Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Risk Escalation & Reporting Procedure

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Purpose	To set out the process and responsibilities for completing risk assessments and the escalation of risk from local business areas through committee structures to the Trust Board.
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Responsible Committee	Quality Committee
Approved by	Trust Board
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Table of revisions

Date	Section	Revision	Author
September 2012	All	Content streamlined in accordance with the Risk Management & Assurance Strategy review. Patient safety and finance content strengthened. Process changes to section 1, 2, 3, 4, 5 and appendices. Section 1 'Risk Register Process' and 5 'Risk Registers' have been merged to form new section 3.	Alison Lennox, Risk Manager Kevin Wynn Associate Director Risk & Safety
September 2012	2 (now 1)	Added in types of risk assessment to cover Quality Impact Assessment and Downside Risk	Kevin Wynn AD Risk & Safety
September 2012	3 (now 2)	Risk Assessment process refined in line with Risk Management & Assurance Strategy, with more emphasis on escalation, transfer and review of risks.	Alison Lennox, Risk Manager
September 2012	4	Details of the Quality Committee and the Finance and Investment Committee added. Table 2 Group structure' removed. New Table 2 added to indicate risk and assurance flow between senior committees and groups. Risk Management Group removed as not included in new structure. Amendments to job titles.	Alison Lennox, Risk Manager Kevin Wynn Associate Director Risk & Safety
September 2012	5	This section has been merged with section 1 and rewritten to form new section 3.	Alison Lennox, Risk Manager Kevin Wynn AD Risk & Safety
September 2012	Appendix 1	Moved to Appendix 10 and replaced with Quality Impact Assessment Procedure.	Kevin Wynn AD Risk & Safety
September 2012	Appendix 4	Email address changed on Risk Register Assessment form	Alison Lennox, Risk Manager
September 2012	Appendix 5	Updated Information governance risk descriptions on Risk Matrix in line with DH guidance.	Alison Lennox, Risk Manager
September 2012	Appendix 7	Risk & Assurance Group Terms of Reference amended accordingly with updates made to the procedure.	Alison Lennox, Risk Manager
September 2012	Appendix 8	Risk Register Process Flowchart minor wording changes.	Alison Lennox, Risk Manager
September 2012	Appendix 10	Risk register template moved from Appendix 1.	Kevin Wynn AD Risk & Safety

1. RISK ASSESSMENT

Risks will vary significantly in the scope, content, likelihood and impact and hence the measures for addressing them will also vary. Having identified a risk, a thorough risk assessment will be carried out following the guidance for ongoing risk assessment, described in section 2 of this procedure.

Risk assessment is the overall process of risk identification, risk analysis and risk evaluation. The process facilitates the Trust's management, reduction or eradication of identified risks in order to protect the safety of patients, staff, visitors, and the organisation as a whole for issues such as finance, reputation, litigation etc.

The identification of risk takes many forms and involves both a pro-active approach and one which reviews events retrospectively. When risks have been identified, each one will be analysed in order to assess what the likely impact would be, the likelihood of this impact occurring and how often it is likely to re-occur. When evaluating risks; consideration of the existing controls in place for that risk and more importantly the adequacy and effectiveness of those controls will form part of the assessment.

It is important to realise that not every risk can be controlled at an acceptable level. Risks that cannot be managed will be passed up through the management lines to ultimately to the Trust Board, which is notified of all significant (extreme level) risks within the organisation that cannot be adequately eliminated or controlled.

1.1 Who should undertake a risk assessment?

Any individual can, and should, identify hazards in their area as part of their responsibilities outlined in this procedure and within the Health and Safety Policy. Risks can be identified on a daily basis throughout the Trust by any employee.

Each local business area will have a nominated lead that is responsible for overseeing the process. The identified lead will have an understanding of risk management and in particular the principles of risk assessment.

Risk assessment and action plans will be owned and undertaken within each directorate, local business area/subject specific area as appropriate, so that they are well focussed and relevant to that particular area.

1.2 Types of risk assessment?

1.2.1 Subject/task specific

Subject and task specific risk assessments are described in a number of procedural documents; Health & safety Policy, Moving and Handling Policy, Security Policy and Slips, Trips and Falls Policy. These documents provide guidance on this type of risk assessment and cross references to the risk escalation process detailed in this procedure.

1.2.2 Quality Impact Assessment

In the delivery of the Trust's strategic objectives there are a number of major service development projects which will significantly alter the way the Trust works. It is important that there is a process through which the impact of such service change proposals can be assessed in terms of both the quality and financial effect.

The Quality Impact Assessment (QIA) procedure is a key element of Trust process to identify risks relating to cost improvement plans and other service developments. Output from this process will also be used to inform a view of directorate and corporate risk.

The QIA procedure is described in detail at *Appendix 1.* Risks emanating from this process are escalated according to the guidance detailed in this procedure.

1.2.3 Downside Risk Assessment

In order to have a secure future the Trust must be able to demonstrate how it will mitigate any financial risks (i.e. remain solvent) in a way that is consistent with the delivery of our mission "Saving lives, caring for you".

Downside risk assessments consider the potential financial losses that may occur in the delivery of strategic objectives. It is the financial risk associated with losses, and explains "worst case" scenarios. The Trust has identified a number of scenarios through the organisations financial governance process, and the Board has reviewed them through a downside risk workshop.

Section 7 of the Integrated Business Plan 2012-17 shows the extent to which each material financial risk faced by the Trust can be directly mitigated. It also describes how the worst reasonable downside case has been estimated and how the Trust's overall contingency plans will operate in each case. These mitigation plans operate in the context of the Trust's overall financial governance approach which is set out in the Governance Handbook.

1.2.4 Risk Register Assessment

This procedure focuses on the process for assessing risks for inclusion in risk registers. A template risk register assessment form including guidance on completion is provided at *Appendix 4.*

2. RISK MANAGEMENT PROCESS

Risk assessment will be carried out as an integral part of day to day business, but is particularly important when there is a change in service provision or circumstances. The Trust has adopted a risk management process which reflects best practice. A flowchart outlining this risk management process is available in *Appendix 2*.

The information below details the key steps that should be followed:

2.1 Step 1 *Establish the Context*

Consideration should be given to the environment and activity in which a risk is being assessed, for example; objectives, scope and parameters of the activity, and business area in which the risk management process is being applied. The process is undertaken with full consideration of the need to balance costs, benefits and opportunities.

2.2 Step 2 *Identify Risks*

The first and most important step is to consider what possible hazards there are or could be, e.g. what, when and how something could happen that represents a source of potential harm. It is important that risk assessment is multi-disciplinary to obtain an objective and balanced view of the risk identified.

Make use of information that is already being collated, for example the following sources can be used to help identify risks:

- General risk assessments undertaken by managers
- Review of national reports i.e. Audit Commission, National Patient Safety Agency (NPSA), Care Quality Commission (CQC)
- Review of new and revised legislation
- Reports from external assessments i.e. NHS Litigation Authority (NHSLA), Care Quality Commission (CQC) and Health and Safety Executive (HSE)
- Issues identified through incidents, concerns, complaints and claims
- Specific regulatory risk assessments undertaken by the Risk & Safety Team
- Other business and financial risks as identified by Executive Directors through the business planning and performance review process
- Consideration of risks against achievement of Trust objectives and local department/team objectives
- Quality Impact Assessment process.

Appendix 3 provides a list of questions and risk issues that should be considered.

2.3 *Step 3 Analyse Risks*

2.3.1 *Risk Controls*

It is important to consider and document the controls that are currently in place which prevent risks from occurring or help limit the damage that could occur. There are three types of controls to consider:

Physical Controls – such as; protective equipment, lifting and handling equipment, warning signs and task design, e.g. two clinicians to check drugs details prior to administration

Procedural Controls – such as; policies, procedures, clinical protocols

Professional Controls – such as; compliance with external regulatory standards, national and local guidelines, quality standards and clinical guidelines

Controls are ineffective without the necessary information, instruction and training. Therefore consider the adequacy of training, equipment, staffing or resources. It is also essential to think about any gaps in control – e.g. out of date policies, ineffective policies or absence of procedural documents.

The gaps in control should be considered and addressed in the risk treatment plan. Further detail on the development of risk treatment plans is described in section 3.5.

2.3.2 Risk severity

The consequence or impact of the risk occurring and the likelihood that it will occur should be considered. This can be measured in terms of the actual or potential severity of physical injury, impact on services, or impact for the Trust.

The likelihood or probability of the risk occurring will be considered in terms of how often the risk will occur if the existing controls fail, or if effective safeguards cannot be applied.

Consequence and likelihood are combined to produce a level of risk; consequence x likelihood = risk score. A systematic common approach to the process, quantifying and scoring of risk is defined in *Appendix 5 - Risk Matrix.*

This will give an overall risk score which can be expressed numerically, or in classifications of low (green), moderate (yellow), high (orange), or extreme (red) risk.

2.4 *Step 4 Evaluate risks*

The analysis of risk enables all identified risks to be evaluated in terms of their potential significance. When evaluating risks it is important to consider the context of a risk, such as; is this likely to have an effect upon patient care and clinical outcomes, patient experience, staff well-being, financial implications, legal obligations, adverse publicity, the potential for impact on service provision, or the possibility of claims or complaints against the Trust.

Determining which risks are more or less significant will enable the executive directors and senior managers to consider the wider context of risks. Consideration can also be given to the most appropriate course of action necessary to control, reduce, or in certain cases transfer the risk. In some circumstances, the risk evaluation may lead to a decision to undertake further analysis.

2.5 Step 5 *Treatment of risks*

Risk treatment involves identifying a range of options aimed at reducing risks to a tolerable level or to transfer risks where appropriate.

The purpose of a risk treatment plan is to:

- Prevent loss, harm or injury occurring
- Protect patients, staff, services and the organisation from loss, harm or injury
- Limit the extent of any loss, harm or injury that might occur
- Maximise recovery and disseminate learning.

The focus of a risk treatment plan is based on two general principles:

1. *Reducing the consequences of the risk (where possible).*
2. *Reducing the likelihood of the risk*.

Risk treatments may be based on operational, technical, financial, legal, social, humanitarian or other criteria. Selecting the most appropriate options involves balancing the costs of implementing each option against the benefits derived from it. In general, the cost of managing risks needs to be commensurate with the benefits obtained.

Risk treatment plans will record existing controls, implementation arrangements for the new controls together with achievement dates and an estimated residual risk score. There will also be clear evidence that the implementation of those controls will reduce the risk to a level that is acceptable.

The following factors will be considered with regard to risk mitigation;-

- ***Eliminate:*** Not proceeding with activity likely to generate the risk

- ***Reduce:*** Reducing or controlling the likelihood and consequences of the occurrence

- ***Transfer:*** Arranging for another party to bear or share some part of the risk, through contracts, partnerships, joint ventures, etc

- ***Accept:*** Some risks may be minimal and retention acceptable.

