NHS England

Risk Management Policy and Process Guide

South West Neuromuscular Operational Delivery Network

Contents

1. Introduction

This document provides guidance on the policy, process and procedures for risk management in the South West Neuromuscular Operational Delivery Network (SWNODN).

Risk management is the recognition and effective management of all threats and opportunities that may have an impact on the SWNODN's reputation, its ability to deliver the service it has been commissioned to provide and the achievement of its objectives and values.

The SWNODN is committed to developing and implementing a risk management policy and process that will identify, analyse, evaluate and control the risks.

2. Purpose

The aim of this policy and process document is to:

- Evidence the importance of risk management to the SWNODN.
- Support staff to understand their roles and have a consistent approach to risk management.
- Ensure that correct systems and processes are in place to manage corporate and operational risks across the SWNODN.

It is the policy of the SWNODN that:

- We seek to reduce risks that are a threat to the delivery of our objectives and put in place actions that address the likelihood and impact of each risk to an acceptable level.

This policy and process document supports this by:

- Setting out a risk management framework which provides assurance to the SWNODN Executive Board and NHS England ODN Oversight Board that appropriate processes are in place to manage corporate and operational risks effectively.
- Recommending procedures for the effective identification, prioritisation, treatment and management of risks to minimise or maximise the effect of an uncertain event or set of events on the delivery of objectives.
- Ensuring a cohesive approach to the governance of risk.
- Identifying risk management resources.
- Establishing risk management as an integral part of the SWNODN culture.

All identified risks will be required to:

- Be recorded with a core minimum amount of information as set out in this document.
- Be assessed on the likelihood of the risk being realised and the level of impact should the risk be realised.
- Have an identified risk owner and action owner.

The policy element of the document describes the governance structures in place to ensure that risks are managed and escalated through the SWNODN as appropriate.

It sets out the respective responsibilities for corporate and operational risk management for the SWNODN Clinical Governance and Risk Group, the SWNODN Executive Board, the SWNODN Management Office and SWNODN staff.

The document describes the standard process to assist staff to identify, analyse and manage risks in their respective Trusts or areas of specialty.

3. SWNODN Staff Role in Risk Identification and Management

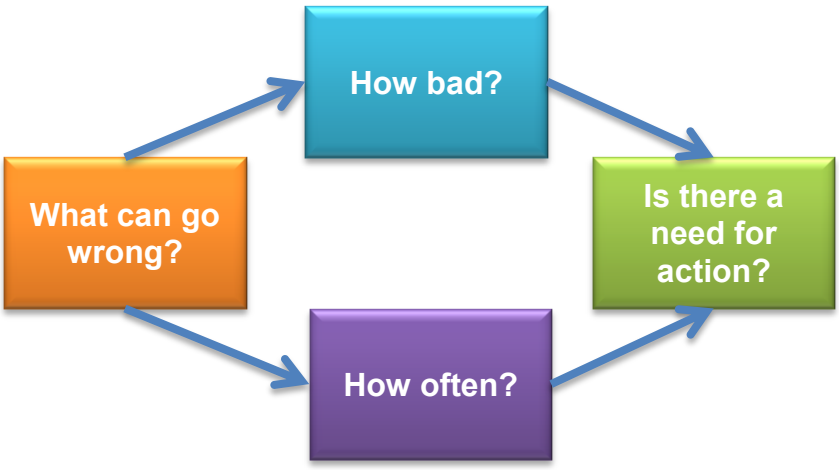
SWNODN staff in provider trusts will use their local risk management processes but will also adhere to the principles of this SWNODN Risk Management Policy.

Any member of the SWNODN can sit on the SWNODN Clinical Governance and Risk Group, which meets three times a year, and assist in the planning and management of negating risks to the SWNODN.

Each member of staff should identify any risks in related to their specialty or work place environment that may have an impact on SWNODN client groups. Such risks, however small, should be reported to the SWNODN Manager who will recommend the best course of action and whether the risk needs to be added to the SWNODN Risk Register.

