The Dudley Group
NHS Foundation Trust

Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

**Ref:** FOI-042024-000826

**Date**: 13/05/2024

**Address / Email**:

Dear

**Request Under Freedom of Information Act 2000**

Thank you for requesting information under the Freedom of Information Act 2000.

**Request**

**Please could you provide a copy of your corporate risk register and risk policy document which includes your risk appetite and risk scoring methodology.**

**Response**

**Under Section 36(2)(c), we cannot provide our corporate risk register, Section 36(2)(c) – prejudice to the effective conduct of public affairs therefore this exemption has been applied.**

**Please find attached risk policy document as per your request.**

If you are dissatisfied with our response, you have the right to appeal in line with guidance from the Information Commissioner. In the first instance you may contact the Information Governance Manager of the Trust.

Information Governance Manager
Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ
Email: dgft.dpo@nhs.net

Should you disagree with the contents of our response to your appeal, you have the right to appeal to the Information Commissioners Office at.

Information Commissioners Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113
www.ico.org.uk

If you require further clarification, please do not hesitate to contact us.

Yours sincerely

**Freedom of Information Team**
**The Dudley Group NHS Foundation Trust**

The Dudley Group
NHS Foundation Trust

| RISK MANAGEMENT STRATEGY | | |
|---|---|---|
| | **DOCUMENT TITLE:** | **RISK MANAGEMENT STRATEGY** |
| | **Name of Originator/Author /Designation & Specialty:** | [redacted] – Deputy Director of Governance<br>[redacted] – Chief Nurse<br>[redacted] – Director of Governance |
| | **Director Lead:** | Chief Executive |
| | **Target Audience:** | This strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust |
| | **Version:** | 5.1 |
| | **Date of Final Ratification at Board of Directors:** | Q & S Committee<br>Date: 20 December 2022 |
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| | **Registration Requirements Outcome Number(s) (CQC)** | Safe, Effective, Caring, Responsive and Well led |
| | **Relevant Documents /Legislation/Standards** | NHS Foundation Trust Code of Governance |
| | **Contributors:** | **Designation:** |
| | **The electronic version of this document is the definitive version** | |

**CHANGE HISTORY**

| Version | Date | Reason |
|---|---|---|
| 1.0 | Oct 2010 | New Document |
| 2.0 | Oct 2015 | This document replaces the Risk Management Strategy and Risk Management Policy approved in October 2010. |
| 3.0 | November 2017 | Full review following implementation of DATIX Risk Management software |
| 3.1 | May 2018 | Minor amendment to reflect new BAF reporting (Reported Audit Committee 22.05.18) |
| 4.0 | June 2020 | Full review |
| 5.0 | December 2022 | Full Review |
| 5.1 | December 2023 | Minor amendment section 2.2 |

**A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.**

**Contents**

# THE DUDLEY GROUP NHS FOUNDATION TRUST

# RISK MANAGEMENT STRATEGY

## The Dudley Group NHS Foundation Trust's Risk Statement

We are committed to delivering high quality services, which are safe and promote the wellbeing of service users, their relatives and carers, staff, and other stakeholders. We will ensure consistent risk management systems and processes are in place for continuous quality improvement and safer patient care. Risk is defined as the effect of uncertainty on objectives. Managing risk is a key organisational responsibility and as such is seen as an integral part of the Trust's governance arrangements. The Trust is committed to implementing the principles of good governance, defined as:

**The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity, and openness.**

The Trust recognises that the principles of good governance must be supported by an effective risk management system which is designed to deliver improvements in patient safety and care as well as promoting the safety of its staff, patients, and visitors. This strategy describes the consistent and integrated approach we will take to the management of all risk across the Trust.

The principles of risk management apply to all staff across all areas of the Trust regardless of the type of risk. The Board of Directors have overall accountability to ensure that risk management, quality, safety, and patient experience receive priority and the necessary resources within budgets, to achieve the Trust's strategic objectives. The Board of Directors recognise that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

The Trust is committed to having a culture that supports the management of risk which underpins and supports the business of the Trust. The Trust will demonstrate this by an ongoing commitment to improving the management of risk throughout the organisation by doing this we will ensure the safety of our patients, visitors, and staff, and in operating effective risk management the organisation's leadership is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow our business and services. Considered risk taking is encouraged, together with experimentation and innovation within authorised governance framework as long as they support the delivery of our objective, whilst our priority is to reduce those risks that impact on safety and patient experience, and reduce our financial, operational, and reputational risks wherever practicable.

Diane Wake Chief Executive

## 1. INTRODUCTION

Effective risk management processes are essential to the delivery of high quality and safe healthcare services.
The Trust is committed to ensuring robust risk management systems are in place to ensure to reduce harm to patients and staff, to create safer environments for care delivery and to support the achievement of the organisation's corporate objectives.

