Sherwood Forest Hospitals Foundation Trust Board Assurance Framework
MARCH 2014

Objective	Risk no.	Risk description	Cause	Consequence	Risk owner	Gross impact	Gross likelihood	Gross RAG Status	Existing controls	Sources of assurance	Expiry date	Gaps in assurance	Net impact	Net likelihood	Net RAG Status	Action for further control	Action owner	Due date	Movement from prior assessment
What is the Trust's objective?	Risk ref	Describe the risk which threatens the achievement of the objective	What might cause the risk to occur?	What are the possible consequences if the risk occurs?	Individual ultimately accountable for managing the risk	Rating of 1 to 5	Rating of 1 to 5	IxL	What existing controls and processes are in place to manage the risk?	What **positive** assurances are there? What benefits have these brought?	When is the assurance valid until?	What has not yet been done?	Rating of 1 to 5	Rating of 1 to 5	IxL	What further action (if any) is necessary to address the gap?	Who is responsible for this action?	When must it be completed?	Red / Amber / Green
Strategic Objective 1: Achieve the best patient experience.	1.1	Clinical risk including medication risks and risk of failing to update care plan for patients due to not communicating effectively with patients and their GPs within agreed timescales	Increase in number of complaints and PALS concerns reported by patients and carers Patient administration systems not operating correctly. Systems for sharing patient information with GPs not operating correctly. History of patient if seen in clinic again may not be as up to date as needed.	Increased delays in arranging patient appointments leading to poor patient experience. Failure to promptly share patient information with GPs leading to delayed treatment, inappropriate care and potential impact on clinical outcomes.	Medical Director	4	4	16	Additional temporary typing staff recruited. WinScribe has been implemented and fully rolled out to manage and measure workload. The PPC reorganisation has dealt with discharge summaries and RTT pathways. Post implementation review available in next month. The Global Trigger tool looks at medication errors and is reported quarterly with feedback to divisions and Board via PSG and QGRC. Microbiologist lead antibiotic ward round with a dedicated pharmacist, have redesigned the drug chart to include a specific antibiotic section and are currently undertaking a Tazocin audit to ensure	Monthly typing up report to CGC provides performance overview Survey of GPs informs assessment of progress. Turnaround plan in respect of the 5 day target is managed via the performance contract Typing turnaround sustained for over 6 months.	31/10/13 for 5 day target		4	1	4		Director of Operations		
	1.2	Variable quality of the healthcare environment between PFI new build and retained estate	Insufficient investment in the capital programme to replace/refurbish retained estate. Lack of ability to fully finance required developments.	Higher costs and/or poor patient experience through continued reliance on retained estate for key aspects of service delivery	Director of Strategic Planning and Commercial Development	3	3	9	In year investment in high risk estate areas. Improved links between the Corporate and Divisional risk management processes to identify, manage and address risks in a coherent and joined up manner	TMB Reports	01/09/2014	Phase 1 of the Estates Strategy was completed in December 2013. Phase 2 will be completed September 2014. 'Better Together' Estates workstream in place.	3	3	9	Estates rationalisation programme needs to be developed on the back of the 'Better Together' Programme	Director of Strategic Planning and Commercial Development	Sep-14	
	1.3	Failure to implement process and procedures to ensure robust timely management of Complaints	Failure to meet commitment to patient care and principles of NHS constitution Failure to be compliant with CQC registration requirements	Reduced service quality and opportunities for lessons learnt/service improvement Reputational impact	Director of Nursing	4	4	16	Complaints team have been strengthened with 1 specialist interim complaints manager overseeing the team. Peformance management tool/spreadsheet - assessed weekly as a minumum Daily dialogue between divisions and complaints team New process for complaints management currently progressing through a workforce change process	Complaints backlog is now cleared. Quarterly reporting on performance and themes to Trust Board via Patient Experience Report Weekly meetings with divisions Weekly monitoring report issued and reviewed	ongoing	New complaints & PALS structure being re-designed and will involve re-structure of teams to ensure the new process can be implemented but Divisional Teams have given their commitment to continuing with current processes until new process implemented	3	2	6	Implemention of the new process following workforce change process. Updated complaints policy Temporary staff recruited pending implementation of new structure	Director of Nursing	June 2014 for implementation of new process following consultation	