Staff should also use their knowledge of services across the region to identify any unequitable service provision across the South West for the ODN's client group and other stakeholders.

Staff should consider the following when identifying if there is a risk or not:



All risks should be reported to the SWNODN Management Office using the SWNODN Risk Identification Form (Appendix E).

Each member of staff should assist in the regular assessment of the risks they have raised within their specialty area which are on the SWNODN Risk Register. This

could be via updates at the ODN Hub meetings. These updates will be reported back to the SWNODN Clinical Governance and Risk Group.

Staff should ensure they are familiar with the SWNODN risk management governance set out in this policy and escalate any risks or issues as per the SWNODN Risk Management Governance and Escalation Route (Appendix A).

Staff should also ensure they undertake and attend any mandatory and other relevant training courses in relation to risk reporting and management as appropriate to their level of responsibility within their provider trust.

4. Risk Management Roles and Responsibilities

Each area of the SWNODN must be aware of the SWNODN Risk Management Governance and Escalation Route (Appendix A).

As detailed in section 3, it is the responsibility of all SWNODN staff to maintain risk awareness, identifying and reporting risks as appropriate to their line manager AND the SWNODN Management Office if it relates to SWNODN services, premises ODN services are delivered in and ODN clients.

To support the governance and escalation process, Appendix B sets out the specific risk management responsibilities.

4.1 Risk Management Roles

4.1.1 Risk Lead & Manager

The Risk Lead & Manager will be the first point of contact within the SWNODN for staff wishing to raise a risk that may impact on delivery of the SWNODN objectives. They will ensure that SWNODN Risk Register entries are valid and supported by an appropriate risk assessment. They will manage the associated administration of the Risk Register including presentation of risks for review and quality assurance at the SWNODN Clinical Governance and Risk Group and ensure:

- SWNODN staff are consulted to identify and assess risks and determine mitigating actions.
- Action Plans for RED and ABMBER risks are reviewed via the SWNODN Clinical Governance and Risk Group and escalated as appropriate.
- Promote the risk management policy, procedures and best practice within the SWNODN.
- Any changes to the SWNODN Risk Management Policy and Process are communicated to SWNODN staff and host organisations.
- Information and knowledge on risks are shared with SWNODN staff and host organisations.

4.1.2 Risk Owner

All risks will have an identified Risk Owner who is responsible for ensuring that the risk is managed, including the ongoing monitoring of the risk, ensuring controls and further actions are in place to mitigate the risk and reporting on the overall status of the risk. It is the responsibility of the Risk Owner to escalate risks where appropriate in line with local risk procedures and risk escalation process detailed in Appendix A.

Due to the cross-organisational work of the SWNODN, Risk Owners can be within NHS Trusts (hosting ODN staff or delivering MDT clinics), Clinical Commissioning Groups and NHS England.

4.1.3 Action Owner

All risks have Action Owner(s) to whom the Risk Owner has delegated responsibility for ensuring the delivery of a task or activity that will help to mitigate the risk and to provide regular reporting on progress.

4.1.4 SWNODN Management Office

The SWNODN Management Office will support the SWNODN Clinical Governance and Risk Management Group by providing assurance on the implementation of the risk management policy and the management and review of the SWNODN Risk Register.

5. Risk Management Process

5.1 Risk Identification and Recording

5.2 Identification of Risk

When identifying a risk consideration should be given to what could pose a potential threat (or opportunity) to the achievement of objectives within the context of the SWNODN. Risks should be grouped into Risk Domains as identified in the Appendix D – Risk Scoring and Rating Matrices.

Risks and issues often get confused and a useful way of remembering the difference is:

- Risks are things that might happen and stop us achieving objectives, or otherwise impact on the success of the SWNODN.
- Issues are things that have already happened, were not planned and require management action.

