Paper ref:	TB (05/20) 003

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	COVID-19: Risk Mitigations		
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Report Author	Kam Dhami, Director of Governance		
Meeting	Trust Board (Public)	**Date**	7th May 2020

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The focus of debate needs to be on whether the mitigating actions do reduce the likelihood of occurrence to the typical occasional rating proposed. It may be that the Board requires closer monitoring of the quantities of actions' impact. In a handful of cases the severity indices are reduced and we should discuss the credibility of that proposal.

Risk management is led through the Gold Command work-stream. This is intended to tackle the difficulty of poacher-turned-gamekeeper in individuals designing solutions that are an advance on base but do not fix the issue sufficiently. In a number of cases the risk challenge is duration. For both workforce and equipping the Executive consider we have solutions to carry us through to June, but a more sustained period of difficulty may pose greater challenges. For that reason the governance proposed is quite intense.

The highest residual risks relate to psychological trauma which is covered elsewhere on the agenda, clinical harm which requires in coming days greater exposition and quantification, and other Majax events during COVID-19 – with cyber risk being covered later in the private Board.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	**x**	Public Health Plan		People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	**X**

3. Previous consideration *[where has this paper been previously discussed?]*

Gold Command

4. Recommendation(s)

The Trust Board is asked to:

a.	**DISCUSS** the sufficiency of the identified COVID-19 mitigating actions
b.	**APPROVE** the proposed governance arrangements for managing and monitoring mitigation and expect a status report on the 30 COVID-19 risks and any additions in June 2020

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	x	30 risks logged on Safeguard						
Board Assurance Framework		n/a						
Equality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 7th May 2020

COVID-19: Risk Mitigations

1. Introduction

1.1 The Board is aware of the Trust's plans for responding to the global pandemic which is both dynamic in nature and without precedent. COVID-19 has brought about radical changes to the way in which the nation is living and working and as a consequence how the Trust is providing care and treatment to its patients.

1.2 The identification and management of risk has always been essential to ensuring the Trust is able to provide safe, high quality care, and never has that been more important than now when decisions are being made in uncharted territory.

1.3 This paper presents to the Board the risks that have been identified relating to the Surge phase of the Trust's response to COVID-19 and details the steps to be taken in advance of events occurring to reduce adverse and potentially long term effects. Some thought has been given to Restoration but further examination of that will take place over the coming fortnight as the plan is developed.

2. COVID-19 risk identification

2.1 There are risks being faced on a daily basis by the organisation, many of which are being managed but continue to pose challenges. These risks have not been specifically documented as risks as many are now issues that are being actively managed by Silver command. A full log of these discussions exists.

2.2 The Trust was quick to make changes to the running of services when the country went into lockdown on 23rd March and there was a need for self-distancing and isolation. These included:

- Stopping face to face visiting
- Deployment of phones and tablets to wards for patients to stay in contact with family and friends
- Cancelling routine elective surgery (early March)
- Significant reduction in face to face outpatient appointments, using technology instead where possible
- Reassigning of inpatient wards for treating COVID-19 positive and negative patients

2.3 Listed below are examples of actions taken over the past 6 weeks that are now seen as **controls** for developing and managing future risks:

- Provision of hotel accommodation for staff so that they can remain at work and safeguard their families
- The strength of the IT infrastructure has allowed 'working from home' to be possible for some staff
- Personal Protective Equipment (PPE) stores opened and advice provided on what to wear in which circumstances to ensure staff are protected in their work areas.
- For those with young children, the Trust nursery has stepped in to take children up to 8 years, allowing staff to continue working
- Restructuring our district nursing teams to better support Care Homes, whilst providing PPE and infection control advice to those units in Sandwell.

2.4 Trust plans have, out of necessity, been created at speed and where possible tested against other organisations. National guidance has been followed or exceeded. The risk profile therefore focuses on:

- Risks to delivery of the plan; and
- Risks that the plan does not match the challenge because the challenge is mis-predicted.