Risk management should be embedded in all the organisation's practices and processes in a way that it is relevant, effective, and efficient. The risk management process will become part of, and not separate from, those organisational processes. In particular, the management and mitigation of risk should be embedded into policy development, business and strategic planning and review, and the change management processes.
The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to maximise, though not necessarily eliminate, threats, maximise opportunities and reduce risk.

Risk is an inherent part of the delivery of healthcare. This risk management strategy outlines the Trust's approach to mitigation and management of risk throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.

This Board approved strategy for managing risk identifies accountability arrangements, resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

This strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Management of risk is the responsibility of all staff and managers at all levels who will be expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The strategy will be supported by:

- A comprehensive risk assessment (refer to Risk Assessment Practical Development And Reviewing Guideline)
- Face-to-face workshops
- An annual plan with key performance indicators (KPI's) linked to risk maturity development
- Robust Board Assurance Framework (BAF)

### 1.1 The Principles of the Strategy

Risk Management Principles
This strategy follows the principles of ISO 31000:

- Creates value
- Integral part of our processes
- Is an active part of decision making
- Explicitly addresses uncertainty
- Is undertaken in a systematic, structured, and timely manner

- Is based on the best available information
- It takes human and cultural factors into account
- Is transparent and inclusive
- Remains dynamic, iterative and responsive to external and internal change
- Facilitates continual improvement

**1.1.1 The overall purpose of risk management at the Trust is to:**

- Reduce the level of exposure to harm for patients, colleagues, or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable
- Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment, or sources of income
- Continuously improve performance by proactively adapting and remaining resilient to changing circumstances or events.

**1.1.2 The Trust will establish an effective risk management system which ensures that:**

- All risks are identified that have a potential adverse effect on quality of care, safety, and wellbeing of people, and on the business, performance, and reputation of the Trust
- Priorities are determined, continuously reviewed, and expressed through objectives that are owned and understood by all staff
- Risks to the achievement of Trust strategic and local objectives are anticipated and proactively identified and managed
- Controls are put in place, effective in their design and application to mitigate the risk, and understood by those expected to use them
- The operation of controls is monitored by management
- Gaps in controls are rectified by management and robust actions identified
- Management are held to account for the effective operation of controls
- Assurances are reviewed and acted on
- Staff continuously learn and adapt to improve safety, quality, and performance
- Risk management systems and processes are embedded locally across operational divisions and in corporate services including business planning, service development, financial planning, project and programme management and education

**1.1.3** Risks can be linked to other risks, incidents, or complaints. Multiple risks can impact upon and influence each other and as such collective reviews should be considered.

**1.1.4** When seeking assurance about compliance to national standards, alerts, and guidance - risks, incidents and associated action plans, complaints, claims and procedural documents must all be considered.

## 2. STATEMENT OF INTENT/PURPOSE

### 2.1 Risk Appetite

Resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks.

Every organisation will have a different perception of the level of risk it is comfortable with and needs to be clear about what is and is not acceptable. An organisation's risk appetite is defined as "the amount and type of risk that an organisation is prepared to seek, accept or tolerate."

Risk appetite levels will depend on circumstances; for example, a Trust may have a low tolerance to taking risks which may impact on patient or staff safety, but may have more appetite for opportunity risks such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation

Expressing risk appetite can enable an organisation to take informed decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board. The absence of appetite setting can result in erratic or inopportune risk-taking exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development.

The Board of Directors will schedule a review of its appetite for risk throughout the year, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. These periodic reviews and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine KPI's and the organisational capacity to control risk. The review will consider:

- Risk leadership
- People
- Risk policy and strategy
- Partnerships
- Risk management process
- Risk handling
- Organisational outcomes.

### 2.2 Risk Appetite Statement

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

On a quarterly basis the Trust will establish its risk appetite within its Board Assurance Framework. The Board Assurance Framework will define the

Board's appetite for risk in the achievement of strategic objectives for the financial year in question.

To view the Trust's current Risk Appetite Statement, visit the Trust website Publications - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

Alternatively, please contact the Board Secretary.

Risks appetite will be assessed using the Risk Appetite Matrix for NHS organisations (**Appendix 1**).

Risks throughout the organisation should be managed within the Trust's Risk Strategy. Where it is considered that locally, risk cannot be contained within the stated appetite, this must be escalated through the Divisional Governance Structure to the Risk and Assurance Group then to the Board.

## 3. DEFINITIONS

Refer to (**Appendix 2**).

## 4. DUTIES (RESPONSIBILITIES)

### 4.1 Individual Responsibilities

Management of risk is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in various day to day activities conducted by members of staff. The following sections define the organisational expectations of particular roles or groups:

### 4.1.1 Chief Executive

The Chief Executive is the accountable officer for The Dudley Group NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As the accountable officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement. Operationally, the Chief Executive has designated responsibility for implementation of this strategy as outlined below.