Action will be taken as soon as possible, at all levels of the organisation as appropriate, to eliminate, transfer or reduce the risk. Each risk must be allocated a risk owner who will be responsible for taking appropriate action to minimise its impact.

A risk treatment plan will be developed for all risks at directorate and corporate levels, and for all other risks as appropriate to the level of detail

required. For low level risks with less complex risk treatments the actions can be placed directly onto the risk register. At corporate, and occasionally at directorate levels, it is likely that action/implementation plans may already exist to mitigate risks. In such circumstances it is appropriate to cross reference appropriate action/implementation plan in the risk treatment section of the associated risk register.

All Risk Treatment Plans will be reviewed in accordance with the risk management process described in this procedure.

A Risk Treatment Plan template is provided at *Appendix 6.*

2.6 Step 6 *Communicate & Consult*

Risk Register Assessment forms have been provided as a way to communicate and consult on risks that have been identified through the risk management process. When risks are identified and recorded locally, a risk register assessment form will be submitted to the relevant local management forum for consideration and agreement of ownership. It is expected that decisions are made in these forums to determine whether the risk is recorded on the local risk register or not, and also if the risk needs to be escalated to directorate/corporate levels.

Where a risk is discussed and agreed for addition to a risk register in the absence of a completed risk register assessment form, it is acceptable for it to be documented directly onto a risk register. It is necessarily to complete a risk register assessment form when a risk is being transferred between departments or escalated to higher level registers.

A risk may be identified and transferred from one area to another in order to accept risk ownership and responsibility for action. Ownership of risks is based on the person or department with most control over delivery of the risk treatment plan. Where risk ownership is unclear, the Risk & Safety Team should be contacted for further advice.

Each directorate/local business area and/or subject specific/Trust group maintain their own risk register for all identified risks that are deemed to be within their management control.

Levels of responsibility and management of risks are provided as general guidance in Table 1 (below) against the severity of risk score; however, it is noted that where a judgement is made to escalate or accept a risk, particular attention should be paid to the consequence score alone due to its nature.

Table 1: Responsibility and Management of Risk Levels

Level of Risk	Responsibility
Low Risk (1 to 3) Moderate Risk (4 to 6)	Managed at a local team/departmental level. Local management to determine and develop risk treatment plans or to manage through routine procedures; and include all risk details in the local risk register. This level of risk may be short-lived.
High Risk (8 to 12)	Managed at local team/departmental level, unless escalated to Directorate or Trust/Subject specific group. Where there is a consequence score of 4 or 5 alone, this will be considered for escalation to the Risk & Assurance Group regardless of the likelihood score.
Extreme Risk (15 to 25)	Managed at local team/departmental level and/or Directorate or Trust/Subject specific group depending on management control, treatment plan and which are felt to have wider implications for the Trust. Risk Leads consider escalation and review at Risk and Assurance Group (R&AG) where consideration is given to placing the risk on the CRR and Board Assurance Framework (BAF). This action also applies to risks with a consequences score of 4 or 5. Consider bringing risks, as appropriate, to the attention of the Trust Executive Group (TEG)

There may be occasions where there could be high or extreme level risks managed at Directorate and/or Subject specific/Trust group risk registers, this is determined by the judgement and consideration by local managers during the risk evaluation process.

2.7 Step 7 Monitor and Review

It is expected that:

- Risk assessments should be a regular agenda item for directorate, Trust groups and local business area meetings to ensure risks are constantly identified, monitored and re-evaluated throughout the year

- Recognised forums will discuss and agree risk descriptions, controls, risk scores, risk treatment plans, ownership and timescales to determine priority risk treatments for implementation. These forums will make decisions on the movement of risk within the organisation

- As risks are treated, risk scores may be reduced to a tolerable level or eliminated and should be archived. Alternatively, if risks are not managed or the treatment plan has not been effective, the risk score could increase. In these circumstances a decision would need to be made by the relevant group with regard to the treatment plan or acceptance of risk.

Risk registers will be used to inform priorities, and for the implementation and monitoring of agreed controls.

It is essential to ensure that risk assessments and risk treatment plans plans are re-visited at corporate, directorate and local business area meetings as new risks are identified or any service change is planned.

Actual progress against risk treatment plans provide an important performance measure and are incorporated into the Trust's performance management, measurement and reporting systems. Monitoring and review also involves learning lessons from the risk management process, by reviewing events, the treatment plans and their outcomes.

All risks identified and assessed will be monitored, reviewed and re-assessed at review periods determined by the frequency of Trust groups/forums held, and could depend on the judgement made by the risk owner. However, the following guidance has been provided to assist managers in monitoring, reviewing, re-assessment and archiving of risks.

Risk Level	Period of review
Local/departmental risks (less than 8)	Six monthly
Directorate/Trust Group/Subject Specific risks (greater than 8)	Quarterly
Corporate risks (greater than 15 and consider consequence scores of 4 or 5.	Monthly
Archived risks	At least annually

3. RISK REGISTER PROCESS

NHS organisations are required to produce a comprehensive organisation-wide risk register that is capable of recording all types of risk. Within Yorkshire Ambulance Service NHS Trust this is referred to as the Corporate Risk Register.

The Trust recognises that identified risks will be managed at the appropriate level and decisions made within an appropriate timescale.

The risk register is a living document which is populated and updated through the organisation's risk assessment and evaluation process. This process enables all risks to be quantified and ranked. It provides a structure for collecting information about risks that will:

- Support the analysis of risk
- Support decisions about whether or how these risks could be mitigated and monitored

- Provide a framework for Board scrutiny and prioritisation of actions
- Support strategic analysis and organisational decision making.

There are three levels of risk register used within the Trust; local business area, directorate and a Corporate Risk Register (CRR). The Trust's CRR is held centrally and maintained by the Standards and Compliance Directorate.

The directorate and local risk registers act as a repository for all directorate specific information and are held centrally along with the CRR. They can be accessed and amended by the identified risk leads for each business area, their nominated deputies, Senior Managers and Executive Directors.

3.1 Corporate Risk Register

The criteria for a risk to be included in the Corporate Risk Register include;

- The risk represents an issue that has the potential to hinder achievement of one or more of the corporate objectives
- The risk cannot be addressed at directorate/departmental level and/or Trust group
- It requires further control measures to reduce or eliminate the risk
- It is likely to require considerable input of resources to resolve the risk (finance, people, time, etc)

The process for inclusion of risks on the Corporate Risk Register is outlined in *Appendix 8*, in summary it involves;

- Risks to be considered by directorate, local business area and or subject specific/Trust groups/forum and communicated to the relevant risk lead, who will in turn review the risk contents and report to the Risk and Assurance Group

- The Risk and Assurance Group will consider additions to the CRR from risk lead reports and risk register assessment forms presented to the group.

Please refer to Appendix 10 which provides the Trust's risk register template.

4. DUTIES

The following duties have been identified specifically in relation to this procedure. Further detail on wider risk management duties can be found in the Risk Management & Assurance Strategy and the Governance Handbook.

4.1 Trust Board

The Trust Board has overall accountability for risk management. The Board will receive the Corporate Risk Register and Board Assurance Framework, at least three times per year, as a formal mechanism for highlighting and considering strategic risks and associated management plans.

4.2 Audit Committee

The purpose of the Audit Committee is to seek assurance and provide advice to the Board on the adequacy and effective operation of the Trust's internal systems of control and risk management across all areas of Trust business.

The Committee comprises all of the Non-Executive Directors, with the exception of the Chair. Members have an extensive knowledge and experience from finance, business, commerce and the public sector, equipping them to effectively scrutinise all areas of Trust activity.

The committee will apply independent and objective scrutiny and challenge to review the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives, primarily through review of the Board Assurance Framework and Corporate Risk Register.

4.3 Finance and Investment Committee

The Finance and Investment Committee is a formal sub-committee of the Trust Board and includes three Non-Executive Directors, the Executive Director of Finance and Performance, the Chief Executive and senior managers. The Committee undertakes objective scrutiny of the Trust's financial plans, investment policy and major investment decisions, and as such plays a pivotal role in financial risk management. It reviews proposals for major business cases and reports on the commercial activities of the Trust, and also scrutinises the content and delivery of the Trust cost improvement programme.

4.4 Quality Committee

The Quality Committee consists of a number of executive and non-executive directors, and managers from a range of governance functions across the Trust.

The Committee has lead responsibility for risk management and undertakes objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from adverse events and infection prevention and control. The Committee will also scrutinise and support the Board in gaining assurance on workforce governance, health and safety and information governance issues.

The Committee scrutinises the quality impact assessments of cost improvement plans prepared by the Executive team, to support the Board in gaining assurance on the safety of service changes. The Committee also scrutinises and supports the Board in gaining assurance on workforce governance, health and safety, and information governance issues.

4.5 Trust Executive Group

Reporting to the Trust Board, the Trust Executive Group meets fortnightly and is accountable for the operational management of the Trust and the delivery of objectives set by the Trust Board. It is also the formal route to support the Chief Executive Officer in effectively discharging his responsibilities as Accountable Officer.

The Trust Executive Group is underpinned by management groups to provide effective governance across the whole of the Trust's activities.

4.6 Senior Management Group

The Senior Management Group consists of Executive Directors and Associate Directors and is chaired by the Chief Executive. The Group carries delegated responsibility from the Trust Executive Group for:

- Identification and management of key risks, including the Board Assurance Framework and Corporate Risk Register.
- Action to address key risks to delivery and on operational issues and problems.

In addition to its monthly standing agenda items, the group's work plan includes a quarterly detailed review of the Corporate Risk Register and Board Assurance Framework, to inform reporting to the Board on risks and to monitor the delivery of risk treatment plans.

4.7 Risk and Assurance Group

The Risk & Assurance Group reports to the Quality Committee and advises the Trust Executive Group and Senior Management Group on any risk management issues.

The Trust manages risk operationally through its management structures. Selected representatives from each local management area across the Trust attend the monthly meeting, which is chaired by the Executive Director of Standards and Compliance.

