Integrated Risk Management Policy

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1 Introduction

1.1. NHS Direct is committed to minimising risk through a framework of integrated governance supported by a proactive risk management culture. In accordance with our agreed Clinical Assumptions, which can be found in appendix 6, we will prioritise patient safety, taking account of risks and benefits to the patient.

1.2. This policy addresses the service needs of NHS Direct and the requirements for an effective system of internal control in line with guidance from the Department of Health.

1.3. The policy stands alone, however other relevant NHS Direct policies are: the Adverse Incident Management Policy; the Information Security Risk Guidance Document; the Confidentiality Policy; the Disciplinary Policy; the Complaints and Feedback Policy; the Records Management and Information Lifecycle Policy; Freedom of Information Policy; Health and Safety policies; the Research Adverse Incident Policy and relevant supporting procedures and guidance.

2 Purpose

2.1. To establish and communicate NHS Direct's policy regarding corporate risk management and to describe key roles and responsibilities of individuals involved in the process of risk management.

3 Scope

3.1. This policy covers everyone that is employed by NHS Direct and any contractors, and partners that are involved in activities within NHS Direct's control.

4 Policy Statement

It is NHS Direct's policy that:

4.1. Risk management shall be an integral part of day-to-day management and quality improvement at all levels within the Trust. NHS Direct shall adopt a whole systems approach encompassing risks in relation to integrated governance. In accordance with our clinical assumptions, in taking decisions about the management of risk, we will prioritise patient safety, taking account of risks and benefits to the patient.

4.2. Risk management shall be as much about identifying opportunities to succeed as avoiding failure and mitigating losses.

4.3. A robust risk management process and effective ongoing communications will assist in safeguarding the Trust's reputation and assets from litigation and adverse media interest.

4.4. NHS Direct's risk management systems will comply with all relevant statutory and regulatory requirements including Standards for Better Health and NHS Litigation Authority risk management standards.

4.5. Key performance indicators for risk management shall be developed, implemented and reviewed to measure the effectiveness of the risk management system.

4.6. An integrated approach to risk management shall be adopted where risks are aligned to the Trust's business objectives at all levels of the organisation.

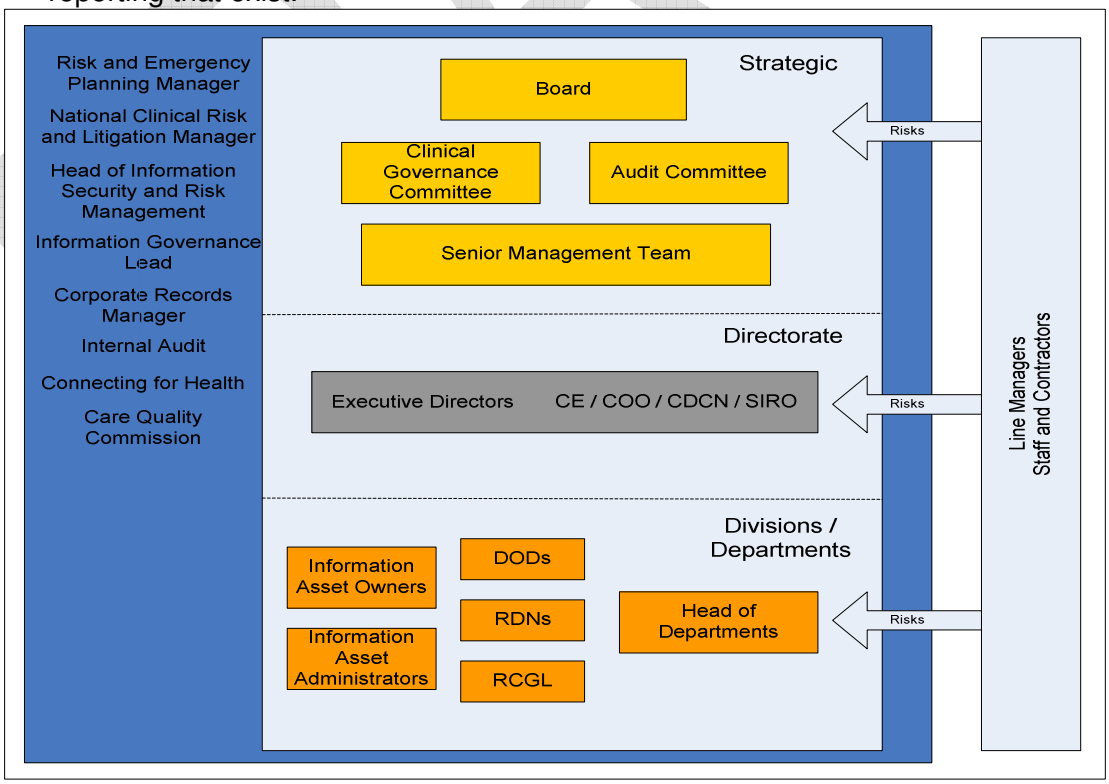
4.7. Risk management processes at all levels of the organisation will be aligned.

