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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	COVID-19: Recovery Phase Risks		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Toby Lewis, Chief Executive and Kam Dhami, Director of Governance		
Meeting	Trust Board (Public)	**Date**	4th June 2020

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

The paper outlines specific risks associated with COVID-19 Recovery and Restoration. The Board is directed to consider the residually high items in the main paper.

The full list of recovery risks is show in the annex.

As with surge the highest volume of risks relates to workforce. However the recovery plan depends on both IT capability and the continued permissive approach to finance. Both have high ratings of concern.

Gold Command recognises further work to do on equipping data across the more diverse supply chain landscape.

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.	**CONSIDER** the risks set out and their mitigation
b.	**ACCEPT** or tolerate the red rated post mitigation scores shown

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

Trust Risk Register	x	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: 4th June 2020

COVID-19: Recovery Phase Risks

1. Introduction

1.1 Last month the Board considered risks to successful delivery of the Surge plan. The commitment remains to achieve post mitigation scores as per that paper by the end of June, and confirm conclusion of that work at the July Board meeting. A more detailed set of clinical risks, which span both Surge and Restoration was discussed at the May quality and safety committee.

1.2 This document considers the related but distinct issues of executing the Recovery/Restoration/Reset plan. Post mitigation scores are higher than for the surge plan albeit that probably reflects the nascent development of the plan and the position will improve next month.

1.3 A review of the Trust's approach to COVID-19 is included in the 2020-21 Internal Audit Plan, at the request of the outgoing Audit and Risk Management Committee chair.

2. COVID-19 risk identification

2.1 A subset of the Gold Group has developed this summary of risks. Mitigation proposals and scoring have been overseen by the Chief Executive as SRO for our pandemic response.

2.2 We will use CLE in June to socialise clinical groups to this assessment of risk bearing in mind the work they each currently doing on implementing the plans they have. Many of the risks need calibration against our equipping cell and consideration with partners in our ICPs around work with care homes and other suppliers.

2.3 Given the longer term nature of the recovery programme, financial risks do feature in this assessment. The position is not about Trust I&E but ensuring funds are readily available to make sure recovery capacity is well used.

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.

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 rated residual risk after mitigation. 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**

Category	Risk Statement	Current Risk Score	Mitigations	Target Risk Score
3. Workforce	There is a risk that large scale and short notice staff absence due to tracking and quarantine leads to insufficient staff to manage both red zones and recovery area.	**5 x 5 = 25**	• Large scale antibody testing is implemented during June 2020 to ensure we have available employees • Trust grows bank resourcing in niche areas (NNU etc.) to provide more flex beyond agency staff • Introduction of routine test screening for antibody negative staff in selected areas in late June	**3 x 4 = 12**

4.2.1 This risk is rated highly because we are relying on mitigations that have not yet been tested and we have limited data on the underlying antibody rate. We will quickly know

if this adequately mitigates the chance of losing employees from service at scale and short notice.

4.3 **Equipping**

Category	Risk Statement	Current Risk Score	Mitigations	Target Risk Score
12. Equipping	There is a risk that Trust supply chains for equipment are severely disrupted by planned or unexpected national procurement exercises leading to an inability to fulfil patient commitments made in the recovery plan.	**5 x 3= 15**	▪ Create cell on equipping needs that is tracked centrally against supply (reporting day's supply to tactical) ▪ Specify supply chain geography and pre-label national procurement with a higher baseline to take account of failure points	**4 x 3 = 12**

4.3.1 The high rating for this risk reflects experience during the pandemic. The diversity of supply requirements, albeit from established pre C-19 supply chains, inherently raises risk, at the same time as other markets are changing purchasing models. The Trust is well placed but will need to navigate the varied approaches being applied to national, regional and local purchasing.

4.4 **Assets**

Category	Risk Statement	Current Risk Score	Mitigations	Target Risk Score
15. Assets	There is a risk that quadrupling or more of the scale of video based consultations due to infrastructure overload or helpdesk swamping leads to failed patient contact.	**4 x 4 = 16**	▪ Undertake headroom simulations of multiple users to test break points in 'cold' environment ▪ Collect routine data on speed of consult weekly during Q2 to build confidence ▪ Engage suppliers in our work as part of their Social Responsibility commitment to public service	**4 x 2 = 8**

4.4.1 This risk ought to be mitigated by strong pre-planning and testing. Significant focus will be needed by IT senior management to ensure delivery of a massive transformation in care models. The Trust needs to become, and credibly can via Visionable, a favoured partner for innovators in the tech market in this field.