Once identified, SWNODN staff should complete a SWNODN Risk Identification Form (Appendix E) and send to the SWNODN Management Office.

The risk needs to be described clearly to ensure that there is a common understanding by stakeholders of the risk. The recommended form for risk description is to identify the cause, the event and the effect. Appendix C includes guidance on how to write a risk.

5.3 Risk Assessment and Scoring

It is vital that all risks are assessed in an objective and consistent manner if they are to be managed, and to guide operational, project and programme planning and resource allocation.

In order to manage its risks effectively the SWNODN needs to know what risks exist. The systematic identification and assessment of risk is vital to the SWNOD's risk management process. The SWNODN will use the NHS National Patient Safety Agency Healthcare risk assessment made easy guidance to support this function.

Risks are firstly assessed on the probability (likelihood of the risk happening) and secondly on what would happen (consequence) should the risk occur.

When assessing how likely it is that a risk will occur, take into account the current environment. Consider the adequacy and effectiveness of the controls already in place within the environment, which could address the causes of the risk and therefore the likelihood of the risk being realised; for example, systems, policies, training and current practice.

When assessing what the impact of the risk could be if it happened, consider what the consequence of the risk would be in most circumstances within your environment and what is reasonably foreseeable.

The assessment is completed by scoring the likelihood and consequence. The SWNODN has adopted the NHS National Patient Safety Agency risk grading system. Appendix D sets out the SWNODN scoring tables which are based on a scale of 1 - 5 and the SWNODN risk rating matrix which gives the scoring a RAG status.

The SWNODN's procedure is to score and rate a risk twice as a current score and post action score.

Risks are also assessed in terms of proximity i.e. when the risk would occur. Estimating when a risk would occur helps prioritise the risk. The proximity scale used in the SWNODN is:

- zero to three months;
- three to six months;
- six to nine months;
- nine to twelve months; and
- twelve months plus.

5.4 Action Planning

Following completion of the risk assessment, consideration must be given to whether the risk requires further management actions that ideally minimise the likelihood and/or impact of a threat or maximise the likelihood of opportunities. For each risk an action plan to eliminate, minimise or maximise the risk is required.

It is not always possible to identify and then fully implement actions that eliminate or minimise a risk. Where this is the case, it is essential that the significance of the risk that remains is understood and the SWNODN, in accordance with the risk the SWNODN Executive Board, confirms that it is prepared to accept that level of risk. This is known as the residual risk.

5.5 Monitoring and closure

The implementation of the action plan and the level of risk must be kept under review.

Where implementation of action plans is not producing the anticipated results, the risk should be re-assessed and a revised action plan agreed as necessary.

Once all possible actions have been completed, or the event has passed, the risk should be closed and moved to the closed risk register for audit purposes.

The SWNODN CGRG, will be responsible for monitoring progress against the Action Plan and tracking any identified high risk areas.

Actions for learning and improvement will be shared as required with the SWNODN CGRG. Actions will be shared with SWNODN Executive Board and NHS England ODN Oversight Board.

6. Reporting and Escalating Risks

6.1 SWNODN Risk Register

The SWNODN has a Risk Register which is an integral part of the system of internal controls and defines the highest priority risks which may impact on the SWNODN's ability to deliver its objectives. The Risk Register enables the SWNODN Executive Board and NHS England's ODN Oversight Board to be assured of the management of these risks.

The SWNODN Clinical Governance and Risk Group (CGRG) will manage these risks on behalf of the SWNODN Executive Board.

It should be remembered that Risk Registers are subject to Freedom of Information (FOI) requests, therefore wording of risks should be sensitive to this and should not reference blame to other organisations in the Risk Register

6.2 Escalating Risks

The governance and escalation diagram set out in Appendix A also includes an example of the process for how risks can be escalated for inclusion on the SWNODN Risk Register. It is recommended that at each level Amber and Red risks are escalated.

