The Whittington Hospital NHS
NHS Trust

ITEM: 08/147

DOC: 3

MEETING: **Trust Board**
15 Oct 2008

TITLE: Risk management strategy

SUMMARY:
The overall risk management system in place across the Trust has continued to be developed during 2008/09 to enhance its effectiveness.

Following the Ernst & Young due diligence recommendations, the Risk Register (RR) and Board Assurance Framework (BAF) have been discussed and reviewed by the Trust Board, Audit Committee and Executive Committee throughout the year and in addition the Board committee structure has changed.

As recommended, the Risk Management Strategy now includes the direction that the BAF is mapped to the Trust's corporate objectives. The Trust Board should note that the mapping exercise has been completed under a separate exercise and where elements in the BAF could not be cross referenced to the corporate objectives, these have been removed from the BAF and where appropriate added to the Risk Register. This change to the BAF was approved by the Audit Committee in September. The BAF will be presented to the Trust Board every quarter.

The Risk Management Strategy has also been revised to outline the changes to the process for monitoring the Risk Register. The RR now includes a measure of residual risk following mitigation. Risks with an initial risk rating of Low (9 and below) are held on a separate risk register that is reviewed annually by the Executive Committee. Risks with a rating of High (Red15-25) will be reviewed every 3 months and Moderate (Amber 10-14) every 6 months, by the Executive Committee. Risks whose residual risk rating following mitigation falls to nine or below will remain on the register for a further review three months post change and then removed to the separate register should the risk rating remain at nine or below. This change in RR monitoring was approved by the AC in September. The RR will be reviewed by the AC every six months. The Trust Board will review the overall hospital risk register annually in March of each financial year.

Newly identified risks that are added to the BAF and RR will be notified to the Trust Board through the Chief Executive's monthly report.

In addition to each of the changes outlined above, the Risk Management Strategy reflects the requirements as set down in the NHS Litigation Authority's 'RISK MANAGEMENT STANDARDS FOR ACUTE TRUSTS'.

The Risk Management Strategy now requires ratification by the Trust Board.

ACTION: To ratify the risk management strategy

REPORT FROM:	**Fiona Elliott, Director of Planning & Performance**

SPONSORED BY:	**David Sloman, Chief Executive**

Financial Validation Lead: Director of Finance	N/a

Compliance with statute, directions, policy, guidance Lead: All directors	N/a

Compliance with Healthcare Commission Core/Developmental Standards Lead: Director of Nursing & Clinical Development	Reference: C07ac

Compliance with Auditors' Local Evaluation standards (ALE) Lead: Director of Finance	Reference: ALE 4.1

Compliance with requirements of FT application and monitoring regime Lead: Director of Planning & Performance	Reference: Monitor Compliance Framework

The Whittington Hospital NHS
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The Whittington Hospital

Risk management strategy

Revised September 2008
To be reviewed March 2009

1 What is risk management?

Risk management is the systematic identification, analysis and economic control of those hazards, which pose a risk to patients, visitors, or staff within the hospital. Its overall strategic aim is to improve the care offered to our patients by managing risks, although it is acknowledged that the complete elimination of all risks is not always possible. Good risk management awareness and practice at all levels is crucial for the success of any organisation. Risk is inherent in everything that an organisation does, whether it be: treating patients, determining service priorities, managing a project, purchasing new medical equipment, taking decisions about future strategies or even deciding not to take any action at all.

2 Purpose of this strategy

This strategy has been updated to take account of recent guidance and developments in the field of risk management in the NHS. It will specifically cover relationships within the organisation for different aspects of risk management and will set out the overall philosophy within the Hospital for the implementation of risk management.

3 Overall risk management philosophy

The primary aim of the Whittington Hospital is to provide high quality health care, which is sensitive to the needs of the community**.** As part of this objective, the Trust has a duty to minimise the potential risk of harm to patients, members of staff and the public.

The management of risk is a key organisational responsibility. All members of staff have an important role to play in identifying and minimising inherent risks. This will be achieved within a progressive, honest, open and non-punitive environment, where mistakes and untoward incidents are identified quickly and acted upon in a positive and constructive way. To assist in the process of openness, the hospital has a policy for staff raising health care concerns.