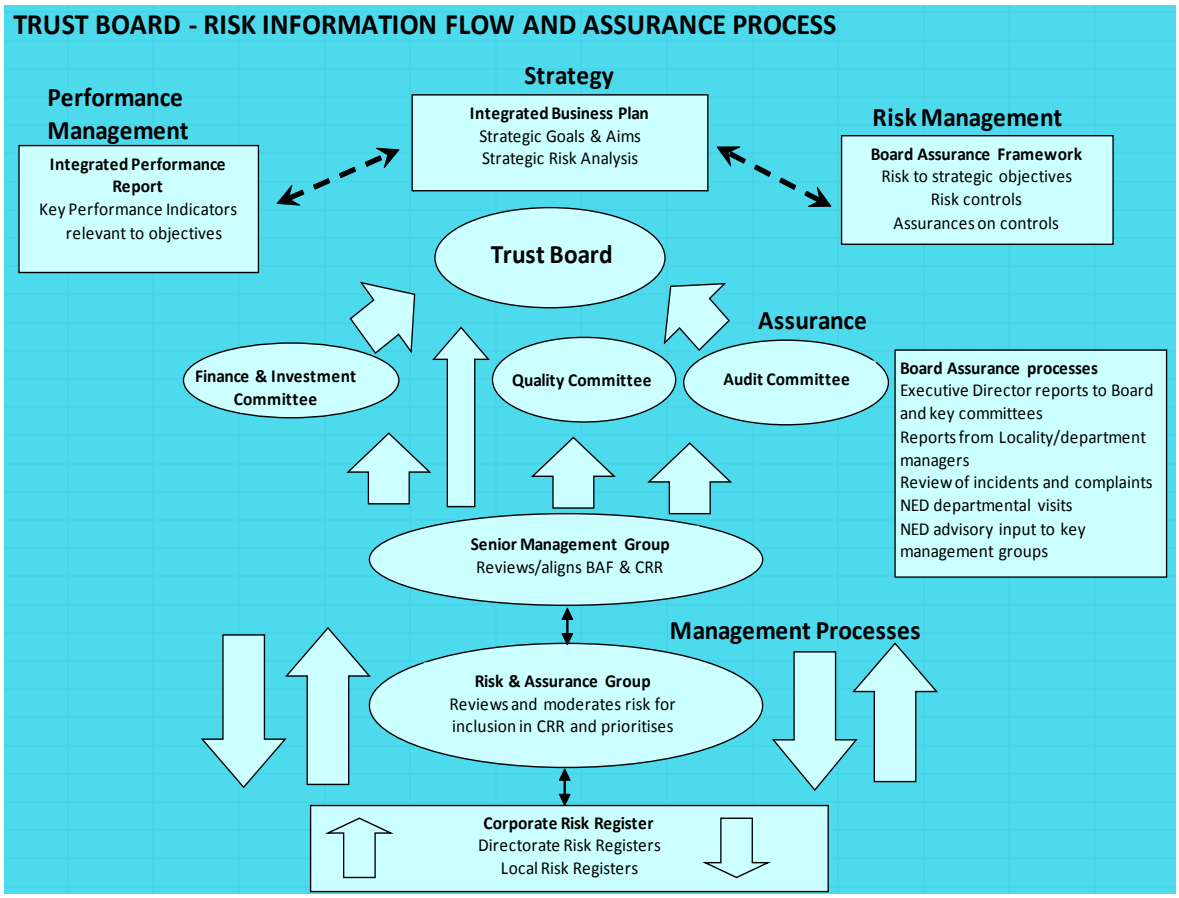
This group receives reports on all directorate risk registers and specific risk issues from the members, including representatives from all other associated risk management groups. These groups include the Health and Safety Committee, which is a source of internal assurance on non-clinical risks and the Clinical Governance Committee, which provides internal assurance on clinical risk issues.

The Risk and Assurance Group moderates risks that are submitted to the group for consideration and/or addition to the CRR. The group reviews and monitors the CRR. It has a primary role in monitoring progress in reducing and mitigating risks.

Further information can be found in the *Risk & Assurance Group Terms of Reference at Appendix 7*.

A schematic overview showing the flow of risk information and assurance between the committees and groups identified in Section 4 is provided in Table 2 below:

Table 2



4.8 Trust Groups/Forums

Risks are managed and monitored through various Trust groups identified within the organisational structure. Depending on the risk context and level of management of risk e.g. departmental, directorate or subject specific will depend on where risks are managed within the organisation. Groups will discuss and debate risk issues, making decisions on the movement and management of risk within the Trust.

4.9 Executive Directors

Executive Directors have responsibility for ensuring that the Risk Escalation & Reporting Procedure is implemented within their directorates and local management structures. They are required to encourage an open and honest culture, where risks are identified quickly and mitigated within a positive and constructive way.

All directors have responsibility to constructively challenge the decisions of the Trust Board and help develop proposals on priorities, risk mitigation, values, standards and strategy.

4.9.1 Executive Director of Standards & Compliance

The Executive Director of Standards and Compliance has specific overall responsibility for ensuring there are arrangements in place for risk escalation and reporting processes, and providing reports on risk management, as required.

4.10 Associate Directors

Associate Directors have responsibility for implementing the Risk Escalation & Reporting Procedure within their departments. They will:

- Empower staff to identify and manage risks within a positive and constructive way
- Ensure communication of risks between departments and/or other directorates occurs where risks are transferrable
- Ensure local risk registers are developed and maintained
- Support monitoring and reviewing of departmental risk registers within agreed local forums/groups
- Escalate risks that cannot be managed locally or that pose a threat to Trust objectives.
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4.10.1 Associate Director Risk & Safety

The Associate Director of Risk and Safety has overall responsibility for managing the risk escalation process and maintaining the BAF and CRR. This role is supported primarily by the Risk Manager, plus; the Health & Safety Manager, Information Governance Manager, Local Security Management Specialist and members of the Risk & Safety Team.

4.11 Risk Manager

The Risk Manager will provide support to the Associate Director of Risk & Safety in the following ways:

- Regular maintenance of the Corporate Risk Register on behalf of the Risk & Assurance Group

- Provide reports to the Risk & Assurance Group, highlighting areas of concern and risks as necessary
- Support implementation of the Risk Escalation and Reporting Procedure throughout the Trust by providing advice and guidance, as appropriate.

4.12 Risk Leads

At directorate level, selected risk management leads within each directorate/management area manage the risk escalation process and maintain their respective risk registers. They will:

- Ensure that any risks scoring 15 or more and/or with a consequence score of 4 or 5 with the potential to impact on Trust objectives, are considered and acted upon.
- Attend the Risk and Assurance Group to present new and revised risks for consideration and/or addition to the Corporate Risk Register
- Ensure risk treatment plans are produced and filed managed in a timely manner for all directorate/departmental or subject specific risks
- Ensure that action is taken as soon as possible, at the lowest possible level to eliminate, transfer or reduce risk
- To monitor and progress identified actions from CRR risk treatment plans
- Manage the risk escalation process and support the maintenance of directorate/departmental and/or subject specific risk registers, ensuring that risks are acted upon immediately and reviewed at regular/agreed intervals
- Attend associated Trust groups/forums to discuss and present new/revised risks
- Monitor and review progress against risk treatment plans for their respective directorate risks.
- Ensure the completion of risk register assessment forms, where appropriate e.g. to identify and transfer risks
- Challenge the structure and management of risk registers within their directorate/local management areas, representative committees/groups and/or subject specific groups.

4.13 Safety Systems Managers

Safety Systems Managers will provide support and guidance within directorate and local business areas, as required, to support implementation of the Risk Escalation and Reporting Procedure.

4.14 Locality Managers

Locality Managers will ensure effective dissemination and implementation of this procedure. The managers have responsibility for establishing and maintaining the local risk registers, implementing resulting risk treatment plans and ensuring that systems are in place to assess, treat and reduce risks within the local areas. They also have responsibility for establishing local arrangements which enable the appropriate communication, monitoring and learning from risk issues.

4.15 Staff

All staff within the Trust have a responsibility to familiarise themselves with the contents of this procedure and comply with it accordingly, through identification of risks.

Staff will be required to participate in activities which are commensurate with the procedure.

4.16 Project/Programme Management Teams

Risks specifically identified through projects/programmes will be managed through project risk logs. Escalation of project risks will be considered in two ways;-

- Risks directly affecting the project management process and/or project itself will be reported through Trust groups/forums, and where necessary to the relevant directorate management team/operational area (following the escalation process highlighted within section 3 of this document)

- Risks specifically related to issues that have a risk score of 15 or higher and/or with a consequence score of 4 or 5 (regardless of likelihood) will be considered for escalation to the most appropriate department/directorate and/or subject specific group.

- The relevant Risk Lead will be informed, in order that they can consider further escalation of risk to the Risk & Assurance Group, where appropriate (following the escalation process highlighted within section 3 of this document).

Any risks that remain beyond the life of a project will be transferred to the most appropriate department/directorate/subject specific group risk register.

5. ASSOCIATED PROCEDURAL DOCUMENTS

The Risk Escalation and Reporting Procedure should be read in conjunction with a number of YAS related procedural documents that underpin the arrangements described within it;

Risk Management & Assurance Strategy
Policy for the Development of Procedural Documents
Incident & Serious Incident Reporting Policy
Investigation, Analysis & Learning from Adverse Events Policy
Health & Safety Policy
Infection Prevention and Control Policy
Equality and Diversity Strategy

6. MONITORING COMPLIANCE

This procedure will be monitored by the Risk and Assurance Group at monthly meetings and annually through review of the group's terms of reference identified within Appendix 7 of this procedure. Any deficiencies identified will be reported to the Quality Committee.

7. EQUALITY IMPACT ASSESSMENT

All public bodies have a statutory duty under a range of equality and human rights legislation to undertake an Equality Impact Assessment of all procedural documents. This document has been subject to the Trust's equality impact assessment process.

Appendix 1

Quality Impact Assessment Procedure

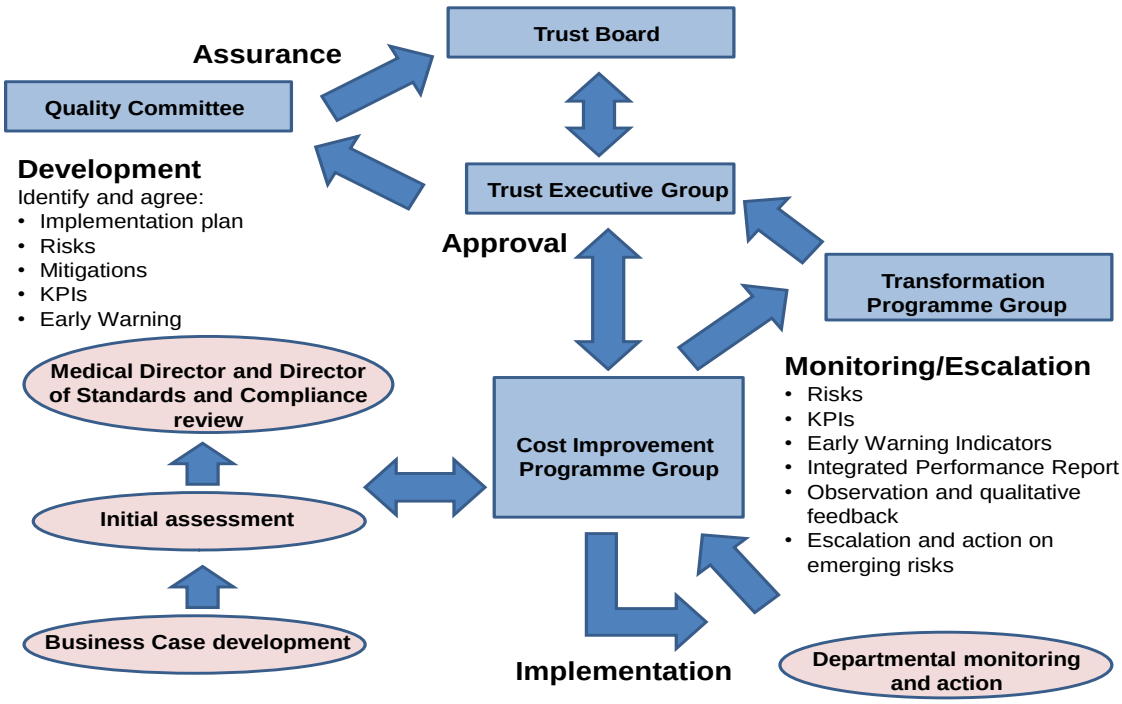
1. BACKGROUND

The Integrated Business Plan sets out the Trust's vision and strategic objectives for the next 5 years. This will be a period of intense change, and success will require the delivery of major service development projects, whilst also maintaining and improving quality of the service and achieving significant cost reductions through increased efficiency.