4.5 **Clinical Care**

Category	Risk Statement	Current Risk Score	Mitigations	Target Risk Score
20. Clinical Care	There is a risk of delayed patient presentations for new conditions due to patient concerns about COVID-19 leading to worse patient outcomes	**5 x 4 = 20**	▪ Continued work to promote care options through June as part of recovery plan ▪ Specific communications aimed at high risk groups	**4 x 3 =12**

4.5.1 Absent second surge, we should know by July, and certainly by August, whether the bounce-back that health outcomes need has happened with lockdown release and school return. A very different mitigation plan will be needed if not. It may be that specific conditions or populations need a more targeted approach. EQC will be used to discuss this in some detail.

4.6 **Other Events**

Category	Risk Statement	Current Risk Score	Mitigations	Target Risk Score
31. Strategic	There is a risk that con-current COVID-19 and severe seasonal winter flu drives patient demand above and/or workforce supply below planned scenarios leading to extended waits for care or other harms.	**5 x 4 = 20**	▪ Work to ensure Trust, ICP and ICS all plan on a winter focus in developing current recovery plans ▪ Create fall back supply contracts with IS and elsewhere to take account of main gaps ▪ Undertake best flu vaccination campaign that we have ever operated	**5 x 3 = 15**
32. Strategic	There is a risk that implementation of April 2020/21 Place based population budgeting is delayed by and/or is incompatible with COVID-19 recovery plan implementation leading to damaged working relationships between partners and long term challenges to collective financial stability.	**4 x 4 = 16**	▪ Make this work the core business of the monthly ICP Boards ▪ Create provider alignment to develop shared spend plan and risk dynamic in advance of commissioner clarity ▪ Engage HWBB in expectation of this work being completed on time ▪ Involve CCG MDs in Trust business ▪ Fund and support ICP OD programme	**4 x 3 = 12**

4.6.1 Two very different H2 risks are cited above. The management challenge is to take the actions now to prevent their crystallisation. Modelling for winter is part of the restoration plan countdown over the next fortnight and P&I are working the demand data through presently. The place based budgeting work is eighteen months behind but has the advantage of a new CCG AO and real drive from the commissioning MDs. With

significant financial challenge in some parts of the Black Country it is important that local funds are committed to the local long term outcome challenge of poverty and deprivation.

5. Forward governance – next 3 months

5.1 As with Surge the intention is to use Gold meeting to consider the risk mitigations. The expectation is that target rating can be lowered and can be met by the end of July 2020.

5.2 From July's meeting we will use the CLE-risk management committee to track all our C-19 risks, alongside the usual risk register process. Upload onto Safeguard is taking place. The Recovery, Surge and wider Trust risk will be reported monthly to the Board.

5.3 The Trust's Board is due to revise its SBAF via the July 9th away session. We can consider there the strategic issues arising from COVID-19 around our estate, digital and financial plans for 2020-2025.

6. Recommendations

6.1 The Trust Board is asked to:

a. **CONSIDER** the risks set out and their mitigation
b. **ACCEPT** or tolerate the red rated post mitigation scores shown

Kam Dhami
Director of Governance

28th May 2020

Annex 1: COVID-19 recovery risks and mitigations
Annex 2: COVID-19 risk assessment matrix

