Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Risk Identification, Assessment, and Management Policy

This procedural document supersedes: CORP/RISK 30 v.2 – Risk Identification, Assessment and Management Policy

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The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor	Chief Executive
Author/reviewer:	Matthew Kane
Date written/revised:	July 2017
Approved by:	Board of Directors
Date of approval:	25 July 2017
Date issued:	15 November 2017
Next review date:	July 2020 - **extended to June 2022**
Target audience:	Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	15 November 2017	Changes to reflect new committee structure and reformatted Board Assurance Framework	M Kane
Version 2	September 2015	Minor changes to reflect the implementation of the online integrated risk management system (Datix).	M Dixon
Version 1	11 August 2014	This is a new procedural document and replaces CORP/RISK 18 v.2 – Risk Assessment Policy (Clinical and Non Clinical) and CORP/RISK 10 v.4 – Risk Management Strategy.	M Dixon

Contents

Wards / Departments / Teams / Nominated Leads

- Identify risks and hazards
- Conduct risks assessments as appropriate
- Manages risks rated 1-7
- Escalates risks rated 8 or above.
- Reviews local risk assessments (at least annually).

Care Group / Directorate Management Teams

(Care Group Director / Executive/Corporate Director = accountable lead)

- Accountable for all Care Group/ Directorate risks, including those escalated. Monitors and reviews Care Group / Directorate Risk Register (monthly).
- Ensures action plans in place, and monitors them.
- Escalates (but continues to review and monitor) risks rated 15 or above.

Management Board

- Monitors and reviews Corporate Risk Register (monthly).
- Approves additions / removals / changes to the Corporate Register.
- Where addition to the Corporate Register is not approved, specifies required action.
- Approves action, where appropriate.

Board of Directors

- Receives Corporate Risk Register (6-monthly).
- Determines risk appetite and tolerance
- Approves Board Assurance Framework (risks against strategic aims).

GOVERNANCE ASSURANCE COMMITTEES

Care Group Clinical Governance Groups

- *Manages clinical risks on Care Group risk register.*
- *Identifies Care Group level risk themes from reported incidents, complaints and claims.*
- *Nominates appropriate leads to conduct formal risk assessments.*

CGC and other committees with a remit pertaining to specific areas of risk or clinical governance

- *Identifies risk themes within their remit.*
- *Nominates appropriate leads to conduct formal risk assessments where themes have been identified, and escalates where appropriate.*

ANCR, F&P and QEC

- *Seeks assurance regarding risk management and control on behalf of the Board of Directors*
- *Receives Corporate Risk Register*
- *Reviews Board Assurance Framework*
- *Identifies trust-wide risk themes.*
- *Nominates appropriate leads to conduct formal risk assessments where themes have been identified, and escalates where appropriate.*

1 INTRODUCTION

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust ('the Trust') recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances all, by their very nature, involve a degree of risk. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust. Failure to manage risk effectively can lead to harm, loss or damage in terms of both personal injury but also in terms of loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation and adverse or unwanted publicity.

This policy covers all aspects of risk assessment and management within the Trust. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, organisational or financial. Risk management is embedded within the Trust's overall performance management framework and links with business planning and investment.

The Board of Directors has overall responsibility for corporate governance, including risk management. The Board has legal and statutory obligations to ensure that there are robust and effective risk management processes and structures in place.

The Trust uses an online integrated risk management system to record risk assessments and risk registers at all levels. The system enable risk register reports to be produced for review and audit purposes, and also enables risks to be escalated as appropriate, therefore supporting a culture of proactive risk management.

This policy is intended for use by all employees and contractors engaged on Trust work in respect of any aspect of that work. Although the management of key strategic risks is monitored by the Board, operational risks are managed on a day to day basis by employees throughout the Trust. The Trust's Board Assurance Framework and Corporate Risk Register provide a central record of the organisation's principal risks.

2 PURPOSE

2.1 The purpose of this policy is to ensure that risks to the following areas are identified, assessed and managed; in addition to being prevented and controlled so far as is reasonably practicable:

a. the Trust's patients, visitors and members of the public
b. the Trust's strategic objectives
c. the Trust's employees,
d. the reputation, finances and business continuity of the Trust
e. the property, sites and equipment owned by the Trust

2.2 This policy highlights the legal requirements placed on the Trust by the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, to carry out risk assessment to identify the hazards and risk associated with the workplace and the work carried out by employees.