Risk management provides a framework, which allows the Hospital to improve upon the good quality care, treatment and rehabilitation of patients being provided in an ever improving environment through risk mitigation. It will achieve this through a pro-active process of risk identification and assessment, with the objective of improved prevention, control and containment of risk. All staff will be made aware of the importance of risk management through induction and mandatory refresher training.

4 Risk management structure

It is important that there are clear lines of responsibility and accountability for risk management within the Hospital. This will take the form of specific named posts within the organisation as well as committees ultimately reporting through to the Trust Board.

The Hospital will take a holistic approach to managing risks within the organisation, so that clinical governance, organisational controls, health and safety risks and financial risks are integrated. The overall risk management structure to facilitate this is shown in Annex 1.

5 Responsibility of managers

The Chief Executive is the officer accountable for overall risk management within the Hospital and will:

- ensure that performance targets and the performance management framework for risk management across the organisation is in place
- provide overall risk management assurance to the Trust Board

The Director of Planning & Performance has overall responsibility for ensuring the verification of organisation risk management controls to the Trust Board and will:

- regularly update the Hospital Risk Management Strategy
- work with other directors to integrate risk management across the hospital
- ensuring that all board members and executives receive relevant risk management awareness training

The Corporate Secretary has overall responsibility for reporting the assurance framework to the Trust Board and will:

- collate the assurance framework for the Trust Board

The Director of Nursing & Clinical Development and the Medical Director have joint overall responsibility for ensuring the implementation of clinical governance/risk management within the Hospital and will:

- collate the Healthcare Commission's Annual Health check for the Trust Board
- ensure the processes and procedures to support clinical governance, infection control and health and safety, including incident reporting, are effectively operating across the hospital
- ensure the Trust has access to professional advice on clinical governance and health and safety issues
- ensure staffs' training needs are identified in relation to clinical and non clinical risk management and that adequate training is available
- ensure that there is a routine programme for induction of all new staff to clinical and non clinical risk management as well as refresher training for existing staff.
- provide regular performance reports to the Board in relation to clinical and non clinical risk management
- convene meetings e.g. the Clinical Governance Committee, as agreed in its Terms of Reference, to ensure effective management and communications of issues
- work with other directors to integrate risk management across the hospital
- be responsible for the management of clinical negligence claims and complaints about patient care.

The Director of Facilities has overall responsibility for ensuring the implementation of health and safety, fire prevention and security aspects of non clinical risk management within the Hospital and will:

- implement adequate arrangements for health and safety, security, and fire management across the hospital
- convene meetings e.g. the Health & Safety Committee, as agreed in its Terms of Reference, to ensure effective management and communications of issues
- monitor the effectiveness of these arrangements across the hospital and provide regular performance reports to the Board
- ensure staffs' training needs are identified in relation to health and safety, fire prevention and security and that adequate training is available
- ensure the effectiveness of the medical devices services across the trust
- ensure the Trust has access to professional advice on health and safety, security and fire protection issues
- work with other directors to integrate risk management across the hospital

The Director of Finance has overall responsibility for ensuring the implementation of financial and business risk management with the Hospital and will:

- ensure the financial and business performance systems within the hospital are robust
- provide information and financial/business risk management assurance to the Board
- provide support to the Trust's Audit Committee
- ensure relevant policies and procedures are reviewed and updated
- work with other directors to integrate risk management across the hospital

All managers and heads of departments have a responsibility throughout the hospital to stimulate the awareness and understanding of their staff in the identification and reporting of hazards, risks and adverse events, including near misses. All managers must ensure that they respond in a constructive way and that any adverse incidents are reported immediately, through the agreed reporting systems.

It is vital that any member of staff who reports an adverse incident is given feedback on any action taken, with some clear indication as to how that particular risk situation has been reduced or eliminated to prevent recurrence.

The performance of these responsibilities will be identified within job descriptions and will be monitored through local performance mechanisms and overall by the Trust Board.

All managers will have risk management objectives set as part of their Performance Development Review.

All staff have a responsibility to minimise risks to themselves and others by their actions. They must comply with safe systems of work, rules, procedures and instructions associated with their

work and report any hazards, accidents, incidents etc. to their manager. There is also a *staff raising healthcare concerns policy* in place in the Trust.