4.8. Acceptable levels of risk shall be determined by the external circumstances within which the Trust operates, together with the risk appetite of the Board and its key stakeholders.

4.9. The Board shall approve a means of determining the way in which risks are scored in terms of likelihood and consequence for use throughout the Trust.

5 Roles and Responsibilities

5.1. All staff and managers have responsibility for risk management. Specific roles are outlined at Appendix 2. The diagram below provides an overview of the key roles in risk management, differentiating those with functional roles from the advisory/compliance roles and indicating the different levels of risk reporting that exist.



6 Risk Management Pathway

6.1. Identify the risks

6.1.1. Risk Identification / Creating the Risk List

6.1.1.1. A list of risks will be identified using a variety of techniques including the controls assurance framework based on objectives, data mapping exercises, risk identification workshops, scenario analysis, incident investigation, and others.

6.1.1.2. The risks should be categorised into one of the following seven groups. Where more than one category applies, the category recorded on the register should be the one with the most significant consequence.

Strategic	Competition, customer changes, industry changes, customer demand, research & development, intellectual capital
Financial	Income, costs, interest rates, credit, liquidity and cash flow
Operational	Accounting controls, information systems, recruitment, supply chain, regulations, culture, board composition, service delivery
Hazard	Public access, employees, properties, products and services, contracts, natural events, suppliers, environment
Compliance	Health & safety, standards for better health, environmental, trade descriptions, data protection, information governance

Clinical	Patient harm, serious adverse incidents, clinical sorting
Reputational	Adverse impact on customer satisfaction ratings, deterioration in perception of brand, adverse / negative press, media / customer group interest

6.1.2. Risk Description

6.1.2.1. Risk description involves identifying an event or circumstance that may occur and describing its potential impact.

6.1.2.2. The convention NHS Direct is using for risk description is a causal statement "If…, then…" An example of risk described using this convention is as follows:
"If NHS Direct does not win the [name] contract, then we will lose £[x] million income in 2009-10"

6.2. **Assess risks**

6.2.1. Initial Risk Estimation

6.2.1.1. Initial Risk estimation is the assessment of the consequence of the risk occurring (either in terms of threats / opportunities) and probability of the risk happening at the point that the risk is identified. This assessment will be carried out when the risk is first identified.

6.2.1.2. The risk scores will be used to prioritise the key risks that need to be analysed in more detail.

6.2.2. Target Risk Estimation

6.2.2.1. Target Risk estimation is the assessment of the consequence of the risk occurring (either in terms of threats / opportunities) and probability of the risk happening once you have controls in place and have carried out any additional actions to treat the risk.

6.2.2.2. This is a measure of how controllable the risks is and will be used to prioritise the risks that NHS Direct has the most control over so that management activities are appropriately directed.

6.2.3. The agreed frameworks for estimating risk in NHS Direct can be found at Appendix 3.

6.3. **Determine actions to respond to risks**

6.3.1. Risk mitigation is the process of selecting and implementing appropriate actions and controls to modify the risk. Mitigation options include:

6.3.1.1. **Take opportunities** for circumstances where the potential gain seems likely to outweigh the potential downside,

6.3.1.2. **Tolerating** the risk, supplemented by contingency plans if deemed necessary,

6.3.1.3. **Treating** the risk in an appropriate way to constrain the risk to an acceptable level or actively taking advantage, regarding the uncertainty as an opportunity to gain a benefit,

6.3.1.4. **Transferring** the risk, for example by insurance or paying a third party to take the risk in another way,

6.3.1.5. **Terminating** the activity giving rise to the risk where possible and appropriate.

6.4. Risk reporting

6.4.1. All the risks identified shall be collated in risk registers, with details of the initial risk score assigned and the action plan as required. The risk register template can be found at Appendix 4.