The major risks to the plan delivery have been categorised in the following four areas:

a. Workforce supply, resilience and skills
b. Equipping supply and distribution
c. Estate and organisational infrastructure
d. Clinical care provision

As this implies, and beyond Surge or Restoration, we have not created a risk profile for the exit phase of the pandemic. The Board may wish to consider this.

2.5 Executive-led conversations have taken place to anticipate the potential for non-delivery of the Trust's plans as a route to identifying the risks. Additionally, the 'brain-storming' approach has been used with a number of groups to elicit wider contributions, including for example on the workforce risks, and Group-level involvement through the April Executive Quality and Risk Management Committees.

3. Risk assessment

3.1 **Annex 1** sets out the risks identified to date *(there is a risk that X will happen because of Y which may result in Z*), the position at which the risk assessment currently stands, the planned actions to mitigate the risks materialising and the target rating which will be reached when all the actions have been successfully achieved.

3.2 Board members will be familiar with the Trust's Risk Assessment Matrix which is shown at **Annex 2**. The risk rating is a judgement as to the likelihood that harm/damage/loss may occur and the expected severity of that harm/damage/loss.

- **Likelihood** of harm occurring will be influenced, for example, by the number of times a procedure / task is required to be completed, the number of people involved in the activity, the amount of particular hazardous substance involved in the procedure.

- **Severity** of harm will be influenced by the expected effect upon individuals and or the Trust and its capabilities or reputation.

In order to standardise these judgements, the Risk Assessment Matrix, is used to assist this process. Numerical values for likelihood and severity are multiplied to achieve an overall risk rating. Consideration of likelihood and severity will be influenced by the controls already in place.

3.3 The identified risks are logged on the Trust's electronic risk management system, Safeguard, and have detailed actions plans, including leads and timescales.

4. Risk analysis and mitigation

4.1 Summarised below are some of the key risks shown in Annex 1. The author has selected the top three from the current risk rating. The Board may wish to consider other high rated risks beyond that selection. The key issue in all cases is whether occasional Likelihood can be achieved by mitigation. Occasional meaning both rare and short duration. The implication is that short duration is measured in days not longer. That suggests agility in the control and governance model and an ability to respond. To date that has been observed in the approach taken. It is however evident that the longer the pandemic continues the more we de-sensitise to triggers and the greater the likelihood of other issues intruding. Those externalities are indeed the highest rated residual risks.

4.2 **Workforce**

1. There is a risk of increased psychological trauma (work or home) due to COVID-19 leading to staff harm or prolonged absence.		**2.** There is a risk that staff accrue annual leave at scale due to the pressures of COVID-19 leading to an adverse impact on clinical service delivery during restoration.		**3.** There is a risk that a loss of clinical expertise and leadership through sustained non-availability leads to staff and/or patient harm.	
Current: 5x5=25	**Target: 3x5=15**	**Current: 5x4=20**	**Target: 2x4=8**	**Current: 4x4=16**	**Target: 1x4=4**

4.2.1 Two of these high rated risks are ones where data exists or can be obtained and the position can be quantified and managed. Both are high rated because neither presently are assessed within Silver Command. This will be resolved for the next report and it is expected that the yellow ratings shown can be achieved. Both are of course 'duration risks', and would be impacted by second surge.

4.2.2 Psychological trauma has a clear plan and proposed scorecard. The challenge is to ensure grip and focus on this and governance of that programme will be discussed in Gold Command. Based on evidence presented by the Chief Nurse from Italy, in

particular, it is imperative that the Trust is bold in providing service options and firm in insisting upon their use. Efficacy cannot be predicted.

4.3 **Equipping**

8. A lack of appropriate PPE due to shortage in the supply chain or that resources are inadequate for the job lead to staff being put at unnecessary risk of COVID 19.		**9.** There is a risk that availability of fixed or semi-fixed equipment cannot be scaled up to plan leading to patient harm.		**10.** There is a risk of shortfall in consumables or single products because they cannot be sourced at scale, on time or for duration of plans leading to patient harm.	
Current: 4x5=20	**Target: 3x5=15**	**Current: 4x4=16**	**Target: 2x4=8**	**Current: 3x5=15**	**Target: 2x5=10**

4.3.1 Issues associated with equipping span a series of domains from medicines through consumables to protective uniform. In all cases the context of the risk is the same:

a) Does the Trust adequately understand its forward need?
b) Can that need by met in the market and can the Trust obtain supply?
c) How well does the Trust distribute internally?
d) Do end users understand how to make best use of the provided supply?