3 DUTIES AND RESPONSIBILITIES

3.1 Chief Executive

The Chief Executive has overall accountability and responsibility for risk management within the Trust and for compliance with the relevant regulations, and is responsible for making the Trust's Annual Governance Statement. Delegated responsibility for the implementation of this policy is as shown below.

3.2 Employees

Management of risk is a fundamental duty of all employees whatever their grade, role or status. Employees are required to follow Trust policies and procedures, which explain how this duty is to be undertaken.

In particular, all employees must ensure that identified risks and incidents are reported and dealt with swiftly and effectively, reported in line with relevant Trust policies to their immediate line manager and, if appropriate, their health & safety representative, in order that further action may be taken where necessary. Health and safety is a core element of each employee's KSF (Knowledge and Skills Framework) outline.

3.3 Executive/Corporate Directors

The Executive and Corporate Directors are responsible for those risks which are relevant to their areas of responsibility. In particular, the Medical Director and Director of Nursing, Midwifery & Quality are responsible for risk that has a direct impact upon patient care, safety and quality of care, and the Director of Finance for financial risk. The allocation of risks to individual Directors is shown in both the Board Assurance Framework and Corporate Risk Register.

3.4 Deputy Director of Quality & Governance

The Deputy Director of Quality and Governance is responsible for the operation of the Trust's online integrated risk management system, and ensuring Care Group Directors and managers are supported to fulfil out their responsibilities in line with this policy.

3.5 Trust Board Secretary

The Trust Board Secretary, on behalf of the Chief Executive, is responsible for the Board Assurance Framework and Corporate Risk Register.

3.6 Care Group Directors /Managers

Care Group Directors and managers of departments will ensure that they have a lead for:

- The development of a Care Group/department risk register using the Trust's online integrated risk management system.
- The implementation of risk management systems and processes, both clinical and non-clinical, in each ward or department concerned.
- Ensuring attendance of staff at appropriate education and training sessions.
- Implementing specific policies and procedures.
- Raising risk awareness amongst all staff at operational level.
- Ensuring compliance with external assurance assessments and standards.

3.7 Board of Directors

The Board of Directors is responsible for ensuring that robust systems of internal control and management are in place, and for reviewing the effectiveness of internal controls through its assurance framework. This responsibility is supported through the governance committees of the Board of Directors (see 3.8).

To inform the Annual Governance Statement made by the Chief Executive in the annual accounts, the Board of Directors must be able to demonstrate that it has been informed, through the assurance framework, about all significant risks and that it has arrived at its conclusions on the totality of risk, based on the evidence presented to it.

3.8 Board Committees

The Audit and Non-clinical Risk, Finance and Performance and Quality and Effectiveness Committees are established as governance committees of the Board of Directors. The committees' primary role in respect of risk management is to seek assurance on behalf of the board that internal control and risk management systems are sufficiently robust to ensure delivery of organisational objectives. Where there are significant concerns or gaps in assurance or control, the committees escalate these to the Board.

Each committee owns relevant risks on the board assurance framework and corporate risk register. The committees review both documents at each of their meetings. The ANCR also monitors the integrity of the financial statements of the Trust, while the QEC monitors clinical governance standards.

3.9 Management Board

The Management Board is responsible for monitoring and reviewing the Corporate Risk Register on a monthly basis and approving any changes.

3.10 Clinical Governance Committee (CGC)

The Clinical Governance Quality Committee is responsible for the operational aspects of clinical risk, clinical governance and patient safety.

4 ASSURANCE FRAMEWORK AND RISK REGISTERS

4.1 Board Assurance Framework

The board assurance framework is a tool to enable the Board to assure itself that the principal risks to the achievement of its organisational objectives are being appropriately managed. It is interlinked with the corporate risk register and is structured around the Board's strategic objectives.