### 4.1.2 Directors

Executive and Non-Executive Directors have a collective responsibility as the Board of Directors to ensure that the risk management processes are providing adequate and appropriate information and assurances. They are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role.

Additionally, Executive Directors are accountable and have overall responsibility for ensuring that their divisions are implementing the Risk Management Strategy and related policies/guidelines and have structures in place to support this. They have specific responsibility for managing the Trust's strategic risks relating to their areas of responsibility in addition in accordance with the Bribery Act 2010, they also hold the responsibility of ensuring that the Trust had adequate procedures in place to mitigate bribery risks.

**The following Directors also have specific responsibilities as follows:**

**Chief Finance Officer**
The Director of Finance has responsibility for financial governance and associated financial risk and directing any fraud risks to the Trusts Local Counter Fraud Specialist

**Chief Nurse / Medical Director**
The Chief Nurse and Medical Director have joint responsibility for clinical / quality governance and delegated authority for quality improvement. The Chief Nurse is the executive lead for safeguarding and infection control and the Medical Director clinical audit and effectiveness.

**Chief Operating Officer**
The Chief Operating Officer has responsibility for health and safety, emergency planning and operational risks.

**The Trust Board Secretary**
The Trust Board Secretary is responsible for maintaining the Board Assurance Framework.

**Executive Directors**
The individual Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of the Board Assurance Framework and Corporate Risk Register and the promotion of risk management to staff within their Divisions.

Executive Directors have responsibility for the oversight of risk within their own areas of responsibility.

### 4.1.3 Chiefs of Service/ Clinical Directors / Senior Managers / Divisional Leads

Chiefs of Service / Clinical Directors / Senior Managers / Divisional Leads take the lead on risk management and set the example through visible leadership of their staff. They do this by:

- Taking personal responsibility for managing risk.
- Creating a culture where staff can be confident that escalated risks will be acted upon.
- Ensuring risks are updated regularly and acted upon.
- Identifying and managing risks that cut across delivery areas
- Discussing risks on a regular basis with staff to help improve knowledge about the risk faced; increasing the visibility of risk management and moving towards an action focussed approach.
- Facilitating a forum for risks to be reviewed collectively with the multidisciplinary team to allow for wider input, challenge and assurance, as well increasing opportunities for shared learning.
- Communicating across their areas on what top risks are and doing so in plain language.
- Escalating risks from the front line onwards to senior leaders and where significant to the executive directors.
- Linking risk to discussions on quality, safety, and finance, and stopping or slowing down non-priority areas or projects to reduce risk demonstrating a real appetite for setting priorities.
- Ensuring staff are suitably trained in management of risk.
- Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve.

- Fostering a culture, which encourages all staff to take responsibility in helping to manage risks. Ensuring that people do not feel “blamed” for identifying and escalating risks.
- Ensuring that risk management is included in appraisals and development plans where appropriate.

Chiefs of Service/ Clinical Directors / Senior Staff / Divisional Leads are expected to be aware of and adhere to risk management best practice:

- Identify risks to the safety, effectiveness and quality services, finance, delivery of objectives and reputation- drawing on the knowledge of frontline colleagues.
- Identify risk owners with the seniority to influence and be accountable should the risk materialise.
- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do.
- Identify the actions needed to reduce the risk and assign action owners.
- Record risks on the risk register
- Check frequently on action progress, especially for high severity risks.
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so.
- Implement a process to escalate the most severe risks and use it.

### 4.1.4 Corporate Governance Risk management Team

The Risk Management Business Partners support Divisions and Corporate services with providing the necessary training and tools to empower staff to undertake risk identification and risk assessment. A robust Governance Framework is embedded within Divisions to ensure monitoring of risk mitigation and identification of blockers for escalation. This is supported by the provision of risk reports presented at Governance Meetings detailing exceptions for the attention of the speciality/directorate/division

### 4.1.5 Local Counter Fraud Specialist LCFS

The LCFS will undertake periodic fraud risk assessments in line with the Ministry of Justice guidance to assess how fraud and bribery may affect the Trust. The LCFS will retain full records of any locally or nationally recognised fraud risk and share these with the Trust as required. Any fraud risks identified shall be reviewed and monitored by the LCFS and discussed with the senior trust officer. The LCFS will report any such risks to both the Director of Finance and the Audit Committee for oversight. Any fraud risks deemed to be high risk shall be considered by the Trust for inclusion within the Trust’s risk register. The LCFS shall review the Trust’s Anti-fraud and Bribery Policy bi-annually (or in line with any legislative changes) to ensure that this remains robust in mitigating fraud and bribery across all Trust services. The LCFS shall complete an annual return on behalf of the Trust, against the NHS Counter Fraud Authorities Standards for Providers. The identification and monitoring of fraud risks shall help satisfy the associated risk assessment standard.”