4.3.2 (a) and (c) are within the control of the organisation. (d) is also in that control but data-sets are less available to track this, which is why approaches such as PPE wardens have been adopted to provide eyes and ears at ground level. The Trust has used the daily bulletin to very visibly encourage Speaking Up and challenging reporting. (b) is being tackled nationally and we have visibility of our own data and that of others. We do not have visibility of future supply chain that is nationally purchased. This is currently adequate and oral assurance has been provided that it will remain so. International supply interruption clearly cannot be ruled out.

4.4 **Assets**

18. Risk to supply of Oxygen due to level of use and possible external supply issues may lead to patient harm.		**19.** Risk to estate due to supply chain issues leading to areas of the Trust being unfit for purpose.		**20.** There is a risk of overload of our IT infrastructure due to multiple teams working off site leading to reduced performance.	
Current: 4x5=20	**Target: 2x5=10**	**Current: 3x4=12**	**Target: 2x4=8**	**Current: 3x3=9**	**Target: 1x3=3**

4.4.1 The Trust Chairman has reviewed the oxygen supply position, working alongside the Director of System Transformation and her team. All external guidance has been duly considered and appraised. A review of long term oxygen supply through into Midland Met is being completed for assurance.

4.4.2 Many of these risks are impacted by the provision of care in other Trusts, in that supplier and supply chain may be diverted to service those more pressing needs, as they were earlier in the pandemic by the development of the Nightingale Hospital

Birmingham. There is control for that in peer working and system working, which the Trust actively contributes too.

4.4.3 The presented IT infrastructure risk is associated with home working. The Board has previously accepted that Infrastructure risk is adequately assured within the SBAF based on the visibility we have through PTRG monitoring. The Digital Major Projects Authority will re-examine the last eight weeks data when it meets at the end of May.

4.5 Clinical Care

24. There is a risk that services will be overwhelmed due to a surge of patients requiring follow up and new appointments, which will be difficult to deliver and may lead to poorer outcomes.		**25.** Risk to patient health deteriorating due to scaling back of services for COVID-19 leading to poorer outcomes, functionality and diagnosis.		**26.** Risk of delayed presentation of patients as patients are not attending healthcare premises due to COVID-19 leading to poor outcomes, functionality and diagnosis.	
Current: 5x5=25	**Target: 2x5=10**	**Current: 4x5=20**	**Target: 2x5=10**	**Current: 5x3=15**	**Target: 3x4=12**

4.5.1 The focus of analysis during April has been on clinical care delivery during COVID-19. Review has taken place of all deaths in March, and timelines and processes established for April review. The approach and initial outcomes has been shared with NHS Midlands and no amendments or alternative approaches proposed. Meanwhile, standard safety measures have been monitored across areas like the Safety Plan. All-cause mortality data is understood on a Trust level, but district level data will come in time.

4.5.2 The other two risks highlighted above are focused on known patients waiting and unknown patients waiting to present. The scale of the former has been quantified. The scale of the gap of the latter can be seen in data. The intention is to develop a series of longer term scenarios for this 'iceberg'. The Trust has proposed that this work is done at STP level and a reply to that proposal is awaited. No regional modelling is yet visible.

4.6 Other Events

28. There is a risk that another simultaneous Major Incident would not be managed as effectively as possible because of stretch from COVID-19 response leading to slower or inadequate service recovery		**29.** There is an increased risk of a cyber-attack due to the current criticality of the NHS caused by COVID-19 which could result in a prolonged IT outage and severe service disruption.	
Current: 4x5=20	**Target: 3x5=15**	**Current: 3x5=15**	**Target: 2x5=10**

4.6.1 Gold command review considered that these risks are actually the least-mitigated in our current state. That partly reflects the diffuse nature of the threats faced. The mitigation for other Majax specifically references a split team model, and the Board may wish to see names and roles to assure itself over the summer months of the manpower bandwidth to achieve this.