The framework summarises the controls in place to mitigate each risk, and highlights where there are gaps in these controls. It also provides a summary of positive assurances received by the Board and its sub-committees in relation to these controls, highlighting where there are gaps in assurance.

The Chief Executive is required to sign an Annual Governance Statement each year, and the board assurance framework informs the declarations to be made in this statement.

The framework shows a summary description of each risk, along with a numerical and red/amber/green risk rating for the current risk after controls, for ease of use by the Board. The assurance framework shall also show the executive lead, the relevant committee, the direction of travel, controls in place, assurance received, gaps in assurance, action being taken to address gaps and target rating.

The framework will be continually reviewed and updated to ensure that it continues to provide the Board with assurance.

The board committees review the full Board Assurance Framework in addition to receiving the Corporate Risk Register for information, in order to avoid taking a fragmented approach to risks at this level.

The board committees each focus on the risks which pertain to their remit and terms of reference. They seek assurance on behalf of the Board that key controls are in place and review risks through their annual work plans. The assurance framework is used to drive the agenda for the committees who will undertake occasional deep dives into the risks for which they are responsible.

The Board receives the board assurance framework and corporate risk register on a quarterly basis.

At least once a year, the Audit and Non-clinical Risk Committee will review whether the assurance framework process and format remain fit for purpose, and recommend changes to the Board where appropriate.

4.2 Corporate Risk Register

The corporate risk register is a tool to enable the Management Board to review and manage the organisation's most important risks. It is interlinked with the assurance framework, and is held on the Trust's online integrated risk management system.

The register will include:

- Source and consequence of the risk
- Executive/corporate director owner and lead committee
- The original, current and target risk rating
- Controls that are in place
- New and developing controls
- Owner of the new/developing controls and target date

Escalation of risks for consideration by Management Board shall be through the Trust Board Secretary.

The Management Board shall review and approve the corporate risk register on a monthly basis. Where changes to risks are made, this shall be reflected in the assurance framework and reported to the board committees as appropriate.

Where changes to the corporate risk register are proposed which affect the content of the assurance framework (i.e. addition or deletion of risks), the proposed change shall be reported to the board committees as appropriate in addition to being presented to the Board of Directors for approval.

The board assurance framework and corporate risk register will be reported to each board committee meeting and to the Board of Directors on a quarterly basis.

At least once a year, the Management Board will review whether the corporate risk register process and format remain fit for purpose, and agree changes where appropriate.

4.3 Directorate / Care Group Risk Registers

Each Care Group and department will be responsible for maintaining their own risk register on the Trust's online integrated risk management system. The registers will be populated as a result of risk assessments, incidents, complaints and claims. The Care Group risk register will be a standing agenda item at clinical management team meetings.

Any risk identified as "Extreme" and that cannot be controlled and managed within the Care Group / directorate will be escalated to the corporate risk register for consideration by the Management Board via the Trust Board Secretary.

All high and extreme level risks identified within the corporate risk register will require a supporting action plan which will ensure that the risk is managed to an acceptable level. The action plans will be monitored by the Lead Director.

5 ORGANISATIONAL RISK PRINCIPLES

The Board of Directors has agreed the following principles with regard to its role in relation to risk:

(i) The Board will consider all aspects of risk in relation to the decisions it makes and the information it receives. This will include:

a. The risk of inaction
b. Reward, where applicable
c. How risks link to the Trust strategy, values and culture
d. The adequacy of risk management and controls
e. Structures and escalation processes
f. The overall risk profile and risk burden of the Trust, and its capacity to manage that risk

(ii) The Board will assess risks both initially and on an ongoing basis, recognising that where risks are dynamic its risk tolerance and strategies must be dynamic to reflect this.

(iii) The Board will work to ensure it has sufficient information regarding key risks by, among other things:

a. Seeking external advice where appropriate.
b. Seeking ongoing assurance from management regarding the control and management of risks.

(iv) The Board will mitigate risk as far as it feels that it is sensible and appropriate to do so.

(v) The Board will ensure that risk surveillance and triangulation are factored into its work and discussions on an ongoing basis.

6 RISK ASSESSMENT PRINCIPLES

Risk assessment is the process of identifying, describing, measuring and recording risks. Judgments are made about the harm that might arise from an activity and the probability that the harm will occur.