7. Who should be aware of this Policy

This policy and process document is applicable to all corporate and operational risks that the SWNODN could be exposed to, including information governance, programme, project and clinical risks and those arising from the oversight of the neuromuscular services carried out in the South West.

Therefore, any organisation involved in the direct delivery of SWNODN's clinical services should be made aware of this policy and process document. This will include host and provider trusts (acute and community) as listed below.

7.1 Host and Provider Trusts

Trust	Location	Hosting Staff	Hosting NM Clinics
North Bristol NHS Trust	Southmead Hospital	√	√
Plymouth Hospitals NHS Trust	Derriford Hospital	√	√
	Plymouth Child Development Centre		√
University Hospitals Bristol NHS Foundation Trust	Bristol Royal Hospital for Children	√	√
	Bristol Royal Infirmary		√
Peninsula Community Health	St Austell's Community Centre	√	√
Royal Cornwall Hospitals NHS Foundation Trust	Royal Cornwall Hospital	√	√
Northern Devon Healthcare NHS Trust*	Exeter Community Hospital	√	
Gloucestershire Royal Hospitals NHS Foundation Trust	Gloucestershire Royal Hospital		√
Taunton & Somerset NHS Foundation Trust	Musgrove Park Hospital		√
Torbay & South Devon NHS Foundation Trust	Torbay Hospital		√
Vranch House	Vranch House School		√
Livewell Southwest *(formerly Plymouth Community Healthcare)*	Mount Gould Community Hospital		√
Royal Devon & Exeter NHS Foundation Trust	Mardon Neuro-Rehab Centre		√

** To change to Royal Devon & Exeter NHS Foundation Trust in July 2016*

7.2 Other organisations

There will also be a number of other organisations that may need to be made aware of risks that have been identified by the SWNODN including:

- NHS England Specialised Commissioning
- Clinical Commissioning Groups
- Clinical Reference Groups
- Third sector organisations

7.3 Distribution Plan

This policy and process document will be sent to all members of the SWNODN Executive Board and NHS England ODN Oversight Board.

This document will be made available to all SWNODN staff and each hosting and provider trust via the SWNODN internet site and through e-mail.

8. Training and Support

To support the implementation and embedding of the risk management policy and procedures:

- All SWNODN staff should ensure familiarity and compliance with the SWNODN risk management governance set out in this policy and illustrated in the escalation diagram (Appendix A).
- All SWNODN ODN staff should Undertake and/or attend mandatory and other relevant training courses in relation to risk reporting and management as appropriate to level of responsibility within provider trust.
- Each Trust employing SWNODN staff has a mandatory and statutory training policy and training prospectus that details what risk training is available and what the training requirements are for each staff group / type.
- At annual staff appraisal and development reviews Line Managers review staff compliance with mandatory and statutory training requirements.
- SWNODN Management Office staff and SWNODN CGRG members will receive appropriate training as required.

Further guidance and support is available from the SWNODN Management Office.

9. Assuring Implementation of this Policy

The SWNODN Management Office will be responsible for assuring the implementation of the policy and procedures. This will be through discussions with Risk Leads, identified on the Risk Register, and the SWNODN Clinical Director. The recommendations of the reviews will be reported to the SWNODN Clinical Governance and Risk Group (CGRG) for consideration and where required, further action taken.

NHS England will conduct an annual audit to provide an independent assessment of the design of the risk management policy, processes and procedures and the extent to which they are applied across the organisation. The recommendations of the review will be reported to the SWNODN Executive Board.

The SWNODN Clinical Governance and Risk Group (CGRG) will oversee the establishment and maintenance of an effective system of assurance on risk management through approval of the risk management policy, regular reporting on the management of SWNODN risks and progress updates against audit recommendations.

10. Equality and health inequalities analysis

This procedural document forms part of the SWNODN's commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

As part of the development of this document, its impact on equality has been analysed and no detriment identified.