6 Role of Committees

The Trust Board and its sub committees are responsible for the overall implementation of the risk management strategy at the Whittington Hospital, which covers all risk management and assurance aspects within the hospital, for example:

- Clinical governance
- Environment
- Organisational issues
- Workforce planning & training
- Finance
- Corporate Governance

The Audit Committee is responsible for verifying the implementation of risk management across the whole organisation. This will be undertaken in conjunction with the audit function and does not preclude other forms of external verification if appropriate. The Audit Committee will provide assurance by reporting direct to the Trust Board on its findings and recommendations. It may utilise either the internal or external audit function to provide an independent assessment. The Audit Committee will be responsible for monitoring the Trust's Assurance Framework and Healthcare Commission's Annual Health Check core standards on behalf of the Trust Board and ensuring that linkages across issues are made and that organisational learning is achieved. It will be through these mechanisms that the Audit Committee will confirm the status of risks.

Executive Committee is responsible for ensuring the Trust's performance against its objectives and that that governance and assurance systems operate effectively and thereby underpin deliver of clinical care, teaching and research. The Executive Committee will be responsible for monitoring the Trust's Risk Register on behalf of the Trust Board and ensuring that linkages across issues are made and that organisational learning is achieved.

Clinical Governance Committee is responsible for the implementation of clinical governance as defined in Clinical Governance: Quality in the new NHS[1] across the Hospital; monitoring and reporting its progress to the Assurance Committee.
Clinical Risk Committee is responsible for identifying, maintaining an overview of and prioritising clinical risk, to input this into the Trust's overall risk management process and to support the integration of clinical risk into the clinical governance processes.

Health and Safety Committee will be responsible for the operational implementation of the Health and Safety Strategy and related policies, including fire safety and security issues.

The Hospital Management Board will be responsible for the hospital's overall health and safety strategy.

[1] NHS Executive
Clinical Governance: Quality in the new NHS March 1999

Other Committees have a role in the implementation of the risk management across the hospital. This includes the Infection Control Committee, local Clinical Risk Management Groups, which review all clinical adverse accidents within Directorates, Security and Personal Safety Committee, the Fire Safety Committee, the Environment and Food Hygiene Group, and the Business Planning Group. The overall role of the above committees and groups is to:

- Monitor the effectiveness of the accountability framework which encompasses management structures and practices
- Ensure the core processes required to provide the desired outcomes are in place
- Ensure the necessary capability is available to deliver the effective operation of processes and internal controls
- Continuously monitor and review the system of internal controls and encourage learning
- Ensure adequate communication and consultation at all levels with the organisation and external stakeholders.

7. Resources

7.1 Staff

In addition to the resources and expertise held within the above committees, there are posts that have a specific risk management role across the hospital:

Risk manager is responsible for:

- ensuring the provision of advice on clinical governance, health and safety and other areas of risk/litigation across the hospital
- monitoring the implementation of risk management policies and procedures in clinical and non clinical areas
- horizon scanning to identify learning from the external environment and other organisations which may be relevant to the trust
- Identifying, escalating and ensuring the management of areas of actual or potential risk, including analysis and grading of incidents, in relation to health and safety
- identifying training needs and ensuring the provision of relevant training for existing staff and induction of all new staff.

The Assistant Director of Nursing (Risk Management) manages the risk management function.

Health & Safety Advisor is responsible for:

- providing professional advice on technical health and safety matters

- monitoring the implementation of risk management policies and procedures in relation to health and safety

- undertaking a training needs analysis and ensuring the provision of relevant training for existing staff, managers and induction of all new staff, recording attendance and following-up non-attendance. They will maintain a process for monitoring compliance with all of the above

- Identifying, escalating and ensuring the management of areas of actual or potential risk, including analysis and grading of incidents, in relation to health and safety

Moving and Handling Advisor is responsible for:

- overseeing the implementation of the Moving & Handling Policy across the hospital

- ensuring that current legislation and national standards of practice are in place

- identifying training needs and ensuring the provision of relevant training for existing staff and induction of all new staff.