The main purpose of risk assessment is to determine whether planned or existing control measures are adequate or need to be improved. It also promotes an improved awareness of risk and a better appreciation of the necessity for control measures.

6.1 Risk Identification

The Trust operates two major systems to facilitate the identification of risk:

- Proactive risk identification, through identification of risks before they lead to harm. This includes interventional near miss reporting.
- Reactive risk identification, through the adverse incident reporting process; Datixweb.

In order to identify risk, teams should conduct a detailed review of the activity or area being reviewed, including any hazards perceived, and any incidents that have occurred. Once hazards and potential risks have been identified, they should be formally assessed.

6.2 Legal Requirements

The Management of Health and Safety at Work Regulations 1999 (MHSWR) require employers to assess the risks to the health and safety of the groups below which are created by their undertaking, in order to identify the measures that are required in order to comply with statutory provisions.

- employees whilst they are at work;
- non-employees
- new or expectant mothers
- young persons, taking into account the young persons' inexperience, immaturity and lack of awareness of risks;

Further specific risk assessments that are required to be completed in accordance with the MHSWR 1999 include:

- Lone Working
- Violence and aggression
- Stress
- Slips, Trips and Falls, including Working at Height
- Musculoskeletal Disorders

There are a number of other regulations which suggest a requirement for risk assessments, including the Health and Safety (First-aid) Regulations 1981; the Environmental Protection Act 1990 and the Provision and Use of Work Equipment Regulations 1998. The relevant regulations should be referred in relation to any area of work undertaken as part of the business of the Trust, in order to determine where a risk assessment may be required.

6.3 Risk Assessment Documentation

The findings of the risk assessment must be recorded using the Trust's online integrated risk management system (http://dbhdatixweb/datix/live/index.php). All staff who document risks using this system should receive appropriate training.

Documenting a risk using the Trust's online integrated risk management system requires the employee documenting the risk assessment to:

- describe the risk in full, covering the cause (situation giving rise to the risk), the event that may occur, and the effect of that event
- assign a 'risk owner' (the manager who is responsible for the area which the risk assessment affects)
- identify the appropriate review frequency (monthly for all risks rated 8 or above)
- describe any action already taken and control measures already in place
- determine the adequacy of existing control measures
- determine the likelihood of injury or harm arising, quantify the severity of the consequences of this harm, and assign a risk rating
- determine the target risk rating using the same principles
- identify potential additional control measures or actions, with timescales for implementation or details of process being followed.
- identify any specific legal duty or requirement which is relevant to the risk
- identify any reported incidents that relate to the risk
- provide sufficient information to enable the risk owner to monitor and manage the risk appropriately.

7 RISK ASSESSMENT PROCESS

The risk assessment process can be broken down into steps as follows:

(a) Identify potential hazards or risks - Carry out a pre-assessment walkthrough or review of the activity to identify hazards or potential risks. Be systematic, list all credible/foreseeable hazards and consider all possibilities.

(b) Plan the assessment - Assessments should be planned and prioritised for a specific area or activity and should cover likely risk issues including:

- work activities
- property and equipment
- known hazards
- accident and incident reports
- known 'near misses'
- risks to achievement of specified objectives or targets

(c) Define the nature of the risk – Once identified, the risk should be defined. What might occur, or is occurring, and what adverse consequences might this cause?

(d) Identify the people at risk - Identify all those who might be at risk including staff, contractors, patients, and the public.

(e) Analyse exposure - Identify under what conditions, when and how exposure to the risks takes place.

(f) Detail and evaluate the existing controls in place - Evaluate how the risk is being controlled, taking into consideration statutory compliance requirements and whether the controls are effective in practice.

(g) Quantify the risk – Determine the likelihood and consequences of the risk being realised using the Risk Matrix shown at **Appendix 2.** Use these scores to allocate a risk rating.

(h) Identify further controls - Identify further control measures or actions required to reduce the risk, and prioritise these.

(i) Develop action plan - An action plan should be drawn up to implement any further control measures required. This should identify who is responsible for actions, and timescales for completion. This plan should be monitored at the identified appropriate level, dependent on the risk rating. Where actions require escalation in order to gain approval, this should be undertaken.

