Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	9
Date of Meeting:	25 November 2020		

Title of Report:	Board Assurance Framework 2020/21
Status:	For Discussion
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Appendices	Appendix 1: BAF 2020/21 v10.6

1. Report

The Board Assurance Framework (BAF) is a key mechanism for ensuring that the Board is able to monitor those risks that could prevent the Trust from achieving its objectives.

This is the Board's fifth view of the 2020/21 BAF which is attached at Appendix A. Following the discussion at the October meeting, the following changes have been made to the Framework:

- The description of BAF 3 has been updated to include reference to the need to ensure compliance with PHE guidance around COVID-19. Various sources of control and assurance have also been added as well as actions to fill identified gaps.
- BAF 8 has been updated to include information around complaints handling and trend analysis as a source of assurance.
- The whole framework has been updated to ensure that key dates are added to each risk, and that the change box reflects that this is assessed quarterly and not monthly.

The Clinical Governance Committee met on 11 November, and spent a significant amount of time reviewing both their allocated risks and the others on the framework that impacted on their work. It has not yet been possible to put into effect all of the changes and adjustments arising from that review, but one of the key highlights was a proposal to increase the rating of BAF 4 (failure to manage the pressures of COVID-19) from (5x3=15) to (5x4=20). The Committee were of the view that although it was clear that the Trust is fully focused on managing this risk, the indications are that the likelihood of the Trust having difficulty in managing the pressures of this second wave of the outbreak is higher than it was a few months ago. The full outcomes of the Committee's review will be reflected in next month's update to the Board.

2. Recommendations

The Board of Directors is asked to review the Board Assurance Framework and:

- Agree that the rating for BAF 4 be increased from (5x3=15) to (5x4=20);
- Confirm the risk descriptions;
- Provide any comment or feedback on the controls, assurances, and suggestions on gaps and actions;
- Identify any gaps where additional risks may need to be added to the BAF.

3. Legal / Regulatory Implications

The Board of Directors is required to have a Board Assurance Framework in place for

the year. In addition the Board Assurance Framework is one of the key sources of evidence to support the preparation of the Annual Governance Statement.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Board of Directors requires assurance that the Trust's priority objectives will be delivered, and must have regard to the key risks which may impact on this delivery. The Board Assurance Framework is the mechanism for monitoring the effectiveness of the controls that are in place to manage or mitigate these risks.	

5.	Resources Implications (Financial / staffing)
The production and maintenance of the Board Assurance Framework is the responsibility of the Head of Corporate Governance in conjunction with the relevant Executive Directors of the Trust.	

6.	Equality and Diversity
No issues have been identified in this report.	

7.	References to previous reports
This paper should be read in conjunction with the Strategic Framework for Risk Management, and quarterly update reports are presented to the Board.	

8.	Freedom of Information
Public.	

Royal United Hospitals Bath
NHS Foundation Trust

BAF 1	
Strategic objective	• Recognised as a listening organisation, patient centred and compassionate • Meet the individual needs of patients and carers, through high quality treatment and care throughout the patient journey: putting the patient at the heart of all we do. • Quality improvement and innovation each and every day
Risk	**If the Trust fails to capture or respond to patient experience feedback and learn from complaints, claims, incidents and inquests, it may result in avoidable patient harm, decrease in patient safety and outcomes, and a decrease in patient confidence in the Trust's services, further leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.** **The COVID-19 pandemic has limited patient choice and detrimentally affected the patient experience**

Trust Values	Making a Difference	Lead Executive(s)	Medical Director and Director of Nursing & Midwifery
Latest Review Date	18 November 2020	Board Monitoring Committee	Clinical Governance Committee

Risk Rating	Date	Consequence	Likelihood	Score	Change since last Quarter	Related BAF & Corporate Risk Register Entries		
Initial	30/04	4	4	16		ID	Score	Summary Risk Description
Current	01/09	4	3	12				
Target		4	1	4				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*	
	8	12			

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
Ward accreditation Programme and Ward Triangulation Table. Patient & Carers Experience Group	**Internal assurances:** Quarterly patient experience report to Quality Board, including data on complaints handling and trend analysis.	

Complaints and PALS systems and processes including monitoring themes. Duty of Candour processes and compliance monitored Being Open Policy. Internal Audit process. Participation in eQuest patient surveys. Participation in national patient surveys. Monthly Quality Board meeting.	Quarterly Incidents, Claims and Inquests reports and Learning from Deaths to CGC and Board of Directors. Improvement plans following national patient surveys. Patient Stories at Board of Directors meetings and made available on intranet for staff. Delegation of any concerns by Board of Directors to Clinical Governance Committee. In addition, the Clinical Governance Committee has its own assurance workplan to which it adds items on a quarterly basis. Lead for Claims, Inquests and Risk meets regularly with Divisions to share learning. Improving Together has a breakthrough objective to improve patient safety. The driver metrics associated with this are to increase awareness of harm events as demonstrated by increased datix reporting, and the number of safety-related improvements implemented will also be tracked. Review of the patient safety priorities and Quality Account priorities by the Council of Governors' Quality Working Group. Executive 'Go and See Walks'. **External assurances:** Monthly Friends and Family Scores. Annual CQC Picker Results (national patient surveys). Council of Governors – feedback from members and the public. KPMG internal audit review of Duty of Candour gave significant assurance. An action plan has been developed and is being delivered. CQC liaison meetings with core services. Health Watch feedback and commissioned work	

