London Ambulance Service NHS Trust

Risk Assessment and Reporting Procedure

DOCUMENT PROFILE and CONTROL

Purpose of the document: The objective of the Procedure is to ensure that assessments of all foreseeable risks arising out of work activities are undertaken, and to identify the requirements to be taken to establish short, medium and long term control measures.

Sponsor Department: Governance and Assurance

Author/Reviewer: Head of Governance and Assurance – March 2018.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
27/03/15	3.11	Risk and Audit Manager	Further minor amendments
25/03/15	3.10	IG Manager	Document Profile and Control update
20/03/15	3.9	Head of Governance & Assurance and Risk and Audit Manager	Minor amendments to reflect changes in the organisational structure.
15/10/14	3.8	Risk and Audit Manager	Document reviewed to reflect changes in management and committee structure
14/06/2013	3.7	Audit & Compliance Manager	Document reviewed and minor changes in line with NHSLA requirements
07/08/2012	3.6	IG Manager	Document Profile & Control update
19/06/2012	3.5	Audit & Compliance Manager	Minor changes in line with NHSLA requirements and updated monitoring table
22/11/2011	3.4	Audit & Compliance Manager	Amendments to Appendix 1 - Process Flow Chart (to include escalation to SMG)
16/02/2011	3.3	Governance & Compliance Manager	LA167 reformatted, Updated Appendix 5.
08/02/2011	3.2	Governance & Compliance Manager and Audit & Compliance Manager	Minor amendments to responsibilities and appendix 4.
24/01/2011	3.1	Senior Health, Safety and Risk Advisor, Governance & Compliance Manager and Audit & Compliance Manager	Minor amendments following approval at RCAG on 11/01/2011: LA167 (net rating calculation added), updated description of Risk, updated figure 1, monitoring section reviewed.
13/12/2010	2.2	Governance &	Major re-write - document reviewed

		Compliance Manager and Audit & Compliance Manager	and merged with HS004 Risk Assessment Procedure and TP046 Risk Register Procedure. 1. Inclusion of requirements for conducting local risk assessments and reporting, including the management of Risk Registers. 2. Redefined processes for; a) Risk identification, b) Risk evaluation, c) Risk mitigation/controls, d) Risk escalation and reporting. 3. Addition to appendices; 1) Process Flowchart 2) New Risk Reporting form, 3) Risk Matrix.
23/07/10	2.1	Governance & Compliance Manager	Reformatted
04/07	0.1	Head of Governance	First draft

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/005	Risk Management Policy and Strategy	
	Management of Health and Safety at Work Regulations (1999)	
	Health & Safety at work Act 1974	
	NHSLA Risk Management Standard for Ambulance Trusts	
	EMAS Risk Register Guidelines	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

The Trust's approach to managing risks is based on identification and assessment of issues and/or hazards (to individuals or the organisation) which present themselves whilst conducting business on a day to day basis. The assessment should aim to enable the employer to identify and prioritise the requirement to establish short, medium and long term control measures.

The Trust has a duty under the Management of Health & Safety at Work Regulations 1999 to carry out assessments of risks to the health and safety of staff and patients.

In order to comply with the requirements of the Care Quality Commission and the National Health Service Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts. The LAS encourages all staff to report risks and requires all managers to control the significant risks in their workplace and work activities.

This document is intended for use as a framework for the Trust's Risk Register to enable the achievement of the strategic objectives by identifying and managing risks in a structured way. Proactive risk management is integral to the effective corporate governance of the Trust.

2. Scope

This Procedure applies to all London Ambulance Service NHS Trust (LAS) staff and all those working on behalf of the Trust.

3. Objective

To ensure that assessments of all foreseeable risks and to identify the requirements to be taken to establish short, medium and long term control measures.

4. Responsibilities

4.1 Chief Executive

The Chief Executive has overall responsibility for the management of all risks.

4.2 Trust Board

The Trust Board has corporate responsibility for the Trust's system of internal control and for robust risk management.

The Trust Board will receive assurance, based on sufficient evidence and via a quarterly assessment of the Trust's Assurance Framework, that internal

controls are in place; that they are operating effectively; and that the objectives are being achieved.