### 4.1.6 All Staff

All staff are encouraged to use the risk management processes as a mechanism to highlight areas they believe may cause harm to patients and or

services and could be improved. Where staff feel that raising issues may compromise them or that the response may not be effective, they should be aware and encouraged to follow the guidance in the Raising Concerns Policy

Staff side representatives have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment

### 4.2 Board of Directors, Committee and Group Duties and Responsibilities

The Trust Board and its delegated committees are responsible for assuring that the risks are being managed appropriately by taking into account the gaps, mitigation, and Trust tolerance levels, and providing assurance to the Board where appropriate or raising any concerns to other relevant committees. Each BAF risk is aligned to a committee. It is the Committees responsibility to see the BAF risk at each committee and review/update the assurance level for each risk at the end of the committee meeting.

#### 4.2.1 Board of Directors

The Board of Directors is responsible for ensuring that the Trust has effective systems for identifying and managing all risks whether clinical, financial, or organisational. The risk management framework helps deliver the responsibility for implementing risk management systems throughout the Trust.

#### 4.2.2 Audit and Assurance Committee

The Audit Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

- To maintain an oversight of the Trust's general risk management structures, processes, and responsibilities, including the production and issue of any risk and control related disclosure statements

#### 4.2.3 Finance and Performance Committee

The Finance and Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues, and for providing assurance that these are being provided safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust Corporate Risk Register as they relate to the remit of the committee. They will ensure as part of the reporting requirements, and to report any areas of significant concern to the Board as appropriate.

#### 4.2.4 The Quality and Safety Committee

The Quality and Safety Committee is responsible for providing the Trust Board with assurance on all aspects of the quality of clinical care; governance systems including risks for clinical, corporate, workforce, information and research and development issues; and regulatory standards relating to quality and safety. The committee will consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the

committee. They will ensure, as part of the reporting requirements, and to report any areas of significant concern to the Board as appropriate.

### 4.2.5 Workforce and Staff Engagement Committee

The Workforce and Staff Engagement Committee is responsible for providing the Trust Board with assurance on all aspects of governance systems and risks related to the workforce, and regulatory standards for human resources. The committee will consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the committee. They will ensure as part of the reporting requirements, and to report any areas of significant concern to the Board as appropriate.

### 4.2.6 Risk and Assurance Group

The Risk and Assurance Group report to Quality and Safety Committee. The Risk and Assurance Group provide an oversight forum for the significant risks

## 5. GOVERNANCE STRUCTURE TO SUPPORT RISK MANAGEMENT

There are different operational levels in place to deliver the governance of risk in the Trust:

- Board of Directors
- Executive Directors Team Meetings
- Divisional/ Directorate Management Teams

Risk management by the Board is underpinned by a number of interlocking systems of control. The Board reviews risk principally through the following related mechanisms:

**5.1** The Board Assurance Framework (BAF) sets out the strategy objectives. It identifies key risks in relation to each strategic objective along with the controls in place, the gaps in those controls and assurances available on their operation. The BAF may be used to drive the Board agenda and a summary BAF is presented to the Board.

**5.2** The annual governance statement, which is signed by the Chief Executive Officer, sets out the organisational approach to internal control. This is produced as part of the annual report (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the Board with the annual report and accounts.

## 6. PROCESS FOR MANAGING RISK

The Trust's risk management framework ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

1. Clarifying objectives (establish the context)
2. Identifying risks to successfully achieve objectives
3. Analysing risks
4. Evaluating and Treating risk
5. Monitoring and review of the risk

### 6.1 Stage 1 – Clarifying Objectives

Consider how risk impacts on the delivery of our strategic aims or local objectives.

### 6.2 Stage 2 – Identifying Risks to Objectives

Once the objectives have been identified then risks can start to be identified. Consideration should be given to:

- Review of all sources of information that may help identify the risks to the objective e.g., Incident data, complaints, experience surveys etc.
- Discussion with wider staff/stakeholders who can collaboratively explore risk to ensure risks have been fully understood

### 6.3 Stage 3 – Defining and Analysing Risks

Please refer to Risk Assessment and Management in Datix Guideline.pdf)

Once the risk has been identified then:

- Describe it so that others understand what the risk is. Think about the cause, effect, and impact. It is important that the description is clear and concise.
- Assign an owner to the risk.
- List the key controls (actions) being taken to reduce the likelihood of the risk happening or reduce the impact.
- Review the risk severity score (use risk matrix **Appendix 3**) then consider what the contingency action plan is, i.e., what will you do should the risk happen
- Rate the likelihood of the risk materialising.
- Rate the consequence of the risk happening.

All of these must be recorded on the Trust central risk (s) register (DATIX Risk Management) following risk assessment and agreement in the division. The following sections describe in detail how to complete the risk register.