4.6.2 The cyber risk score shown reflects the analysis done against the NHS Midlands KLOE standards issued. The Board's 'closed cyber group' will report to the private Board and may consider that this test is too narrow and that this target score cannot be achieved.

4.7 The bulk of the mitigations outlined are similar:

- Substitution of one approach with another – is that fall back documented?
- Scaling back of service or its transfer – are triggers quantified?
- Foresight through central controls in Silver – do data flows support this?
- Overwhelming focus just on COVID-19 – will the wider NHS permit this?

Risks are owned across the Executive group with principal leadership as follows:

- Workforce – Chief Executive
- Equipping – Chief Finance Officer
- Assets – Chief Operating Officer
- Clinical Care – Medical Director
- Other – Director of Governance

5. Forward governance – next 3 months

5.1 The monthly executive Risk Management Committee (RMC) will oversee the COVID-19 risks and satisfy itself through robust challenge that the actions taken to manage the identified risks have been achieved and evidence is available to confirm this to be the case, or they are actively being managed to achieve the target rating. ***The target risk scores will be updated weekly at Gold Command and the Board advised if any target score will not be reached by 1st July.***

5.2 The existing monthly report to the Clinical Leadership Executive will include an update on any risk rating movements and action plan delivery, escalating any matters of concern. This is intended to ensure that COVID-19 risks are viewed alongside other risks in the organisation.

5.3 Next month's Board risk report will cover:

- These COVID-19 risks (amended and updated)
- Our usual Trust risk register
- Risks associated with the recovery and restoration plan

As the pandemic is a dynamic situation it is likely that some lower rated risks in the annex will be removed on next presentation if their residual score is below 6.

5.4 The 4 clinical care risks will be considered at the monthly Executive Quality Committee and Board Quality and Safety Committee to allow more in depth discussions on the actual or potential harm to patients and to receive data on clinical outcomes and reported incidents. This will be examined alongside the data-set to track recovery against the patient wait data cited in the Gold paper before the Board today. A Chief Executive led review of clinical care risks will take place on 15th May because by then we

will have largely completed the mortality review work being led through the Medical Director's team.

5.5 The Audit and Risk Management Committee on 2nd July will be asked to assure the Board that Q1 governance of COVID-19 risks has been adequate, and escalate any unresolved matters.

6. Recommendations

6.1 The Trust Board is asked to:

a. **DISCUSS** the sufficiency of the identified COVID-19 mitigating actions
b. **APPROVE** the proposed governance arrangements for managing and monitoring mitigation and expect a status report on the 30 COVID-19 risks and any additions in June 2020