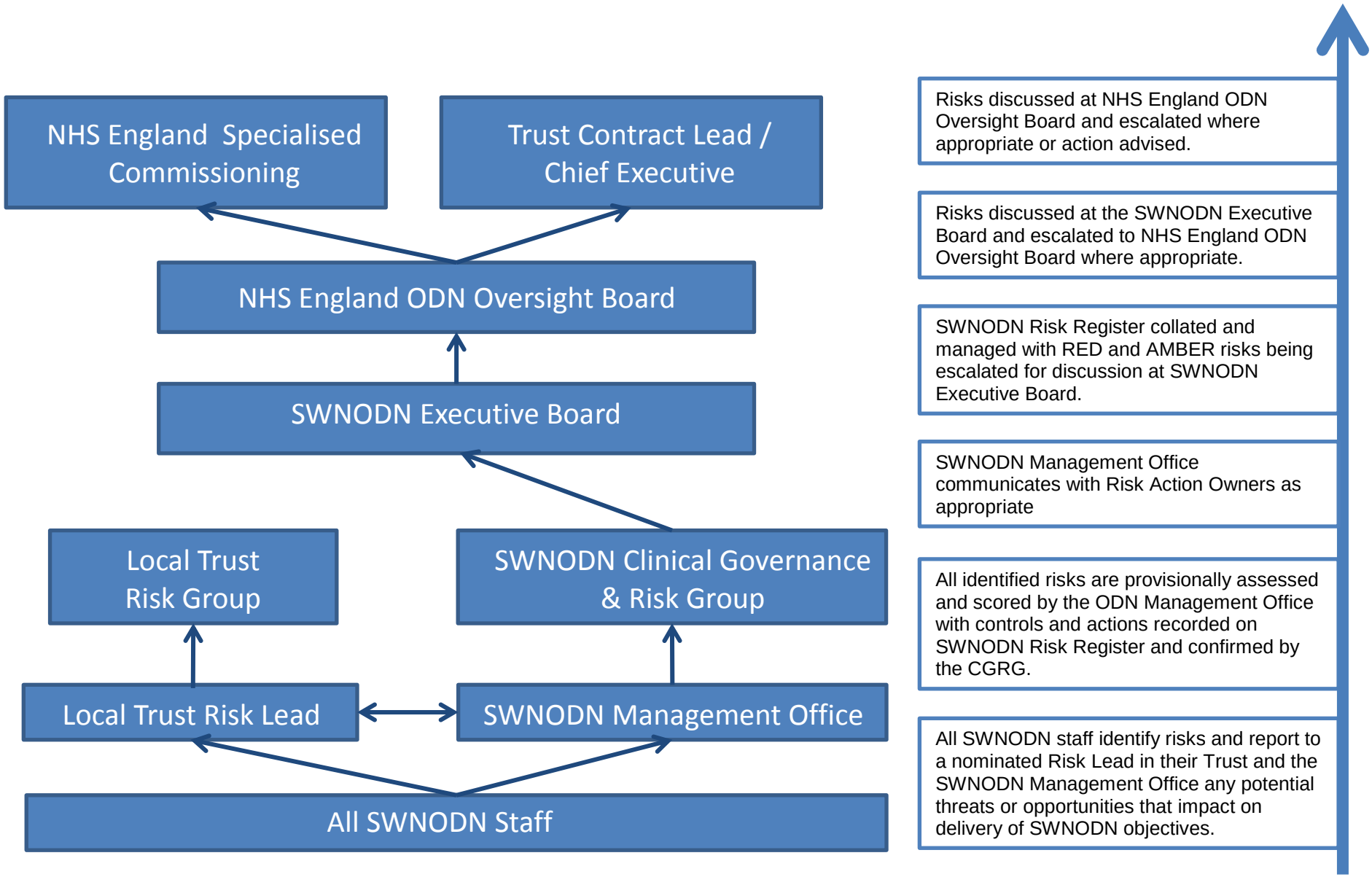
Document approved by the SWNODN Executive Board on 1 August 2016

Review date: The Risk Policy will be reviewed annually or sooner if required.