	Programme of regular CQC liaison meetings and core service liaison meetings	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
	Embedding learning from serious incidents	Serious Incident Panel in the process of being set up as a sub-group of the refreshed Quality Board to oversee investigations and learning from incident and Duty of Candour breaches Implementing actions arising from the Serious Incident internal audit review – on the work plan	July 2020 Sept 2020	Achieved Achieved
Hiatus in CCG quality assurance work since the BSW merger		Director of Nursing and Midwifery to engage with BSW CCG – *collaborative working among the 3 local acutes is being developed. The DoNM is now a member of the BSW Quality Surveillance Group. The Quality Contract and Schedule is being reviewed.*	Mar 2021	Ongoing
	Feedback from friends and family	A new process for obtaining feedback from friends and family is to take effect from 1 July 2020. This will ask questions about patients' overall experience and others that are linked to True North measures – *The A3 around being a listening organisation is being reviewed*	Feb 2021	
Unable to properly understand patient and carers' experience		The work of the Patient and Carers' Experience Group is under review as to whether a different approach ought to be taken. The aim is to make the Group more dynamic and representative Option to run See It My Way sessions virtually is being explored A Volunteer Strategy is under development	Dec 2020	

BAF 2	
Strategic objective	• Be an outstanding place to work where staff can flourish • Be a flexible and dynamic employer of choice, providing rewarding careers, staff support, clear and open communications and compassionate leadership
Risk	**If shortages in the supply of registered nurses, doctors and other healthcare professionals impacts on the Trust's ability to fill vacancies, it will affect the provision of consistently safe and high quality care, workload, staff morale and resilience. This will impact on the Trust's status as an employer of choice in the local area, further reducing the ability to recruit and retain staff, and further impacting on patient care and experience.** **Although the Trust has been successful in reducing the current numbers of unfilled vacancies, concerns remain about the sustainability of the measures that have been taken to achieve this.**

Trust Values	Everyone Matters	Lead Executive(s)	Director for People
Latest Review Date	1 October 2020	Board Monitoring Committee	People Committee

Risk Rating	Date	Consequence	Likelihood	Score	Change since last Quarter	Related BAF & Corporate Risk Register Entries		
Initial	30/4	4	4	16	⟷	ID	Score	Summary Risk Description
Current	01/09	4	2	8				
Target		4	2	8				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*
	8	8		

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
Improving Together Programme – investment in staff. Trust Membership of QUEST Investment in staff engagement and team development N&MW Strategy 2017 - 2020 Medical, N&M, AHP and scientific workforce Planning Groups N&M Recruitment & Retention Group and action plan	**Internal Assurance** Workforce Reports and risks to Strategic Workforce Committee Monthly Workforce Metrics Reports to Management Board and Board of Directors Stress Audits EAP monthly reports	

Ongoing international recruitment programme Trust and Divisional workforce plans Talent management and succession planning programme. Leadership Strategy Preceptorship Policy for Nurses, Midwives and AHPs Health and Wellbeing Strategy Values embedded Trust objectives, appraisal process and recruitment Agency controls and rota support Neutral vendor contract in place for nurse agency (with Bristol Trusts) Electronic staffing dashboard Implementation of Allocate rostering system HEE CPD funding – every nurse, midwife and AHP receives £1000 and a plan is developed for how this will be used Recruitment and retention of nursing staff is a Breakthrough Objective Freedom to Speak Up agenda	People Committee review and challenge Director ward/department 'Go and See Walks' 'Go Engage' quarterly survey results Health & wellbeing Activities monitored via H&W steering group Monthly monitoring of staff survey actions at Strategic Workforce Committee N&M Recruitment & Retention Plan reviewed at monthly N&M Workforce Planning Group Analysis of trends emerging from Freedom to Speak Up disclosures **External Assurance** Annual Staff Survey Results Annual Patient Survey Results Friends and Family Test results E&Y Well-Led assessment in 2018	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
No current approved Leadership Strategy		Leadership Strategy is in development		
	Vacancies in key roles (e.g Associate Director of Organisational and People Development	Post to be advertised in September	Dec 2020	
Resourcing of BSW strategic workforce planner		Due for recruitment in September	Dec 2020	
Effectiveness of BSW Local Workforce Action Board		Clear structure and position now in place with scope for further development in the future	Dec 2020	
Effective and responsive rostering system		Roll out of the Allocate system has been delayed as a result of the COVID-19 pandemic	Mar 2021	

BAF 3	
Strategic objective	• Continue to place patient safety and quality improvement at the heart of all we do. • Meet individual needs of patients and carers, through high quality treatment and care throughout the patient journey: putting the patient at the heart of what we do. • Quality improvement and innovation each and every day.
Risk	**If the Trust fails to maintain clinical standards, through inadequate clinical practice, failures of governance, or lack of effective compliance with Public Health England COVID-19 IPC guidance, this may result in avoidable patient harm and a deterioration in patient safety and outcomes, failure to comply with regulatory standards, and could lead to regulatory intervention, adverse publicity, reputational damage, and loss of confidence by patients and the local community.** **The COVID-19 pandemic has brought about delays in access to diagnoses and pathways, and as a result, long waiting lists**

Trust Values	Making a Difference	Lead Executive(s)	Medical Director and Director of Nursing & Midwifery
Latest Review Date	18 November 2020	Board Monitoring Committee	Clinical Governance Committee