### 6.4 Stage 4 Evaluate the Risk

Not all risks can be dealt with in the same way. The 5T's (as below) provide an easy list of options available to anyone considering how to manage and or mitigate risk:

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

In most cases the chosen option will be to treat the risk. The key questions in this instance are:

- The action taken to manage the risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control the risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

## 6.5 Stage 5 Monitoring and review of Risk (Risk Registers)

### 6.5.1 Local Risk Log

Each division / directorate may have a local risk log. This log will contain the operational and strategic risks that are routinely managed within the service, and for which the service has the required resources, controls, and mitigation within the parameters of risk set by the risk appetite and no further actions are required to mitigate the risk.

If actions are required to mitigate the risk to its lowest level, the risk assessment will be escalated to the Trust Risk Register (recorded on DATIX) until such time as the actions have been satisfactorily discharged. These risks will be documented on the Trust Risk Assessment Template in DATIX.

Once the actions have been completed and the identified risks are mitigated to their lowest risk score, the risk assessment may be held locally within the departments / wards Local Risk Log and will be reviewed in line with local documented risk procedures. There is no Trust requirement defining which risk assessment forms should be used to document Local Risk Logs risks that have no actions outstanding.

Please note that in all circumstances in which a risk has mitigating actions that are required to be taken this will be recorded on the Trust Central Risk Register (DATIX).

### 6.5.2 Local Risk Registers

Local risks are risks that impact on the delivery of local objective at ward / department and are to be managed at that level. These will be managed through local governance and risk management arrangements within the directorates and the division and are recorded on the Trust Central Risk Register on Datix

### 6.5.3 Significant Divisional/Directorate Risk Registers

The significant divisional / directorate risks are risks that impact on the delivery of the objectives at a division / directorate level and have a risk score of 15 or above. These are managed through local governance and risk management arrangements within the directorates and the division and are recorded on the Trust central risk register.

Each division / directorate will ensure that it has a system in place for approving all new or emerging risks (local or division / directorate) which will be escalated / deescalated as appropriate with all divisional risks of 15 or above reviewed on a quarterly basis by the Risk and Assurance Group.

Risks that cannot be managed appropriately or fully at divisional level will be escalated to the appropriate Executive Director by the division for consideration for inclusion on the Corporate Risk Register. The Executive Director will ensure that the Risk and Assurance Group is made aware of all locally identified extreme risks that have been escalated to them.

### 6.5.4 Corporate Risk Register

The Corporate Risk Register (CRR) is a collection of risks that include those that directly impact on to the delivery of the corporate directorate objectives, those that cannot be managed at Divisional level and those that impact on a larger/Trust wide scale. Risks on this register are owned by an Executive Director. This is regularly reviewed by the Executive Directors and reported to the relevant delegated committee of the Board of Directors.

### 6.5.5 Board Assurance Framework (BAF) Risks

The Board Assurance Framework is a collection of key risks to the delivery and / or achievement of the Trust's stated strategic objectives and annual goals, these are the significant strategic risks that threaten an objective the achievement of mandated NHS quality, performance, or financial metrics.

### 6.5.6 Review Frequency

It is essential that risks are reviewed on a routine and regular basis. Risk registers should be used a tool to support this process and not an additional task.

It is important that actions listed to mitigate risk, strengthen controls and enhance assurance levels are managed in line with individual deadlines agreed.

The designated Governance Group in conjunction with the Trust's Governance Team will monitor this process closely ensuring actions follow SMART principles, are closed in a timely manner and the risk is appropriately updated to reflect this.

In addition to this it is important that the risk is regularly reviewed in line with the below timeframes:

- All risk scoring 20 or above should be reviewed in detail and updated on at least a **monthly basis**
- All risk scoring 12-16 should be reviewed in detail and up-dated at least bimonthly
- All risk scoring below 12 should be reviewed in detail and up-dated at least quarterly.

Risk reviews should be documented on the DATIX risk register entry; even if up-dates are limited or no change is noted **this should be detailed in the progress notes**.

### 6.5.7 Escalation and De-escalation of Risks

The consequence of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example a significant divisional risk to the Corporate Risk Register reviewed by the Risk and Assurance Group, Board committee, and finally the Board.

Risks will be escalated or de-escalated within the defined tolerances and authority to act for each level.

**For example:** a significant divisional risk scoring 15 or above (high or extreme) should only be escalated to the Corporate Risk Register if it is **not** manageable within the service. If the risk is manageable within the service, then it remains on the Significant Divisional Risk Register. In a case whereby the risk is to be escalated to the Corporate Risk Register this would be discussed with the appropriate Director and agreed for inclusion by the Executive team. The risk owner should discuss and seek approval through the divisional risk structure before the risk is escalated to the next level

Once an escalated risk has reached the Corporate Risk Register, the Board delegated committee will consider the risk control options advised and make recommendations for action. The risk will then be de-escalated and returned to the risk owner for implementation. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

If in analysing the risk, the Board delegated committee identifies that the risk impacts on the Trust's strategic objectives outside the set risk appetite, the risk will be escalated to the Board Assurance Framework (BAF).