This assurance is provided through a system of monitoring and review by the Senior Management Group (SMG), Quality Committee, the Audit Committee and the Trust Board.

4.3 Senior Management Team (SMT)

The SMT is responsible for the implementation and, oversight and monitoring of all risk management processes and activities within the Trust, and for ensuring that the objectives of the risk management policy and strategy are achieved. The Senior Management Team will oversee the implementation of the Risk Assessment and Reporting Procedure (TP035). The group will routinely review the corporate risk register and any proposed additions or deletions to this. The Senior Management Team will have delegated responsibility for a number of the CQC regulation outcomes.

4.4 Audit Committee

The Audit Committee has responsibility for reviewing the adequacy of risk and control related disclosure statements. The Committee reviews the risks with a high scoring (15+) on a quarterly basis.

4.5 Clinical Safety Development and Effectiveness Committee

The Clinical Safety Development and Effectiveness Committee's focus is on three core areas and therefore has responsibility for the review of risks relating to clinical safety, professional development and education and effectiveness and experience. The risks are discussed at each meeting, making recommendations for improving practice which will be informed and led by the Groups which feed into the committee.

4.6 Area Clinical Quality & Governance Meetings

The Area Clinical Quality &Governance meetings oversee and review, and provide assurance on the operational arrangements for clinical quality, safety and risk management. The meetings are made up as follows:

The South Area Clinical Quality & Governance MeetingThe East Area Clinical Quality & Governance Meeting
The West Area Clinical Quality &Governance Meeting

The Area Clinical Quality & Governance meetings will receive information from their respective areas regarding proposed risks and are responsible for the identification and management of risk at a local level. They will provide reports to the Clinical Quality Safety and Effectiveness Committee on risks that have a clinical focus to enable discussion and recommendations for improving practice.

The Area Clinical Quality & Governance meetings are also responsible for escalating risks to the SMT in accordance with this procedure.

4.7 Directorate Groups/Committees

The directorate groups/committees (Appendix 5) will receive information from their respective departments regarding proposed risks and are responsible for the identification and management of risk at a local level. The directorate groups/committees are made up as follows:

Corporate Services
IM&T
Finance & Performance
Workforce Directorate
Nursing and Quality
Transformation and Strategy
Communications
Medical

The directorate groups/committees are also responsible for escalating risks to the SMT in accordance with this procedure.

4.8 Project Groups/Boards

Project Groups/Boards have responsibility for assessing risks within the parameters of the project assigned. They also have responsibility for monitoring and reporting risks in accordance with this procedure.

4.9 Governance and Assurance

Governance and Assurance are responsible for the co-ordination and maintenance of the Corporate Risk Register.

Governance and Assurance provide update reports to the SMT, Audit Committee, and Clinical Safety Development and Effectiveness Committee.

4.10 Directors

Each Director is accountable for the risk registers within their Area/Directorate. In addition Directors are also accountable for specific risks on the Corporate Risk Register.

Directors devolve the day to day responsibility for maintaining and reviewing risk registers to senior managers within their Directorate.

4.11 Risk Register Administrators

Each Directorate has a Risk Register Administrator who is responsible for the coordination of updates and escalation of risks as directed by the Director.

The Risk Register Administrator will centrally update the local risk register after each meeting and coordinate actions and updates (Appendix 4).

4.12 Managers and staff

All risks should be assessed by managers and staff who have responsibility for, or have prior knowledge of, the existence of a risk. Staff have a responsibility to report risk and managers have a responsibility to manage risk as reported to them.

The Risk Management Policy and Strategy (TP/005) sets out in more detail specific responsibilities of senior managers relating to Risk Management and its implementation Trust-wide.

