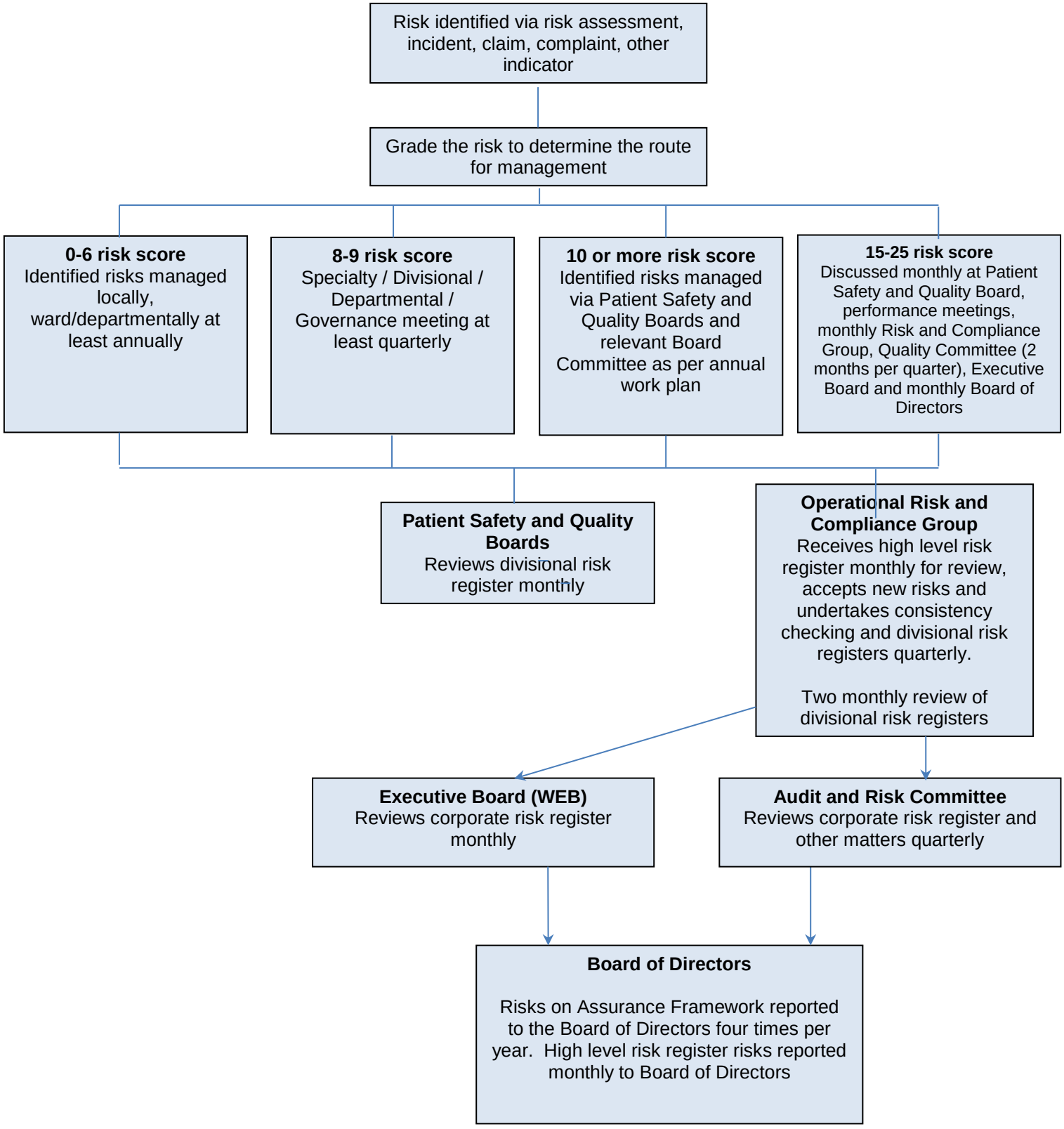
Structure and flow chart for the management of assurance and risk



Step 1: Determine Priorities

Risk is defined as anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful (for a summary of key terms used in this document see Appendix 1). The Board of Directors and senior management will be clear about objectives for each service and express these in specific, measurable, achievable ways with clear timescales for delivery.

Step 2: Identify Risk

Evaluating what is stopping, or anticipating what could prevent the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risks should not be confused with issues, which are things that have happened, were not planned and require management action.

Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats.

Risks need to be clearly described to ensure there is a common understanding by stakeholders of the risk. The recommended way for describing a risk is **risk of.....due to .....resulting in,** as follows:

Steps to write a risk	
Identify the risk	Risk **of** .....
Identify the cause of the risk	Risk **due to** .....
Identify the impact of the risk	Risk **results in**

Appendix 2 includes guidance on how to write a risk.