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	1.4	Failure to manage the patient pathway	Not having effective processes for managing 18 week pathway in PPC specialties. Lack of safe operating procedures. Not reviewing post and diagnostic	Timeliness of diagnosis, poor management of patient pathway	Medical Director	5	4	20	Additional staff training in 18 weeks. SOP's in place.	18 week management. Validation of 18 weeks. Unanswered telephone log. ICPI's		Not consistently achieving 18wks across all specialties	5	3	15	BSU teams realigned to ensure increased focus and attention on the 18 week process. Additional resource has been deployed into PC & S	Director of Operations	Mar-14	

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Strategic Objective 2: Improve patient safety and provide high quality care.	2.1	Failure to reduce the Trust's Hospital Standardised Mortality Ratio (HSMR) indicator by 10% during 2013/14 (baseline HSMR at 01/04/13 = 116)	Clinical strategies and policies not aligned to enable reduction in HSMR. No clear actions idenitifed to reduce HSMR. Lack of clinical engagement and staff understanding to enable improvements in care to be made	Detrimental impact on patient care and clinical outcomes. Potential reduction in public confidence which will impact on Adverse impact on primary care referral patterns and commissioning including potential loss of business. Linked to this a loss of income which could lead to certain n services no longer being economically viable.	Executive Medical Director	5	5	25	Trust wide mortality action plan has been developed and is on track Internal Mortality Group has been established with responsibility for implementing actions to reduce HSMR Joint CCG and Trust Mortality Group continues to meet to monitor progress and initiate remedial action where appropriate. Monthly monitoring of HSMR through the use of Dr Foster data. Clinical and operational workstreams established tasked to implement actions to reduce HSMR. Associate Medical Director for Patient Safety appointed. Patient Safety Lead has been appointed to focus on key deliverables. The action plan based on keogh recommendations is being implemented which will influence mortality rates	HSMR has reduced consistently and monthly reports are produced for QGRC and CCG Mortality Group. Triangulation between incidents, complaints and morbidity and mortality meetings. Cardiac arrest rate has fallen. Mortality from 'big five' has continued to fall and stabilise.	30/04/2014	Vitalpac electronic monitoring system has been supported and the project is established with timescales to roll out in psring 2014	5	4	20	Develop an implementation plan for Vitalpac within next three months with full roll out of the system by the end of the current financial year. Continue to implement and monitor the delivery of the action plan relating to Keogh and the Trust mortality action plan. Agreed patient safety programme for 2014/15 Patient Safety Steering Group oversees progress across all mortality and safety workstreams. Patient Safety Fellow has been appointed	ITC Service Lead CEO Each action has an assigned executive lead and responsible manager. Medical Director	Full implementation by the end of Dec 2014 Each specific action has a completion date and progress is monitored at a weekly project meeting. Executive review of the action plan is undertaken at programme Management Board March 2014	Red
	2.2	Failure to reduce patient harms which include pressure ulcers, falls, medication errors and hospital acquired infections	Insufficent capacity to ensure training needs are met Insufficient resources to make improvements needed to reduce harm rates	Failure to deliver improvements in quality to meet Trust prioirites and contractual requirements from CCG Failure to instill confidence in general public, governors	Executive Director of Nursing & Executive Medical Director	4	4	16	Ward assurance dashboard set up to facilitate the monitoring of measures Monthly meetings with matrons FOCUS IT tool set up to enable clinical teams to review performance and set actions which can then be monitored by the management teams Establishment of medicines safety project and recruitment of falls nurse Harms projects monitored at Patient Safety Steering Group	Improvement in pressure ulcer performance during last 12 months. 30% reduction in grade 2 and 3 pressure ulcers. Zero grade 4 pressure ulcers for 12 months. Reduction in falls with harm in Jan & Feb 2014	30th April 2014	IT system refinement and development to facilitate the monitoring of harms information	4	3	12	Work with IT to develop new tool to enable clinicians to track and monitor performance Succesful bid to NHS England. New softward solution is being sought	Deputy Director of Nursing & Associate Medical Director	Jun-14	