It is important that risks are reviewed regularly to ensure appropriate action, including closing of risks or implementation of action plans where necessary.

## 7. COMPLETING A RISK ASSESSMENT

Refer to **Risk Assessment and Management in Datix Guideline.pdf** for specific guidance on completing a risk assessment.

## 8. ASSURANCE

Assurances on controls are the methods by which the organisation measures the effectiveness of the controls in place. There are three broad levels of assurance as detailed below:

| Assurance Level | Assurance Source |
|---|---|
| **Level 1:** | Provided by those responsible for delivering specific objective/operation. Generally provided by those that own and manage risk, by its nature this can be subjective, but its value is that it comes from those who know the business, culture, and day to day challenges |
| **Level 2:** | Functions that oversee risk. Associated with oversight of activity separate from those responsible for delivery. Provides valuable management insight. More objective than the level 1 |
| **Level 3:** | Functions that provide independent assurance. Generally, includes internal audit, regulators, external bodies. Independent of the 1st and 2nd level, providing a higher level of assurance |

## 9. HORIZON SCANNING

Horizon scanning is about identifying, evaluating, and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations, The integrated Care System (ICS) and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation/regulation
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- NHS England publications
- Local demographics
- Seeking stakeholder's views
- Risk Assessments
- International developments

All staff have a responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

## 10. TRAINING/SUPPORT

The Trust will ensure that there is accountability, authority, and appropriate competence for managing risk, including implementing the risk management process and ensuring the adequacy, effectiveness, and efficiency of any controls. This will be facilitated by:

- Identifying risk owners that have the accountability and authority to manage risks at both directorate, divisional and corporate level
- Identifying who is accountable for the development, implementation, and maintenance of the framework for managing risk
- Identifying other responsibilities for people at all levels in the organisation for the risk management process
- Establishing a performance measurement and external/internal reporting and escalation processes; and
- Ensuring appropriate levels of recognition of risk and sharing best practice.

To enable all staff to fulfil their respective roles and responsibilities, the Trust's Corporate Governance Team will provide support, guidance, and training in risk management by offering bespoke and 1:1 training required to support this strategy.

The training and development for risk management is bespoke to the individuals' roles and responsibilities.

In summary:

- All Trust staff will receive basic risk awareness on induction with mandatory updates.
- All identified risk managers will receive training in the DATIX risk module, to develop and manage risks. This will include the importance of being clear and concise when defining risk to ensure controls and planned mitigating actions are specific.
- Divisions will identify any further training requirements in respect of risk management and will arrange an agreed training event with the Corporate Governance Team.
- Bespoke training, 1:1, small and large groups will be provided on request
- Specific training will be provided for the Board, in respect of high-level awareness of risk management. Risk awareness sessions are included as part of the board's development programme.

## 11. PROCESS FOR MONITORING COMPLIANCE

| | Lead | Tool | Frequency | Reporting arrangements | Acting on recommendations and Lead(s) | Change in practice and lessons be shared |
|---|---|---|---|---|---|---|
| Organisational risk management arrangements and supporting structures | Board Secretary | Review of Terms of Reference | Annually | The Board will review the risk management arrangements, and terms of reference of committees annually. | As delegated by the Board | Via committees of the Board |
| Review of Board Assurance Framework | Board Secretary | BAF report | At least quarterly | Board of Directors | As delegated by the Board | Via committees of the Board and / Lead Directors |
| Review BAF and Corporate Risk Registers | Directors | BAF and Corporate Risk Register reports | Monthly/bimonthly/ quarterly (for BAF) dependent on frequency of committee meeting | Committees of the Board | As delegated committees of the Board and / Lead Directors | Via Directors to Divisions or specialties |
| Review of organisation wide significant risk registers | Directors | Risk registers | Quarterly | Report to Risk & Assurance Group<br><br>Summary report of key issues from Chair of Risk & Assurance Group to Quality and Safety Committee | As delegated by the Board | Via committees of the Board and / Lead Directors |
| Process for the management of risk locally | Divisional Directors | Risk Register Reports | Monthly<br><br>Quarterly | At Directorate and Divisional Governance and management meetings | General Managers, Clinical Directors, Lead Directors | Via Directorate risk management arrangements |

| | Lead | Tool | Frequency | Reporting arrangements | Acting on recommendations and Lead(s) | Change in practice and lessons be shared |
|---|---|---|---|---|---|---|
| | | | | Directorate Reports to Risk & Assurance Group | | |
| Process for ensuring board members and incident managers receive relevant risk management awareness training | Mandatory Governance & Training Manager | Mandatory Training Reports | At least annually | Mandatory Training Reports to Chairman and Chief Executive or Lead Director | Chairman, Chief Executive/ Lead Directors | Via appraisal process |