The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning process and compliance requirements.

Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive. In order to do this the Board of Directors, senior leaders and divisional teams will identify what is uncertain, consider how it may be caused and what impact it may have on the objective and service.

Step 3: Assess Risk

All risks must be assessed in an objective and consistent manner. Risks are

assessed on the probability, i.e. the likelihood of a risk happening and on what would happen (impact) should the risk occur.

The magnitude of a risk can be estimated by multiplying the severity of impact by the likelihood of the risk occurring using a standard 5x5 risk scoring matrix to score likelihood and impact of a risk.

The Trust procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured

- **Current risk score -** this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented

- **Target / residual risk score -** this is the score that is expected after the action plan has been fully implemented

Staff should be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating target / residual risk and risk scoring matrix guidance is provided at Appendix 4.

Step 4: Respond to the Risk

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

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*
- **Accept / Tolerate** - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- **Avoid / Terminate** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer*

arrangement.

- **Modify** - this strategy involves specific controls designed to change either the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:

The following three types of control are used to modify risk:

(i) **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks etc.

(ii) **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits

(iii) **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls are designed to maintain resilience.

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

Step 5: Report Risk

The structure and flow chart for the management of assurance and risk above confirms how risks are reported throughout the organisation.

All risks must be recorded on the Risk Register. It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the high level risk register which is an integral part of the Trust's system of internal control and defines the risks which may impact on the Trust's ability to deliver it's objectives.

Risks which score 15 or higher must be brought to the attention of the Head of Risk and Governance for escalation to the appropriate committee for consideration and potential inclusion on the high level risk register. The Risk and Compliance Group will also consider for inclusion on the high level risk register risks scored at 12 as highlighted by the divisions. The high level risk register prioritises risk, populated from risk assessments carried out both at a strategic and operational level.

The Risk and Compliance Group, on behalf of the Audit and Risk Committee and Board, oversees the high level risk register, with identified Board Committees or groups overseeing the management of risks on behalf of the Trust.

Key outputs from the risk management system will be reported to relevant staff/committees depending on the residual risk score as follows:

- ≥15 – each formal meeting of the Board of Directors
- ≥10 – [Relevant] Committee of the Board of Directors as part of the Committee's annual work plan
- ≥8 – Specialty/Divisional /Departmental Governance meeting at least quarterly
- ≥≤6 – Ward/Departmental Management at least annually

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

The Quality Committee, which has a specific role for clinical risks, receive the risk register on a monthly basis.

Risk registers from divisions are scrutinised through their Patient Safety Quality Boards and every two months by the Risk and Compliance Group. They are reviewed to ensure that risks within the division and their directorates are captured. Each division reports on their risk registers on a quarterly basis to the Quality Committee. The

The Executive Team will be informed by the Director of Nursing (or relevant Executive Director) of any new significant risk arising at the first meeting opportunity.

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

Step 6: Review Risk and Risk Closure

Risks will be reviewed at a frequency proportional to the residual risk. Discretion regarding the frequency of review is permitted. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

- ≥15 – at least monthly
- ≥10 – at least quarterly
- ≥8 – at least bi-annually
- ≤6 – annually

Step 7: Risk Closure

A risk can be closed and moved to the closed section of the electronic risk register system for audit purposes when:

i. There is a change in practice which removes the hazard
ii. Where the risk / event has passed
iii. Where it is clear that the action taken to treat a risk eliminates all reasonably foreseeable exposure to that risk

Completion of actions does not necessarily mean that a risk can be eliminated and closed.

Each division should have governance arrangements which define a clear process for authorising the closure of risks by managers / through appropriate directorate / department or divisional meeting and ensure that all staff are aware of this. The reason for closure should be stated on the risk register.

High level risk register - for risks scoring 15 or above which are included within the Corporate Risk Register, risks that are proposed for closure should be reviewed for closure by the Risk and Compliance Group prior to closing the risk.

It is good practice to periodically audit closed risks to satisfy that the risk is no longer present.

6. Training

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

a) Risk Register
The Risk Register provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto the risk register.

b) Risk Management Training
Training is required to effectively manage risks in line with the process set

out above. Bespoke risk management training will be available to teams, tailored to their specific needs. This could include sessions on:

- Operational use of the electronic risk register system and guidance on how to articulate a risk, controls and actions (group or individual)

- Advice and guidance on management of risk in their area

- Peer review of risk registers

- Support with the development of risk registers

c) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk management process by staff from the Governance and Risk team. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

d) Divisional, Ward and Departmental managers will have further more detailed risk management process training incorporating how to use the Risk Register database before access to the database is enabled.