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	2.3	Failure to deliver improvements in care quality required by external regulatory reviews (Keogh & CQC) and contractual requirements (Quality Schedule & CQUIN).	Insufficient capability and capacity to deliver improvements within the accelerated timescales Inability of clinical teams to implement reduction strategies Lack of project resources to drive improvements	Inability to meet improvement targets and standards identified. Risk to Registration with CQC. Reputational risk which impacts on patient choice, staff choosing to work at SFH and confidence of commissioners	Executive Director of Nursing & Executive Medical Director	5	4	20	Weekly project meetings to review progress of action plans Programme Management Office supporting and ensuring robust project management Additional resource to support delivery of selected key actions Actions plans being integrated to bring together Keogh, PWC and CQC recommendations Immediate increase in nursing staffing levels at night introduced post Keogh Summit CQUINS monitored via quality committees	Action plan on track and being scrutnised at Programme Management Board Positive assurance from CQC - Complaince action reduced to Minor for Outcome 16 No additional risk summit required Investment in nursing (£4 Million) agreed at Dec'13 Trust Board External reviews noting 'Keogh' actions in practice e.g. Care and Comfort mentioned in Junior Drs report Positive assurance from recent Keogh Review 23 groups of action- 6 recored as assured and 17 partially assured. No areas recored as not assured	30th April 2014	Implementation of all actions are not complete, outcomes are not yet evident or it is too early to tell if the changes are embedded and sustainable	4	3	12	Implementation of new nursing establsihments and skill mix Continue to implement and monitor the delivery of the CQC & Keogh action plans continue wwekly meetings with divsions to monitor action plan	Executive Director of Nursing CEO	March 2016 May 2014	Amber
	2.4	Failure to implement preventative measures resulting in a serious, largely preventable safety incident (never event)	Inadequate systems and processes to prevent the incident from happening. Immature patient safety culture	Severe harm/death to our patients. Failure to instill confidence in our patients and general public. Potential regulatory action.	Executive Director of Nursing & Executive Medical Director	5	3	15	Stronger focus on patient safety within the Trust. Guidelines and procedures. Duty of candour emphasised. Communication of never events list. Patient safety fellow with an expanding patient safety programme of work.	Previous good record of not having never events. CNST level 2 NHSLA Level 1 Open relationship with CCG's Comprehensive programme of risk management training.	31/04/2014	Implementation of new nursing establishments to increase workforce number. Developing quality governance framework Sustained and embedded governance systems and processes including risk management training.	5	2	10	Implremenation of the quality of safety strategy. Continue to implement risk management training. Finalise restructure of Governance Support Unit.	Executive Director of Nursing. Head of Governance	01/04/2014 Ongoing.	

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Strategic Objective 3: Attract, develop and motivate effective teams	3.1	Failure to appropriately manage and train staff to carry out their work.	Managers and supervisors not sufficiently skilled to lead and appraise their teams. Insufficient training opportunities and poor attendance at those opportunities that are presented. Appraisals not being undertaken compliance rate currently 75.54% of a target of 79% Whilst appraisals have been completed the quality of the appraisal may not be seen to support and develop staff. Staff not completed	Increased sickness absence. Poor staff experience outcomes in the staff survey. Staff unclear about what is expected and required of them. Poor quality patient care. Increased patient and staff health and safety incidents. If the Trust cannot deliver contracted activity this may lead to financial penalties from the Commissioners. Competence of staff in relation to mandatory training not sufficient	Executive Director of Human Resources	4	3	12	Procedures and policies have been revised and updated in respect of training, sickness absence, appraisals and recruitment Additional central resources have been recruited to progress and implement sickness Management Policies and also Staff Appraisal Procedures. New performance management framework has been implemented. Sickness absence panel to more effectively performmance manage sick absence to audit return to work interviews. mandatory training completion reports escalated through Management to CG&Q	Quarterly Board reports covering sickness absence, staff appraisals and training. Monthly Board reports highlighting performance with sickness absence, appraisal completion rates and fixed and variable pay expenditure Staff and patient surveys Sickness absence and appraisal reports and actions to Finance and Performance Committee. Workforce and Training Education Committee reports	31/03/2014	Gap in Board knowledge in relation to the effectiveness of the arrangements that are in place.	4	3	12	Action required to assess the effectiveness of the new arrangements including: embedding into objectives of Managers, holding managers to account, improving appraisal completion rates, improving information and data provided. Develop robust process for assessing quality of appraisals. Improve mandatory training performance reporting to monthly reports and provide data for ward dashboards.	Executive Director of Human Resources	31/03/2014	
	3.2	Failure to attract appropriately skilled staff	Lack of appropriately skilled staff in the labour market both within the UK and Nationally. (specifically in Radiology and Finance) Poor reputation of the Trust given significant negative media.	Poor quality patient care Increased patient and staff health and safety incidents. Increased variable pay expenditure due to reliance on agency staff.	Executive Director of Human Resources	5	4	20	Procured external companies to assist with international recruitment, (Medical and Nursing). Framework in place to managing the media to ensure good news gets into the press to attract high quality staff to the Trust.	Quarterly Board reports covering staff in post and vacancy rates by staff groups. Monthly Board reports highlighting fixed and variable pay expenditure against plan. Staff and patient surveys 40 Registered Nurses recruited Q3	31/03/2014		5	4	20	Appointment of Project Manager to assist with the enhancement of the in-house bank. Review of perceptorship support for nurses. Develop effective in-house bank to increase nursing supply. Review staffing skill mix for medical staff in hard to fill specialties. Consider alternative staffing models for	Executive Director of Human Resources Deputy Director of Nursing Deputy Director of HR	31/03/2014	