It is important that there is a process through which the impact of such service change proposals can be assessed in terms of both the quality and financial effect. This will enable any risks to quality within the proposed developments to be identified and mitigated. It will also support the tracking of key indicators during the implementation of new developments, to enable an early warning of any adverse consequences and implementation of appropriate management action.

This procedure outlines the method for evaluation of service change proposals in relation to the impact on quality. It also sets out the process for on-going monitoring of agreed schemes and for escalation of any issues arising. A summary of the procedure is shown below.

Overview of the Quality Impact Assessment Process



This procedure applies to all service development proposals and Cost Improvement Programme (CIPs) business cases and forms a key part of the toolkit used by the CIP Group in its overall management of the programme.

2. DEVELOPMENT OF BUSINESS CASES

2.1 Business cases for new developments must be produced using the agreed Trust template (Appendix 1), with further detail added as required for more substantial schemes. The business cases must provide sufficient information to facilitate an objective review of the quality implications.

2.2 In relation to the potential impact on quality, business cases are expected to include:

- Consideration of the potential impact on safety, clinical effectiveness and patient experience, as well as operational impact and the potential effect on the reputation of the Trust.
- Risks to quality & the proposed mitigating actions
- KPIs which will be used to track impact of implementation and provide early warning of unintended adverse impact. Such performance indicators might include: operational performance information, sickness levels, patient and staff incidents, complaints, Ambulance Clinical Quality Indicators (ACQI), Clinical Performance Indicators (CPI).

2.3 Advice and support on the development of business cases can be obtained from the Associate Director of Finance and the Associate Director of Quality.

3. ASSESSMENT PROCESS AND CRITERIA

3.1 Business cases will undergo an initial assessment led by the Associate Director for Quality, in liaison with other senior clinicians and managers as appropriate, using the documentation provided and the assessment tool below:

1 - Costs & Savings	Negative Impact	Minimum Impact	Positive Impact
(a) Type of savings	No savings or minimal anticipated	Minimal impact on savings, but has potential for improved levels of productivity.	Both cash savings and improved productivity is expected
(b) Cost of change. Likelihood that costs will not be a barrier to implementation	Change requires significant non-recurrent resources such as capital costs for adapting buildings. Change will incur significant extra costs.	Change requires additional resources, but resources are non recurrent resources that are less than one year's savings. Change will incur extra costs.	Change can be achieved with minimal or no additional resources. Change will create efficiency savings
2 - Quality			
(a) Impact on clinical quality	Significant reduction in clinical quality	Not anticipated to have any impact (favourable or adverse) on quality of care delivered to patients	Clinical quality will be improved resulting in better outcomes anticipated for patients
(b) Impact on patient and staff safety	Increased risk to patient safety	Not anticipated to have any impact on patient safety	Improved patient safety, such as reducing the risk of adverse events is anticipated
(c) Impact on patient and carer experience	Significant reduction in patient and carer experience	Not anticipated to have any impact on patient and carer experience	Improved patient and carer experience anticipated
(d) Impact on operational effectiveness	Significant adverse impact on operational performance	May have some adverse impact on operational performance	Improvements on operational performance expected
(e) Impact on Trust reputation with patients, staff and other stakeholders	Significant adverse impact on Trust reputation	May have some adverse impact on Trust reputation	An improved positive impact on Trust reputation is expected
3 - Ease of implementation			
(a) Likely speed of implementation	Will take longer than 3 years	Can be achieved between 1 - 3 years	Can be achieved within 1 year
(b) Ease of organising the change	Affects multiple organisations	Affects multiple departments within the Trust.	Affects a small number of directorates or a number of teams within the Trust
(c) Degree and complexity of support and commitment required	Likely to be significant resistance from most stakeholders	Likely to get some resistance from some stakeholders.	Likely to achieve good engagement from stakeholders

3.2 Feedback will be provided to the author of the business case, with further information requested from lead managers as necessary to address any initial queries. Issues relating to the quality impact assessment will also be reviewed as part of the Cost Improvement Programme Group agenda, to ensure that cross departmental concerns can be appropriately addressed.

3.3 The business cases will then be reviewed by the Executive Director of Standards & Compliance and the Executive Medical Director, prior to reporting to the Trust Executive Group for approval.

3.4 Recommendations from the quality impact assessment process will be reported to the Quality Committee and Board to enable Non-Executive Director scrutiny of the recommendations and proposed mechanisms for on-going monitoring of quality and safety before implementation. This will complement the financial scrutiny of the Cost Improvement Programme undertaken by the Finance and Investment Committee and the independent assurance role of the Audit Committee in relation to all aspects of Trust business.

4. MONITORING & ESCALATION

4.1 The designated lead manager and other managers, whose departments are directly affected by the proposed service change, are responsible for tracking relevant KPIs as the change progresses.

4.2 Key risks identified through the quality impact assessment process will be included in the Trust risk register and will be subject to monitoring via the Trust risk management processes set out in the Risk Reporting and Escalation Procedure.

4.3 On-going tracking of key Trust projects, including the achievement of milestones, delivery of identified benefits and management of key risks will be reviewed in the Service Transformation Group.

4.4 The Cost Improvement Programme is recognised as a key element of the overall change programme within the Trust, and a separate Cost Improvement Programme Group with Executive Director membership is therefore also in place under the auspices of the wider service transformation programme, to maintain a more detailed monitoring of the CIP schemes in particular.

4.5 The KPIs relevant to each service change and specific early warning indicators identified as part of the quality impact assessment process will be tracked through the CIP Group, and will also be monitored in the Trust Executive Group and Board as part of the Integrated Performance Report. Where concerns are identified via this monitoring process, the risks will be reviewed to ensure that prompt, appropriate action can be taken to mitigate any risks.

4.6 A full review of the quality impact assessments will be undertaken at month 6 of the implementation plan and reported to the Quality Committee and Board.

5. REPORTING

5.1 The template for reporting monthly to the CIP Management Group is shown in the Recording Quality Impact Assessment template (below)

5.2 All designated lead managers are expected to complete this template for their respective schemes on a monthly basis, to support effective monitoring of implementation, identification and management of any associated risks.

Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Yorkshire Ambulance Service NHS Trust
Efficiency and Productivity 2012/13
Assessment of impact on quality

Scheme:	
Scheme Number:	
Description of scheme:	
Anticipated annual recurrent financial benefits of scheme (£000s):	
Project Lead:	

Overall Quality RAG rating	

Approved by	
Alison Walker Medical Director	**Steve Page Director of Standards & Compliance**
Date	

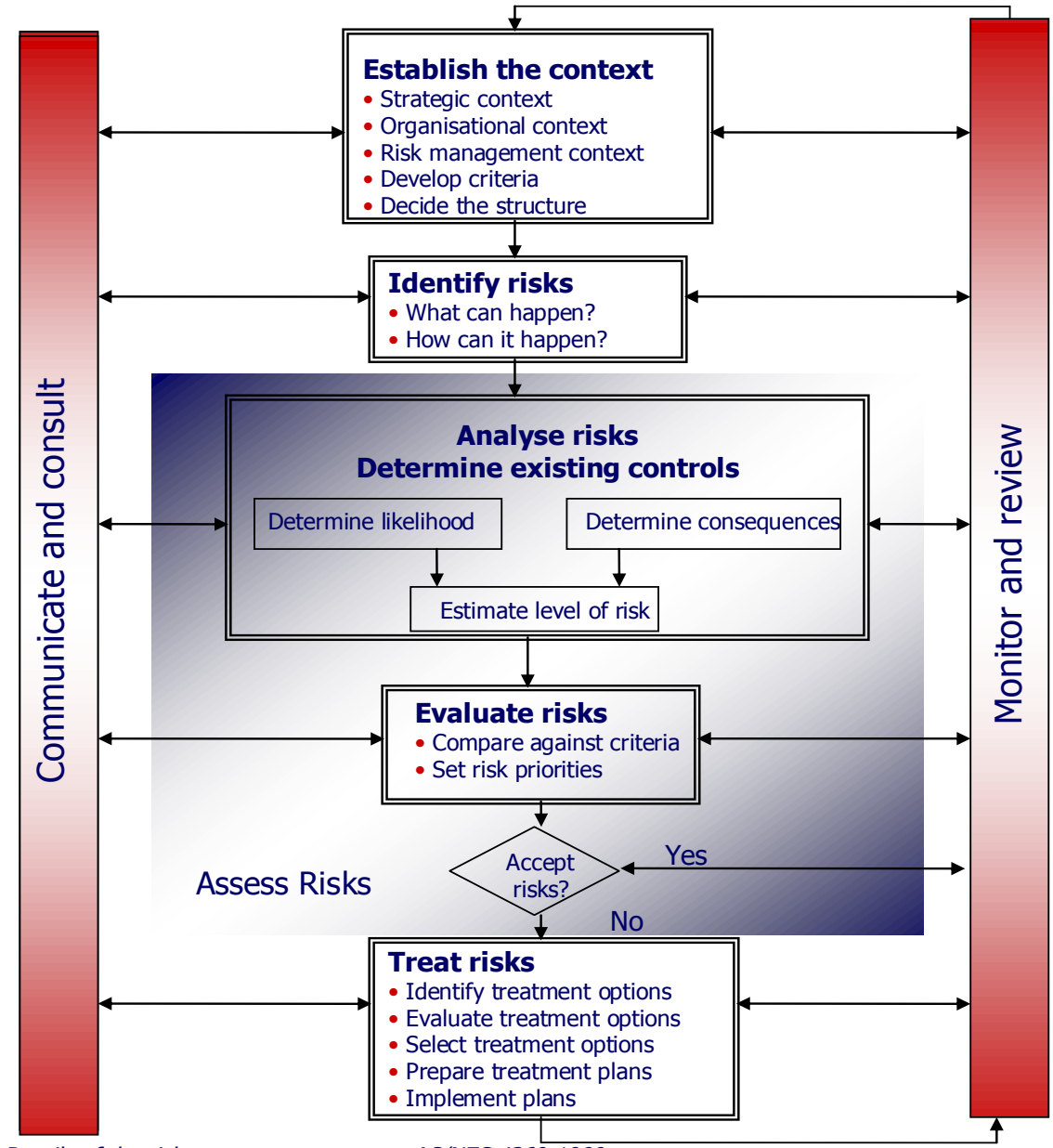
Risk		**Description of Risk**	**Mitigation**
1	**Impact on clinical quality**		
2	**Impact on patient safety**		
3	**Impact on patient & carer experience**		
4	**Impact on operational performance**		
5	**Impact on Trust reputation**		