Risk Rating	Date	Consequence	Likelihood	Score	Change since last Quarter	Related BAF & Corporate Risk Register Entries		
Initial	30/04	4	5	20		ID	Score	Summary Risk Description
Current	01/09	4	3	12				
Target		4	1	4				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*	
	8	12			

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
Ward accreditation Programme	**Internal assurances:**	

Nursing and Midwifery peer audit programme. Monitoring through Action Groups: Dignity and Privacy, Nutrition and Hydration. Ward Quality Dashboard and performance framework (including escalation). CQC Insight data. Duty of Candour processes and compliance monitored via Management Board. Clinical Outcomes Group meetings. Morbidity and Mortality Group meetings. Clinical Governance Committee meetings. Monthly Executive Performance Review meetings with Divisions. Bi-monthly Mortality Review Group – the Lead for Claims and Inquests now coordinates a review of mortality data, Learning from Deaths, inquests and complaints in order that the information is held centrally and enables the identification of trends for learning and improving care Deteriorating Patient Steering Group – this is to be subsumed within a wider Patient Safety Committee. This new committee will streamline the work that takes place in relation to falls and pressure ulcers Infection, Prevention and Control metrics presented quarterly to Board of Directors within Quality paper. Mortality Review Group Patient Safety Driver metrics on divisional scorecard	Reports on elements of Safety and Quality to Management Board, Quality Board, Board of Directors and Clinical Governance Committee. Discussion at Monthly Executive Performance Review meetings with Divisions. Triangulation of Executive 'Go and See Walks' via Executive Huddle Meetings. Self-assessment of the core services against the CQC's domains undertaken. Core service leads in depth review and challenge through divisional performance meetings, Quality Board and by Executive leads (including review of evidence and performance data). Nursing Intensive Support Clinical Review process in place – reporting to Divisional performance meetings. Ward and Outpatient accreditation programme developed aligned to the CQC standards and continuous improvement and monitoring system. Ward staffing reviews now revised and in place. Never events reviewed via CGC Learning from Deaths reviewed quarterly by Board of Directors. Detailed guidance on the use of PPE set out on the Trust intranet **External assurances:** Regular review of Dr Foster data. Outcome of commissioner visits to clinical areas and reports of the visits. External Agency Visits Feedback from patient experience. Outcomes and feedback from bi-monthly meeting of the CCGs' Clinical Outcomes and Quality Assurance Committee which reviews and monitors all elements of the quality contract.	

Quarterly patient safety summits are to be held with a view to identifying areas of concern and learning from investigations. This will be driven by the work of the Patient Safety Committee IPC Reference Group set up Specific Outbreak Policy implemented	Outcomes of reviews by peers or regulators; eg; CQC IRMER inspection, NHSE review of chemotherapy services, NHSI IP&C review, PH peer review etc. Review of progress in addressing recommendations from 2018 CQC inspection. CQC liaison meetings with core services. Internal Auditor review of CQC action plan given significant assurance Self-assessment completed against NHSE/I IPC BAF	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
	Consistent use of Improving Together to help drive improvements in clinical standards	Embedding the use of driver and tracker metrics into the monthly executive performance review meetings with the divisions	Dec 2020	
Implementation of a Quality Strategy		To be launched in the autumn and overseen by Quality Board – *this is to be merged with the Patient Safety Strategy. A separate Nursing and Midwifery Strategy is to be launched in January 2021. – on target*	Sept 2020	Ongoing
	Ability for staff to raise concerns about poor clinical standards	Monthly meetings with the Freedom to Speak Up Guardian to continue – *in place* Steps to be taken to ensure that more junior staff (bands 2 and 3) are able to raise concerns	Sept 2020	Ongoing
	Medicines Management	The Chief Pharmacist now routinely attends Quality Board and Management Board. Medicines Management is to be reviewed by Internal Audit.	Dec 2020	
	Audit of effectiveness of COVID related measures (PPE, social distancing etc)	Audits instigated and being carried out by divisional Heads of Nursing	Jan 2021	Ongoing
Implementation of National Patient Safety Strategy		• Setting up Patient Safety Steering Group • Reviewing the model for Patient Safety Specialists	Jan 21 Apr 21	

BAF 4	Recognised as a listening organisation, patient centred and compassionate
Strategic objective	
Risk	**If the Trust fails to effectively manage the pressures of the COVID-19 outbreak for both patients and staff directly infected, it will fail to maintain safe levels of care and treatment. The Trust will also not be able to offer urgent clinical care for patients not infected with Coronavirus as capacity and staffing levels will not support safe delivery of care.** **There is a secondary risk related to public confidence in accessing healthcare providers which may result in patients not seeking help in an emergency in both primary and secondary care. This may result in patients presenting t the Trust late and with advanced symptoms.** **There is also the risk that the Trust will fail to effectively manage the transition back to the wider range of clinical activity, with the result that services are unable to cope with demand, patient safety is compromised and staff morale is affected.**

Trust Values	• Everyone matters • Making a difference • Working together	Lead Executive(s)	Chief Operating Officer
Latest Review Date	10 November 2020	Board Monitoring Committee	Clinical Governance Committee

Risk Rating	Date	Impact	Likelihood	Score	Change since last Quarter	Related BAF & Corporate Risk Register Entries		
Initial	30/04	5	4	20		ID	Score	Summary Risk Description
Current	10/11	5	4	20				
Target		5	2	10				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*	
	15	15			