Annex 1

SANDWELL AND WEST BIRMINGHAM NHS TRUST

COVID-19: Recovery Phase Risks

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 that employee anxiety about working conditions leads to behaviours, including absence, which prevents the Trust from implementing its recovery plan at the intended speed.	**3 x 3 = 9**	▪ Active data and frontline stories about workplace safety are given local prominence as counter to national focus on deficits ▪ Large scale antibody testing is implemented during June 2020 to ensure we have available employees	**2 x 3 = 6**
2.	**Workforce**	There is a risk that employee fatigue or leave necessities due to COVID-19 leads to less staff availability than is required by the recovery plan.	**4 X 3 = 12**	▪ Trust continues to both promote and monitor "take your leave" message to employees for Q2 ▪ Introduction of strong local planning systems for rostering to ensure that booking horizons are observed ▪ Maintain wellbeing offer developed under C-19 throughout Q2 and monitor take up through PWS	**2 x 3 = 6**
3.	**Workforce**	There is a risk that large scale and short notice staff absence due to tracking and quarantine leads to insufficient staff to manage both red zones and recovery area.	**5 x 5 = 25**	• Large scale antibody testing is implemented during June 2020 to ensure we have available employees • Trust grows bank resourcing in niche areas (NNU etc.) to provide more flex beyond agency staff • Introduction of routine test screening for antibody negative staff in selected areas in late June	**3 x 4 = 12**
4.	**Workforce**	There is a risk of the need for short notice redeployment of employees in response to a second surge leading to disruption in service provision and / or increased absence owing to fatigue.	**4 x 3 = 12**	▪ Overwhelming focus on recruitment and start dates to reduce stretch created by vacancies ▪ Structured ICP support to trace programme in vulnerable communities to reduce s/s likelihood ▪ Clear prioritisation criteria for which services/staff stand	**2 x 4 = 8**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigating Actions	Target Risk Rating (Likelihood v Severity
				down against agreed surge volumes	
5.	**Workforce**	There is a risk that unavailability of staff in local care homes leads to an inability to discharge patients resulting in staff to patient ratios needing to be exceeded.	**3 x 3 = 9**	▪ Large scale antibody testing is implemented during June 2020 with Trust support ▪ Trust continues to provide IC and PPE support to care homes	**3 x 2 = 6**
6.	**Workforce**	There is a risk that unavailability of staff in local care homes leads to the implementation of a mitigation plan with SWB redeployees being moved to unfamiliar care settings creating other staffing gaps.	**3 x 3 = 9**	▪ Development of care home bank by the Trust to support homes with allocatable employees ▪ Agree through ICP a care home step in plan using either council commissioned beds or RR beds run by the Trust ▪ Coordinated effort across SWB to ensure either side the border homes are supported by peer aid	**3 x 3 = 9**
7.	**Workforce**	There is a risk that returning redeployees and brigadees exhibit higher levels of absence or exit as a result of role changes leading to staff to patient ratios being exceeded.	**3 x 3 = 9**	▪ Track and support redeployees with structured 30 day 'check in' organised via 3116 service in HR ▪ Pull PDR documents for wave 1 and 2 redeployees in August to understand clarity of career planning in place	**1 x 3 = 3**
8.	**Workforce**	There is a risk of an increasing volume of shielded staff due to changes in national or local policy resulting in staffing gaps in key areas across the Trust.	**2 x 3 = 6**	▪ Work with ICP to develop local shielding criteria linked to our risk assessment tool ▪ Ensure our work-while-shielding offer is clear for all employees and IT capacity exists for these staff	**2 x 3 = 6**
9.	**Workforce**	There is a risk that staffing COVID-19 red areas is compromised by resistance among employees to working in higher risk environments leading to staffing gaps	**4 x 3 = 12**	▪ Publish cross infection and antibody data to employees on a red/blue basis to tackle idea that exposure rates are higher ▪ Actively track wellbeing in red areas using PWS and intervene early in red areas	**2 x 2 = 4**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigating Actions	Target Risk Rating (Likelihood v Severity
10.	**Workforce**	There is a risk that delayed or deferred education programmes create capacity gaps for supervision or reduced patient access for students leading to unsatisfactory experiences / outcomes for those we are training	**4x3 = 12**	▪ Track via CLE education committee all incoming roles so that oversight can be ensured ▪ Develop or resource additional mentoring places on a trial basis as part of gear up to new medical schools and expansion of nurse training places ▪ Specifically incentivise high quality supervision in how we PDR score or remunerate supervisors	**3 x 2 = 6**
11.	**Workforce**	There is a risk that alternative approaches to clinical consultation and ward based care will lead to a reduction in medical education provision at UG and PG level leading to a fall in our educational reputation	**3 x 3 = 9**	▪ Undertake evaluation of learning 6-8 weeks after new students start in role and discuss with University Partners ▪ Consider how recordings of consultations could be recorded with consent to assist in post event learning	**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
12.	**Equipping**	There is a risk that Trust supply chains for equipment are severely disrupted by planned or unexpected national procurement exercises leading to an inability to fulfil patient commitments made in the	**5 x 3= 15**	▪ Create cell on equipping needs that is tracked centrally against supply (reporting day's supply to tactical) ▪ Specify supply chain geography and pre-label national procurement with a higher baseline to take account of failure points	**4 x 3 = 12**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
		recovery plan.			
13.	**Equipping**	There is a risk that national procurement exercises result in incompatible consumables and other dependencies being provided to the trust leading to an inability to fulfil patient commitments made in the recovery plan.	**3 x 3 = 9**	▪ Document clear dependencies diagram to permit good understanding of risk points ▪ Ensure bandwidth in EBME function to try and source local solutions (key man problem?)	**3 x 2 = 6**