6.4.2. Risk Registers should be reported in accordance with the appropriate reporting regime:

Risk Register	Reporting Regime	Purpose
Strategic	Monthly to SMT	To highlight strategic risks and allow monitoring of action plans.
	Quarterly to Audit Committee	To provide assurance that strategic risks are being managed.
	Monthly to Board via Chief Executives report and dashboard	To provide assurance that strategic risks are managed.
Directorate	Quarterly to SMT	To highlight directorate risks and provide updates on action plans.
	Annually to Audit Committee	To provide assurance that directorate risks are being managed.
Department & Divisional	Quarterly to Executive Director /	To highlight risks and provide updates on action plans
	Annually to SMT	Monitoring and updates on action plans.
	Annually to Audit Committee	To provide assurance that risks are being managed.
Programme / Project	Included in Programme / Project Initiation Document	To highlight project risks and provide updates on action plans.
	Monthly to Programme Management Board for duration of project.	Monitoring and updates on action plans.

NB: The Programme / Project reporting cycle should be used by all programmes / projects in the organisation.

6.5. Risk Escalation

6.5.1. The process for risk escalation is outlined in Appendix 5.When a risk is escalated the manager will undertake a process of challenge using the following options:

6.5.1.1. **Accept** the risk

The first challenge option is to accept the risk in its current format and to enter it onto the manager's risk register.

6.5.1.2. **Amend** the risk
The second challenge option is to amend the risk in one of the following ways:
- Rephrase the risk description
- Change the risk owner
- Change the initial risk score, target risk score or current risk score
- Amend the action plan

Once the risk has been amended the risk will be either accepted and be entered onto the manager's risk register or rejected where it will remain on the original risk register.

6.5.1.3. **Reject** the risk
The final challenge option is for the manager to reject the escalation of the risk.

6.5.2. The decision to accept, amend or reject should be recorded in the original risk register and where appropriate onto the manager's risk register. These decisions should be recorded in the decision log column of the risk register.

6.6. Adverse Incident Occurrence

6.6.1. All serious incidents are investigated and reviewed as appropriate in accordance with the Trust's Adverse Incident Management Policy. If a new risk is identified a risk assessment should be undertaken using the process outlined in this policy. If the incident relates to a risk already identified the current risk assessment should be reviewed and the risk and incident record should be linked for audit purposes.

6.7. Consultation

6.7.1. During the risk description phase, the risk owner will identify stakeholders with an interest in or affected by the risk. Stakeholders must be consulted to establish their relationship with the risk and what influence this might have on the risk management process. To ensure a holistic approach to risk management consultation must be ongoing.

6.8. Risk review

6.8.1. All risks which are above the risk tolerance threshold should be reviewed by the risk owner at least every fortnight to ensure they are updated and managed appropriately. The risk owner should review progress on the actions agreed to mitigate the risk and make an assessment of the current level of risk including:

6.8.1.1. Establishing whether actions have been completed or are on target for completion.

6.8.1.2. Recording all updates in the column marked "Action Plan Update", including when actions have been completed and changes to the action or target completion date.

6.8.1.3. Re-evaluating the risk score and record the current risk score on the risk register. Any changes in the risk status will be recorded in the "Risk Status" column.

6.8.1.4. Arrows should be used to show changes in the risk score:
No change ↔
Increase ↑
Decrease ↓

6.9. **Risk Register Amendment Process**

6.9.1. The Risk Register Coordinator should record all amendments to risks and the reasons for these changes on the risk register. The process for completing and updating the risk register can be found in Appendix 4 (part 2).

6.10. **Assurance Regime**

6.10.1. Risk Register Owners should submit the following information to the Risk and Emergency Planning Manager via riskmanagement@nhsdirect.nhs.uk to provide assurance that risk are being managed:

6.10.1.1. Risk Registers on a monthly basis

6.10.1.2. Agendas and minutes evidencing any discussion of the risk register

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Appendix 1: Definitions

Any expression, to which a meaning is given in the Health Service Act, or in the Financial Directions made under the Act, shall have the same meaning in this Policy:

"Action Owner"	The individual responsible for completing the actions to mitigate the risk.
"Adverse Incident"	Any event or circumstance that could or did lead to unintended or unexpected harm, loss or damage to persons, property or the organisation.
"Clinical Risk"	An uncertain event or set of events which, should it occur, will have an effect upon patient care
"Controls Assurance Framework"	Comprehensive method for the effective and focused management of the principal risks to meeting the Trust's objectives.
"Corporate Risk"	An uncertain event or set of events which, should it occur, will have an effect upon the achievement of objectives.
"Information Risk"	An uncertain event or set of events which, should it occur, will have an effect on persons, property or the organisation.
"Initial Risk Score"	The calculation of risk consequence and probability excluding control mechanisms.
"Risk List"	The simple list of areas of risk, derived from relevant objectives
"Risk Management System"	The detailed explanation of how things work in practice. It includes this policy, the reporting processes that secure implementation of the policy, the standard forms, IT system and processes to support implementation, together with local application of the policy
"Risk Mitigation"	Is the process of selecting and implementing appropriate controls to modify the risk.
"Risk Owner"	The individual responsible for: • Completing the entry on the risk register, • Assigning actions to mitigate the risk and completion targets for these actions (in consultation with action owners) • Reviewing the risk at least every fortnight to ensure that the action plan is being implemented, the current risk score is calculated and that all stakeholders are being updated regarding the management of this risk.
"Risk Register"	The register is a refined and developed version of the Risk List. It is a table which shows – the risk assessment, risk mitigation actions, re-assessment and action plans. The table thereby shows the risk portfolio of the whole organisation or a selected part of it.
"Risk Register Coordinator"	Is the individual who is responsible for ensuring that the risk register is kept up to date and reviewed at least once a month.
"Risk Register Owner"	The risk register owners are as follows: Divisional Risk Register – Divisional Director Department Risk Register – Head of Department Directorate Risk Register – Executive Director Strategic Risk Register – Chief Executive Officer Information Risk Register – Chief Information Officer Programme Risk Register – Programme Manager Project Risk Register – Project Manager
"Risk Tolerance"	Is the level of risk the Trust is prepared to tolerate
"Target Risk Score"	The calculation of risk consequence and probability including control mechanisms. This score provides a measure of how controllable the risk is and will help management decide which risks they should be focusing their attention on.

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Appendix 2: Roles and Responsibilities

Functional Roles

Role	Responsibilities
Staff and contractors	• Be familiar with the Trust's policy on and approach to risk management, • Take a risk management approach to their work, • Take responsibility for the risks they 'own', • Highlight ways in which the business objectives may be at risk and could be managed better, • Consider how the Trust might reduce its exposure to risk, • Engage with risk management by reporting incidents and occurrences using Datix, • Ensure that any obvious and emerging risks not previously identified are appropriately reported.
Line managers	• Implementing the risk policy in their area, • Ensuring that staff, contractors and partners, as appropriate, are aware of NHS Direct's Risk Management Policy, • Ensuring that staff undertake appropriate risk management training
Regional Clinical Governance Leads	• To support the Regional Director of Nursing to deliver the clinical risk agenda. • Overseeing the regional management of the Datix clinical risk management system.
Regional Directors of Nursing	• Implementing the Adverse Incident Management Policy at the regional level, • Ensuring clinical risks are identified and forwarded to the Divisional Operations Director for inclusion in the Divisional risk registers as necessary, • Ensuring clinical risk is reported on within the monthly clinical governance report, • Implementing and embedding learning from clinical risk episodes (incidents, complaints and feedback).
Divisional Operations Directors and Heads of Departments	• Implementing the risk management policy at regional / department level, • Identifying and managing risks, for consideration by their Executive Directors and then the Senior Management Team (SMT), • Identifying, assessing and developing a strategy to manage risks to achieving the objectives set out in their business plan, • Monitoring and reviewing the management of risk for which they are responsible, • Reporting quarterly to their Executive Director on the identification and management of risk, • Reporting annually to the SMT on the identification and management of risk, • Ensuring that corporate and clinical risk is integrated, • Ensuring that divisional business continuity arrangements are in place.
Information Asset Owner	• The SIRO will nominate a senior manager to undertake the role of information asset owner (IAO) for each information