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
• Following daily and weekly guidance provided by national bodies including Public Health England, Department of Health and NHSI/E	• Daily tracking of agreed performance metrics • Assessment against Project plan to increase capacity within the organisation and the wider community (beds, staff & equipment)	

• Gold, Silver and Bronze Command structure that is responsible for the strategic, tactical and day to day management of the response to the outbreak (in line with Major incident response) • Executive team oversight of the response and challenge provided to the actions that are being taken • Full Board of Director oversight • BSW system response and engagement with regional critical care network • Clinical Pathway group supporting COVID and non-COVID activity pathways	• Gold action log and risk register • Regular bed and resources modelling to ensure capacity and/or resources to support clinical services • Specific PPE tracking via Gold to ensure 72+ hour provision in all PPE supply lines.	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
Ability to accurately forecast national and local modelling impact		Local modelling of impact and daily monitoring of actual performance The Trust has set its own assumptions	Ongoing	
Effective risk management with regard to certain classes of staff including those from a BAME background (see BAF 13)		Provision of holistic support from team and divisional level up, including via Occupational Health Shielding staff have returned to work	Ongoing	
Pressure on resources as a result of restart		Active consultation with divisions and services in terms of PPE requirement, bed numbers, staffing and social distancing requirements	Ongoing	
The pandemic has significantly limited space at the hospital – beds, clinical space, clinical waiting rooms, diagnostic areas and office space – in order to minimise contact risk and support infection control		Different ways of working are being implemented – virtual working, virtual outpatients. What services can be moved off-site?	Ongoing	
A significant waiting list backlog has developed – it is estimated that it will take 2 years to fix. The number of patients waiting 52 weeks		Use of independent sector facilities to continue– available at least until the end of March 2021 Phase 3 structure is being revised, with a focus on electives, non-electives and winter planning	Ongoing	

or more for elective care has risen sharply				
System level response		Creation of Urgent Care Flow Board Encouraging patients to think of 111 first; considering booking arrangements for 'minors' at ED Consideration of the role of GPs Capital – 'Rapid improvement events' (hackathons) held to identify urgent needs (diagnostics for RUH) and provide funding Shared learning across the region Re-establishment of Clinical Cabinet Escalation triggers in place in the event of a spike in cases	Ongoing	
Winter – potential for a combination of flu, COVID and Diarrhoea and vomiting				

BAF 5	
Strategic objective	Review, challenge and support the actions we take to improve our performance against national standards; with regard to equality and diversity, and in response to research, evidence and best practice
Risk	**If the Trust fails to meet the NHS Constitutional targets (RTT 18 weeks, diagnostic 6 weeks, A&E 4 hours and cancer waits), patients will experience poor quality of care and potentially adverse outcomes, the Trust's reputation with its regulators, commissioners, patients and the local community will deteriorate, and the Trust could be subject to regulatory intervention. This would also affect morale among staff and potentially make the trust a less favourable place to work.** **Impact of Covid-19 Incident Response – as a result of the Covid-19 pandemic, there has been a reduction in patients accessing healthcare coupled with a need to postpone many routine activities in response to the Covid demand on services. This has resulted in a reverse of impacts on our national standards. A&E 4 hour performance has improved during the pandemic whilst a negative impact on RTT, diagnostic and cancer pathways has been seen.**

Trust Values	Making a Difference	**Lead Executive(s)**	Chief Operating Officer
Latest Review Date	11 November 2020	**Board Monitoring Committee**	Clinical Governance Committee

Risk Rating	**Date**	**Consequence**	**Likelihood**	**Score**	**Change since last Quarter**	**Related BAF & Corporate Risk Register Entries**		
Initial	30/04	4	5	20		**ID**	**Score**	**Summary Risk Description**
Current	30/09	4	5	20				
Target		4	3	12				
Risk Appetite								

Risk Score	**Q1** *(Apr May Jun)*	**Q2** *(Jul Aug Sept)*	**Q3** *(Oct Nov Dec)*	**Q4** *(Jan Feb Mar)*	
	16	20			

Key Controls *(what are we doing about the current risk?)*	**Assurance on Controls** *(How do we know if the things we are doing are having an impact?)*	**Level/ Change**
Detailed challenge and support at Management Board	**Internal:** CGC assurance of processes surrounding key risks and issues Detailed operational performance report to Board	

Regular oversight from Board of Directors and at Clinical Governance Committee Ongoing internal delays review in relation to DTOCs Divisional performance reviews Phase 2 COVID Response Programme Board and sub-group structure	Board level debate of key risks and issues Internal audit reports **External** NHSI Single Oversight Framework rating CQC Insights Report	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
Ability to maximise site capacity to manage increased demand for elective care – social distancing impact and site layout		Assessing options of environmental enhancements to increase ward and outpatient waiting room capacity Working with Independent Sector partners to maximise use of IS capacity	July 2020 Q3/4 20/21	Ongoing
	Unknown unmet need for healthcare as patients have not accessed primary and secondary care due to the perceived risk of Covid-19	Liaising with GP colleagues to look at different ways of supporting patient needs and building patient confidence National communication plan Local communication plan	Ongoing	

BAF 6	
Strategic objective	• Be an environmentally sustainable organisation that is fit for the future • Reduce our environmental impact by reducing our carbon emissions and our carbon footprint • To become carbon neutral by 2050 in line with the climate change act (2008) • To implement and maintain an RUH strategic vision for sustainability
Risk	**As a major organisation in B&NES and (the NHS) being a major contributor to UK carbon emissions, failing to enable an appropriate strategy and outcomes for year on year reduction in the RUH environmental impact and carbon emissions will lead to a failure to meet the 2050 carbon neutral target. It may also result in future regulatory intervention and a decrease in staff and public confidence leading to adverse publicity that damages the Trusts' reputation.** **The Trust's target is now to become carbon neutral by 2030, which will be more difficult to achieve**