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	3.3	High levels of clinical posts filled using temporary staff resulting in a financial and quality risk. Increased costs of agency spend and risk of temporary staff not trained/inducted appropriately to area of work	Permanent workforce insufficient to meet business needs. Insufficient staff having appropriate skills and knowledge to deliver required services. Insufficient appropriately skilled and qualified staff in the labour market.	Increased reliance on temporary staff affecting the cost and quality of services delivered	Director of Operations/ Director of HR	4	4	16	New and innovative approaches to recruitment process including the use of Trust Open Days. Utilising existing partnership arrangements to fill "hard to recruit" posts; Extending nursing roles to cover medical staff; 2013/14 establishments have been set at 2012/13 outturn results; Invested in strengthening the Nurse Bank; Minimise use of Agency and Bank Staff to cover Band 2 posts is prohibited from June 2013; Procured arrangements for international recruitment, alternative ways of working being fully utilised to ensure safety.	Heatmap reporting to Clinical Governance and Quality Committee is used to flag recruitment hotspots and drive corrective action; Financial and HR reports to Trust Board highlighting cost and use of temporary staff Monthly board Reports highlighting vacancies	31/03/2014	Hard to recruit posts have been identified and agencies are focussing attention on those roles but to date have had limited success.	4	4	16	Continue to identify new strategies and recruitment markets; At the same time we need to ensure that current momentum in this area is maintained and that complacency does not set in where we have been successful in reducing the use of temporary staff; We need to develop radically different workforce models to inform our Workforce Strategy and Planning Work, linked to clinical strategies and to form a key element in our business planning processes going forward.	Director of Operations; Executive Director of Nursing and Quality: Executive Director of Human Resources	31/03/2014	
	3.4	Failure to deliver strategic objectives.	Instability at the Board level due to the high level of turnover and interim appointments.	Lack of continuity leads to reduction in the quality of services and patient care with increased costs. Weakened governance arrangements results in failure to drive improvements in patient care. Lack of consistency in Board oversight results in failure to identify and address emerging clinical, operational and financial issues	Chief Executive	4	3	12	Interim Board has been replaced with substantive appointments: - 3 x NEDS from 01/05/13; - Director of Operations from 01/06/2013; - Chairman from 10/06/2013 - CEO from 10/06/13; - 2 x NEDs from 01/07/2013 - Director of Corporate Services/Company Secretary from 27/08/2013 - Director of Strategic Planning and Commercial Development from 02/12/2013 - 2 x NEDs from 01/11/13 In addition, a new Interim Medical Director was appointed on 01/10/2013 and the interviews for this substantive position take place during the second week of February 2014. Following this appointment, all Board positions will be substantive.	Formal sub-committee structure is now in place and operational; New Terms of Reference agreed for each of the sub-committees in the structure; Monthly "real-time" reporting to Trust Board by sub-committee chairs with sub-committee minutes the month after; PwC diagnostic on Board Governance successfully delivered and Board assesses progress against the diagnostic in a monthly basis. Exec Team have regular away days to develop and improve team and individual performance	31/12/2013	Induction programme for new NEDs and Chair is required (timetabled for summer 2013); Board Development Programme needed to support the Unitary Board commences January 2014 PwC scored the Board at 4 (down from 13 January 2013) against Monitor's Quality Governance Framework (QGF) in December 2013	3	2	6	Need to deliver the actions required to address the current gaps in assurance;	Chief Executive Chief Executive	30/09/13 31/12/13	