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	asset identified on the information asset register. • The IAO should be a member of staff senior enough to make decisions concerning the asset at the highest level such as the director with responsibility for the asset. • The IAO takes ownership of the organisations' information assets for the management of information risk. • The role of the IAO is to understand and address risks to the information assets they 'own' and to provide assurance to the SIRO on the security and use of those assets.
Information asset Administrator	• The IAO will nominate local managers to undertake the role of information asset administrator (IAA) for each information asset held by the organisation. • Information Asset Administrators will provide support to the IAO in relation to management of information risk for the information assets they control. • Information Asset Administrators ensure that policies and procedures are followed, recognise actual or potential security incidents, consult their IAO on incident management, and ensure that information asset registers are accurate and up to date.
All Executive Directors	• Implementing the risk policy at the Directorate level, • Identifying and managing the risks faced by their directorate, for consideration by the SMT, • Identifying, assessing and developing a strategy to manage risks to the objectives set out in the Directorate Business Plan, • Monitoring and reviewing the management of risk for which they are responsible, • Reporting quarterly to SMT on the identification and management of risk.
Senior Information Risk Owner	The Chief Executive Officer will nominate an Executive Director to undertake the role of Senior Information Risk Owner (SIRO). • Takes ownership of the organisations' policies for the management of information risk, • Takes ownership of the information asset register. • Acts as an advocate for information risk on the board, • Provides written advice to the accounting officer on the content of their Statement of Internal Control in regard to information risk.
Clinical Director Chief Nurse	Leads the management of clinical risk in the Trust.
Chief Operating Officer (COO)	Leads the management of operational risk in the Trust and has responsibility for ensuring that the organisation develops effective business continuity arrangements.
Chief Executive	• Has the ultimate management responsibility for risk and implementation of the Board's policy and reporting requirements. • Securing adherence to the Trust's integrated risk management policy, • Reporting quarterly to the Audit Committee on the Trust's management of risk, • Signing the Statement of Internal Control detailing the Trust's risk management arrangements as the designated

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	Accounting Officer (MPM, 2007), • The preparation and maintenance of an effective Controls Assurance Framework.
SMT	The SMT ensures that assessment and management of risk is an explicit feature of the Trust's approach to authorising and managing existing and new work. The SMT members also act as 'risk owners' in respect of strategic risks. • Identifying and managing the strategic risks faced by the Trust, for consideration by the Board, • Identifying, assessing and developing a strategy to manage risks to achieving the objectives set out in the Trust's business plan, • Reviewing bi-monthly its assessment of strategic risk, • Oversight of directorate risks alongside identification and management of strategic risks, • A quarterly review of each directorate's management of risks, • An annual review of each region's management of risks, • A periodic review of the effectiveness of the Trust's risk management arrangements.
Clinical Governance Committee	The Clinical Governance Committee is responsible for developing and recommending, to the Audit Committee, a clinical governance strategy and annual action plan. The committee is responsible for identifying serious unresolved risks to the Audit Committee for monitoring.
Audit Committee	The Audit Committee is responsible for providing assurance to the Board on the adequacy of all risk and control assurance disclosure statements. It reviews the establishment and maintenance of an effective system of risk management across the whole of the organisation's activities that supports the achievement of the organisation's objectives. The Audit Committee is authorised to monitor the implementation of the risk policy on behalf of the Board. • Instilling a culture of risk management, • Satisfying itself that risks are managed appropriately, • Reporting on risk management as part of the Trust's internal control arrangements in the Annual Report, • Reviewing the Controls Assurance Framework, • Undertaking investigations and recommending appropriate remedial action when there has been a major failure of risk management, including having authority to require individuals to attend the committee and give evidence, to access appropriately anonymised records, to call independent witnesses and to request independent legal advice.
Board	The Board has ultimate responsibility for the management of NHS Direct's risks. It monitors the Trust's approach to the management of risk, and its effectiveness in managing risk through the Audit Committee which provides quarterly updates. The Board is responsible for considering strategic risk and ensuring such risks are effectively managed. The Board shall agree the Trust's risk management strategy, policy and risk tolerance criteria for strategic risk.

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Advisory / Compliance Roles

Role	Responsibility
Internal Audit	• Reporting on NHS Direct's compliance with the Risk Management Policy, • Reporting on the adequacy of financial and other related management controls, • Independently verifying Assurance Statements in accordance with guidance from the Department of Health, • Undertaking specific reviews of risk management arrangements as tasked by the Audit Committee or Chief Executive, • Undertaking targeted reviews of operational areas deemed to be high risk by management.
Risk and Emergency Planning Manager	• The design, development and implementation of the Trust Risk Management Strategy and reviewing and monitoring the strategy to ensure it is compliant with current legislation and the Department of Health's 'Standards for Better Health', • The development, implementation and monitoring of all risk management policies for the Trust, • The promotion of risk management practices that foster a fair open and learning culture and to ensure that the organisation learns from incidents and in so doing reduces the likelihood of reoccurrence, • The development and implementation of a Trust wide risk assessment programme and the implementation of specific risk assessment training, • The design and implementation of a comprehensive programme of risk management training to meet NHS Direct's legal obligations and the educational needs of all levels of staff within the organisation, • Maintaining and co-ordinating the Trust's strategic risk register and providing training and support on the risk profiling process, analysis and evaluation of risks, • Providing expertise and support for the Executive Directors, Heads of Departments and Regional Directors in monitoring their local risk registers and providing guidance on the management of risks, • Providing risk management advice and expertise to the Trust as a whole, • Compiling risk reports for the Audit Committee.
National Clinical Risk and Litigation Manager	• Overseeing implementing and reviewing the Adverse Incident Management Policy including Being Open Guidance, • Advising on the provision of appropriate training in the effective use of the policy, • Raising the profile of incident reporting, analysing and monitoring trends to identify areas of risk, • Co-ordinating the identification and implementation of national actions arising from incidents and clinical risk, • Supporting organisational learning and providing reports to the Associate Director of Clinical Governance and the