Kam Dhami
Director of Governance

30th April 2020

Annex 1: COVID-19 risk mitigations
Annex 2: COVID-19 risk assessment matrix

Annex 1

SANDWELL AND WEST BIRMINGHAM NHS TRUST

COVID-19: Risk Mitigations

A. WORKFORCE

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigating Actions	Target Risk Rating (Likelihood v Severity
1.	**Workforce**	There is a risk of increased psychological trauma (work or home) due to COVID-19 leading to staff harm or prolonged absence.	**5 x 5 = 25**	• Absence impact collectively expected to be modest but early intervention model key to mitigation – Trust wellbeing offer • Tracking of psychological wellbeing at departmental level • Rigorous implementation of revised Trust sickness plans	**3 x 5 = 15**
2.	**Workforce**	There is a risk that staff accrue annual leave at scale due to the pressures of COVID-19 leading to an adverse impact on clinical service delivery during restoration.	**5 x 4 = 20**	• Manage annual leave across 24 month period and report data for each individual not less than quarterly centrally • In surge scenario insist on 70% of year 1 AL in year one • Consider targeted buy out in 20-21 (employer not employee initiated)	**2 x 4 = 8**
3.	**Workforce**	There is a risk that a loss of clinical expertise and leadership through sustained non-availability leads to staff and/or patient harm.	**4 x 4 = 16**	• Leadership key personnel map to ensure resilience in key specialties combined with external executive led recruitment to provide greater resilience • Rationalisation of senior nursing roles to permit greater focus on clinical care at ward and matron level	**2 x 4 = 8**
4.	**Workforce**	There is a risk that changes to national shielding guidance would increase absence meaning that not enough staff are available to look after our patients.	**4 x 4 = 16**	• Remote support for redeployed staff whilst looking after patients (over prolonged period some CPD support may be needed..)	**1 x 4 = 4**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigating Actions	Target Risk Rating (Likelihood v Severity
5.	**Workforce**	There is a risk that the planned staffing ratios and skill mix due to lack of supply leads to staff and/or patient harm.	**3 x 5 = 15**	• The Trust can achieve its ratios under current plan and will use Safety Plan controls to track patient harms. This should permit intervention in hotspot areas	**2 x 4 = 8**
6.	**Workforce**	There is a risk that more than 30% absence means that we do not have enough staff to look after our patients.	**2 x 5 = 10**	• Centralised approach to absence grip, and related approach to leave in the short term – permitting redeployment • Rationalisation of multi-site locations to fit foreseeable workforce in advance of MMU (see Gold recovery plan)	**1 x 4 = 4**
7.	**Workforce**	There is a risk that ancillary support structures do not have enough staff to meet the needs of increased workload which may lead to infection or patient flow harms.	**3 x 3 = 9**	• Virtual deployment of staff shielding to assist with clinical admin functions. • Additional volunteers from non-clinical / non-patient facing departments to be trained to join brigades to support in such areas as cleaning and portering. • Assessment of critical work to release further staff for brigade work.	**2 x 3 = 6**

B. EQUIPPING

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
8.	**Equipping**	A lack of appropriate PPE due to shortage in the supply chain or that resources are inadequate for the job lead to staff being put at unnecessary risk of COVID 19.	**4 x 5 = 20**	• Increase contract with laundry service for reusable gowns, throughput and/or additional gowns. • Locally source bespoke items with firms (innovate) • Reuse only in extremis after Gold approval	**3 x 5 = 15**
9.	**Equipping**	There is a risk that availability of fixed or semi-fixed equipment cannot be scaled up to plan leading to patient harm. [Equipment available for surge plan, and being confirmed for recovery plan. Key risk is either super surge or long term surge, or peer aid.]	**4 x 4 = 16**	• Equipment tracking through tactical and reliance on off supply chain suppliers to maintain continuity (risk posed by scaled up Nightingale) • In-house medical engineering function geared to up to devise solutions for mis-use or re-use of non-patient facing kit • Peer aid across BCWB STP system	**2 x 4 = 8**
10.	**Equipping**	There is a risk of shortfall in consumables or single products because they cannot be sourced at scale, on time or for duration of plans leading to patient harm.	**3 x 5 = 15**	• Review and revise patient pathways to decide on provision of care where equipment is not available. • Consumables stock levels centrally reported with base of 20 days' supply required. Key risk remains supply chain stock not local stock.	**2 x 5 = 10**
11.	**Equipping**	Due to unprecedented demand, equipment could fail if used continuously resulting in disruption or delay in patient care.	**3 x 5 = 15**	• Consideration, based on a risk assessment, of use of alternative equipment (case by case basis) [DN need revised assessment of unreplaceable kit]	**2 x 5 = 10**
12.	**Equipping**	Unfamiliarity with equipment by some staff may lead to errors in use resulting in patient	**3 x 5 = 15**	• Training provision for deployed staff and adequate support and supervision for redeployed staff.	**1 x 5 = 5**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
		harms.		• June refresh of key equipment training using video tech	
13.	**Equipping**	Risk of local gaps or stretch due to diversion of provisions to other parts of the system leading to shortfalls in fixed or consumable supply.	**3 x 4 = 12**	• Participation in STP wide work to support neighbours and develop escalated foresight	**2 x 4 = 8**
14.	**Equipping**	International trade policy barriers lead to short term or long term supply interruption resulting in an inability to deliver the plan	**3 x 4 = 12**	• Understanding of supply chain to Trust permits alternative purchasing options to be prioritised	**2 x 4 = 8**
15.	**Equipping**	Risk that new evidence necessitates changes in product acquisitions resulting in delay to delivery of surge plan.	**2 x 5 = 10**	• Continue to use existing equipment until alternatives are available.	**2 x 5 = 10**
16.	**Equipping**	Risk of breakdown or shortfall of fixed and semi-fixed equipment due to intensity of use leading to patient safety compromise.	**3 x 3 = 9**	• Review and revise pathways to decide on provision of care where equipment is not available. • Discuss with Birmingham Nightingale Hospital for short term release of available equipment.	**2 x 3 = 6**
17.	**Equipping**	There is a risk that sourcing or maintaining equipment dependent upon a key person leads to unanticipated weakness in plan delivery.	**3 x 3 = 9**	• Changes in allocation of manpower within medical engineering function and purchase of external input as needed	**1 x 3 = 3**