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	3.5	Failure to develop clinicians into effective managers in the Trust - don't have effective clinical leaders to drive appropriate changes	Lack of effective development programme for clinical leaders, lack of clarity of roles and responsibilities	Poor leadership in divisions and clinical services Failure to develop strategic clinical service plans	Director of Human Resources	4	3	12	Clinial Leadership development programme being implemented. Development for senior divisional management teams including CD's. Effective performance management meeting structure in place for each division.	Divisional performance reported monthly to Board			4	3	12	Completion and Evaluation of development programme		31/03/2014	

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Strategic Objective 4: Achieve Financial sustainability.	4.1	Failing to find a solution to PFI excess burden	DH disagrees with outcome of methodology or will not fund result of methodology	Deficit trading position continues to escalate	Chief Financial Officer	5	4	20	Monitor License recognises the need to isolate the PFI impact from underlying financial performance; Disrretionary reporting requirements have been added to our licence conditions so they are updated monthly Monitor have requested they are updated if the Mid Notts Review outputs does not contribute to the PFI burden.	Monthly reports to Finance and Performance Committee and to the Trust Board. Paper outlining Trust initerpretation of the excess PFI burdern has been developed, taken through F&P and shared with Monitor; The £18,3m assessment has been built into the annual plan and the monthly discretionary requirement reporting Monthly meetings	31/03/2014	Further discussions with Monitor and DH	5	4	20	Further disucssions with Monitor and DH	Chief Financial Officer. Chief Financial Officer.	ongoing	
	4.2	Insufficient cash liquidity.	Failure to secure sufficient cash financial support.	Insufficient cash available at short notice results in failure to pay staff and suppliers leading to breach of statutory responsibilities and shortfall in availability of essential medical supplies. Failure to maintain going concern status	Chief Financial Officer	5	3	15	Support obtained for 2013/14 of £26.9m Initial discussions and application for 2014/15 being processed via Monitor	Monthly report to Trust Board and Finance and Performance Committee outlining cash position and forecast cash flows.	31/12/2013	Commitment to liquidity support for the final quarter of 2013/14 has not yet been received. Liquidity support needs to be aligned with the Trust demonstrating delivery of CIP's. 6 month review of liquidity support expected following completion of ARA.	5	2	10	Obtain commitment to liquidity support for the final quarter of 2013/14. Shape a Trust wide view of our benchmark ambition, taking into account all the existing work already focusing on these performance targets	Chief Financial Officer.	30/11/13	
	4.3	Failure to have an agreed financial improvement plan	Inadequate information on market opportunities and threats. Sub optimal Contract agreement with Commissioners. Planning process insufficiently project managed.	Inability to adequately plan capacity. Insufficient progress on factors the Trust can influence (efficiency agenda) and lack of support for factors the Trust can not influence (excess PFI burden)	Chief Financial Officer	5	**4**	20	Actively engaging with commissioners and other partners to deliver the 'Better Together' and 'Better Care Fund' agendas through the Mid Notts joint working	Monthly report to Board of Directors. Monthly Monitor returns	31/03/2014	Impact of 'Better Together' QIPP on 2014/15 contract and internal capacity to be determined	5	**4**	20	Ongoing engagement with 'Better Together' and 'Better Care Fund' partners. Strengthening of programme and project arrangements around associated change.	Chief Financial Officer	Ongoing	
	4.4	Failure to adequately performance manage the agreed operational and financial plan	Processes and information are not robust enough at divisional level	Inability and capacity of the organisation to deliver the agreed plan	Chief Financial Officer	5	**4**	20	Monthly divisional performance management meetings in place with full executive engagment.	Enhanced scrutiny of key issues and associated mitigating actions	31/03/2014	Relationship of Service Line to divisional performance need to be strengthened.	5	**3**	15	Ongoing development of performance management arrangements at serive line level	Chief Financial Officer	31/05/14	