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	Clinical Governance Committee, • Overseeing the national management of the Datix incident and feedback management system, • Co-ordinating the Clinical Directorate risk register and any risks associated with litigation.
Corporate Records Manager	• Advising the Trust on compliance with legislative responsibilities with regards to the Freedom of Information Act and Environmental Information Regulations. • Ensuring corporate records are managed and retained in line with the Trust's Record Management and Information Lifecycle Policy. • Responding to information requests generated from Parliament and the Departments of Health
Information Governance Lead	Advising the Trust on information governance requirements in line with the IG toolkit.
Head of Information Security and Risk Management	Advising the Trust on information security requirements in line with the IG toolkit.
Programme / Project Boards	All Programme / Project Boards are responsible for ensuring that an assessment of the risk to achieving the objectives of the programme / project is carried out and managed throughout the life of the programme / project using the process outlined in this policy. They are responsible for providing appropriate reporting to the Programme Management Office (PMO) within the CE's office, on the subject of risk, for the duration of the project and escalating risks as appropriate. Reporting timescales will be determined by the PMO.
Care Quality Commission	Independently verifying assurance statements issued by the Trust in accordance with guidance from Department of Health for example Standards for Better Health.
Connecting for Health	Independently verifying assurance statements issued by the Trust in accordance with guidance from the Department of Heath for example the Information Governance Toolkit.

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Appendix 3: NHS Direct Core Risk Assessment Matrices

Table 1: Consequence Definitions

Descriptor	1	2	3	4	5
Impact on the safety of patients staff or public (physical / psychological harm)	Minimal injury requiring no / minimal intervention or treatment No time off work required Undocumented complaint / inquiry	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Documented complaint	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident Documented complaint	Major injury leading to long-term incapacity / disability Requiring time off work for > 14 days Mismanagement of patient care with long-term effects Repeated serious complaints Low performance rating	Incident leading to death Multiple permanent injuries or irreversible health effects Inquest/Critical Ombudsman Report Gross failure to meeting national standards
Individual Experience	Reduced quality of user experience / clinical outcome, not directly related to delivery of clinical care.	Unsatisfactory user experience / clinical outcome, directly related to the delivery of care	Unsatisfactory user experience / clinical outcome. Short term effects – expected recovery < 1 month	Unsatisfactory user experience / clinical outcome. Long term effects – expected recovery > 1 month. Third party involvement of an MP or solicitor.	Unsatisfactory experience / clinical outcomes. Continued ongoing long term effect / death
Objectives / Project (1)	0-10% failure to achieve objective / project	11-30% failure to achieve objective / project	31-50% failure to achieve objective / project	51-75% failure to achieve objective / project	76-100% failure to achieve objective / project
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss <£10K	Minor organisational / personal financial loss £10-100K	Significant organisational / personal financial loss £100K-1m	Major organisational / personal financial loss £1m-10m	Severe organisational / personal financial loss >£10m
Adverse publicity / reputation	Rumours, no media coverage Little effect on staff morale	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media – adverse publicity < 3 days. Public confidence in the organisation undermined. Use of services affected.	National / international media – adverse publicity > 3 days. MP concern. Questions in Parliament. Court enforcement. Public inquiry / Fatal Accident inquiry.

Table 2: Probability Definitions

Probability rating	Description
1	<0.1 %
2	0.1-1 %
3	1-10 %
4	10-50 %
5	>50 %

NB:

(1) When assessing the consequence of failure to achieve objectives the following applies:
Strategic Risk = Strategic Objectives
Directorate Risk = Directorate Objectives
Department Risk = Department Objectives
Divisional Risk = Divisional Objectives
Programme / Project Risk = Programme / Project Objectives

Table 3: Risk Scoring = probability (P) x consequence (C)

		Probability				
		1	**2**	**3**	**4**	**5**
Consequence	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5

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

	1-4	LOW RISK
	5-12	MODERATE RISK
	15-25	HIGH RISK

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Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk using the "If… then…" statement.