## 12. EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

## 13. REFERENCES


HM Treasury (2021) Orange Book - GOV.UK (www.gov.uk) HM Treasury

National Audit Office (2011) Good Practice Guide: Managing Risks in Government. [Accessed 13/11/2017]

Good Governance Institute (2020) Board guidance on risk appetite | Good Governance (good-governance.org.uk)

# APPENDIX 1 RISK APPETITE

| RISK APPETITE LEVEL / RISK TYPES | 0 NONE<br>Avoidance of risk is a key organisational objective. | 1 MINIMAL<br>Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential. | 2 CAUTIOUS<br>Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential. | 3 OPEN<br>Willing to consider all potential delivery options and choose while also providing an acceptable level of reward. | 4 SEEK<br>Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk). | 5 SIGNIFICANT<br>Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust. |
|---|---|---|---|---|---|---|
| **FINANCIAL**<br>**How will we use our resources?** | We have no appetite for decisions or actions that may result in financial loss. | We are only willing to accept the possibility of very limited financial risk. | We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern. | We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor. | We will invest for the best possible return and accept the possibility of increased financial risk. | We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks. |
| **REGULATORY**<br>**How will we be perceived by our regulator?** | We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully. | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks. | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |
| **QUALITY**<br>**How will we deliver safe services?** | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| **REPUTATIONAL**<br>**How will we be perceived by the public and our partners?** | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks. | We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders. |
| **PEOPLE**<br>**How will we be perceived by the public and our partners?** | We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest. | We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. | We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains. | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan. |



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## APPENDIX 2

## DEFINITIONS

**Accreditation:** formal, official recognition.

**Action:** a response to control or mitigate risk.

**Action Plan:** a collection of actions that are: specific, measurable, achievable, realistic, and targeted.

**Assessment:** a review of evidence leading to the formulation of an opinion.

**Assurance:** confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved (*Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health*. *Taking it on Trust, Audit Commission (2009), Care Quality Commission, Judgement Framework,* (2009).

**Board Assurance Framework (BAF):** a matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them, the gaps in those controls and the assurance that is available.

**Clinical Audit:** 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change' *(Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence).*

**Compliance:** act in accordance with requirements.

**Contingency plan:** the action(s) to be taken if the risk occurs.

**Consequence:** the result of a threat or an opportunity.

**Corporate Governance:** the system by which boards of directors direct and control organisations in order to achieve their objectives.

**Control:** action taken to reduce likelihood and or consequence of a risk.

**Cumulative Risk:** the risk involved in several related activities that may have low impact or be unlikely to happen individually, but which taken together may have significant impact and or be more likely to happen; for example, the cumulative impact of cost improvement programmes.

**Data:** blocks of unprocessed facts.

**Escalation:** referring an issue to the next appropriate management level for resolution, action, or attention.

**Empirical:** based on observation or experience.

**Evidence:** information that allows a conclusion to be reached.

**External Audit:** an organisation appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust.

**Gap in Assurance:** failure to gain sufficient evidence that policies, procedures, practices, or organisational structures on which reliance is placed are operating effectively.

**Gap in Control:** Failure to put in place sufficient effective policies, procedures, practices, or organisational structures to manage risk and achieve objectives.

**Hazard:** a potential source of damage or harm.

**Information:** knowledge that is gathered as a result of processing data.

**Internal Audit:** the team responsible for evaluating and forming an opinion of the robustness of the system of internal control.

**Internal Control:** a scheme of checks used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation.

**Inherent Risk:** the level of risk involved in an activity before controls are applied.

**Integrated Risk Management:** a process through which organisations identify, assess, analyse, and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g., patient safety, health and safety, complaints, litigation, and other risks.

**Key Risk/Key Control:** risks and controls relating to strategic objectives.

**KPI:** Key Performance Indicator

**Likelihood:** the probability of something happening.

**Management Assertions**: a statement made, whether oral or written.

**Mitigation/treatment of risk**: actions taken to reduce the risk or the negative consequences of the risk.

**Negative Assurance:** evidence that shows risks are not being managed and/or controlled effectively e.g., poor external reviews or serious untoward incidents.

**NICE:** National Institute for Health and Care Excellence

**PALS:** Patient Advice and Liaison Service

**Policy:** a document setting out the corporate plans for achieving a strategy.

**Quality:** treatment and care that is safe, effective and provides a positive patient experience.

**Reasonable:** based on sound judgement.

**Reassurance:** the process of telling others that risks are controlled without providing reliable evidence in support of this assertion.

**Residual Risk:** the risk that is still present after controls, actions or contingency plans have been put in place.

**Risk:** the uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance.

**Risk Appetite:** the level of risk that the organisation is prepared to accept, tolerate, and be exposed to at any point in time.

**Risk Capacity:** the maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.

**Risk Management:** the processes involved in identifying, assessing, and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress.