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	4.5	Reduced funding from Commissioners	Further deterioration of the financial health of the local economy. Unforseen alterations to allocations and/or demand for services exceeds agreed activity plan.	Increased financial gap. Quality of service provision severely challenged Commissioners seeking further savings from the trust over and above agreed CIPs	Trust Board	5	4	20	PBR based contract. QIA process in place for CIP's. Monthly divisional performance meetings	Direct relationship between activity and income	31/03/2015	Mitigation of performance risks. Clear ownership at service line, divisional and Trust level.	5	**4**	20	Clear triangulation and mapping of 2014/15 contract to division and service line.	Chief Financial Officer	30/04/14	
	4.6	Failure of delivery of year on year CIPs	Complexity of change means the Trust fails to deliver year on year CIPs in a sustained and transformational way.	Scale of transformation required is beyond existing organisational boundaries Reduced level of influenceable spend.	Trust Board	5	4	20	Development of longer-term CIP plan which is clinically led. PAS implementation in 2014 to support benefits realisation. Incorporated into Board strategy development for October plan submission.		2014/15	Schemes of required value not yet identified. Further work required to develop pipeline over next 3-5 years.	5	4	20	Understand scale for change programme that is stretching but achieveable	Chief Executive Chief Executive	October 31st	
	4.7	Lack of financial management across the Trust	Staff within the Trust do not have a thorough awareness/understanding of good financial governance	Expenditure exceeds available financial resource	Trust Board	5	4	20	Budgetary control system in place		Ongoing	Relationship of Service Line to divisional performance need to be strengthened.	5	4	20	Ongoing development of performance management arrangements at serive line level	Chief Financial Officer	31/05/14	

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Strategic Objective 5: Communication and engagement channels need to be strengthened with health and social care partners	5.1	Planned restructure of services identified in the 'Better Together' Review.	Poor relationship with other health and social care partners in the Nottinghamshire health economy. Restructure of services not implemented as planned.	Planned savings for the Trust and the local health economy not delivered.	Director of Strategic Planning and Commercial Development	4	3	12	The Trust is a member of the 'Better Together' Programme. The Trust is providing clinical leadership in the development of the 'Better Together' review.	Monthly reports to the Trust Board; Monthly reports to TMB; Monthly reports to the Newark Strategy Group	01/03/2015	Better Together' realisation plan needs strengthening.	4	3	12	Analysis and assessment of impact from the findings, conclusions and recommendations of the 'Better Together' review when it is complete.	Director of Strategic Planning and Commercial Development: supported by lead managers for different organisation	01/03/2015	

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	5.2	Clinical strategy does not fully reflect the requirements of commissioners and other stakeholders.	Clinical strategy not updated regularly. Insufficient involvement of stakeholders in setting clinical strategy.	Failure to deliver new and innovative services for patients to fully meet commissioner requirements.	Executive Medical Director	4	3	12	Programme Board Structure and programme of work have been developed. Assistant Director of Operations has been appointed to focus on delivery of the Clinical Strategy. Two streams of work have been implemented to inform the strategy - Theatres and Operations. Service improvement process has been developed. Service improvement programme in initiation process at SFH and dovetailing with CCG 'Better Together' Programme. Agreed 3 workstreams; flow, elective and 24/7. Continuation of Newton Europe work on OP and Theatres ongoing as Elective Programme Board.	Implementation of Care Delivery group outputs from Better+Together.	31/03/2014	Gaps in transformation skills and pathway redesign skills have not yet been quantified; Divisional based strategies are currently under development;	4	4	16	Fully review the business cases from Better+Together, to understand impact and implications for service delivery	Director of Operations, Director of Strategic Planning & Clinical Director	31/03/14	
	5.3	Failure to rectify governance failings and emerge from breach of authorisation		Trust remians in breach of authorisation leading to potential loss of business and take over	CEO	5	4	20	Review of governance across the trust by PwC. Recommendations and action plans reviewed by PMO workbooks and reviewed weekly at Programme Board.	Integrated programme/project workbooks developed and being refined to incorporate QGF and Financial Governance. PwC scored the Trust against Monitor's Quality Governance Framework at 4. (down from 13 January 2013) in December 2013.			4	3	12	Consolidated action plan developed and quality improvement group established. All actions have accountable owners. Quality improvement Group reports to Programme Board monthly.	CEO	30.01.2014	

Impact ratings 1 to 5

1	Insignificant
2	Minor
3	Moderate
4	Major
5	Extreme

Likelihood ratings 1 to 5

1	Rare
2	Unlikely
3	Possible
4	Likely
5	Almost certain

Likelihood X Consequence

		Insignificant = 1	Minor =2	Moderate = 3	Major = 4	Catastophic = 5
Rare - 1		1	2	3	4	5
Unlikely - 2		2	4	6	8	10
Possible -3		3	6	9	12	15
Likely - 4		4	8	12	16	20
Certain - 5		5	10	15	20	25