Quality Domain		**Key Considerations**	**RAG Rating**	**Comment**
1	**Clinical Quality**	How will / have clinical staff be / been engaged in the development of the scheme?		
2	**Patient Safety**	Does the scheme maintain or improve patient safety? If so how?		
		Has the potential impact of the scheme been considered on: Patient Safety / Avoidable harm?		
		Infection control and prevention?		
		Safeguarding vulnerable children and adults?		
		Have risks been identified and mitigated?		
3	**Patient Experience**	Have patients or carers been involved in the development of the scheme? If not please explain		
		Has an Equality and Diversity Impact assessment been carried out on the scheme? If not please explain		
		Has the potential impact of the scheme been considered on: Whether patients are treated professionally?		
		Whether patients are treated by suitably qualified and experienced staff?		
		Whether patients have the right to make choices about the healthcare they receive?		
		Whether patients are treated with dignity, respect and compassion?		
		The continual improvement in the standards of care and quality of services provided to individuals.		
4	**Impact on Operational Effectiveness**	Has appropriate evidence been used in assessing the potential impact on operational effectiveness?		
		Are clinical outcomes measured clearly identified?		
		Are KPIs focused on outcomes rather than process?		
5	**Impact on Trust reputation**	Has any impact on Trust reputation been suggested/mitigated?		

APPENDIX 2

RISK MANAGEMENT PROCESS

The Trust has adopted the national framework below which reflects best practice:



Details of the risk management process AS/NZS 4360:1999

The Australia/New Zealand, (AS/NZS:4360) Risk Management Standard has been adopted by the Trust in order to facilitate effective risk management throughout the organisation. Using the key stages and processes identified within AS/NZS:4360 the Trust is able to identify and evaluate risks, and to develop risk treatment plans for their management and reduction.

APPENDIX 3

Examples of Risk Issues and Questions to Consider when identifying risks

(This is not an exhaustive list)

Potential Risk Issues that could be considered:

Organisational Arrangements	**National Benchmarking**
• Incident reporting • Litigation • Complaints • Serious incidents • Clinical audit • Dealing with emergencies • Research and development • Business continuity • Access to support and advice • Patient Surveys • PALS • Maintenance and use of equipment • Conveyance arrangements • Food Hygiene	• NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts • Dissemination of learning from Regional and National reporting systems e.g. SUI's, National Patient Safety Agency (NPSA) • Recommendations from Confidential Enquiries and other national reports and enquiries e.g. Shipman Enquiry • National Guidance e.g. NICE, NSF's, JRCALC • Coroners reports • Health and Safety Executive • Environment Agency • NHS Central Alert Systems • Media and Professional journals
Health & Safety	**Record Keeping**
• Manual handling • COSHH • Violence and aggression • Waste • Fire code	• Clinical records • Non-clinical records • Data collection • Storage and retrieval • Content • Filing
Consent Issues	**Procedural Documents**
• Policy • Process • Patient Information	• Clinical • Non-clinical • Financial
Staffing	**High Risk Areas**
• Numbers • Skill mix • Competence & Staff Training • Access & availability of training • Induction • Supervision • Volunteers • Sickness / Absence • Improving Working Lives	• Access & Response • A&E Operations • PTS Operations • Medical • Medicines Management • Medical Devices • Infection Prevention & Control • Safeguarding • Security & Personal Safety
Business Risks	
• High levels of demand • Not meeting national targets • Lack of business objectives • Pay /non-pay overspends • Agency costs • Lack of capital budget • PCT's not supporting business case • External relationships poor • PR / Reputational issues • Compliance with regulations, other statutory requirements and contracts	

Questions that could be considered when identifying risks:

- Are all statutory, regulatory, clinical and contractual requirements being met?
- What activities relating to patient care are provided in the local business area or directorate? High risk areas such as; A&E Operations, Access & Response and Infection, Prevention & Control, will require particular attention.
- Who provides the services? Are staff competent? Are they properly supervised? Are they suited to the task? Are staffing levels adequate?
- How are services which are provided on a 24 hour basis maintained to an appropriate standard at all times?
- How effective are infection prevention and control measures in the area?
- Do staff have the appropriate information, instruction and training to use equipment? Is the equipment maintained in a safe and operational state? Do staff know how to report defects?
- Have the statutory Health and Safety assessments been carried out in the area e.g. Manual Handling, COSHH, DSE
- Is the Trust Waste Management Policy followed correctly e.g. sharps, infected waste
- How are the facts determined in the event of a complaint or litigation? Consider the availability, quality and scope of the clinical records.
- Are record keeping standards sufficient to provide adequate information in the event of queries concerning treatment?
- How effective is Trust-wide communication of clinical issues? Are there systems in place for learning from past experience – utilising internal information from audit, complaints, incident reporting and claims, and external data from national reports, Care Quality Commission publications and Confidential Enquiries?
- Are effective clinical procedures in place that reflect good practice and are they in line with the relevant professional standards? Are all relevant staff aware of them? Do all staff know what is expected of them?
- Are prescribing and administration of drugs reviewed on a regular basis? Are controlled drugs managed safely and legally? How are drugs stored?
- What are the key priorities in the area in the event of a disaster e.g. prolonged power cut, flood, and fire. Are staff aware of them?
- Are there any particular targets / objectives the area is aiming for?
- Is there a planned or unplanned increase/reduction in activity?
- Are all national targets being met?
- Is there a lack of capital budget?
- Is the reputation of the service threatened?
- Is there potential to lose a service with subsequent loss of income?
- Are there any significant changes to services planned?

APPENDIX 4 Risk Register Assessment Form (template)

The following should be completed; discussed with local management team; and emailed to risk&safety@yas.nhs.uk

For completion by the person/committee/group identifying a risk;-

Date of Completion	Please state the date the risk assessment was completed.
Risk Context	Determine the primary **Context** of the risk e.g. Harm to patient safety, financial, regulatory, reputation etc
Cause of risk	What would most likely cause the risk to occur? E.g. due to…. increased workload causing immediate activation at start of shift
Consequence from risk (refer to Risk Matrix Table 2a)	What are the potential consequences if the risk were to occur? E.g. resulting in……failure to check medical equipment at the start of every shift
Source of Risk Notification	What brought this risk to your attention? State where the risk originates e.g. incident, complaint, local risk assessment, national guidance etc.
Directorate/ Local business area	Where has the risk been identified? Where is the risk likely to be owned? Please state the Directorate and where appropriate the local business area/department e.g. fleet, estates maintenance, CBU
What Existing Risk Control Measures are in Place?	Briefly list any controls which are currently in place to manage the risk e.g. risk assessments, policies/procedures, contingency plans etc.
Initial Action	Can any action be taken at this stage to reduce or eliminate the risk? Describe any action taken.
Responsibility for Initial Action	Identify the person (s) taking initial action and those who are known at this stage that will be required to take responsibility for any identified actions.

Impact On Objectives	State how the risk will impact on the Trust's Strategic Values, Goals and Aims.
Risk Score **C x L**	Determine the risk score by establishing the context of the risk and the consequence, and multiplying by the likelihood of the consequence occurring, taking into consideration the strength of existing controls already in place. The risk score should focus on the risk at the time of assessment. Please state the scores allocated and risk colour. e.g. 5 x 3 = 15 RED
Further Action (Risk Treatment)	Briefly identify a potential range of options for treating risks. Consideration should be given when selecting the most appropriate options to balancing the costs of implementing each option against the benefits derived from it. It may also be appropriate to consider strengthening existing controls as a risk treatment option.
Responsibility for Further Actions	Identify the person(s) at this stage (if known) that will be required to take responsibility for any further identified actions (as described above).
Timescales for Further Actions	Identify the estimated timescales for the identified actions to be progressed and completed that are known at this stage.
Residual Risk Score **C x L**	Re-score the risk, taking account of the controls and potential risk treatment plans. The final score should reflect the target reduction expected following treatment. Please state the scores allocated and risk colour. e.g. 4 x 2 = 8 AMBER
Personnel Involved in this Risk Assessment	List the members of staff/groups involved in the risk assessment

Risk Assessment Completed by	Who has taken the lead on completion of the risk assessment? Write the name of the assessor here
Risk Transferred to Directorate/department, if applicable	Please state the directorate/department agreed to take overall management of the risk and associated risk treatment plans.
Manager Responsible	Who owns the risk? Identify a named person, who will be responsible for taking action to effectively manage the risk and coordinating with other personnel as required.
Entered on to Local Risk Register	Date that the risk was identified and placed on local business area risk register (Complete if appropriate)
Entered on to Directorate Risk Register	Date that the risk was identified and placed on Directorate risk register (Complete if appropriate)
Entered on to Corporate Risk Register	Date that the risk was identified and placed on Corporate register (Complete if appropriate)
Date of Review	When will the risk be reviewed?
Risk Assessment Confirmed by & when?	Please state the local management group/directorate group and/or the Risk & Assurance Group the risk assessment was confirmed by? Please also state when it was confirmed.

APPENDIX 5

Risk Matrix

The practice of grading risks should be integral to day-to-day business and practice. It provides a mechanism which incorporates consequence and likelihood/probability scales by which to ascertain risk scores identifying level of subsequent action required to be taken as appropriate (Table 1).

It provides broad descriptors on consequence grading and the likelihood/probability table (Tables 2 and 3). This is to provide guidance only and is not a list of exhaustive descriptors. Where clarity is needed, discussion and agreement should be reached through local management structures.

Instructions for use

Step 1: The potential **consequence** (effect) that might arise from the risk is identified and scored from any of the descriptors in Tables 2 e.g. moderate; assessed score 3.
For strategic risks greater emphasis should be placed on the consequence score in consideration of its potential effect on the delivery of strategic objectives.