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

7. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnership.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

8. Monitoring and Audit

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

- All verified significant risks are reported to the Board of Directors at each formal meeting of the Board

- All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of a Committee of the Board
- Risks of ≥15 are reviewed by the Risk and Compliance Group, with risks of 12 also reviewed when requested by divisions
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and ≥80% of risks are within review date and none are overdue for review by 6 or more months

Compliance with the above will be monitored by the Head of Risk & Governance, reviewed by the Director of Nursing and reported within an annual report submitted to the Quality Committee.

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

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

9. Associated Documents/Further Reading

This policy/procedure should be read in accordance with the following Trust policies, procedures and guidance:

- Incident Reporting, Investigation and Management policy
- Complaints policy
- Claims policy
- Being Open / Duty of Candour Policy
- Major Incident policy
- Blood Transfusion policy
- Capability policy
- Claims Policy
- Complaints Policy
- Consent Policy
- DOLS
- Electronic Patient Record Standard Operating Procedures
- Emergency Preparedness,
- Inquest Policy
- Mandatory Training Policy
- Managing External Visits Policy
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Policy for Developing Policies
- Policy on the implementation of NICE guidelines
- Promoting Good Health at Work

Resilience and Response Policy
- Falls Prevention and Management policy
- Fire Safety Strategy
- Freedom of speech/Whistleblowing policy
- Health and Safety policy
- Induction policy
- Infection Control policies
- Information Governance Strategy and associated policies

Policy
- Race Equality Scheme
- Raising Concerns Policy
- Risk Management Policy
- Safe Management of Contractors
- Safeguarding
- Security Policy
- Waste Policy

All operational policies, procedures and guidance also support the effective management of risk.

Appendix 1

Glossary of Terms used within Policy

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

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

Appendix 2

Risk Register Guidance - Risk Description

This section describes how to articulate a risk for the risk register.

Risk description should describe the risk, what is causing the risk (i.e. What the risk is due to) and the impact.

The risk should be articulated clearly and concisely with appropriate use of language, suitable for the public and with acronyms spelt out in the first instance.

Think of the risk in 3 parts and write it using the following phrases:

There is a risk of.....

This is due to / caused by.....

Will result in / have an impact on.....

The example below provides a useful guide to help staff define the risk accurately and precisely:

Objective: To travel from Huddersfield Royal Infirmary to Calderdale Royal Hospital for a meeting at a certain time.		
Risk Description		**Comment**
Failure to get from HRI to CRH for a meeting at a certain time	X	This is simply the converse of the objective
Being late and missing the meeting	X	This is a statement of the impact of the risk and not the risk itself
Eating on the shuttle bus is not allowed so I was hungry	X	This does not impact on the achievement of the objective
Missing the shuttle bus causes me to be late and miss the meeting	√	This is a risk that can be controlled by ensuring I allow enough time to get to the shuttle bus stop
Severe weather prevents the shuttle bus from running and me getting to the meeting	√	This is a risk that I cannot control but against which I can make a contingency plan

Be careful and sensitive about wording of risks as risk register are subject to Freedom of Information requests.

Appendix 3

Assessing Risk and Calculating Residual Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring, i.e. multiplying the consequence / severity score by the likelihood score.

The Trust procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured

- **Current risk score -** this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented

- **Target / residual risk score -** this is the score that is expected after the action plan has been fully implemented and refers to **the amount of risk remaining after treatment**.

The Trust uses a standard 5 x 5 scoring matrix set out at Appendix 4

Appendix 4

Risk Grading Matrix

Impact

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

Likelihood

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

	Impact /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 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
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

2 Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely**	**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
How often might or / does this happen	Not expected for years	Possible Annual Occurrence	Possible Monthly	Possible to occur weekly	Expected to occur daily
Probability	< 1 in 1000 chance	≥ 1 in 1000 chance	≥ 1 in 100 chance	≥ 1 in 10 chance	≥ 1 in 5 chance

Differing Risk Scenarios

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

Risk Grading

Risk grading makes it easier to understand the division / directorate / Trust risk profile. It provides a systematic framework to identify the level at which the risks must be managed and overseen in the organisation, prioritise actions and resources to address risk and direct which risks should be on the corporate risk register.

Having assessed and scored the risk using the 5x5 risk scoring matrix, use the table below to grade the risk as very low, low, moderate, high or significant.

Table 3 Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**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

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

1 - 3	Very Low risk
4 - 6	Low Risk
8 - 12	Medium Risk
10-12	High Risk
15-25	Significant

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