Yeovil District Hospital NHS
NHS Foundation Trust

RISK MANAGEMENT STRATEGY

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RISK MANAGEMENT STRATEGY

1 INTRODUCTION

1.1 The Chief Executive and the Board of Directors (BoD) at Yeovil District Hospital NHS Foundation Trust (the Trust) are committed to a strategy, which minimises risks and achieves compliance with statutory requirements through a comprehensive system of internal controls and committees, whilst maximising the potential for flexibility, innovation and best practice in delivery of its strategic objectives. The Trust is committed to ensuring the safety of patients, staff, the public and stakeholders against risks of all kinds.

1.2 As part of governance arrangements, this strategy outlines the risk management framework, emphasising the way that the Trust can implement its strategic objectives through an integrated risk management approach. Integrated risk management is the identification and assessment of the collective risks, both corporate and clinical, that affect the value and the implementation of the Trust's strategic objectives so that risks are not seen in isolation. This Risk Management Strategy aims to maximise the value of an integrated risk management approach by demonstrating the Trust's risk profile and investigating mitigating actions and controls.

1.3 A clear understanding of the key strategic objectives and a commitment to corporate governance will ensure that risk analysis and management are applied throughout the organisation. The Risk Management Strategy also endeavours to promote a culture whereby patient safety and quality are at the heart of all clinical practice and all staff are open to sharing learning from the experiences related to the management of risk.

1.4 The Strategy will support the Trust, directly employed staff and shared service providers in managing risk through safe systems of practice, including the identification of risk and the use of clinical guidelines and protocols to minimise risk. The Assurance Committees on behalf of the Board of Directors will ensure that safe systems and robust risk management arrangements are in place for delivering quality and safe care.

1.5 Reducing risk can lead to an improvement in patient safety and quality of care. Equally, improved quality of care may lead to a reduction of clinical risk. Risk management is therefore regarded in the Trust as an integral part of quality governance. It is the Trust's aim to ensure that all professionals working within the organisation know that quality governance, assurance and patient safety are part of their daily responsibility and embedded in their working practices.

1.6 Having the capability to reduce risks does not necessarily imply that the Trust should reduce the risk. Inevitably all risk cannot be eliminated entirely and there needs to be an understanding of the levels of risk faced by the Trust to allow an assessment of which areas of risk which should be prioritised.

2 PURPOSE

2.1 The purpose of this Risk Management Strategy is:

- to demonstrate an organisational risk management structure in which all the Committees have shared responsibility for managing risk across the organisation
- to outline a process which ensures that the Board of Directors undertakes regular review of risk through the Assurance Framework and Corporate Risk Register
- to ensure the development of a system for implementation of seamless risk management strategies in all areas of the organisation including business planning, delivery of care and planned developments

- to identify within the Strategy documentation and process, the roles and responsibilities of key individuals in post with responsibility for advising on and coordinating risk management activities

- to identify the respective roles, responsibilities and accountability undertaken by the Board of Directors, managers and staff for areas of risk

- to identify the responsibilities of all managers/clinicians and staff and their authority with regard to managing risk

- to outline the process for risk assessment for all types of risk including those that relate to specific areas including projects

- to identify risks against standards set by regulators such as the Care Quality Commission and NHS Improvement

2.2 In the implementation of this Strategy, the Trust will support the adoption of a no blame culture regarding the reporting of adverse incidents in line with NHS England, National Reporting and Learning Service (NRLS) and the Serious Incident Framework – Supporting Learning to Prevent Recurrence of Harm 2015.

2.3 The Trust has committed to 'Being Open' and the contractual 'Duty of Candour' applies, ensuring openness and transparency when dealing with patients and families when harm occurs.

2.4 The Trust is committed to delivering fully inclusive and accessible services and meeting the standards set out in the Equality Delivery System (EDS2). The EDS2 is designed to help organisations review and improve their equality performance and embed equality into services through identifying future priorities and actions.

3 ARRANGEMENTS FOR RISK MANAGEMENT

3.1 The Trust will ensure that the management of risk is established throughout the organisation with guidance on roles, responsibilities, processes and procedures.

3.2 Risk may be defined as the possibility of incurring loss or the likelihood of adverse consequences arising from an event. Risk may also be described as the potential for a hazard to prevent the achievement of organisational objectives leading to a detrimental impact on patients, staff and members of the public.