- Identifying, escalating and ensuring the management of areas of actual or potential risk, including analysis and grading of incidents, in relation to health and safety

- providing professional advice and identifying areas of actual or potential risk

Local Security Management Specialist is responsible for:

- Providing professional advice on technical security matters

- Monitoring the implementation policies and procedures relating to security safety issues

- Identifying training needs and ensuring the provision of relevant training for existing staff, managers and induction of all new staff

- Identifying, escalating and ensuring the management of areas of actual or potential risk, including analysis and grading of incidents, in relation to health and safety

Fire Safety Consultant is responsible for:

- Providing professional advice on technical fire safety matters

- Monitoring the implementation policies and procedures relating to security safety issues

- Identifying training needs and ensuring the provision of relevant training for existing staff, managers and induction of all new staff

- Identifying, escalating and ensuring the management of areas of actual or potential risk, including analysis and grading of incidents, in relation to health and safety

Assistant Director of Education is responsible for:

- Ensuring risk management awareness training is included in the Trust's induction

- Assisting in the development and provision of education as identified from the risk management training needs analysis undertaken by the H&S advisor
- recording induction attendance
- following-up induction non-attendance
- Maintaining a process for monitoring compliance with all of the above.

Many other posts will have a significant role to play in assessing, managing and minimising risks, for example infection control, medical physics and staff occupational health services.

7.2 Financial resource

Expenditure may be required to minimise risks. Risks are considered against other demands with due weight given to the risks identified. Consideration will be given to the probability of risks occurring balanced against the possible cost/seriousness of the risks presented.

Managers should take due care to address risks where practicable and/or ensure other relevant managers/bodies are informed when necessary. See Annex 2 for details in relation to specific responsibilities for notification of serious risks. Managers will give priority in instances where incidents have or are likely to cause accidental death or serious injury of patients, visitors or staff or have caused major property damage.

Allocation of resources by managers will be in accordance with the hospital's Standing Financial Instructions. Risks identified as a priority within the Board Assurance Framework and the hospital's Risk Register will be included within the Trust's business planning of overall resources. Risks will be assessed through the business planning process within departments and directorates as well as the Trust's overall Integrated Business Plan. The Trust's Business Planning Group will also ensure planning and allocation of funding takes account of identified risks.

8 Assessment of risks

Both clinical and non-clinical risks should be assessed in relation to the achievement of the Trust's corporate objectives. Bottom up risk identification will in general terms, be assessed through staff incident reporting and risk assessments; whilst organisational risks will assessed through business planning, serious untoward incident investigations and HR processes such as recruiting and disciplinaries. Top down risk identification will come through the ongoing development of the Board Assurance Framework, strategic business planning and contract management.

The grading system will determine the investigation level by linking the score for severity with an appropriate investigation level.

It is important that clinical and non-clinical risks are graded through a similar process to enable the organisation to identify significant risk so that they can be addressed. This enables informed decisions to be made in respect of resources, whether it be money or time/effort or expertise.

All risks will be assessed through a probability versus impact matrix to enable them to be graded in a like manner. Risk assessors will take into consideration any mitigation of the risk

that may have already happened when it comes to the initial formal grading of the risk and this will be noted in the baseline assessment. In order to help inform this process guide definitions are provided for grading overall risks (Annex 3). However this is not a precise science and therefore risk assessors should use this only as an indication, together with other information/knowledge/expertise available to them.

The risk is first assessed in terms of its probability (i.e. what is the likelihood of x happening, either on its own or as a consequence of something else e.g. a power failure) and then the impact should the risk happen. The probability and impact descriptors are:

1 negligible
2 unlikely
3 likely
4 highly likely
5 certain

The overall risk assessment would therefore be a multiplication of the probability and the impact to give a score from 1 - 25:

RISK SCORING MATRIX

Prob / Impact	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

The degree of significance placed on the risk will clearly be related to its grading.

The Risk Manager will maintain the Hospital Risk Register. Risks on the register will be mapped to the Board Assurance Framework to determine their significance in terms of delivery of the corporate objectives.

In addition to risks that a director may identify within their own directorates and add to the risk register, risks are also be identified and recorded from the following sources:

1. Risks identified from risk assessments
2. Risks identified from Confidential Enquires (NCEPOD, CISH, SHOT, CEMACH, HCC reviews)
3. All serious untoward incidents
4. Appropriate high risk incidents
5. Incidents that appear to have formed or are forming a trend, e.g. patient falls, NG tube placement

6. Maternity risks, as currently identified in a separate risk register.
7. Risks identified from the Human Tissue Act
8. Risks identified from NPSA reports and alerts
9. Risks identified from the Information Governance Framework

Risks on the hospital risk register with a rating of High (Red15-25) will be reviewed every 3 months and Moderate (Amber 10-14) every 6 months by the Executive Committee. Any risk with an initial risk rating of Low (9 and below) will be held on a separate risk register that would be reviewed annually, in June, by the Executive Committee. Risks whose residual risk rating following mitigation falls to nine or below will remain on the register for a further review by the Executive Committee three months post change and then removed to the separate register should the risk rating remain at nine or below. New risks added to the Risk Register will be notified to the Trust Board through the Chief Executives monthly report. The Risk Register will be reviewed by the Audit Committee on a six monthly basis.