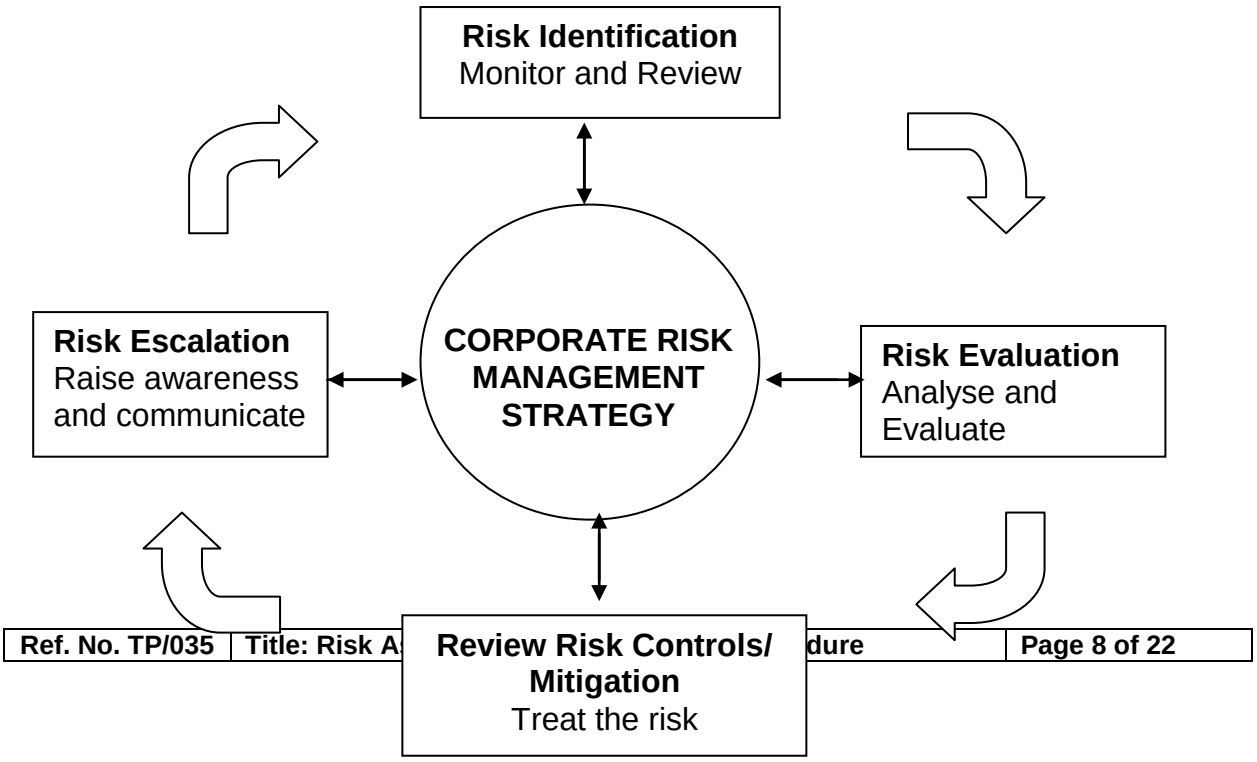
5. Definition of Risk

A Risk is defined as the probability (combination of likelihood and consequence) that a specific adverse event will occur in a specific time period or as a result of a specific situation.

6. Risk Assessment and Reporting Procedure

A Risk Register is one of the basic building blocks of risk management and provides a unified repository for the recording and monitoring of risks at both the local and corporate level within the Trust. Interaction with the risk register occurs at all stages of the risk management process from risk identification, assessment, through to risk response development and monitoring.

Figure 1 shows the Generic risk management process. Each of the risk management phases is described in the following paragraphs, along with how they utilise the risk register.



The Risk Identification and Reporting Flowchart (Appendix 1) describes the process for Risk Assessment and Reporting as described in sections 6.1 to 6.4. The Risk Assessment and Reporting Form (LA167) is set out in Appendix 2 with accompanying guidance notes, which provides managers with the information necessary to complete the assessment forms in a consistent manner.

6.1 Risk Identification

The initial identification of a risk takes place in the workplace by an individual/team who have the responsibility for carrying out the risk assessment.

Risks will be identified in several ways:

- Operational risks will be identified and assessed where they occur (by any member of staff/project team) and will then be reported as set out in section 6.4.

- A periodic 'top down' assessment of strategic risks led by the Executive Management Team will take place every year and will be linked with the development of the service plan.