11. Glossary

Action plan	Sets out the activities that will address the identified gap and reduce, eliminate or minimise the risk.
Assurance	External evidence that risks are being effectively managed (e.g. planned or received audit reviews).
Control(s)	Actions in place to manage the risk.
Corporate risk register	A record of the risks identified through internal processes that will impact on the delivery of the SWNODN's strategic objectives or major programmes.
Impact	Is the result of a particular threat or opportunity should it actually occur.
Issue	A relevant event that has **happened**, was not planned and requires management action.
Likelihood	Is the measure of the probability that the threat or opportunity will happen, including a consideration of the frequency with which this may arise.
Operational risks	A risk or risks that have the potential to impact on the delivery of business, project or programme objectives. Operational risks are managed locally within the provider trust. However, operational risks that affect SWNODN services in more than one Trust should be escalated to the SWNODN Clinical Governance and Risk Group and provider trusts.
Opportunity	An uncertain event that would have a favourable impact on objectives or benefits if it occurred.
Risk	A risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of business, project or programme objectives. A risk can be a threat or an opportunity.
Risk assessment	The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk. The risk is compared against predetermined acceptable levels of risk.
Risk management	The systematic application of management policies, procedures and practices to the task of identifying, analysing, assessing, treating and monitoring risk.
Risk proximity	The estimate of the timescale as to when the risk is likely to occur. It helps prioritise risk and to identify the appropriate response.
Threat	An uncertain event that could have a negative impact on the delivery of objectives or benefits, should it occur.

Appendix A – SWNODN Risk Management Governance and Escalation Route



Appendix B – SWNODN Risk Management Responsibilities

Title	Responsibilities
NHS England ODN Oversight Board	**Responsible for:** • Articulating the key risk management priorities for NHS England. • Protecting the reputation of NHS England. • Providing leadership in risk management to the ODNs. • Ensuring the SWNODN's approach to risk management is consistently applied and audit on a yearly basis. • Ensuring that SWNODN assurances demonstrate that all risks have been identified, assessed and all reasonable steps taken to manage those risks effectively and appropriately. • Reviewing high level risks (RED) and providing support to resolve risks or escalation to Risk Owner.
SWNODN Executive Board	**Responsible for:** • Reviewing and discussing the highest key priority risks (RED / AMBER) raised by members of the Clinical Governance and Risk Group with a view to escalating to NHS England ODN Oversight Board. • Providing support to resolve risks or escalate with Risk Owner as appropriate.
SWNODN Clinical Governance & Risk Group (CGRG)	**Responsible for on behalf of the SWNODN Executive Board:** • Providing oversight of the establishment and maintenance of an effective system of assurance on risk management and internal control across the SWNODN activities that support the achievement of the SWNODN's objectives. • Undertaking a detailed review of the SWNODN's Risk Register on a monthly basis and prior to submission to the SWNODN Executive Board. • Identify high risks (RED / AMBER) that need to be escalated to the SWNODN Executive Board. • Recommending to the Executive Board the raising of new risks and closing of identified risks using the SWNODN Risk Register. • Reviewing themes and trends arising from reviews of risks and issues identified. • Reviewing SWNODN risk management arrangements. • Reviewing the risks escalated by the SWNODN Working Groups. • Leading the management of risk by devising short, medium and long-term strategies to tackle identified risk, including the production of any mitigating action plans.
SWNODN Management Office	**Responsible for on behalf of the SWNODN Executive Board:** • Assuring the SWNODN Executive Board that risks accountabilities exist. • Reviewing progress in developing and applying the risk management policy. • Reviewing results of the assessment of the management of risk. • Ensuring the SWNODN Risk Register is reviewed by the SWNODN CGRG on a monthly basis. • Ensuring risk information is available for review by the SWNODN Clinical Governance and Risk Group and the SWNODN Executive Board. • Identify Risk Owner and Action Owner within organisations, ensuring SWNODN risks are actively managed