Step 2: The **likelihood** of the consequence or adverse outcomes becoming 'real' by assigning a predicted frequency of occurrence. If this is not possible assign a probability score to the adverse outcome within a given time frame. Select a score from Table 3 e.g. possible: assessed score 3. In practice this is subjective and can depend on the knowledge and expertise of staff. If unsure, seek advice from another colleague or your Manager.

Step 3: Finally, the above two scores are multiplied using the risk grading matrix in Table 1 to determine the risk score and grading.
e.g. C (consequence) **3** x L (likelihood) **3** = R (risk score) **9 Amber** (High risk).

Step 4: Identify the level at which the risk will be managed in the organisation (table 1), assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Risk Scoring is not intended to be precise mathematical measures of risk, but is useful when prioritising control measures for the treatment of different risks.

Table 1 Risk scoring = consequence x likelihood (C x L)

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

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

Key to risk rating:			
Risk score of 1 - 3	Low	Local Team/Department Risk Register	Adequately Controlled
Risk score of 4 – 6	Moderate		
Risk score of 8 – 12	High	Directorate Risk Register	Inadequately Controlled
Risk score of 15 – 25	Extreme	Corporate Risk Register	

Table 2a - Consequence Scores (General)

Choose the most appropriate risk descriptor for the identified risk from the left-hand side of the table, then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Risk Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Risk Descriptors	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Strategic Risk	No regulatory financial concerns Reactionary and short term management response Increased demand on management time	No regulatory financial concerns Board instability Poor experience for patients/staff REAP level 1 for up to 4 weeks	Regulatory financial concerns in one or more components. Significant breach unlikely. Poor utilisation of resources. Adverse impact on staff/public/stakeholder relationships. Poor coordination of major incident response. REAP level 2 for 4 weeks or more.	Risk of significant financial/regulatory breach in medium-term e.g. 12-18 months, in absence of remedial action. Adverse impact on commissioner's relationships. Adverse impact on clinical outcomes. Insufficient/inappropriate resource to meet demands. Financial loss (retained overheads/redundancy costs). Adverse impact on contract negotiation/agreement. REAP level 3 for 4 weeks or more.	High probability of significant financial/regulatory breach of authorisation in short term e.g. <12 months, unless remedial action is taken. National performance standards adversely affected. Loss of contract income/penalties. Regulatory sanctions. Adverse impact on service developments. REAP level 4 for 2 weeks or more.

Patient Safety e.g. Harm to patients and/or public (including physical and/or psychological harm)	Minimal injury requiring no/minimal intervention or treatment e.g. delay in routine transport for patient No obvious patient harm. Minor injury not requiring first aid or no apparent injury	Minor injury or illness, requiring minor intervention Increase in length of hospital stay or treatment by 1-3 days Minor injury or illness, first aid treatment needed 1-2 people affected No long term consequences.	Moderate injury requiring professional intervention e.g. Vehicle carrying patient involved in a road traffic collision Increase in length of hospital stay or treatment by 4-15 days An event which impacts on a small number of patients Some permanent harm up to a year. 3-15 people affected Possible long term consequences RIDDOR/MHRA/agency reportable incident	Major injury leading to long-term incapacity/disability Increase in length of hospital stay or treatment by >15 days Serious mis-management of patient care with long-term effects 16-50 people affected	Death /life threatening harm Multiple permanent injuries or irreversible health effects A significant event which impacts on a large number of patients - more than 50 people affected STEIS reportable
Harm to staff and/or contractors (including physical and/or psychological harm)	No time off work Minor injury not requiring first aid or no apparent injury	Minor injury or illness, first aid treatment needed Anxiety requiring occupational health counseling (no time off work required) Short term staff sickness/absence (less than 3 days off work) 1-2 staff affected	Moderate injury or illness requiring hospital treatment/outpatient appointments/assessment of social care needs Staff sickness – more than 3 days off work RIDDOR/MHRA/agency reportable incident 3-15 staff affected	Major injury or illness requiring long term treatment or community care intervention Long term staff sickness More than 15 staff affected Post-traumatic stress disorder	Death Life threatening injury or illness Permanent injury/damage/loss of limb/ long term incapacity or disability
Quality	No long term consequences Minimal disruption to routine organisation activity	Minor element of treatment or service suboptimal No long term consequences Single failure to meet internal standards or follow protocols	Treatment or service has significantly reduced quality Possible long term consequences	Major quality implications if findings are not acted on Potential damage to Trust reputation Major long term consequences Repeated failure of service to meet professional standards/ practice guidelines/ operational protocols	Catastophic quality implications if findings are not acted on Trust reputation damaged Catastrophic long term consequences
Clinical Audit (Provision of Clinical Information)	No or limited/single disruption to the provision of timely and accurate clinical information across YAS Meets local clinical audit standards	Minor disruption to the provision of timely and accurate clinical information on an individual CBU/ business area Minor discrepancy with local clinical audit standards	Reduction in the provision of timely and accurate clinical information in CBU's/ business areas Moderate discrepancy with meeting local clinical audit standards	Inconsistent production of timely and accurate clinical information across all CBU's/ business areas Non-compliant with local clinical audit standards agreed by YAS Delay in participation with national and local quality frameworks	Failure to produce clinical information or participate within any local or national quality frameworks Non-compliant with national clinical audit standards

Complaint/Concern / Comment	Minimal injury/no harm to patient Misunderstanding of an element of the service which can be corrected Local rapid resolution anticipated with no service change requirements No media/MP/legal interest anticipated Compliant/concern responded to within 24 hours	Minor injury to patient Single failure to meet internal standards with no consequence Local resolution anticipated, local service change may be required No media interest or requests Potential for local media interest Compliant/concern responded to within 24 hours	Moderate injury requiring professional intervention Single failing resulting in loss of appointment or care Local resolution achievable with support from all parties Local media statement requested Compliant/concern responded to within 25 working days	Major injury leading to long term incapacity or disability Repeated failure to meet internal standards Local resolution anticipated Unresolved concern or complaint (re-opened) Regional media statement requested National media interest anticipated Reported as SUI Inquest/ombudsman inquiry Compliant/concern responded to within 25 working days	Incident leading to death Unacceptable level or quality of treatment/service . Grossly substandard care Resolution expected to be protracted, major trust wide service change may be required National media statement requested Gross failure of patient safety Gross failure to meet national standards Reported as SUI Inquest/ombudsman inquiry Compliant/concern responded to within 25 working days
Coroners' requests / Inquests	No issues or concerns identified clinically or with reputation Operational response time within national target Routine internal review Inquest very unlikely to bring any allegations against Trust or employees	Minor concerns relating to treatment highlighted e.g. not all observations recorded Short delay in operational response time > 3 minutes over national target. Routine internal review Non Contentious Inquest No allegations against Trust or employees Simply fact finding enquiry No risk of criminal or civil litigation No risk of reputational damage	Concerns relating to treatment/care which are not likely to have affected the outcome Moderate delay in operational response time > 5 minutes over national target Internal review required Inquest Some allegations made against Trust and or employees Does not raise significant individual or Trust policy failings Defendable Low level risk of civil litigation claim (i.e. damages not in excess of £20,000) Low level risk of reputational damage (local level)	Major concerns to treatment/care which could have affected the outcome Delay in operational response time > 10 minutes over national target. Escalation to internal Incident Review Group Internal investigation/ Clinical Case Review (CCR) required Escalation to relevant Directors Increased likelihood of receiving a Coroner's Rule 43 letter. Consideration given to instructing solicitors for advice Properly interested person Contentious Inquest Some allegations made against Trust and or employees Raises individual employee failings and or Trust policy concerns Potential to issue Rule 43 Report against person or organisation	Catastrophic / significant issues/concerns which are likely to have affected the outcome Delay in operational response time > 20 minutes over national target. Internal investigation/ Clinicall Case Review (CCR)/Special incident review required Escalation to internal Incident Review Group Escalation to relevant Directors/Trust Board Coroner's Rule 43 letter received Solicitors instructed Properly interested person Contentious Inquests/Public Enquiries Allegations against Trust and or employees

				Some issues defendable Medium level risk of civil litigation claim (i.e. damages not in excess of £100,000) Reputational damage (local level)	Raises issues of national importance Potential to result in public national enquiry (i.e. London Bombings, Mid Staffordshire enquiry) Potential for criminal prosecution and high level award (civil litigation claim i.e. in excess of 100,000 to unlimited damages) Reputational damage (national level)
Litigation Claim	Risk of claim remote Legal challenge minor out of court settlement	Civil action – with or without defence Improvement notice Claim less than £10,000	Class action Criminal prosecution Prohibition notice Claim(s) between £10,000 and £100,000	Criminal prosecution – without defence Executive officer dismissed Claim(s) between £100,000 and £1 million	Criminal prosecution – without defence Executive officer fined or imprisoned Claim(s) >£1 million
Human resources/ staffing levels	Short-term low staffing level that temporarily reduces service quality (less than 1 day)	Low staffing level that reduces the service quality (1-5 days)	Late delivery of key objective/service due to lack of staff/capacity Unsafe staffing level (1-2 weeks) Low staff morale	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level (more than a month) Loss of key staff Very low staff morale	Non-delivery of key objective/service due to lack of staff Constant ongoing unsafe staffing levels or competence Loss of several key staff
Staff Competence	Staff are adequately equipped with the appropriate skills, knowledge and competence to undertake their duties Staff attendance at mandatory/ key training Insignificant effect on delivery of service objectives due to failure to maintain professional development or status (less than 10 staff)	Minor error due to a lack of appropriate skills, knowledge and competence to undertake duties. Insignificant staff attendance at mandatory/ key training Minor effect on delivery of service objectives due to failure to maintain professional development or status (between 11-50 staff)	Moderate error due to limited skills, knowledge & competence to undertake duties Poor staff attendance for mandatory/key training Moderate effect on delivery of service objectives due to failure to maintain professional development or status (between 51-100 staff)	Serious error due to limited skills, knowledge & competence to undertake duties Regular poor/low attendance at mandatory/key training Major effect on delivery of service objectives due to failure to maintain professional development or status (between 101-250 staff)	Critical error due to limited skills, knowledge & competence to undertake duties Significant/ inconsistant low uptake of attendance at mandatory/key training Significant effect on delivery of service objectives due to failure to maintain professional development or status (more than 250 staff)