- Risks will also be identified using the findings and recommendations from internal, external audit reports, serious incident investigations and The Care Quality Commission's five key questions and key lines of enquiry (KLOEs)..

The Risk Assessment and Reporting Form (LA167) in Appendix 2, is used to identify and evaluate potential risks and must be completed by the individual/group for each risk identified (Appendix 3 contains guidance for completion of the form).

Describing the risk in a clear and concise way, identifying the underlying cause, will often help to identify the key actions and controls to mitigate them.

Whoever identifies the risk should stay involved in the assessment stage. The initial assessment will then be refined with the help of colleagues and managers. A risk owner will be identified who will be responsible for reviewing and accepting the assessment for feeding into the risk register via SMT or EMT as appropriate.

6.2 Risk Evaluation

Once identified, risks need to be assessed by the individual/group and reported via the reporting route set out in Appendix 5. Also refer to TP005 Section 7 Committees with Responsibility for Risk Management which describes the roles and responsibilities of Trusts committees and groups for risk management and TP005 Section 4 which sets out the responsibilities of individuals within the Trust for the management of risk.

The risk evaluation phase requires analysis of the identified risk to establish the probability of occurrence and its impact.

In order to evaluate the risk two factors need to be taken into consideration;

1. the **impact** for the potential adverse outcomes relevant to the risk, and
2. the **likelihood** for those adverse outcomes.

The gross impact and likelihood are assessed as if the controls currently believed to be in place or any future actions planned were not actually there. Taking into consideration the mitigating effect of identified management actions already in place determines the net impact and likelihood.

The Risk Matrix in Appendix 3 is used when evaluating the risk to determine the gross risk rating.

6.3 Reviewing Risk Controls / Mitigation

When assessing a risk, it is important to review the controls already in place as it will help to determine further action required to mitigate the risk to achieve the target risk rating.

The final assessment of each risk relates to the target impact and likelihood levels, which refer to the level of potential exposure that is required. If this target level is lower than the level of the net impact and/or net likelihood, further management actions need to be identified and put in place to reduce the impact and/or likelihood of exposures to the acceptable level.

6.4 Risk Escalation

On completion of the LA167 form, a copy must be sent to Governance and Assurance Team as a record of the proposed risk, detailing which local group/committee the proposal will be made to.

Once a decision has been reached by the local group/committee, Governance and Assurance need to be informed of the outcome so that a record of the outcome can be kept and logged in a central database.

6.4.1 Proposal Accepted as a Risk

Where a risk identified through an area / department has implications for the whole trust or, exceptionally, on its own merits presents a risk to the achievement of the Trust's strategic objectives, it is appropriate that it is considered by the SMT for potential inclusion in the Corporate Risk Register.

The authority levels for managing different levels of risk within the organisation have been explained in paragraph 4 'Responsibilities' and set out in detail within TP005 Risk Management Policy and Strategy (also see Appendix 5 for overview).

Risks that have been calculated to have a net risk rating of 8 and above or risks that are identified to have a broader corporate impact will be proposed to the SMT for consideration. If the proposal is accepted as a risk to the Trust, it will be added to the Trust Risk Register, and monitored by the SMT. Where the potential risk is not accepted, feedback and reasoning will be provided to the individual/team who originally identified the potential risk for review and re-submission where necessary.

Risks that have been calculated to have a net risk rating below 8 are added to the relevant local risk register, and monitored by the Area Clinical and Quality Governance Meetings / Directorate Groups (see Appendix 5).

Once the risk assessment and reporting process has been completed, if the potential risk is accepted as a risk to the Trust it will be added to the relevant risk register.

All risks are monitored and reviewed on an on-going basis by the risk owners and the GCT. Once a risk has been mitigated to its target rating, a proposal for moving it to the dormant risk register is made. The SMT review proposals for risks on the Corporate Risk Register and the Area Clinical and Quality Governance Meetings/Directorate Groups review risks on the Local Risk Registers.