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

3. Use table 2 to determine the probability score(s) (P) for those adverse outcomes. If possible, score the probability by assigning the 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. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4. Calculate the risk score (R) by multiplying the consequence (C) by the probability (P). R=C x P

5. Identify the level at which the risk will be managed in the organisation, assign priorities for mitigation, 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.

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Appendix 4: Template Risk Register

Date Created	Raised by	Risk Ref No	Risk Owner	Objective reference	Risk Heading	Description	Initial risk score			Controls	Sources of assurance	Outstanding actions at xx/xx/xx	Action Owner	Completion Target	Review Date	Current Risk Score			Risk Status ↑↓↔	Decision Log	Target Risk Score			Has the risk been escalated (Y/N)	Commentary on actions completed	Risk Controllability
							Consequence	Probability	Total Score							Consequence	Probability	Total Score			Consequence	Probability	Total score			
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									0									0					0			0
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Guidance for completing the risk register

The table below provides details of the information that should be included in each section of the risk register when you first identify the risk:

Date created	What date was the risk identified?
Raised by / source of risk	Who identified the risk? / Who escalated the risk?
Risk Reference No	e.g. FD(1)R001(2) (1) The initial letters are the identifier for the origin of the risk e.g. Department or Region. (2) The numbering is a unique reference to the individual risk.
Risk Owner	Who owns this risk – the role is defined in Appendix 1
Objective Ref No	Each of the objectives in the business plan will have a number that need to be linked to the risks to achieving this objective.
Risk Heading	The risk heading categories agreed for NHS Direct can be found in section 6.1.1. Choose the heading which most appropriately describes the consequence. Where more than one category applies, the category recorded on the register should be the one with the most significant (highest scoring) consequence.
Risk Description	Section 6.1.2 outlines the process for developing the risk description
Initial Risk Score	Using the matrices in Appendix 3 you need to establish the consequence and probability of the risk when it is first identified. The initial risk score is the product of consequence and probability. The spreadsheet will automatically calculate the initial risk score.
Controls	All controls that exist to mitigate this risk should be listed and numbered.
Sources of assurance	List the evidence sources regarding the effectiveness of our controls and systems.
Actions	All actions that will be taken to manage the risk should be listed and numbered.
Action owner	Action owners should be listed and numbered in reference to the actions
Completion targets	Action completion targets should be established and listed in reference to the actions. Ongoing actions should be recorded with a completion target of the end of the financial year.
Review Date	When will the risks next be reviewed, for example what is the date of the next team meeting.
Target risk score	Using the matrices in Appendix 3 you need to establish the consequence and probability of risk occurring once the actions to mitigate have been completed.

When you next review the risk register, complete the following columns:

Outstanding actions at xx/xx/xx	What are the outstanding actions or new actions on the date that risk is reviewed by the risk owner.
Current Risk Score	Using the matrices in Appendix 3, assessment the consequence and probability of the risk on the date that you review the risk
Risk Status	Using arrows express how the risk score has changed every time it has been reviewed. Further details of this process can be found in section 6.9.
Decision Log	All decisions regarding the review and escalation of this risk should be recorded in this column. The risk escalation process is outlined in section 6.6 and Appendix 5.
Escalated (Y/N)	Risk escalation should be recorded on the register by using a Y is the risk has been escalated and an N if is not being escalated.
Commentary on completed actions	What actions have been completed? Have they been successful in managing the risk?
Risk controllability	What is the gap between the current and target risk score? The spreadsheet will automatically calculate this value.