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation/Public confidence	Rumours No public/political concern	Local media area interest – short-term reduction in public confidence Local public/political concern. Elements of public expectation not being met	Local media interest – reduction in public confidence Damage to reputation. Extended local/regional media interest. Regional public/political concern.	Regional/national media interest with less than 1 day service well below reasonable public expectation Loss of credibility and confidence in organisation. Independent external enquiry. Significant public/political concern Significant damage to reputation	National media interest with more than 1 day service well below reasonable public expectation. MP concerned (questions in Parliament) Full public enquiry Total loss of public confidence in organisation. Major damage to reputation
Business programmes/ projects	Temporary defects causing minor short term consequences to time and quality	Poor project performance shortfall in area(s) of minor importance (performance may be related to time, cost & quality – either singularly or in combination of)	Poor project performance shortfall in area(s) of secondary importance (performance may be related to time, cost & quality – either singularly or in combination of)	Poor performance in area(s) of critical or primary purpose (performance may be related to time, cost & quality – either singularly or in combination of)	Significant failure of the project to meet its critical or primary purpose
Financial loss/Contracting	Small loss of budget (£0 - £5,000)	Medium financial loss (£5,000 - £10,000)	High financial loss (£10,000 - £50,000)	Major financial loss (£50,000 - £100,000) Purchasers failing to pay on time	Huge financial loss (£100,000 +) Loss of contract / payment by results Unrecoverable financial loss by end of financial year
Service/business interruption	Loss of ability to provide services (interruption of >1 hour)	Loss of ability to provide services (interruption of >8 hours)	Loss of ability to (interruption of >1 day)	Loss of ability to provide services (interruption of >1 week)	Permanent loss of service or facility
Information risks	Minimal or no loss of records containing person identifiable data. No significant reflection on any individual or body Media interest very unlikely Only a single individual affected.	Loss/compromised security of one record *(electronic or paper)* containing person identifiable data. Damage to a team's reputation/some local media interest that may not go public. Serious potential breach and risk assessed high e.g. unencrypted	Loss/ compromised security of 2-100 records *(electronic or paper)* containing confidential/ person identifiable data. Damage to a services reputation/low key local media coverage	Loss/ compromised security of 101+ records *(electronic or paper)* containing person identifiable data. Serious breach with particular sensitivity e.g. sexual health details Damage to organisation's reputation/local media coverage	Compromised security of a local application / system / facility holding person identifiable data *(electronic or paper).* Compromised security of an organisation / Trust wide application / system / facility holding person identifiable data *(electronic or paper).*

		clinical records lost – up to 20 people affected.			Damage to NHS reputation/national media coverage. Serious breach with potential for ID theft or over 1000 people affected.
Environmental impact	Minimal or no impact on the environment (small spillage or escape of non-clinical or non-harmful material on Trust premises)	Minor impact on environment (spillage or escape of clinical or toxic waste with effects contained within unit or dept)	Moderate impact on environment (spillage or escape of clinical or toxic waste affecting an entire building)	Major impact on environment (significant spillage or escape of clinical or toxic waste with effects contained to Trust property)	Catastrophic impact on environment (significant discharge or escape of clinical or toxic waste with widespread effects beyond Trust property)

Table 2b Specific Risk/Incident Consequence Descriptors

Please note: the following descriptions can be used for two purposes:

- to grade a potential risk, and
- to grade the consequences of an incident that has occurred

	Specific Risk/Incident Descriptors (but are not exhaustive)				
	1	**2**	**3**	**4**	**5**
Risk Descriptors	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Medication error	Incorrect medication dispensed but not taken	Wrong drug or dosage administered, with no adverse effects	Wrong drug or dosage administered with potential adverse effects	Wrong drug or dosage administered with adverse effects	Unexpected death or permanent incapacity Incident leading to long-term health problem
Physical Violence/Aggression	Minimal or no impact	Physical attack/assault such as pushing, shoving, pinching, slapping, hair pulling etc causing minor injury (not requiring immediate medical assessment or treatment)	Assault on patients, public or staff which may have physical health / psychological implications on the victim. Injury may require A&E or GP assessment but no further treatment	Serious Assault resulting in physical injuries that require hospital treatment.	Homicide or attempted homicide resulting in death or serious prolonged injury or disability
Moving/Manual Handling	Malfunction / fault with equipment	Minor injury as a result of moving or handling	Moderate injury to staff as a result of moving or handling requiring more than 3 days sick leave (RIDDOR reportable)	Serious injury to staff resulting in long term damage (RIDDOR reportable)	Unexpected death or permanent incapacity Incident leading to long-term health problem
Hostage Situation		Threats to prevent staff member leaving property but is persuaded and allows	Deliberate delay in the departure of staff using minor threats or physical obstruction	Deliberate delay in the departure of staff using significant threats or physical obstruction	Staff member held hostage using physical force

		exit			
Slip, Trip, Fall	Slipping, falling with no injuries	Slipping, falling with minor injuries requiring first aid only	Slip/trip/fall resulting in injury such as a sprain, requiring medical attention	Slip/fall resulting in injury such as dislocation/fracture/ blow to the head requiring medical attention and hospitalisation	Unexpected death or permanent incapacity Incident leading to long-term health problem
Infection Control and/or ill health	Exposure to blood/ body fluids/other sources of infection with no risk	Exposure to blood/ body fluids/other sources of infection with minimal risk/no sickness Outbreak involving 3 or more patients Physically unwell -doctor attended or treated by staff	Exposure to blood/ body fluids/other sources of infection resulting in short term sickness (min 3 days) Outbreak causing disruption to service or short term closure (days/weeks) Physically unwell -planned admission attendance at A&E (not blue light) or transfer to general medical ward Inoculation contamination with no infection	Exposure to blood/ body fluids/other sources of infection resulting in very serious infection, long term sick leave Outbreak causing medium term closure (weeks/months) Physically unwell - emergency admission to general hospital Inoculation contamination from infected person	Sudden or unexpected death (including where evidence may be related to exposure to infection) Outbreak causing long term closure or termination of service Inoculation contamination causing life threatening disease or death
Confidentiality/Security	Patient information or other confidential information left unattended or was visible to unauthorised staff Computer left logged into a person account but no one was using the computer YAS networks receive minor “hacking” attempts that are safely blocked	Staff involved in a patients care overheard in a public area on Trust grounds speaking about a patient using the patients name Staff communicated excessive patient information to a third party as part of the care of that person, consent not having been specifically denied by the patient Computer logged into an account, but being used by a person other than the account holder. No patient information data entry, email usage or internet usage was performed	Staff communicated confidential and/or sensitive information to other members of the Trust as part of “gossip” Patients record is missing and cannot be found within a week Trust site security is breached and intruders could have had access to confidential information Computer logged into an account, but being used by a person other than the account holder. Patient information data entry, email usage or internet usage was performed	Inappropriate/Accidental communication of obviously confidential information by staff to a third party unaware that the patient or the Trust specifically denied consent to disclose Multiple patient records go missing due to deliberate actions of intruders on Trust sites Trust network security is breached but no confidential information or email accounts were accessible Diaries/Laptops/ Computers with confidential information staff or patient are lost. stolen or missing	Deliberate disclosure to third party by a staff member who was aware that the patient or the Trust specifically denied consent to disclose Publication of any patient information or confidential information that was not specifically authorised by the patient or the Trust Trust network security is breached and confidential information or email accounts were accessible

Table 3 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible where there is evidence and knowledge to determine the frequency.

The probability score can be used appropriately where there is not current evidence or knowledge to support the assessment likelihood.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen?	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	< 5% 1 in 100,000 chance	6-20% 1 in 10,000 chance	21-50% 1 in 1000 chance	50-80% 1 in 100 chance	>81% 1 in 10 chance
	This will probably never happen/recur Will only occur in exceptional circumstances	Unlikely to occur Do not expect it to happen/recur but it is possible it may do so	Reasonable chance of occurring Might happen or recur occasionally	Likely to occur Will probably happen/recur but it is not a persisting issue	More likely to occur than not Will undoubtedly happen/recur, possibly frequently

APPENDIX 6

Risk Treatment Plan - Template

KEY: RAG RATING
RED = Not completed by due date
AMBER = On-target for completion
GREEN = Completed

Risk ID No:	**Risk Description:**						
Current Controls:							
Risk Owner:		**Team/Department &/or Directorate:**					
Actions	**Action Lead**	**Estimated Costs**	**Completion Due Date**	**Date Completed**	**Group/Committee Monitored by**	**RAG Rating (& Progress note)**	

APPENDIX 7

YORKSHIRE AMBULANCE SERVICE NHS TRUST

RISK AND ASSURANCE GROUP

TERMS OF REFERENCE

1. Constitution

The Risk and Assurance Group (hereinafter referred to as the group) is a non-executive group of Yorkshire Ambulance Service NHS Trust (hereinafter referred to as the Trust), and has no executive powers. The Risk & Assurance Group reports to the Senior Management Group and advises the Trust Executive Group and Quality Committee on any risk management issues.

2. Purpose

The group is established to advise on all significant risk arising from all activities within the Trust.

The group will monitor the risk, control and assurance processes established in the Trust. It will review them and report on any weaknesses identified to ensure that the Trust has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and Board Assurance Framework (BAF).

3. Functions

- To coordinate all clinical and non-clinical risk management issues affecting the Trust, making recommendations to, and advising the Senior Management Group, the Trust Executive Group, Quality Committee and Trust Board accordingly.

- The detailed review of financial and other specific risks is undertaken by the relevant expert committee or group, with advice communicated to the Risk & Assurance Group to support its overall co-ordinating role.

- To ensure that the risk management activities of the Trust are measured against the requirements of the NHSLA Risk Management Standards for Ambulance Trusts, the Care Quality Commission regulations, the Audit Commission assessment framework and other internal and external audit requirements.

- To ensure that there is an effective Risk Management and Assurance Strategy and supporting procedural documents.

- To review, update and monitor the Corporate Risk Register (CRR) and maintain clear links with the Board Assurance Framework (BAF).

- To monitor and progress identified actions and non-compliance from CRR and local risk register treatment plans

- To determine the escalation and de-escalation of risks from/to the CRR to ensure significant risks are appropriately prioritised.

- To scrutinize the structure and management of directorate and local/subject specific risk registers, and to monitor progress against their risk treatment plans.

- Group members (risk leads) to scrutinize the structure and management of risk registers within their local management area and/or representative forums.

- Each group member is required to report verbally at each monthly meeting with progress on CRR risk treatment plans.

- To receive members reports from each local management area and/or Trust group/subject specific forum on a quarterly basis, highlighting progress on risks and areas of concern, by exception. The Group will scrutinize the reports and make suggestions for action accordingly

- To receive activity reports from the Compliance Assurance Group (CAG), highlighting progress and risks by exception. The Group will discuss and make suggestions for action accordingly.

- Risk leads to escalate proposed extreme risks for consideration and/or addition to the CRR using risk register assessment forms.

- To complete an annual self-assessment process relating to the effectiveness of the group.

- To undertake any other activities as directed by the Quality Committee and/or Trust committee/group.