6.4.2 Proposal Not Accepted as a Risk

Once the risk assessment and reporting process has been completed, if the potential risk is not accepted as a risk to the Trust it will not be added to the risk register. The local group/committee will provide feedback and reasoning to the individual/team who originally identified the potential risk for review and re-submission where necessary. The submitted LA167 form will be kept as a record of the risk identification and reporting process and decision made.

7. Risk Register Structure

The minimum content and format to be adopted for the Risk Registers is outlined in Appendix 4. All risk registers will be saved centrally on a shared drive and are kept up to date by the delegated teams/individuals, with the GCT keeping an overview.

7.1 Corporate Risk Register

The Corporate Risk Register is a high-level register of the risks (graded 15 and above) which have an impact on the achievement of the Trust's strategic

objectives. It forms part of the Board Assurance Framework and is an important tool to inform strategic planning including prioritisation of resources.

7.2 Local / Departmental Risk Registers

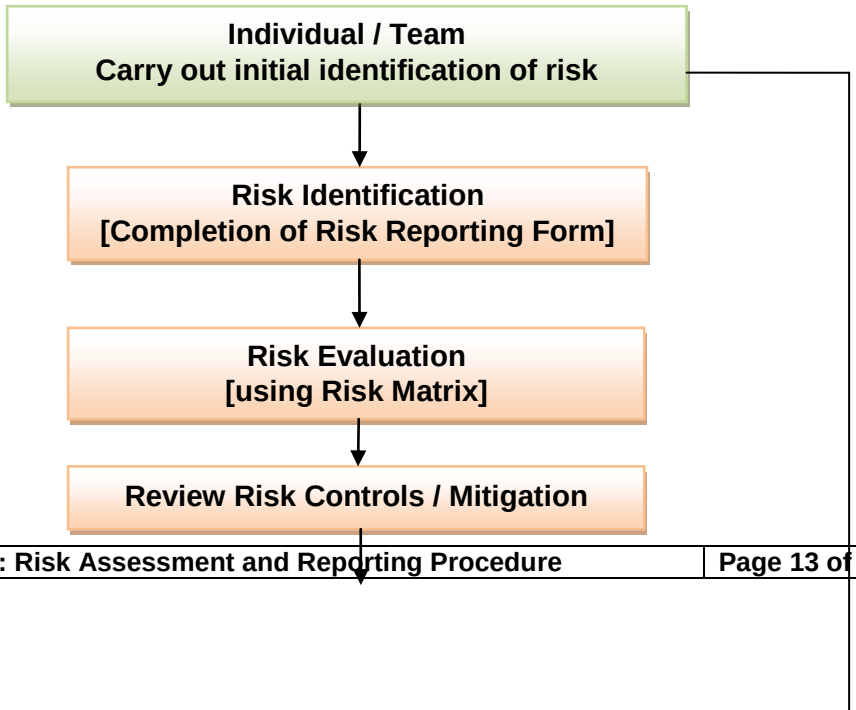
Through the business planning process local objectives are identified, therefore area / departmental risk registers should contain risks which may affect the performance or achievement of those local objectives. Again, these form part of the overall Board Assurance Framework. Appendix 5 details the reporting requirements for each area/directorate.