C. ASSETS

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
18.	**Assets**	Risk to supply of Oxygen due to level of use and possible external supply issues may lead to patient harm.	**4 x 5 = 20**	• Review and revise patient pathways to decide on provision of care where equipment is not available. • Prescribing of Oxygen to be the 'norm'. • Adoption of weaning oxygen protocols. • Suppliers to be contacted at earliest opportunities to keep stock levels high or optimum.	**2 x 5 = 10**
19.	**Assets**	Risk to estate due to supply chain issues leading to areas of the Trust being unfit for purpose.	**3 x 4 = 12**	• Internal Estates team to make remedial repairs • Use of video instruction from supply chain for Estates staff to use. • Use of closed departments to facilitate suppliers. • Closure of departments	**2 x 4 = 8**
20.	**Assets**	There is a risk of overload of our IT infrastructure due to multiple teams working off site leading to reduced performance.	**3 x 3 = 9**	• Reduce homeworking, some staff to return to site • Move to 7-day working across teams to disperse activity and overload to IT infrastructure • Spread log on activity to a wider working day	**1 x 3 = 3**
21.	**Assets**	There is a risk of some of our suppliers being unable to provide support because of a reluctance to come on site or their staff being furloughed.	**3 x 3 = 9**	• Offer support, escorting and appropriate PPE to any suppliers visiting site • Check suppliers availability and ensure viability of service with cash flows	**2 x 4 = 8**
22.	**Assets**	There is a risk that the rapid rollout of new technology to wards and to people at home and the movement of equipment around wards may result in	**3 x 2 = 6**	• Ensure that all rollouts of equipment go through the asset team • Perform updates of equipment checks and stock takes on a monthly basis	**1 x 2 = 2**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
		asset registers becoming out of date and equipment being lost.		• Ensure that equipment is given to named people in communal areas	
23.	Assets	There is a risk that lack of storage due to an increase in infected waste could result in staff illness and infestation.	**2 x 3 = 6**	• Review capacity against demand • Identify safe storage facilities on site • Increase offsite removal contract	**1 x 3 = 3**

D. CLINICAL CARE

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
24.	**Clinical Care**	There is a risk that services will be overwhelmed due to a surge of patients requiring follow up and new appointments, which will be difficult to deliver and may lead to poorer outcomes.	**5 x 5 = 25**	• Phased approach to resumption of services to prevent a surge. • 7-day working and longer day working for all specialities to ensure ability to meet demand over 6 month period • Peer aid with colleagues in BSol and BCWB	**2x 5 = 10**
25.	**Clinical Care**	Risk to patient health deteriorating due to scaling back of services for COVID-19 leading to poorer outcomes, functionality and diagnosis.	**4 x 5 = 20**	• Scale up shielding offer to work alongside general practice • Overt publicity campaign in local community media • Development of more integrated offer with community pharmacies on the back of self-care plans	**2 x 5 = 10**
26.	**Clinical Care**	Risk of delayed presentation of patients as patients are not attending healthcare premises due to COVID-19 leading to poor outcomes, functionality and diagnosis.	**5 x 3 = 15**	• Provision of 'safe' GP services to allow 'safe' consultations. • Straight to test options at scale to allow rapid access diagnostics	**3 x 4 = 12**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
27.	**Clinical Care**	Risk of lack optimum medications due to supply shortage or supply diversion leading to suboptimal patient care.	**3x 3= 9**	• Review and revise patient pathways to decide on provision of care where supply is unavailable. • Source and stock alternative medications.	**3 x 3 = 9**