3.3 Managing risk, clinical and non-clinical, is accepted as a key organisational responsibility and is an integral part of management systems and processes.

3.4 All staff have an important role in identifying, assessing and minimising risk. This can be achieved where there is a culture of openness, being 'fair and open', together with a willingness to admit mistakes. The organisation has a Being Open and Duty of Candour Policy in respect of communicating with patients and/or carers about patient safety incidents.

3.5 The Trust has adopted the principles of risk management, which form the basis of the risk management framework. This will assist in the identification and analysis of all risks. The risks identified may include those which adversely affect the quality of patient care, the ability to deliver services, the health, safety and welfare of patients, visitors and staff or the ability of Trust to meet service and contractual obligations.

3.6 The following methods are to be used in the identification and management of risk:

- maintenance of Strategic Business Unit and Specialty risk registers
- involvement of all staff in the assessment of risk
- ongoing analysis of all clinical, financial and corporate risk
- analysis of incidents, claims and patient experience
- identifying new risks from significant events and near misses
- root cause analysis of significant events and serious incidents
- identifying new risks from national reporting through the Central Alerting System (CAS) e.g. Patient Safety Alerts issued by NHS England, Chief Medical Officer (CMO) Alerts, National Reporting Learning System (NRLS), Medicines and Healthcare Products Regulatory Agency (MHRA)

3.7 The overall Trust responsibility for risk management will rest with the Board of Directors. Other Assurance Committees with responsibility for risk management are:

- Board Assurance Committee - Audit Committee, Governance and Quality Assurance Committee (GQAC), Workforce Committee and Financial Resilience and Commercial Committee
- Executive Committee
- Risk Assurance Committee
- Formal Committees/Steering Groups

3.8 For an explanation of the Committees responsibilities see Section 6.

3.9 Staff are involved in risk management; both through the incident reporting process and through the proactive identification and management of risk in the organisation. Staff level responsibilities for risk management are detailed in Section 7.

3.10 The corporate risk register will be assessed at least quarterly in order to inform the Annual Governance Statement and when procedural, legislative or best practice changes occur.

3.11 The policy, strategy and the principle of risk management will be communicated to staff. Staff will be encouraged in the use of risk assessment to identify both immediate risks and long term risks.

4 RISK REGISTER AND ASSURANCE FRAMEWORK

Arrangements

4.1 The Strategic Business Unit and Specialty risk registers identify and list the risks facing the Trust and the action being taken to mitigate them.

4.2 All Lead Directors (including Lead Clinicians responsible for specific work streams), supported by the Head of Risk and Litigation are responsible for ensuring that risks identified through local mechanisms are included on Strategic Business Unit and Specialty risk registers and the Corporate Risk Register for those scoring 12+ in line with the risk matrix. The Deputy Chief Executive, Chief Nurse & Director of People and

the Deputy Director Quality Governance and Patient Safety are responsible for ensuring that Trust-wide clinical risks are included.

4.3 The Lead Directors and Clinicians are responsible for prioritising risk treatment plans based on detailed analysis and evaluation of risks.

4.4 The Executive Committee and the Assurance Committees will review the Corporate Risk Register as part of their meetings agendas to ensure risk treatment plans are being implemented. The Audit Committee will have overall oversight of the Assurance process.

4.5 Each risk will be scored using the matrix quantification methodology favoured by the NHS. This assigns values between 1 and 5 to both the likelihood of the risk being realised and the possible consequences of this. These are then multiplied together to give a risk rating. The matrix for assessing and rating risk is attached at **Annex B.**

4.6 When deciding if a risk is acceptable, the risk rating will be considered in the light of controls to reduce the risk and the Trust's risk appetite. If significant and effective action has already been taken to minimise the adverse consequences of the risk, then the risk may be termed acceptable. If further controls could be taken to reduce the risk, these will be considered in the light of the urgency of the risk, and the cost and time commitment needed to implement the control.

4.7 Within the Trust, the Strategic Business Unit and Speciality risk registers will become an integral tool in the risk management process used actively by all Directors and their staff. Risk registers will be updated by the responsible leads set out in the risk registers supported by the Head of Risk and Litigation, with risk information being received from a variety of sources.