C. ASSETS

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
14.	**Assets**	There is a risk of sub-optimal functions due to the use of existing assets for new purposes leading to breakdowns, damage and discontinuity of services.	**3 x 2 = 6**	▪ Risk assess recovery plan delivery model to pinpoint specific risks and engage in preventative maintenance programme	**2 x 2 = 4**
15.	**Assets**	There is a risk that quadrupling or more of the scale of video based consultations due to infrastructure overload or helpdesk swamping leads to failed patient contact.	**4x4 = 16**	▪ Undertake headroom simulations of multiple users to test break points in 'cold' environment ▪ Collect routine data on speed of consult weekly during Q2 to build confidence ▪ Engage suppliers in our work as part of their Social Responsibility commitment to public service	**4 x 2 = 8**
16.	**Assets**	There is a risk that Trust ambitions about staff working from home owing to revised health and safety standards are undelivered because of IT failures	**2 x 2 = 4**	▪ Undertake headroom simulations of multiple users to test break points in 'cold' environment ▪ Collect routine data on speed of consult weekly during Q2 to build confidence	**2 x 1 = 2**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
		resulting in lower productivity in key areas of the workforce.		▪ Engage suppliers in our work as part of their Social Responsibility commitment to public service	
17.	**Assets**	There is a risk of GDPR obligations not being met due to innovations in delivery being mis-implemented leading to data protection challenges.	**3 x 3 = 9**	▪ Undertake all necessary assessment and approvals prospectively in June ▪ Produce specific briefing material for users on enhanced GDPR data leakage threat ▪ Complete cyber security delivery plan	**1 x 3 = 3**
18.	**Assets**	There is a risk that the Trust carries significant estate redundancy in primary care or hospital settings owing to changed models of care and new safe working requirements leading to unfunded costs in 2021/22.	**2 x 2 = 4**	▪ Test 2023 estate plans for the Trust against new environment and consider expanding disposals strategy ▪ Ensure delivery of Midland Metropolitan University Hospital on time in 22/23 to move Trust to new estate ▪ Work to develop ICP specific primary care estate plans in 21/22	**2 x 2 = 4**
19.	**Assets**	There is a risk that increasing decontamination requirements leads to downtime on estate and an inability to fulfil patient commitments made in the recovery plan.	**3 x 2 = 6**	▪ Build plan with reduced levels of productivity to account for downtime ▪ Automate and multi skill delivery of all in situ cleaning arrangements so that 'staff communication' does not delay cases	**2 x 2 = 4**

D. CLINICAL CARE

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
20.	**Clinical Care**	There is a risk of delayed patient presentations for new conditions due to	**5 x 4 = 20**	▪ Continued work to promote care options through June as part of recovery plan	**4 x 3 =12**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
		patient concerns about COVID-19 leading to worse patient outcomes		▪ Specific communications aimed at high risk groups	
21.	**Clinical Care**	There is a risk that changes in patient compliance with monitoring for chronic disease conditions due to changes in Trust follow-up processes leads to worsening of disease outcomes	**2 x 4 = 8**	▪ Specific risk assessments to be conducted for Q2 and Q3 implications of recovery plan	**2 x 3 = 6**
22.	**Clinical Care**	There is a risk that patients will delay or not attend for important investigations due to concerns with safety of Trust premises leading to worse outcomes.	**4 x 4 = 16**	▪ Programme to reassure about estate ▪ Tracking data to consider DNA rates ▪ Active patient led communication ▪ Joined up approach with local GPs	**3 x 2 = 6**
23.	**Clinical Care**	There is a risk of patients not having routine assessments undertaken that they would have had at regular appointments due to teleconsultations that will lead to delayed recognition of disease flares or deterioration	**3 x 4 = 12**	▪ Monitor implementation of video consultation programme to test compliance rates	**2 x 2 = 4**
24.	**Clinical Care**	There is a risk of patients or doctors not being engaged with remote consultations due to uncertainty of the required technology leading to reduced patient satisfaction	**2 x 3 = 6**	▪ Specific provision of technological for digitally poor communities ▪ Monitor take up rates and ensure EIA and QIA work completed	**2 x 2 = 4**
25.	**Clinical Care**	There is a risk that staff redeployment for prolonged or recurrent periods due to requirements of the acute service leads to	**3 x 3 = 9**	▪ Design recovery plan to manage and recognise this risk using other providers to manage impact (eg. migraine)	**2 x 3 = 6**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
		a reduction in specialist based care delivery			
26.	**Clinical Care**	There is a risk that a reduction in ability to undertake basic clinical examinations due to changes in provision of care in an out-patient setting leads to an increase in requests for radiological investigations that increase waiting times	**2 x 3 = 6**	▪ Monitoring of before and after data ▪ Good alertness to GP requests for review ▪ Continue C-19 radiological triage	**2 x 2 = 4**
27.	**Clinical Care**	There is a risk that infection control measures required for certain investigations that are potentially AGP prolong the waiting time leading to delayed diagnosis being made	**3 x 3 = 9**	▪ This can be planned for through recovery process but is a recognised national risk ▪ Seven day working models become standard with other procedures being delayed to prioritise these services	**2 x 2 = 4**