**Risk Matrix:** a grid that cross references consequences against likelihood to assist in assessing risk.

**Risk Maturity**: the quality of the risk management framework.

**Risk Owner**: the person/group 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 or part of the organisational to risk.

**Risk Rating:** the total risk score worked out by multiplying the likelihood and consequences scores on the risk matrix.

**Risk Register:** the tool for recording identified risks and monitoring actions and plans against them.

**Risk Tolerance:** the boundaries of risk-taking outside that the organisation is not prepared to go beyond.

**Stewardship:** the process of safeguarding.

**Strategy:** in the NHS a document that sets out the corporate approach and policy to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS.

**Sufficient:** whatever is adequate to provide the level of confidence required by the board.

## APPENDIX 3

## CALCULATING THE RISK SCORE (ADAPTED FROM NPSA RISK MATRIX 2008)

### 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.

| **Domains** | **Consequence score (severity levels) and examples of descriptors** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| | **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.<br><br>No time off work | Minor injury or illness, requiring minor intervention<br><br>Requiring time off work for >3 days<br><br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention<br><br>Requiring time off work for 4-14 days<br><br>Increase in length of hospital stay by 4-15 days<br><br>RIDDOR/agency reportable incident<br><br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >15 days<br><br>Mismanagement of patient care with long-term effects | Incident leading to death<br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on a large number of patients |
| **Quality/complaints/ audit** | Peripheral element of treatment or service suboptimal<br><br>Informal complaint/inquiry | Overall treatment or service suboptimal<br><br>Formal complaint (stage 1)<br><br>Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved<br><br>Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness<br><br>Formal complaint (stage 2) complaint<br><br>Local resolution (with potential to go to independent review)<br><br>Repeated failure to meet internal standards<br><br>Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved<br><br>Multiple complaints/ independent review<br><br>Low performance rating<br><br>Critical report | Totally unacceptable level or quality of treatment/service<br><br>Gross failure of patient safety if findings not acted on<br><br>Inquest/ombudsman inquiry<br><br>Gross failure to meet national standards |
| | **Consequence score (severity levels) and examples of descriptors** | | | | |
| | **1** | **2** | **3** | **4** | **5** |

| | | | | | |
|---|---|---|---|---|---|
| **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<br><br>Unsafe staffing level or competence (>1 day)<br><br>Low staff morale<br><br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff<br><br>Unsafe staffing level or competence (>5 days)<br><br>Loss of key staff<br><br>Very low staff morale<br><br>No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff<br><br>Ongoing unsafe staffing levels or competence<br><br>Loss of several key staff<br><br>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<br><br>Reduced performance rating if unresolved | Single breech in statutory duty<br><br>Challenging external recommendations/ improvement notice | Enforcement action<br><br>Multiple breeches in statutory duty<br><br>Improvement notices<br><br>Low performance rating<br><br>Critical report | Multiple breeches in statutory duty<br><br>Prosecution<br><br>Complete systems change required<br><br>Zero performance rating<br><br>Severely critical report |
| **Adverse publicity/ reputation** | Rumours<br><br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br><br>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)<br><br>Total loss of public confidence |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br><br>Schedule slippage | 5–10 per cent over project budget<br><br>Schedule slippage | Non-compliance with national 10–25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met | Incident leading >25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met |
| **Finance including claims** | Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br><br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br><br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br><br>Claim(s) between £100,000 and £1 million<br><br>Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget<br><br>Failure to meet specification/ slippage<br><br>Loss of contract / payment by results<br><br>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<br><br>Minor impact on environment | Loss/interruption of >1 day<br><br>Moderate impact on environment | Loss/interruption of >1 week<br><br>Major impact on environment | Permanent loss of service or facility<br><br>Catastrophic impact on environment |

## Table 2 Likelihood score (L)

### What is the likelihood of the consequence occurring?

Likelihood may need to be assessed in a different manner depending on the nature of risk. For example, the likelihood that a particular incident will occur is best suited to a likelihood measure that is based on frequency and defined timeframe would help staff (as in table below)

| Type of descriptor | 1<br>Rare | 2<br>Unlikely | 3<br>Possible | 4<br>Likely | 5<br>Almost Certain |
|---|---|---|---|---|---|
| Broad Descriptor | This will probably never occur/happen | Do not expect it to happen/reoccur but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur, but it is not a persisting issue/circumstance | Will undoubtedly happen/recur, possibly frequently |
| Time-framed | 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 | <0.1 % | 0.1-1 % | 1-10% | 10-50% | >50% |

## Table 3 Risk scoring = likelihood x consequence (LxC)

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

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

- 1 - 4 Low risk
- 5 - 12 Moderate risk
- 15 - 16 High risk
- 20 - 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.

**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 the risk multiplying the likelihood by the consequence: L (likelihood) x C (consequence) = R (risk score)