	within each area. • Ensuring all activities undertaken within each of the provider trusts are consistent with the safe operation of SWNODN. • Ensuring staff comply with all organisational policies and procedures and fulfil their responsibility for risk management by identifying, reporting, monitoring and managing risk.
All SWNODN Staff	**Responsible for:** • Participating in the identification, assessment, planning and management of risks relating to team/role. • Keeping a record of identified risks reported. • Assisting in the regular review of the risks on the SWNODN Risk Register related to team/role. • Identify any risks (however small) to their line manager/Trust Risk Lead and comply with local policies and procedures of their provider trust. • Use SWNODN Risk Identification Form to notify the SWNODN Management Office of risks impacting on SWNODN services, clients and other stakeholders. • Ensuring familiarity and compliance with the SWNODN risk management governance set out in this policy and illustrated in the escalation diagram (Appendix A). • Undertaking and/or attending mandatory and other relevant training courses in relation to risk reporting and management as appropriate to level of responsibility within provider trust.

Appendix C – Risk Register Guidance

Risk Field	Guidance on completion
ODN Risk Ref No.	ODN Risk Identify (format ODN-0000)
Risk Web No	To be recorded from local provider trust to ensure link with ODN Risk Register
Who identified the risk	The person who raises with risk with the local provider trust and completes the SWNODN Risk Identification Form
Is it a Risk or an Issue?	A Risk is something that could happen and stop us achieving objectives or impact on the success of the SWNODN. An Issue is something that has already happened and was unplanned and requires management action.
Risk Location	The specific location of the risk. If affects the whole ODN then record as SWNODN.
Risk Proximity	Should be selected based on: zero to three months, three to six months, six to nine months, nine to twelve months and twelve months plus.
Risk Domain	Domains are listed in the Risk Scoring and Rating Matrices (Appendix D).
Specialty Area	Particular area of the network that the risk best sits in (ie, Respiratory, Paediatric Physiotherapy, etc)
Risk Description and Impact	Should describe the risk event, the cause and the impact. The risk should be articulated clearly and concisely with appropriate use of language, suitable for the public domain with acronyms spelt out in the first instance. When working the risk it is helpful to think about it in three parts and write it using the following phrasing: **There is a risk that…… This is caused by …….. Would lead to an impact/effect on ……**
Risk Lead & Manager	Should be the lead for the SWNODN risks. Should include full name and job title.
Risk Owner	Should be the person who owns the risk. Should include name and job title.
Assurance Mechanisms / Monitoring	This should include internal assurance/evidence (eg Board reporting, sub-committee and programme governance) and external assurance/evidence (eg planned or received audits or reviews) that the risk is being effectively managed.
Assessment Score	Should be completed in line with the guidance set out section 5.4 and Appendix D
Action Plan	Should be the actions and activities planned to take place that will, when implemented or completed, reduce, eliminate or minimise the risk.
Completion date for actions	Each action should have a completion date set.
Action Owners	Should be the person responsible to undertaking/implementing any actions plans agreed to manage a risk. Should include for each action name and full job title of person(s) responsible for completing the action (s).
Target Score	The target score this risk should achieve in order to present a low risk and impact to the SWNODN objectives.
Last Review Date	This is to indicate when the risk was last reviewed and/or updated.

Appendix D – Risk Scoring and Rating Matrices

Table 1 – Consequence Scores

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.