Trust Values	• Everyone matters • Making a difference • Working together	Lead Executive(s)	Director of Estates and Facilities
Latest Review Date	1 September 2020	Board Monitoring Committee	Non-Clinical Governance Committee

Risk Rating	Date	Impact	Likelihood	Score	Change since last Quarter	Related BAF & Corporate Risk Register Entries		
Initial	30/04	4	3	12		ID	Score	Summary Risk Description
Current	01/09	4	4	16				
Target		4	2	8				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*	
	12	16			

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
• Monthly, quarterly and annual review and reporting on energy and CO2 performance (elec, gas, fuel oil, waste, water) • Development of new 5 year sustainability plan (2020-2025) • Development of carbon reduction trajectory (to 2030)	**Internal Assurance** • Monthly E&F Divisional Board receives data on energy and CO2 performance and trend • Monthly E&F EPR receives data on energy and CO2 performance and trend	

• Annual collection and review of measured Scope 1 and Scope 2 emissions[1] • Adoption of the NHS Sustainable Development Unit tool for assessing and auditing our sustainability credentials[2] • Development of behavioural change program with support from University of Bath. • Move to 'green' energy supply contracts by April 2021	• Improving Together program includes carbon reduction (sustainability) as True North • Quarterly reporting of sustainability to NCGC and feedback • Feedback from NCGC • Annual update and review of SDAT scoring • RUH Water supply company (Water2business) are engaged to provide additional audits on water consumption, identifying peak usage (potential leaks) until April 2021. • Financial review/reporting via finance team on quarterly and annual utility expenditure. **External Assurance** • Annual ERIC submission to NHSi • Feedback from patients, governors and visitors on the steps that the Trust is taking to improve its environmental sustainability • Development of a carbon sequestration analysis to ascertain when the Trust needs to move from carbon reduction to offsetting	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
Inability to obtain sufficiently detailed measurement of energy use		Commissioning more sub-metering	Apr 2021	
Delivery of 5 year sustainability and carbon reduction targets		Implementation of Sustainable Development Management Plan	Mar 2021	
Implementation of behavioural change programme at divisional level				
Timeliness of move to 'green' energy supply contracts				

[1] Scope 1 emissions - **Direct Emissions** from the activities of an organisation or under their control. Including fuel combustion on site such as gas boilers, standby generators. Scope 2 emissions - **Indirect Emissions** from electricity purchased and used by the organisation.
[2] Sustainable Development Assessment Tool – SDAT

BAF 7	
Strategic objective	• Work together with our partners to strengthen our community • Work in partnership with organisations and groups to build joined-up holistic patient care for all communities in our healthcare region, including looking after population health • Share in the responsibilities of leadership in our healthcare economy and region, driving forward innovative and collaborative approaches to deliver healthcare improvements and efficiencies
Risk	**The Trust fails to deliver its financial target, and this leads to a loss of confidence in the Trust's ability to deliver without a higher level of central control, and could lead to regulatory intervention. Within the health economy, the pressures lead to difficult organisational relationships leading to problems in aligning strategic direction and creating an effective and cohesive health and social care system.** **There is a risk that the overall funding envelope for the system is insufficient for the 3 Acute Trusts**

Trust Values	• Everyone Matters • Working Together • Making a Difference	Lead Executive(s)	Director of Finance
Latest Review Date	2 September 2020	Board Monitoring Committee	Audit Committee

Risk Rating	Date	Consequence	Likelihood	Score	Change since last Quarter	Related BAF & Corporate Risk Register Entries		
Initial	30/04	4	3	12		ID	Score	Summary Risk Description
Current	02/09	4	4	16				
Target		4	2	8				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*	
	12	16			

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
Strategic Plan	**Internal Assurance:**	

Annual Business/Operational Plan Financial Plan and financial reporting Five Year Financial Strategy in place STP Financial Recovery Plan RUH Clinical Commissioning Reference Groups Terms of Reference Clinical Engagement Group CCG Engagement Meetings Stakeholder Engagement Plan PESTLE and SWOT Analysis Business Planning Process. RUH senior staff attendance at Clinical Senate and Clinical Network meetings. CCG QIPP working group Weekly BSW FD meetings Fortnightly Overview and Scrutiny meetings including FDs and COOs	Monthly Finance and Contract Monitoring Reports to Board of Directors and Management Board Monthly CQUIN Scorecard reports to Management Board and Quality Board Clinical Commissioning Reference Group. CCRG Sub-Group (Elective Demand Management Group) to review areas where demand is increasing. Contract Review Board meeting. Audit Committee **External Assurance:** Contracts agreed before the start of the financial year with the local Clinical Commissioning Groups Dr Foster data re market share Regular Executive-to-executive communications with BaNES CCG regarding system QIPP delivery STP engagement. Contract Review Board 1:1 between Trust and CCG Executives Full engagement in Sustainability and Transformation Partnership (STP) by Executives and Chair with monthly scheduled meetings of the STP Acute Alliance – greater focus on service transformation and it is gaining more traction	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
The divisions remain in crisis management mode, particularly in relation to capital expenditure		More peer review and external assurance required, including the different organisations within the system reviewing each other's plans	Ongoing	