Definitions of Significant and Acceptable Risk

4.8 An acceptable risk may be defined as a potential hazard that is either small enough to have an immaterial effect on the achievement of organisational objectives, or is a significant risk that has been mitigated by the establishment of effective controls. These controls may minimise the likelihood of the risk occurring, and/or minimise the adverse consequences should the risk identified occur.

4.9 A significant or high risk may be defined as any risk which has been identified by the Board of Directors, Strategic Business Units or Speciality areas as being potentially damaging to the organisation's strategic objectives. Significant or high risks would be those assessed as having a risk rating of 12 or above (12+) and should be reported in accordance with the risk appetite.

4.10 Risk appetite is a threshold – the amount of risk that an organisation is prepared to accept before it takes action. **Annex A** sets out the Trust's Risk Appetite Statement.

4.11 As part of the risk management process, all risks identified are evaluated and given a risk level rating. The higher the risk level, the greater the likelihood and/or impact of that risk occurring. **Annex B** sets out the risk scoring and assessment guidelines.

4.12 The **risk** level ratings for the Trust are defined as follows:

- **Risk Level – Low (Green) - Risk Matrix Scoring 6 or under -** These represent the lowest levels of opportunity/threat and actions shall be limited to contingency planning rather than active risk management action. Risks can be recorded on the Strategic Business Units and Speciality risk registers. Risk level shall be monitored as part of the 'local' risk register review of activities such as team and senior management meetings.

- **Risk Level – Moderate (Yellow) – Risk Matrix Scoring between 8 and 10**
  These represent moderate levels of opportunity/threat. Risks in this category shall have actions defined on the risk register or on an action plan for risk treatment. Risks shall be recorded on Strategic Business Unit and Specialty risk registers and tabled at appropriate meetings, management meetings and relevant committees with responsibility for risk management.

  The risk level shall be monitored as part of the Strategic Business Unit and/or Specialty managers review together with the status of controls in place and risk treatment.

- **Risk Level – Significant (Amber) – Risk Matrix Scoring between 12 and 15 -** These represent significant levels of opportunity/threat which may have a short or medium term impact on organisational objectives. Risks in this category shall have individual actions plans for risk treatment. Risks shall be proactively managed and reported on at intervals defined in the action plan but as a minimum requirement quarterly to the Executive Committee, Assurance Committees and to the Board of Directors through the Corporate Risk Register.

- **Risk Level – High (Red) – Risk Matrix Scoring 16+ -** These represent higher levels of opportunity/threat which may have a major or long term impact on benefits realisation or organisation objectives and which may also impact on strategic objectives and outcomes positively or negatively.

  Risks in this category shall have individual action plans for risk treatment. Risks shall be proactively managed and reported on at intervals defined in the action plan but as a minimum requirement quarterly to the Executive Committee, Assurance Committees and to the Board of Directors through the Corporate Risk Register.

The Assurance Framework

4.13 The Assurance Framework is designed to provide NHS organisations with a method for the effective and focused management of the principal risks to meeting its strategic objectives. It also provides evidence to support the Annual Governance Statement.

4.14 This is intended to simplify Board of Directors reporting and the prioritisation of action plans, which in turn, allows for more effective performance management.

4.15 The Assurance Framework sets out the strategic objectives and identifies assurances on key controls, ensuring principal risks, mitigating actions and gaps in controls are documented and monitored. A Lead Director responsibility is identified against the objectives. The Assurance Framework is supported by the Corporate Risk Register to identify operational risks.

4.16 The Trust will review their strategic objectives and principal risks on at least an annual basis.

4.17 The Assurance Framework will be presented to the Executive Committee, the Assurance Committees and the Board of Directors quarterly for review and proactive management of gaps in assurance about the delivery of strategic objectives.

5 DEFINITIONS

- **Risk** is the threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. It is measured in terms of likelihood and consequence.

- **Risk management** is about the Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.

- **Risk assessment** is a systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).

- **Principal risks** are those that represent a threat to achieving the Trust's strategic objectives or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder.

- **Operational risks** are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks can be managed by the Strategic Business Unit or Corporate area which is responsible for delivering services.