(j) Quantify the target residual risk - The target residual risk is the lowest level which the department anticipates being able to reduce the risk to, following completion of the action plan. The target residual risk should be quantified, and a timescale set for achieving this reduction.

NB: In some cases, the target residual risk may be the same as the current risk rating. In these cases, no action is required, although existing control measures must be maintained.

(k) Record the findings - The significant findings of the assessment together with any actions identified should be recorded using the Trust's online integrated risk management system. The assessment should be approved by the risk owner, and conveyed to all staff.

(l) Review the assessment - This is required on a regular basis (monthly for all risks rated 8 or above) and under the following circumstances:

- If new equipment is introduced
- If new substances or premises are used
- If new clinical techniques are introduced which impact on staff rosters or patient handling duties
- If other processes or operational parameters change significantly
- Following an accident
- If there is reason to suspect that the assessment is no longer valid
- If there has been a significant change in matters to which the assessment relates

(m) Inform staff - Staff should be informed of:

- Any risks to their health and safety identified by the assessment
- Control measures in place
- Any emergency measures identified
- Planned action to be taken

8 REVIEW AND MONITORING OF RISKS

(a) The responsibility for the risk assessment lies with the manager who is responsible for the area which the risk assessment affects (e.g. on a ward, the ward manager/sister).

(b) Following completion of the online risk assessment, the head of department will approve the assessment on the Trust's online integrated risk management system, to confirm agreement with both the risk assessment and action plan.

(c) The head of department will ensure an action plan is developed where appropriate, and appoint a lead person for each action point together with a completion date. Once finalised, the risk assessment and action plan will be notified to all persons who could be affected by the outcome of the risk assessment.

(d) A programme of monthly review must be established for risks rated 8 or above, to ensure that all agreed actions are carried out within timescales. This will be carried out by the appropriate Care Group or directorate management team within the Care Group / directorate governance arrangements.

(e) All risk assessments rated lower than 8 should be reviewed on an annual basis as a minimum, or as described below.

(f) Risks rated 15 or above should be escalated for inclusion in the Corporate Risk Register in addition to the process outlined above. Risks on the Corporate Risk Register are reviewed monthly by the Management Board.

(g) In addition to the above, risk assessments should be reviewed if they meet the criteria outlined under paragraph 7(l) above.

9 TRAINING/ SUPPORT

The effective implementation of this policy will facilitate the delivery of a quality service, alongside employee training and support to provide an improved awareness of the measures needed to prevent, control and contain risk.

An assessment of the risk management training needs of all staff will be documented within the Trust's Training Review which will be reviewed on an annual basis and action plans developed. This assessment will be linked to incidents, claims, complaints, risk assessments, external assurance and performance indicators.

The Trust's training prospectus will include details of all risk management courses. Local risk management training needs identified by individual areas will be discussed with the risk management department.

The Training Department will maintain records of actual and expected completion of statutory and essential to role training, including corporate induction, and will address and rectify inadequate attendance. Care Groups and departments will address and rectify inadequate attendance at local mandatory training courses.

The Trust will:

- Ensure all employees and stakeholders have access to a copy of this policy
- Provide new employees with corporate induction.
- Provide risk management awareness training to board members, (both Executive, corporate and Non-executive Directors) manager and Care Group management teams on an annual basis.

Those carrying out assessments should be competent to do so and should have attended the Trust's internal training. The assessor should have an understanding of the workplace, an ability to make sound judgements, and knowledge of the best practicable means to reduce those risks identified. Competency does not require a particular level of qualification but may be defined as a combination of knowledge, skills, experience and personal qualities, including the ability to recognise the extent and limitation of one's own competence.

The Health and Safety Advisor, Trust Board Secretary and Deputy Director of Quality & Governance are available to provide support and advice to employees experiencing difficulties in assessing risk.

10 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Risk escalation in the Trust has been supported by initial internal audit reviews to date and the risk management system will continue to be reviewed by the internal auditors.