Effectiveness of controls		Greater use of Internal Audit More triangulation of risk – to include workforce, operations, finance and safety		

BAF 8	
Strategic objective	• Work in partnership with organisations and groups to build joined-up holistic patient care for all communities in our healthcare region, including looking after population health • Share in the responsibilities of leadership in our healthcare economy and region, driving forward innovative and collaborative approaches to deliver healthcare improvements and efficiencies
Risk	**Demand for services across the BSW footprint is not matched by supply and/or the system is not adequately funded. The lack of capacity planning across the system, and the lack of community and social care capacity would have a knock on effect on patient flow.**

Trust Values	• Everyone Matters • Working Together • Making a Difference	Lead Executive(s)	Chief Operating Officer
Latest Review Date	2 September 2020	Board Monitoring Committee	Clinical Governance Committee/Non-Clinical Governance Committee

Risk Rating	Date	Consequence	Likelihood	Score	Change since last month	Related BAF & Corporate Risk Register Entries		
Initial	30/04	4	4	16	⟷	ID	Score	Summary Risk Description
Current	02/09	4	3	12				
Target		3	2	6				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*	
	12	12			

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
STP Engagement Sharing risk of discharge with commissioners Improving Together Programme and introduction of daily improvement huddle targeting whole hospital response Contracting/partnering with tertiary providers in Bristol and elsewhere A&E Delivery Board (AEDB) chaired BSW Chief Executive	System-wide A&E action plan regular review and challenge by NHSI/E Wiltshire Health & Care Board meetings (and BaNES equivalents) Emergency Care strategy via the UCCB. Winter Plan 19/20 supported by Clinical Cabinet – continuation of forum to support emergency care flows	

Partners in Wiltshire Health & Care Wiltshire Integrated Care Board BaNES Integrated Alliance Board Wiltshire delivery group – a system partner forum to drive transformation Business planning of demand and capacity at specialty level Locally developed performance trajectories against improvement plans Effective treatment and discharge planning at ward level Strategic goal set as strengthening partnerships across the wider system :True North with breakthrough objective ***Discharges before Midday*** A Memorandum of Understanding has been signed by the constituent organisations of the BSW ICS	Improving Together programme and roll out of A3 thinking for improvement plans and particularly UTC/Minors and ED 4hrs Local scorecards monitoring locally owned metrics connecting to the True North.	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
Insufficient funding to meet demand		Service transformation	Ongoing	
Alignment of priorities across BSW		Greater engagement and collaborative working	Ongoing	
Emergency pressures		Re-alignment of funding to address gaps in social and community care	Ongoing	

BAF 9	
Strategic objective	• Live our values, so every member of staff knows they matter and are making a difference • Share in the responsibilities of leadership in our healthcare economy and region, driving forward innovative and collaborative approaches to deliver healthcare improvements and efficiencies
Risk	**If the Trust is unable to maintain and develop leadership that can motivate and bring staff on the organisational development journey, this may lead to disengagement, and inconsistency in the adoption of the Trust's values and culture across the organisation, resulting in reduced staff morale and poorer patient outcomes.** **The Trust needs to take specific steps to increase the leadership opportunities for staff with protected characteristics, as illustrated in the Workforce Race and Disability Equality Standards**

Trust Values	• Everyone Matters • Working Together • Making a Difference	Lead Executive(s)	Chief Executive & Director for People
Latest Review Date	9 September 2020	Board Monitoring Committee	People Committee

Risk Rating	Date	Consequence	Likelihood	Score	Change since last Quarter	Related BAF & Corporate Risk Register Entries		
Initial	30/04	4	4	16		ID	Score	Summary Risk Description
Current	09/09	4	3	12				
Target		4	2	8				
Risk Appetite								

Risk Score	Q1 *(Apr May Jun)*	Q2 *(Jul Aug Sept)*	Q3 *(Oct Nov Dec)*	Q4 *(Jan Feb Mar)*	
	12	12			

Key Controls *(what are we doing about the current risk?)*	Assurance on Controls *(How do we know if the things we are doing are having an impact?)*	Level/ Change
Talent management and succession planning project	**Internal**	

Engagement with SW Leadership Academy Aspire Programme for 'ready now' directors Improving Together Programme (executive support workstream, management system training and capability building work stream) Diversity and Inclusion Strategy - recruitment Executive team development programme, extended to Management Board membership Board development programme Organisational values	Staff survey action plans monitored through Strategic Workforce Committee meetings Go Engage survey and team development toolkit Challenge and feedback through TCNC meetings Monitoring through Improving Together Programme Board People Committee **External** Well-Led assessment undertaken in 2018	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
The regional talent management programme has been paused		The regional talent management programme remains paused	Dec 2020	

BAF 11 **Strategic objective**	• Work in partnership with organisations and groups to build joined-up holistic patient care for all communities in our healthcare region, including looking after population health • Share in the responsibilities of leadership in our healthcare economy and region, driving forward innovative and collaborative approaches to deliver healthcare improvements and efficiencies
Risk **QI1**	**If the Trust fails to work effectively as part of the BaNES, Swindon and Wiltshire (BSW) Integrated Care System, the System will not be sustainable and neither the ICS nor the Trust will realise the quality, financial and operational improvement opportunities that would otherwise be available.**

Trust Values	Working Together	**Lead Executive(s)**	Chief Executive Officer
Latest Review Date	28 October 2020	**Board Monitoring Committee**	Board of Directors