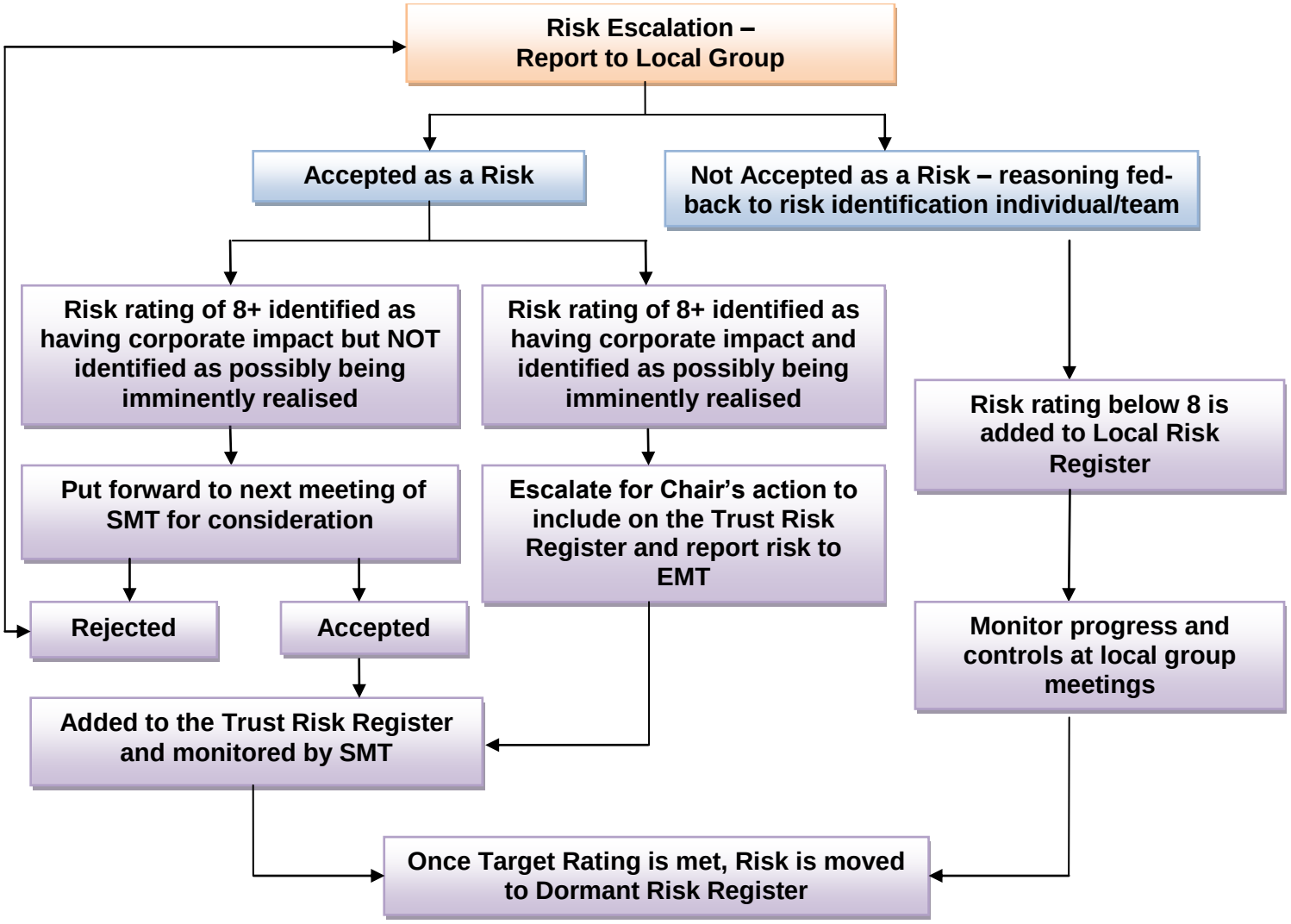
IMPLEMENTATION PLAN				
Intended Audience	For all LAS staff who are responsible for the reporting and management of risk.			
Dissemination	Available to all staff on the PULSE.			
Communications	Revised Procedure to be announced in the RIB and a link provided to the document.			
Training	Risk Register training will be provided to all heads of department and AOM's responsible for risk management in their respective areas.			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**

Risk Assessment and Reporting Procedure (paragraph 6) including: • How all risks are assessed • How risk assessments are conducted consistently • Authority levels for managing different levels of risk within the organisation • How risks are escalated through the organisation	Quarterly Review of Trust Wide Risk Register Quarterly Review of Corporate Risk Register (15+) Quarterly Review of Local Risk Registers	Governance and Assurance report to the Senior Management Team Governance and Assurance report to the Audit Committee ADO's for each operational area report to Area Quality meetings via the South, East and West Area Quality Meetings Corporate Heads of Department report to Finance and Performance, IM&T, Workforce, Corporate Services, Nursing and Quality, Medical, Communications and Strategy and Transformation Directorate meetings.	Quality Committee	Dissemination of learning in accordance with source of risk i.e. learning from risk highlighted via serious incident through SI Action Plan

Appendix 1

Risk Identification and Reporting Process Flow-chart





Appendix 2

LA 167

Risk Assessment and Reporting Form

Name of individual(s) completing assessment:

Department:

Date of assessment completion:

Please refer to the Guidance Notes for details of completion for section 1 to 5.