E. OTHER EVENTS

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
28.	**Sustainability**	There is a risk that another simultaneous Major Incident would not be managed as effectively as possible because of stretch from COVID-19 response leading to slower or inadequate service recovery	**4 x 5 = 20**	• Resilience in key IT/estate/operation/EP functions to run split team response • Peer aid considerations with expertise arranged from neighbouring organisations	**3 x 5 = 15**
29.	**Sustainability**	There is an increased risk of a cyber-attack due to the current criticality of the NHS caused by COVID-19 which could result in a prolonged IT outage and severe service disruption.	**3 x 5 = 15**	Considered in paper to the private Board	**2 x 5 = 10**
30.	**Strategic**	There is a risk that premature NHS reorganisation locally or nationally results in diffused effort during 2020	**2 x 4 = 8**	• Clear local leadership ensures time spent on importance not urgent, with good liaison with STP chair • Well-developed Place relationships at ICP level result in cohesion to approach to care integration	**2 x 4 = 8**

Annex 2

RISK ASSESSMENT MATRIX

1. **LIKELIHOOD:** What is the likelihood of the harm/damage/loss occurring?

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may only occur in exceptional circumstances
2	Unlikely	The event is not expected to happen but may occur in some circumstances
3	Possible	The event may occur occasionally
4	Likely	The event is likely to occur, but is not a persistent issue
5	Almost Certain	The event will probably occur on many occasions and is a persistent issue

2. **SEVERITY:** What is the highest potential consequence of this risk? *(If there is more than one, choose the higher)*

Descriptor	Potential Impact on Individual (s)	Potential Impact on Organisation	Cost of control / litigation	Potential for complaint / litigation
Insignificant 1	**No injury or adverse outcome**	**No risk at all to organisation**	**£0 - £50k**	**Unlikely to cause complaint / litigation**
Minor 2	**Short term injury / damage** e.g. injury that is likely to be resolved within one month	**Minimal risk to organisation**	**£50k - £500k**	**Complaint possible Litigation unlikely**
Moderate 3	**Semi-permanent injury / damage e.g. injury that may take up to 1 year to resolve.**	• **Some disruption in service with unacceptable impact on patient** • **Short term sickness**	**£500k - £2m**	**High potential for complaint Litigation possible**
Major 4	**Permanent Injury** • **Loss of body part(s)** • **Loss of sight** • **Admission to specialist intensive care unit**	• **Long term sickness** • **Service closure** • **Service / department external accreditation at risk**	**£2m - £4m**	**Litigation expected/certain Multiple justified complaints**
Catastrophic 5	**Death and/or multiple injuries (20+)**	• **National adverse publicity** • **External enforcement body investigation** • **Trust external accreditation at risk**	**£4m+**	**Multiple claims / single major claim**

3. **RISK RATING:** Use matrix below to rate the risk *(e.g. 2 x 4 = 8 = Yellow, 5 x 5 = 25 = Red)*

		LIKELIHOOD				
SEVERITY		**Rare 1**	**Unlikely 2**	**Possible 3**	**Likely 4**	**Almost Certain 5**
Catastrophic	**5**	**5**	**10**	**15**	**20**	**25**
Major	**4**	**4**	**8**	**12**	**16**	**20**
Moderate	**3**	**3**	**6**	**9**	**12**	**15**
Minor	**2**	**2**	**4**	**6**	**8**	**10**
Insignificant	**1**	**1**	**2**	**3**	**4**	**5**

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM risk** **Red = HIGH risk**