4. Membership

4.1 The group shall be appointed to comprise of the following risk leads:

Individual membership;-

- Executive Director of Standards and Compliance (Chair)
- Associate Director Risk and Safety (Deputy Chair)
- Risk Manager
- Health & Safety Manager
- Associate Director Business Development
- Information Governance Manager

Directorate representatives from;-

- Operations Directorate
- Workforce and Strategy Directorate
- Finance and Performance Directorate
- Corporate Affairs and Trust Secretary (including FT programme)

Committee/Group representatives from;-

- Health & Safety Committee
- Clinical Governance Group
- Workforce Governance Group

4.2 Nominated deputies will attend in the absence of a Group member. The following post holders will act as specifically nominated deputies for the relevant group members:

- Associate Director Risk and Safety for Director of Standards and Compliance
- Risk Manager for Associate Director Risk and Safety

5. Attendance

Members should endeavour to attend all Group meetings and are expected, as a minimum, to personally attend 75% of meetings per calendar year.

6. Quorum

A minimum of seven members or their specifically nominated deputies are required before any business of the Group can be transacted. (This number can be less, at the discretion of the Chair, in exceptional extenuating circumstances.)

7. Frequency of Meetings

The Group will meet on a monthly basis.

8. Meeting Arrangements

8.1 All meetings will be planned prior to each calendar year providing all members with a minimum of three months notice of the meeting dates and times.

8.2 Members will be notified of the meeting venues when the dates of the meeting are published.

8.3 The agenda for each meeting will be distributed to the members no later than three working days prior to the meeting.

8.4 Members wishing to include items on the agenda in addition to the standing agenda items must notify the Chair in writing no later than seven working days prior to the meeting.

9. Meeting Minutes

The minutes and actions from meetings shall be formally recorded by administration support. The minutes and actions will be distributed to all members of the Group within five working days following each meeting.

10. Reporting Arrangements

10.1 The Deputy Chair of the Group will produce a written report for the Chair to present to the Quality Committee, Trust Executive Group and Senior Management Group.

10.2 Following each meeting, minutes will be shared with other groups/committees for information.

10.4 The Group shall receive written member reports (using the template provided in Attachment A) from each local management area and/or representative committee/group on a quarterly basis. Verbal reports/updates from members will be expected at each other monthly meeting.

10.5 The Group shall receive activity reports from the Compliance Assurance Group (CAG),

11. Monitoring

The functions of the group will be subject to an annual audit. The audit template is attached to the terms of reference at attachment B.

The Associate Director of Risk and Safety will be responsible for collating the findings from the audit and ensuring that an audit report is completed and submitted to the Quality Committee in time for its first meeting of the financial year.

The Quality Committee will review the findings from the audit report and inform the chair of the Risk and Assurance Group of any remedial action required to address any identified deficiencies. Any identified deficiencies and remedial actions will be noted in the minutes of the Quality Committee following each meeting.

The attendance levels of members of the Risk & Assurance Group will be monitored by the Chair of the Group at each meeting. A systematic grid will be provided on the minutes of each previous meeting to assist the Chair in this task.

Any identified deficiencies in the standard for attendance will be noted in the minutes of each meeting, along with remedial actions.

Attachment A (in association with Appendix 7)

Risk & Assurance Group
Members Report

Business Area	
Date	
Author	

1. Directorate Risk Register A brief summary describing the current status of the directorate risk register. The focus should be on providing a summary of the type, number and levels of risk contained on the risk register.
2. Progress against risk treatment plans An overview of progress against risk treatment plans. Specific details should be provided against those actions for which there are potential delays or difficulties in implementation.
3. Risk review Details should be provided of the review of risks contained within directorate risk registers, in accordance with the time frames specified within the Risk Management and Assurance Strategy. A brief summary should also be provided of the findings from this review.
4. Emerging themes and trends From the risk review process, provide details of any emerging themes and trends.
5. Proposed additions to Corporate Risk Register Risks that have been rated as *extreme* that are put before the R&A Group to be considered for addition to the Corporate Risk Register.
6. Any other issues requiring R&A Group discussion Issues from previous sections needing a more detailed consideration by SMG, including any policies requiring review. This might refer to more detailed paper to be presented separately in current meeting.
7. Recommendations Recommendations to R&A Group concerning any assurances received or required.

Attachment B (in association with Appendix 7)

RISK & ASSURANCE GROUP
MONITORING COMPLIANCE – SELF ASSESSMENT AUDIT TEMPLATE

Function	Yes	No	Partial	Comments
Has the Deputy chair undertaken an annual self assessment audit of the Group's effectiveness and subsequently reviewed its terms of reference (ToR) to assess that they are adequately and realistically defined to the Group's role?				
Have members attended within required frequency?				
Has the Group met on a monthly basis?				
Has the Group received reports written reports quarterly and verbal reports monthly from the members, as indicated in the ToR?				
Has the Group received monthly activity reports from the Compliance Assurance Group?				
Has the Group discussed the content of the reports it receives to ensure its member's responsibilities are effectively discharged?				
Has the Group received minutes from all other level 3 committees, at each meeting?				
Has the Group distributed minutes from to other level 3 committee following each meeting?				
Has the Deputy Chair of the Group produced a written report for the Chair to present to the relevant committee/group (SMG), as indicated in the ToR?				
Has the Corporate Risk Register been reviewed at each meeting?				
Has the Board Assurance Framework been discussed at each meeting?				
Have links been made and kept up to date between the BAF and CRR?				
Has the Group monitored the progress of actions identified from each meeting?				
Has the group reviewed the effectiveness of the Risk Management & Assurance Strategy and other procedural documents, as required?				
Have risk register assessment forms been completed and submitted by members of the group, as appropriate?				
Have members been notified of meeting dates/times/venues a minimum of three months in advance?				
Have members received agenda no later than three working days prior to meetings?				
Have the minutes been distributed with the group within 5 days after the meeting?				
Have the minutes been shared with other Committees/Groups form information, as requested or deemed appropriate?				

Yorkshire Ambulance Service NHS
NHS Trust
An Aspirant Foundation Trust

APPENDIX 8

Risk Register Process

STAFF

Ongoing risk assessment, including reviews of: service developments incidents, claims, complaints, audits; national and local targets; business cases; external reviews

Risk identified by staff

Examples of risk issues found in Appendix 1 of Risk Escalation and Reporting Procedure

Discussion & agreement through:
- Team/business area
- Directorate meetings/committee/group

Template found in Appendix 4 of Risk Escalation and Reporting Procedure

Has this risk already been identified?

Complete risk register assessment form

Email Risk Register Assessment Form to riskandassuranceteam@yas.nhs.uk

Assessment of Risk

Is the risk transferable?

Establish the 'Risk Owner'

Communicate with other departments as required

Add to Local Risk Register

APPENDIX 9

MANAGEMENT

Escalation of Risk

Risk score 1-3

Risk score 4-6

Risk score 8-12

Risk score 15-25

If consequence scores 4 or 5 alone, consider following 15-25 score route

Determine Risk Treatment Plan

Risk managed by local management/Trust group

Risk reviewed by directorate management/group/ committee

Risk considered for addition to Corporate Risk Register and reviewed by:
- Risk & Assurance Group
- Trust Executive Group

Annual Review/ Monitoring

Six Monthly Review/ Monitoring

Quarterly Review/ Monitoring

Monthly Review/ Monitoring

GLOSSARY OF TERMS USED/DEFINITIONS OF RISK

Board Assurance Framework
The Board Assurance Framework (BAF) details the principle risks to delivering the Trust's strategic objectives. Its purpose is to help the Trust Board and Executive Team focus on and manage the risks to meeting these. The AF maps the risks to the controls (i.e. actions that manage and mitigate the risks) and to the assurances (i.e. systems, which inform the Board on how effective the controls are)

Consequence
Outcome or impact of an event

Control
An existing process, policy, device, practice or other action that acts to minimize negative risk or enhance positive opportunities

Control Assessment
A systematic review of processes to ensure that controls are still effective and appropriate

Event
Occurrence of a particular set of circumstances

Frequency
A measure of the number of occurrences per unit of time

Hazard
A source of potential harm

Likelihood
Used as a general description of probability or frequency

Loss
Any negative consequence or adverse effect, financial or otherwise

Monitor
To check, supervise, observe critically or measure the progress of an activity, action or system on a regular basis in order to identify change from the performance level required or expected

Risk
The chance of something happening that will have an impact on objectives

Residual Risk
The risk remaining after implementation of risk treatment plans

Risk Analysis
A systematic process to understand the nature of and to deduce the level of risk

Risk appetite
Risk appetite is the degree of risk exposure, or potential adverse impact from an event, that the Trust is willing to accept in pursuit of its objectives. It is recognised that the pursuit of one objective may hinder the achievement of another. Similarly, the relative importance of one objective against another may be influenced by external factors, such as changes in national policy or expectations of stakeholders.

In order to value and compare the relative merits and weaknesses of different risks, the Trust Board will determine the level of risk the organisation is willing to tolerate in different areas. Operating within risk tolerances provides the Trust Board with greater assurance that the organisation will remain within its risk appetite and, as a result, achieve its objectives

Risk Assessment
The overall process of risk identification, risk analysis and risk evaluation

Risk Avoidance
A decision not to become involved in, or to withdraw from, a risk situation

Risk Identification
The process of determining what, where, when, why and how something could happen

Risk Management
The culture, processes and structures that are directed towards realizing potential opportunities whilst managing adverse effects

Risk Management Process
The systematic application of management policies, procedures and practices to the tasks of communicating, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk

Risk Matrix
The mechanism through which all risks are rated and scored consistently

Risk Reduction
Actions taken to lessen the likelihood, negative consequences, or both, associated with a risk

Risk Register
A record of identified risks at both local and corporate levels of the Trust, indicating their source, initial and residual risk rating, controls, risk treatment plans and details of review

Risk Retention
Acceptance of the burden of loss, or benefit of gain, from a particular risk

Risk Treatment
The process of selection and implementation of measures to modify risk

Significant Risk
Significant risks are those which have a risk severity score of 15 or above. These risks will be documented on the corporate risk register, validated and managed via the Risk and Assurance Committee and the Integrated Governance Committee.

Stakeholders
Those people and organisations who may affect, be affected by, or perceive themselves to be affected by a decision, activity or risk.

APPENDIX 10
(Please note: this template is also available in Excel format)

Template - Risk Register

Yorkshire Ambulance Service NHS Trust
Risk Register

Please state Directorate/Department:.....

Risk ID	CRR Ref	Risk Source & Date Added	Directorate / Committee	Dept / Team/ Workstream	Risk Description	Risk Controls in Place	C	L	Risk Score	Risk Treatment Plan	Risk Owner	Comp date	C	L	Resi Risk S
												Appendix 7			