Risk Rating	**Date**	**Consequence**	**Likelihood**	**Score**	**Change since last Quarter**	**Related BAF & Corporate Risk Register Entries**		
Initial	30/04	4	3	12		**ID**	**Score**	**Summary Risk Description**
Current	28/10	5	3	15				
Target		3	3	9				
Risk Appetite								

Risk Score	**Q1** *(Apr May Jun)*	**Q2** *(Jul Aug Sept)*	**Q3** *(Oct Nov Dec)*	**Q4** *(Jan Feb Mar)*	
	12	15			

Key Controls *(what are we doing about the current risk?)*	**Assurance on Controls** *(How do we know if the things we are doing are having an impact?)*	**Level/ Change**
Relationships: Urgent Care Board Elective Care Board Acute Hospitals Alliance	**Internal:** Stakeholder mapping and relationship audits STP and Integrated Care Development updates to Board Triangulation of STP, strategic and annual plans down to specialty level. Finance, Financial Risk and Performance Monitoring Reports to Board of Directors and Management Board	

Joint working initiatives e.g. FLOW discharge pathways, MDT care homes pilot, STP Acute Alliance, pathology hub and spoke governance discussions, Urgent Care Centre partnership, Integrated Care Alliance Joint forums e.g. STP, Clinical Commissioning Reference Groups, Commissioning College, Wiltshire Health and Care Partnership Board, A&E Delivery Board, Health and Wellbeing Boards, Somerset STP Acute Settings of Care and Clinical Forum, Local Health Economy Communications Group Associate Medical Director accountability for GP Engagement System-wide clinical charter and strategy Integrated Care Alliances with Wiltshire and BaNES **Planning:** Long term integrated planning across health community – STP framework and evolving Integrated Care Partnership and Alliances Research and Innovation Director role focused on partnerships and new development opportunities Improving Together infrastructure with a specific True North objective around partnership working, and subject to regular review Strong QIPP delivery framework and budget management processes Estates redevelopment programme focused on capacity management 3-5 year strategic planning process and regular review Population Health Group RUH membership of the Professional Leadership Network **Monitoring:** Performance and Contract Management Systems Regular Management Board and Board Meetings Clinically led, Service Line Management approach Reporting through Management Board and the Board of Directors around system development	Contract Review Board Board of Director Away Day agendas and annual Board review of strategy CoG strategy and outreach groups **External:** STP plan, clinical forum, risk assessment and financial model/monitoring WH&C performance reports to RUH board Direct contractual relationships and business plans with local system providers e.g. Virgin Care (e.g. Sexual Health Services); BEMS (e.g. Urgent Care Centre Tender); STP Acute Alliance; Wiltshire Health and Care NHS long term plan and funding arrangements/ assurances Memorandum of Understanding around joint waiting list management with GWH and SFT Active ICS application programme	

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
Lack of an appropriate statutory vehicle to take the ICS forward		Application has been submitted and is being considered		
Lack of a plan to address the gap in the ICS' finances		Development of the vision and narrative for the ICS. Ongoing work on the drivers of deficit		
Sustainability and quality of out of BSW area care				

Strategic objective	BAF 12
Risk **QI1**	**If there is a disorderly EU Exit that does not adequately plan for the needs of the health service, the Trust's ability to operate a full suite of services for patients may be affected, for example:** - **The availability of key resources, including certain medicines and medical consumables (such as radio-pharmacy isotopes, blood products etc.) may be affected;** - **There may be cost inflation for resources from the EU due to new tariffs or reduced availability (including additional inflation of capital costs);** - **Key support services such as radiology, nuclear medicine and pathology may be at risk due to the inability to access parts for equipment manufactured in the EU;** - **The Trust's capital plans may be put at risk due to contractors losing workforce or being unable to access supplies;** - **Wider system risks may occur that increase operational pressure on the Trust e.g. lack of care home staff resulting in care home closures;** - **Supplies to support the COVID-19 response, including PPE, may be affected;** - **Localised fuel shortages from panic buying may affect staff ability to attend work;** - **EU workforce retention and future recruitment of EU citizens may be affected by uncertainties and immigration rule changes;** **This would result in a reduced level of care for patients and potentially lead to patient harm and possible financial and reputational risk to the Trust.**

Trust Values	• Everyone Matters • Working Together • Making a Difference	**Lead Executive(s)**	Chief Operating Officer – SRO: Deputy Chief Executive
Latest Review Date	16 September 2020	**Board Monitoring Committee**	Audit Committee

Risk Rating	**Date**	**Consequence**	**Likelihood**	**Score**	**Change since last Quarter**	**Related BAF & Corporate Risk Register Entries**		
Initial	30/04	4	4	16		**ID**	**Score**	**Summary Risk Description**
Current	16/09	4	4	16				
Target		3	3	9				
Risk Appetite								

Risk Score	**Q1** *(Apr May Jun)*	**Q2** *(Jul Aug Sept)*	**Q3** *(Oct Nov Dec)*	**Q4** *(Jan Feb Mar)*

	16	16			
Key Controls *(what are we doing about the current risk?)*			**Assurance on Controls** *(How do we know if the things we are doing are having an impact?)*		**Level/ Change**
Expected external reporting to regional office on a range of government-led programmes to prepare for end of transition period. Regular internal reporting to Management Board led by the Interim COO			**Internal assurances:** EU exit Resilience Group, led by Resilience Manager Task & Finish Group to recommence meeting 24 September 2020 and 22 Oct 2020. To review changes required from original EU Exit risks following expected publication of DHSC/ NHSEI guidance on the NHS expected impacts. Board of Director report to be submitted following national Guidance from October 2020 following initial Management Board discussion once NHS Planning guidance received. **External assurances:** NHSEI have indicated the intention to run system exercises in the week of 12 October 2020. Further assurance requirements are anticipated Review learning from desk top/ virtual exercise scenarios in October 2020. National EPRR lead for end of transition planning nominated as Professor Keith Willets. National Briefings will commence in October 2020 following the outcome of political negotiations.		