Section1: Risk Identification

1.1	**Risk Description**	There is a risk that…
1.2	**Underlying Cause / Source – Who might be affected by the Risk**	
1.3	**Date Risk Identified**	
1.4	**Risk Category**	
1.5	**Risk Owner (Lead Director)**	

Section 2: Risk Evaluation

2.1 - Gross Rating

	Likelihood score				
	1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
Impact score					
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** ☐

Section 3: Risk Controls Measures / Mitigation

3.1 - Existing Controls Measures Already in Place

1.	

2.	
3.	
4.	

3.2 Net Rating

	Likelihood score				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Impact score					
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 ☐

3.3 - Further Action Required: Action Plan

Additional control measures to reduce existing level of risk:-	Action Owner	Completion Date

3.4 Target Rating

	Likelihood score				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Impact score					
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 ☐

Section 4: Assurances in Place

1.	
2.	
3.	

4.	

Section 5: Additional Comments

Click on the following icon for Guidance for Completing the LA167 Risk Assessment and Reporting Form:

2012-07-23 LA167 Guidance.doc

FOR OFFICE USE ONLY

Date copy received by Risk Register Coordinator/Governance and Compliance Team:

Name of Committee/Group where risk was considered:

Outcome of proposal: Agreed / Rejected (comments, including Risk ID given):

Appendix 3

RISK MATRIX

Table 1 Impact Score

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.

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

			RIDDOR/agency reportable incident An event which impacts on a small number of patients	Mismanagement of patient care with long-term effects	
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring?

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

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur annually.	Expected to occur at least annually.	Expected to occur at least every 6 months.	Expected to occur at least monthly.	Expected to occur at least weekly.
Probability	< 1%	1-5%	6-25%	25-60%	>60%
	Will only occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

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

Table 3 Risk Score = Impact x Likelihood (I x L)

	Likelihood Score				
Impact 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	Significant risk
	15-25	High 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 impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use Table 2 to determine the likelihood score (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. Use Table 3 to calculate: I (Impact) 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, and 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.

Appendix 4

Risk Register Template

FORMAT

A Risk Register must contain the following information as a minimum;

- Risk Description
- Underlying Cause / Source of Risk (i.e. incident reports, risk assessments, local risk registers, external/audit recommendations, etc)
- Date Risk Identified
- Risk Category
- Risk Owner
- Date Risk Reviewed
- Risk Score; Gross, Net and Target
- Existing Controls
- Action Plan (risk treatment plan with Action Owner and Completion Date)
- Assurances

The Trust would advise using the Corporate Template **LA167A** for the Local Risk Registers. The template can be accessed through the Pulse or by clicking here

RISK ID

The Risk Register Administrator will allocate each risk with an ID based on the directorate/area risk register on which it will be monitored.

The following codes should be adopted;

Directorate/Area	ID code
Corporate Services	**CS**
Information Management & Technology	**IMT**