The Trust Board will review annually, in July, the overall hospital risk register, including the use of the Healthcare Commission's Annual Health Check core standards and will agree the priorities for action. This will inform the allocation of resources. This assessment will be undertaken in line with guidance set out in *Governance in the new NHS* together with *Clinical Governance: Quality in the new NHS* and other relevant guidance.

The Board Assurance Framework (BAF) will be mapped to the Trust objectives. Where elements in the BAF cannot be cross referenced to the corporate objectives (as these may change on a yearly basis), these will be removed from the BAF and where appropriate added to the Risk Register. The BAF will be reviewed by the Audit Committee quarterly and ratified by the Trust Board quarterly.

New risks added to the Board Assurance Framework will be notified to the Trust Board through the Chief Executives monthly report.

9 Risk prioritisation – recommended management action

The list below provides guidelines on the most appropriate action to be taken to manage incidents and prevent a reoccurrence. In all incidents there must be consideration of mitigating actions or contingencies to minimise the impact of the risk. Action plans should be developed for all risks scored as moderate risk or above and should identify the timescales and officer(s) responsible for actions.

Significant risk (20-25). Must be referred to the relevant director and immediately investigated and an action plan to eliminate/reduce/control risk developed. If the risk is not immediately reducible then it will be added to the Trust Risk Register. The Risk Manager will be informed of all significant risks. Control mechanisms will be reviewed by the Executive Committee every three months.

High risk (15-16). The relevant director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. If the risk is not immediately reducible then it will be added to the Trust Risk Register. Control mechanisms will be reviewed by the Executive Committee every three months.

Moderate risk (10-14). The head of department will be informed and will determine the investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms will be reviewed by the Executive Committee every six months.

Low risk (9 and below). The head of department will be informed and will determine the investigation required and the subsequent action plan to eliminate/reduce/control risk. If action

is possible to eliminate the risk of occurrence then this should be taken. A low risk of recurrence may remain and be acceptable. Control mechanisms will be reviewed by the Executive Committee annually.

10 Training and education

The implementation of risk management must be underpinned by sound working practices and training and education for staff, patients and visitors. Risk management training is mandatory at induction and will form part of the annual review of staff development as part of an individual's annual appraisal review. The implementation of risk management by individuals will be performance managed through staffs' individual appraisal reviews.

11 Performance management

The Trust Board will review at least annually, core performance indicators for assessing the management of risk. These will include:

- Clinical governance
- Health and safety
- Infection control
- Accidents and incidents
- Fire incidents
- Security incidents

Financial risk rating will occur monthly through the finance report to Trust Board

12 Annual Assurance statement

The Trust Board will be expected to provide an assurance statement within its Annual Report, in line with Department of Health requirements, to demonstrate assurance of services provided.

13 Other relevant policies

This strategy should also be read in conjunction with the following procedures/policies/strategies which impinge upon risk management. This list is not intended to be all inclusive:

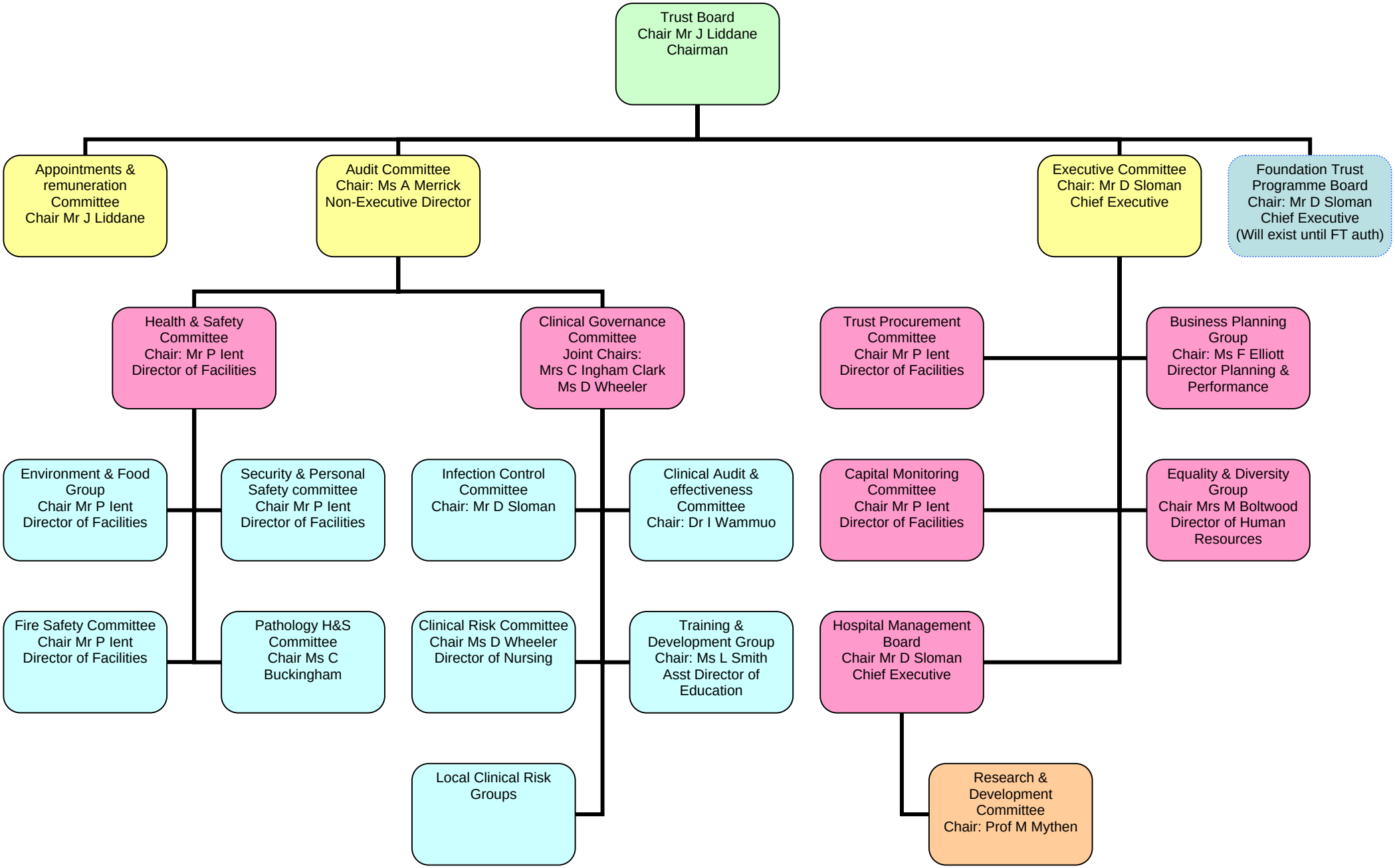
- Anti-fraud policy
- Incident reporting policy
- Assurance Framework Policy
- Clinical governance strategy
- Complaints policy
- Health & safety strategy
- Claims management policy
- Policy for staff raising healthcare concerns
- Procurement procedures
- Serious untoward incident policy
- Standing Financial Instructions
- Standing Orders
- Information security NHS Code of Practice
- Records management NHS Code of Practice

14 Communications

It is an essential part of a Risk Management Strategy that staff are aware of its contents. Managers and heads of departments are responsible for ensuring their staff understand and appreciate its importance and be encouraged to report adverse incidents/potential incidents and to review their own work practises. Each named officer in this strategy will be issued with a copy of this policy.

15 Review

This strategy will be reviewed annually by the Trust Board and revised as appropriate for example when the Whittington Hospital becomes a foundation trust.