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C

	BAF 13
Strategic objective	Be an outstanding place to work where staff can flourish
Risk **QI1**	There is clear and emerging evidence of the risk factors that result in higher prevalence and acuity of Covid-19. If the Trust does not undertake risk assessments with staff identified as 'high risk', we will fail in our legal duty to protect the health, safety and welfare of our staff.

Trust Values	Everyone Matters	**Lead Executive(s)**	Director for People
Latest Review Date		**Board Monitoring Committee**	People Committee

Risk Rating	**Date**	**Impact**	**Likelihood**	**Score**	**Change since last Quarter**	**Related BAF & Corporate Risk Register Entries**		
Initial	26/6/20	4	3	12		**ID**	**Score**	**Summary Risk Description**
Current	15/7/20	4	2	8				
Target	1/8/20	4	1	4				
Risk Appetite								

Risk Score	**Q1** *(Apr May Jun)*	**Q2** *(Jul Aug Sept)*	**Q3** *(Oct Nov Dec)*	**Q4** *(Jan Feb Mar)*	
	N/A	8			

Key Controls *(what are we doing about the current risk?)*	**Assurance on Controls** *(How do we know if the things we are doing are having an impact?)*	**Level/ Change**
Completion of risk assessment • Roll-out of nationally recommended risk assessment document • HR Business Partner support for line managers • Employee Assistance support for staff who request it, including access to counsellors who specialise in support for BAME staff • Staffing Solutions completion of risk assessments with Bank staff identified as being at risk • Regular Trust-wide communications across all channels	• Central collation of Covid-19 risk assessments to ensure corporate oversight of completion and quality • Daily publication of completion rate at Trust, divisional, speciality and ward / team level • Review of progress at Covid-19 Gold Command meetings • Daily reporting to NHSI/E • All local documentation approved through Covid-19 Workforce Group and Gold Command where appropriate • Scrutiny through People Committee	

• Letters sent directly to the homes of BAME staff members and staff who are shielding about the risk assessment process and support available • Identification of 'very high risk' staff using Electronic Staff Record to identify priority risk assessments • Engagement in all national and regional discussions about achieving completion of risk assessments to ensure we are up to date and to learn from good practice • All material – risk assessments, letters, other communications – shaped by the BAME Staff Network (Fusion Network) and tested with other staff to ensure documents are easy to understand • The use of webforms has been introduced to make completion simpler and ensure that all relevant staff are capturewd Supporting health, safety and welfare of staff • Occupational Health support and guidance for staff identified as being at risk, including clear trigger points in risk assessment for OH support • Clear scoring system within risk assessment to ensure appropriate action to be taken • Clarity about which parts of the hospital are appropriate working environments, dependent upon risk assessment score • Signposting to Employee Assistance Programme in all material, recognising, for example, that those returning from shielding are likely to feel anxious • The People Plan requires that health and wellbeing conversations are held annually with every member of staff		

Gaps in Control	Gaps in Assurance	Actions to Address Gaps in Controls and Assurances	Due Date	L/C
• National guidance on those considered 'at risk' is inconsistent and constantly changing • National guidance on data requirements is inconsistent and constantly changing	• As at September 2020 92.2% of BAME risk assessments and 56.8% of other 'high risk' risk assessments completed	• Broaden the communication to raise awareness of those considered to be 'at risk' in line with changing guidance • Broaden the monitoring and incorporate into daily publication of completion rates • Further HR Business Partner engagement with line managers	1/8/20	

APPENDIX A: RISK GRADING CRITERIA

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its Consequence (the scale of impact on objectives if the risk event occurs) and its Likelihood (the probability that the risk event will occur). The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical or psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	There is a risk that other providers could innovate more quickly and deliver more services which add to the cost pressures in the system leading to a reduction in funding available for RUH services without reduction in expenditure. Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR or other agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint or inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment or service Gross failure of patient safety if findings not acted on Inquest or ombudsman inquiry Gross failure to meet national standards

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective or service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective or service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendation or 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	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss or interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood Score

The Likelihood Score is calculated by determining how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for almost certain.

Score	Descriptor	Description
1	**Rare**	Extremely unlikely to happen/recur – may occur only in exceptional circumstances – has never happened before and don't think it will happen (again)
2	**Unlikely**	Unlikely to occur/reoccur but possible. Rarely occurred before, less than once per year. Could happen at some time
3	**Possible**	May occur/reoccur. But not definitely. Happened before but only occasionally - once or twice a year
4	**Likely**	Will probably occur/reoccur. Has happened before but not regularly – several times a month. Will occur at some time.
5	**Almost Certain**	Continuous exposure to risk. Has happened before regularly and frequently – is expected to happen in most circumstances. Occurs on a daily basis

The **Risk Score** is determined by the Consequence (Severity) x Likelihood.

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