	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 not requiring first aid or requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, first aid treatment needed or 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 / MHRA / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability (loss of limb) 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 / patient experience	Peripheral element of treatment or service suboptimal Informal complaint/inquiry Unsatisfactory patient experience not directly related to patient care	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 Unsatisfactory patient experience – readily resolvable	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 Mismanagement of patient care	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report Serious mismanagement of patient care	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) and increases service cost	Low staffing level that reduces the service quality or increases cost of service provision	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

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty Minor recommendations	Non-compliance with standards Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice Reduced performance rating	Enforcement action Multiple breaches in statutory duty Multiple challenging recommendations Improvement notices Low performance rating Critical report	Prosecution Multiple breaches in statutory duty 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	Negligible reduction in scope or quality Insignificant cost increase Considered interim and recoverable position	<5 per cent over project budget Partial failure to meet subsidiary Trust objectives Minor reduction in quality / scope	5–10 per cent over project budget / savings target Definite escalating risk of non-recovery of situation Definite reduction in scope or quality Irrecoverable schedule slippage but will not affect key objectives	Non-compliance with national 10–25 per cent over project budget Irrecoverable schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Irrecoverable schedule slippage that will have a critical impact on project success Key objectives not met
Finance including claims	Small loss, risk of claim remote No or minimal impact on cash flow Overspend / loss of income / claim of less than £10,000	Loss of 0.1–0.25 per cent of Trust's annual budget Readily resolvable impact on cash flow Overspend / loss of income / claim between £10,000 - £49,999	Loss of 0.25–0.5 per cent of Trust's annual budget Individual supplier put Trust "on hold" Overspend / loss of income / claim between £50,000 and £99,999	Uncertain delivery of key objective Loss of 0.5–1.0 per cent of Trust's annual budget Major impact on cash flow Purchasers failing to pay on time Overspend / loss of income / claim between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of Trust's annual budget Failure to meet specification/ slippage Critical impact on cash flow Loss of contract / payment by results Overspend / loss of income / claim >£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

Likelihood score (L)

When assessing likelihood, it is important to take into consideration the controls already in place. The likelihood score is a reflection of how likely it is that the adverse consequence described will occur. Likelihood can be scored by considering:

- Frequency (how many times will the adverse consequence being assessed actually be realised?)

  or

- Probability (what is the chance the adverse consequence will occur in a given reference period?).

Table 2 Likelihood scores (descriptors of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Frequency	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
broad descriptor	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
time-framed descriptor	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

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

	Likelihood				
Likelihood score	**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	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk, taking into consideration existing controls.

2. Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3. Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4. Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action to put further control measures in place.

6. Determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

7. Re-calculate risk after further control measures have been put in place.

Grading each risk will enable the SWNODN CGRG to prioritise actions required, which in turn will inform the Annual Planning programmes.

		Action required	**Review Committee**
1-3	Low risk	To be monitored at least annually	CGRG
4-6	Moderate risk	To be monitored at least annually	CGRG
8-12	High risk	Action plan reviewed monthly*	CGRG SWNODN Executive Board
15	Extreme risk	Urgent action required*	CGRG SWNODN Executive Board NHS England ODN Oversight Board
16-25	Extreme risk	Immediate action required – stop activities causing the risk now*	CGRG SWNODN Executive Board NHS England ODN Oversight Board

* All risks deemed to be ACCEPTED by the SWNODN Governance team, GRMC or Trust Board will be reviewed on an annual basis.

SWNODN RISK IDENTIFICATION FORM

Risk / Issue reported by: **Name:**	**Date:**
Designation:	**Trust:**
Please complete the following in describing the risk: There is a risk that ….. This is caused by …….. Would lead to an impact/effect on …..	
When is this risk likely to occur? ☐ 0 – 3 months ☐ 3 – 6 months ☐ 6 – 9 months ☐ 9 – 12 months ☐ 12 + months	**Speciality Area of risk: (ie, respiratory, cardiology, SWNODN wide)** **What control measures are in place locally?**

Contacts at location of risk:		
Trust Risk Lead:	Name:	
	Job Title	
	E-mail:	
Risk Owner:	Name:	
	Job Title	
	E-mail:	

SWNODN Management Office:	
Date received by SWNODN Office:	
Date added to SWNODN Risk Register	
SWNODN Risk Ref No:	