Trust Board
Chair Mr J Liddane
Chairman
Appointments & remuneration Committee
Chair Mr J Liddane
Audit Committee
Chair: Ms A Merrick
Non-Executive Director
Executive Committee
Chair: Mr D Sloman
Chief Executive
Foundation Trust Programme Board
Chair: Mr D Sloman
Chief Executive
(Will exist until FT auth)
Health & Safety Committee
Chair: Mr P Ient
Director of Facilities
Clinical Governance Committee
Joint Chairs:
Mrs C Ingham Clark
Ms D Wheeler
Trust Procurement Committee
Chair Mr P Ient
Director of Facilities
Business Planning Group
Chair: Ms F Elliott
Director Planning & Performance
Environment & Food Group
Chair Mr P Ient
Director of Facilities
Security & Personal Safety committee
Chair Mr P Ient
Director of Facilities
Infection Control Committee
Chair: Mr D Sloman
Clinical Audit & effectiveness Committee
Chair: Dr I Wammuo
Capital Monitoring Committee
Chair Mr P Ient
Director of Facilities
Equality & Diversity Group
Chair Mrs M Boltwood
Director of Human Resources
Fire Safety Committee
Chair Mr P Ient
Director of Facilities
Pathology H&S Committee
Chair Ms C Buckingham
Clinical Risk Committee
Chair Ms D Wheeler
Director of Nursing
Training & Development Group
Chair: Ms L Smith
Asst Director of Education
Hospital Management Board
Chair Mr D Sloman
Chief Executive
Local Clinical Risk Groups
Research & Development Committee
Chair: Prof M Mythen

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Annex 2

Serious incident/accident reporting responsibilities of key individuals

Notification	Key individual
Serious untoward incident	Any member of staff to their line manager/clinical site practitioner, who in turn informs the senior manager (see policy for details)
RIDDOR	Health and safety advisor
National patient safety agency	Risk manager
NHS Litigation authority	Head of legal services
Medicine & healthcare products regulatory agency	Head of medical physics
Safety of medicine	Head pharmacist
Health Protection Agency	Director of infection prevention and control
NHS Estates	Director of Facilities

Annex 3

Risk management grading matrix

	Impact				
Category	*1*	*2*	*3*	*4*	*5*
Clinical incident	Very minor	Minor injury, cancellation, documentation error, drug error with no clinical effects	Additional treatment, extended stay, longer recovery, consent error, drug error with some clinical effects	Significant error or unexpected significant deterioration in patients condition. SUI, incorrect procedure undertaken, drug error with significant effects	Results in death
Injuries to patients, staff or visitors	Near miss – no identifiable injury	Minor (e.g. cuts bruises, abrasions first aid treatment	Moderate injury – A&E attendance, days off work, extended hospital stay	Major injury (fractures, hospitalisation, extended time off,	Results in death
Equipment failure	Very minor	Minor failure or misuse	Moderate failure or misuse	Major failure/ misuse leading to serious inappropriate treatment or risk	Very significant risk to people, services or property
Security incidents	Minor swearing, verbal abuse, threat or risk to person's well being	Significant verbal abuse or threatening behaviour to staff or other patients/ visitors	Physical assault requiring no treatment or serious violent behaviour requiring active intervention	Serious physical assault requiring treatment and/or time off work	Serious & imminent threat to life e.g. edged weapon threat
Litigation	<£10k	<£100k	<£250k	<£500k	>£500k
Financial risk	Loss or theft <£100	Loss or theft <£10k	Loss or theft <£100k	Loss or theft <£250k	Loss or theft >£500k

Category	*1*	*2*	*3*	*4*	*5*
Service interruption	<1 day routine service	1-7 days routine service	<1 critical service or >7days routine service	1-7 days critical service	>7 days critical or > 10 routine service
Fire	No injuries, and/ or damage, and/or temporary disruption during evacuation etc	Minor injuries, and/or minimal damage, and/or short term (<1 day) local service disruption	Moderate injuries, and/or some structural damage, and/or local service disruption	Significant injuries, and/or major structural damage, and/or multi service disruption	Major fire deaths and/or severe structural damage, and/or large scale closure
Media attention	Routine local press enquiries	National and local media attention of a known event	National and local media attention of a untoward incident	National and local media coverage of a major untoward incident	Significant national press/tv coverage threatening to overwhelm the Trust resources
Information Governance – loss of patient/staff identifiable data	n/a	n/a	Loss of encrypted digital information – unlikely that data is accessible (deal with media attention as row above)	Loss of password only protected digital information – more likely that info is accessible (deal with media attention as row above)	Loss of unsecured digital/paper based information – freely accessible by whomever in possession (deal with media attention as row above)