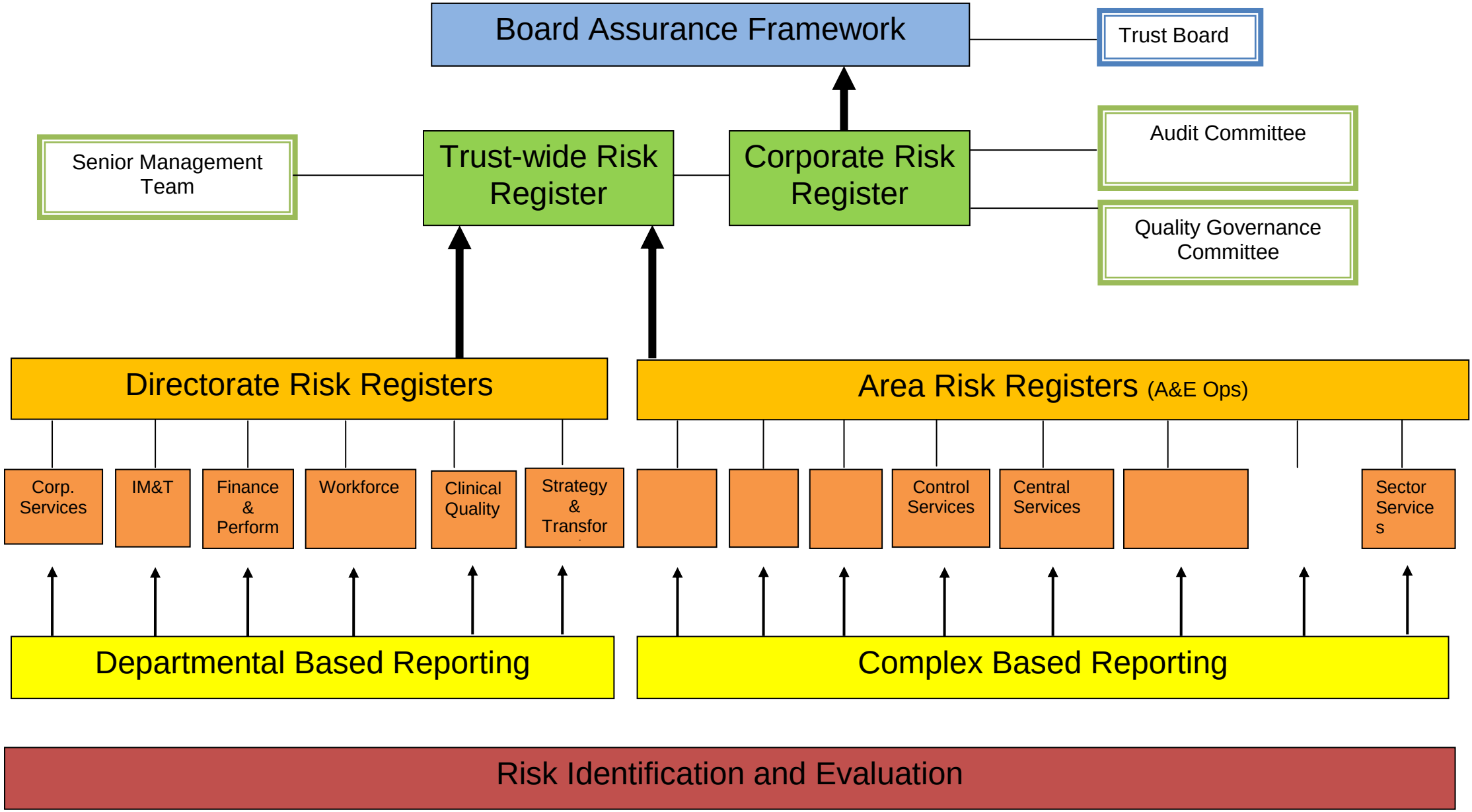
Finance	**FIN**
Human Resources and Organisational Development	**HROD**
Health Promotion	**HP**
Medical	**MED**
A&E Operations	**AE**
Control Services	**COS**
Patient Transport Services	**PTS**
East Area	**EA**
West Area	**WA**
South Area	**SA**

EG: The first three risk identified by Corporate Services should be given an ID of CS001, CS002, CS003; and should continue numerically thereafter.

MAINTENANCE

The Risk Register Administrator will coordinate and centrally update Local Risk Registers as set out in paragraph 4.11.

The Risk Registers must be kept up-to-date and reviewed in accordance with this procedure. The Risk Registers are to be saved on the shared drive.


Board Assurance Framework
Trust Board
Senior Management Team
Trust-wide Risk Register
Corporate Risk Register
Audit Committee
Quality Governance Committee
Directorate Risk Registers
Area Risk Registers (A&E Ops)
Corp. Services
IM&T
Finance & Perform
Workforce
Clinical Quality
Strategy & Transfor
Control Services
Central Services
Sector Service s
Departmental Based Reporting
Complex Based Reporting
Risk Identification and Evaluation