What is being monitored?	Who will carry out the monitoring?	How often	How reviewed / Where reported to?
Correct completion of risk assessments.	Risk lead for ward/department	Annually	Audit / Deputy Director of Quality & Governance
Completion of action plan with each risk assessment where further action is necessary.	Risk lead for ward/department	Annually	Audit / Deputy Director of Quality & Governance
Ward/department level risk register monitored monthly by ward/ department manager.	Risk lead for ward/department	Annually	Audit / Deputy Director of Quality & Governance

Care Group / Directorate level risk register monitored monthly at appropriate forum.	Risk lead for Care Group/Directorate	Annually	Meeting minutes / Deputy Director of Quality & Governance
Corporate Risk Register monitored monthly by the Management Board.	Head of Risk & Legal Services	Annually	Meeting minutes / Trust Board Secretary

11 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 3).

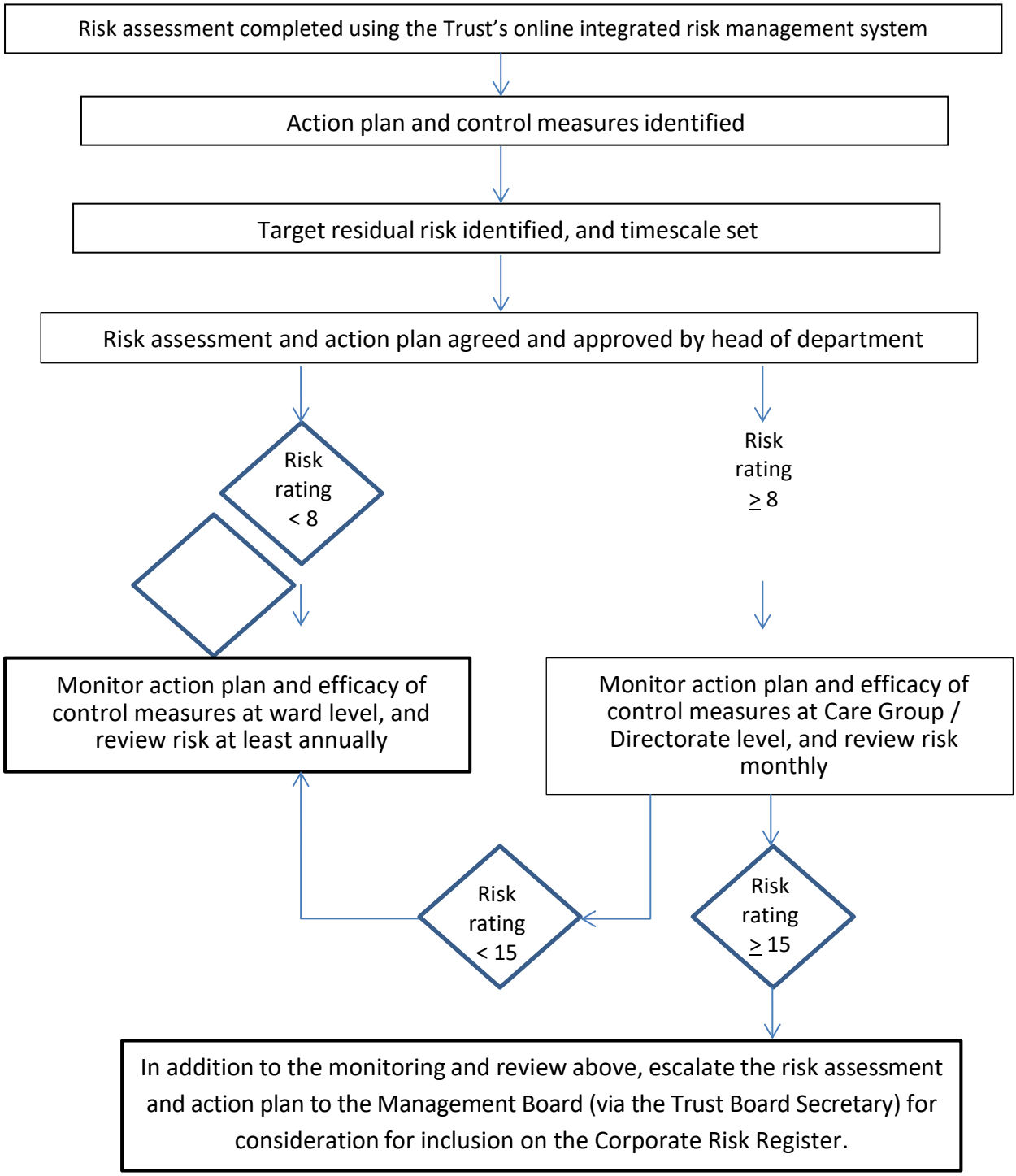
12 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Claims Handling Policy - CORP/RISK 5
- Policy for the Reporting and Management of Incidents and Near Misses - CORP/RISK 13 - *(withdrawn October 2017 and now incorporated into CORP/RISK 33)*
- Serious Incidents (SI) Policy - CORP/RISK 15
- Maternity Service Risk Management Strategy - CORP/RISK 16
- Learning from Incidents, Complaints and Claims - CORP/RISK 20 - *(withdrawn October 2017 and now incorporated into CORP/RISK 33)*
- Incident Management Policy – CORP/RISK 33
- Complaints, Concerns, Comments and Compliments: Resolution and Learning - CORP/COMM 4
- Fair Treatment for All Policy – CORP/EMP 4
- Equality Analysis Policy – CORP/EMP 27
- Raising Concerns: 'We Care, We Listen, We Act' - CORP/EMP 14
- Health and Safety Policy - CORP/HSFS 1
- Security Policy - CORP/HSFS 15