E. OTHER EVENTS

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
28.	**Finance**	There is a risk of up to a £30m difference between in year income and expenditure due to revised and unclear funding models resulting in emergency restrictions being imposed on purchasing and employment in turn creating service gaps or harms.	**2 x 5 = 10**	▪ Track gap via bi-monthly FIC and routinely report position to the Board against required April 2021 start point ▪ Drive work to develop ICP plans for capitated budgets during Q2 and Q3	**2 x 3 = 6**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
29.	**Finance**	There is risk that cash assumptions embedded in the 2019 MMUH FBC are disrupted due to COVID-19 leading to dependencies to the SWB future state model being compromised.	**3 x 3 = 9**	▪ Recalibrate Trust cash plan as part of Q2 financial sustainability work ▪ Understand what reduced cash down scenario actions would be as a response plan	**2 x 3 = 6**
30.	**Infrastructure**	There is a risk that regional transport models are or become inconsistent with workforce and patient assumptions in our recovery plan due to unsynchronised planning leading to non-delivery to time.	**2 x 3 = 6**	▪ Build better connection into WM transport discussions both with CA and with national express	**1 x 3 = 3**
31.	**Strategic**	There is a risk that con-current COVID-19 and severe seasonal winter flu drives patient demand above and/or workforce supply below planned scenarios leading to extended waits for care or other harms.	**5 x 4 = 20**	▪ Work to ensure Trust, ICP and ICS all plan on a winter focus in developing current recovery plans ▪ Create fall back supply contracts with IS and elsewhere to take account of main gaps ▪ Undertake best flu vaccination campaign that we have ever operated	**5 x 3 = 15**
32.		There is a risk that implementation of April 2020/21 Place based population budgeting is delayed by and/or is incompatible with COVID-19 recovery plan implementation leading to damaged working relationships between partners and long term challenges to collective financial stability.	**4 x 4 = 16**	▪ Make this work the core business of the monthly ICP Boards ▪ Create provider alignment to develop shared spend plan and risk dynamic in advance of commissioner clarity ▪ Engage HWBB in expectation of this work being completed on time ▪ Involve CCG MDs in Trust business ▪ Fund and support ICP OD programme	**4 x 3 = 12**
33.	**Governance**	There is a risk of enhanced time, money and distress being created by rising litigation claims associated with COVID-19	**3x3=9**	▪ Diligence in fairly responding to complaints and managing ME processes to manage distress ▪ Good record keeping of key policy decisions during	**2 x 3 = 6**

Risk No.	Category	Risk Statement	Current Risk rating (Likelihood v Severity	Mitigation Actions	Target Risk Rating (Likelihood v Severity
		leading to changes to other plans		pandemic through silver and gold ▪ Continued focus on high quality care by the Trust and scrutiny of practice through Q&S	
34.	**Governance**	There is a risk of claims by employees arising from perceived risk breaches under COVID-19 leading to the need to reprioritise finances and time to meet these claims	**4x2=8**	▪ Strong record keeping of assessments and tracking of adherence to same ▪ Outstanding wellbeing offer put in place to try and mitigate harms	**3 x 1 = 3**
35.	**Research & Development**	There is a risk of reduced R+D activity due to difficulty in patient recruitment and maintaining activity in existing studies leading to a fall in academic reputation of the trust	**3 x 3 = 9**	▪ Target communication at patients and communities about role of science in developing new treatments	**2 x 3 = 6**
36.	**Research & Development**	There is a risk of reduced commercial and CRN trial initiation due to reduced trail commencement nationally leading to reduced income for the R&D department	**4 x 3 = 12**	▪ Increase trial enrolment to take account of lower pick up rates ▪ Monitor specific progress via Group Reviews and CLE	**2 x 3 = 6**

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**