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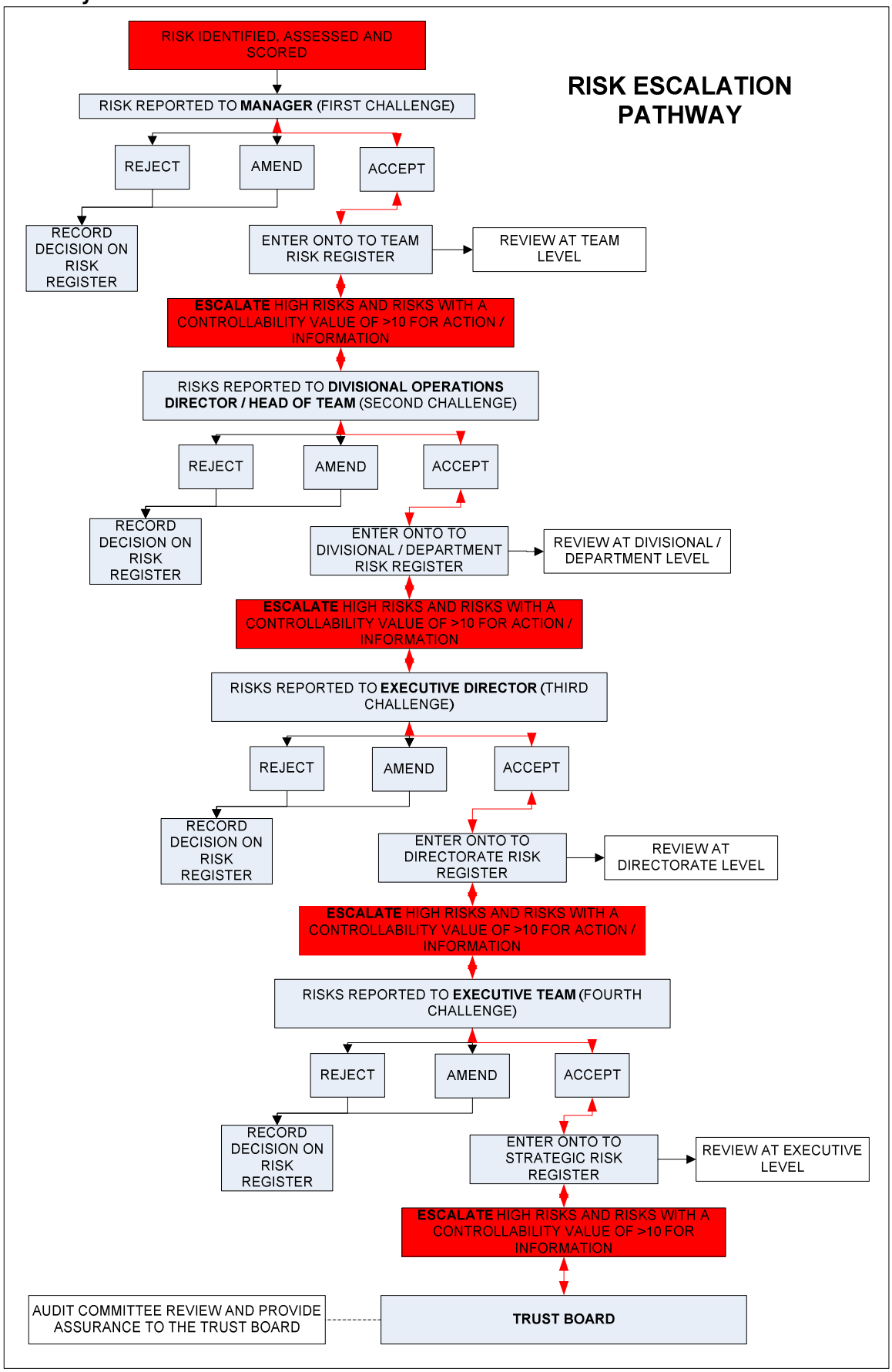
Appendix 5: Risk Escalation Pathway



Appendix 6: Clinical Assumptions

NHS Direct's agreed clinical assumptions are as follows:

Domain	
Safety	Our advice and information will prioritise patient safety, taking account of risks and benefits to the patient. Judgements about risk and benefit will be underpinned by clinical evidence. Where there is a conflict between safety and other factors such as cost and convenience, we will not provide a service that we believe is unsafe.
Evidence-base	Our advice and information will be based on the most robust and up to date clinical evidence. Where evidence is not available, we will adopt the prevailing clinical consensus as expressed in guidelines and current practice.
Staffing	We will deploy staff in the most cost-effective way, with regard to the skills and experience needed to undertake each role. Our staff will be qualified, trained and supported to carry out the responsibilities required of them in their roles.
User empowerment	We support the right of every patient to make decisions about their own health. In providing clinical advice and information over the telephone, on-line or through other channels, we will empower patients to make well-informed decisions by explaining the rationale for our advice.
Health improvement	We will encourage our users to improve their health by offering information to enable them to make and sustain healthy lifestyle choices.
User input	Our clinical services will be shaped by spontaneous and solicited patient and user feedback.

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