13 REFERENCES

- Control of Asbestos Regulations 2012
- Control of Lead at Work Regulations 2002
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Data Protection Act 1998
- Health and Safety at Work Act 1974
- Health and Safety (Display Screen Equipment) Regulations 1992
- Ionising Radiation Regulations 1999
- Management of Health and Safety at Work Regulations 1999 (SI No 3242).
- Management of health and safety at work - Approved Code of practice and Guidance (L21 - HSE)
- Manual Handling Operations Regulations 1992
- Noise at Work Regulations 2005
- Personal Protective Equipment at Work Regulations 1992

APPENDIX 1 – FLOWCHART FOR MONITORING AND REVIEW OF RISK ASSESSMENTS



APPENDIX 2 – RISK MATRIX

Table 1 - Consequence Score

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

	Consequence score (severity levels) and examples of descriptors				
	1 - Negligible	**2 - Minor**	**3 - Moderate**	**4 - Major**	**5 - Catastrophic**
Impact on the safety of patients, staff or public (physical / 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.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/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/ inquiry.	Overall treatment or service suboptimal. Formal complaint - 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. 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/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards.
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 /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 /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 breach of guidance / statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendation / improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches 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% over project budget. Schedule slippage.	5–10% over project budget. Schedule slippage.	10–25% over project budget. Schedule slippage. Key objectives not met.	>25% over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget. Claim less than £10k.	Loss of 0.25–0.5% of budget. Claim(s) between £10k and £100k.	Uncertain delivery of key objective /Loss of 0.5–1% of budget Claim(s) between £100k and £1m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >1% of budget. Failure to meet specification /slippage. Loss of contract / payment by results. Claim(s) >£1m.
Service / business interruption	Loss /interruption of >1 hour.	Loss /interruption of >8 hours.	Loss /interruption of >1 day.	Loss /interruption of >1 week.	Permanent loss of service or facility.
Environmental impact	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic impact on environment.

Table 2 - Likelihood Score

The frequency-based score is appropriate in most circumstances and should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor & Frequency	**Rare** - This will probably never happen /recur.	**Unlikely** - Do not expect it to happen / recur but it is possible it may do so.	**Possible** - Might happen or recur occasionally.	**Likely** - Will probably happen / recur but it is not a persisting Issue.	**Almost Certain** - Will undoubtedly happen / recur, possibly frequently.

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Risk Identification, Assessment & Management Policy	Chief Executive	Matthew Kane	Existing Policy	July 2017

1) Who is responsible for this policy? Name of Care Group/Directorate: Maria Dixon

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide a framework for risk management

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

Date for next review: July 2020

Checked by: Rick Dickinson **Date: July 2017**