- **Risk registers** are repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk registers are available at different organisational levels across the Trust.

- **Risk appetite** is the type and amount of risk that the Trust is prepared to tolerate and explain in the context of its strategy.

- **Risk Matrix** is the mechanism through which all risks are rated and scored.

- **Governance** is the systems and processes by which the Trust leads, directs and controls its functions in order to achieve its organisational objectives, safety, and quality of services, and in which it relates to the wider community and partner organisations.

- **Internal controls** are Trust policies, procedures, practices, behaviours or organisational structures to manage risks and achieve objectives.

- **Assurance** is the confidence the Trust has, based on sufficient evidence, that controls are in place and operating effectively and its objectives are being achieved.

- **Assurance Framework** provides the organisation with a comprehensive method for the effective and focussed management of principal risks that affect the strategic objectives of the Trust.

6 ORGANISATIONAL RESPONSIBILITIES FOR RISK MANAGEMENT

6.1 The Board Governance Structure (the organisation's Committee structure chart) is contained on the Trust's website under the publication section: https://www.yeovilhospital.co.uk/about-us/corporate-information/

Board of Directors

6.2 The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will:

- agree the strategic objectives and review these on an annual basis
- identify the principal risks which may prevent the Trust from achieving its key objectives
- receive and review the Corporate Risk Register and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks
- support the Trust's risk management programme
- review the Risk Management Strategy at regular intervals but as a minimum once every 3 years
- approve Assurance Committee terms of reference annually

Audit Committee

6.3 The role of the Audit Committee is to provide independent verification to the Board of Directors on wider organisational controls and risk management. It is not the Audit Committee's role to contribute to the identification and management of risks, but it will review the findings of internal (and external) audit, together with any agreed management action, with the Lead Director and Lead Clinician responsible and the internal auditors.

6.4 The Committee will:

- oversee the Risk Management Strategy and process
- review the Corporate Risk Register and Assurance Framework at their meetings
- review internal and external sources to provide adequate assurance to the Board of Directors that risks are being appropriately controlled and risk management is embedded throughout the organisation
- receive and consider risk management reports from other Committees and Groups with responsibility for risk
- review the Risk Management Strategy at least annually and approve 3 yearly for ratification at the Board of Directors

Governance and Quality Assurance Committee (GQAC)

6.5 The GQAC acts as a focus for the management of clinical, non-clinical risks, receiving reports and recommendations from the Patients Safety Steering Group, Clinical Outcomes Committee, Patient Experience Steering Group, Risk Assurance Committee and other Committees agreed through the GQAC and included within the Trust's Governance Structure (see Section 6.1).

Executive Committee

6.6 The Executive Committee has delegated powers from the Board of Directors to oversee the day-to-day management of an effective system of integrated governance,

risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives. The Committee will review the effectiveness of the management of the Principal Risks as monitored by the Assurance Framework and operational risks as monitored by the Corporate Risk Register. The Committee will also review and monitor the structures processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Assurance Committees and the Board of Directors.

Risk Assurance Committee (RAC)

6.7 The Risk Assurance Committee (RAC) reviews and tests assurance from Operational Leads for topic areas on behalf of the Assurance Committees and oversees the development and delivery of key governance systems. The Committee will provide exception reports directly to the Board Assurance Committees on topic areas to support the assurance process.

Formal Committees

6.8 There are a number of Committees/Groups that report to the Assurance Committees who are responsible for reviewing and managing the risks under their remit in line with their terms of reference.

7 STAFF RESPONSIBILITIES FOR THE MANAGEMENT OF RISK

Chief Executive

7.1 The Chief Executive as the Accountable Officer has overall responsibility for ensuring the implementation of the Risk Management Strategy, including organisational controls and reporting arrangements and is the Executive Director responsible for Fire, Health and Safety.

Deputy Chief Executive, Chief Nurse and Director of People

7.2 The Director Lead for Clinical Risk has overall responsibility, delegated from the Chief Executive for Quality and Patient Safety, Risk Management and Quality Governance and Assurance, including:

- ensuring implementation of risk management standards and reporting to the Executive Committee, Assurance Committees and the Board of Directors
- providing clinical leadership for the development and implementation of the quality improvement and patient safety plan
- ensuring the effective delivery of clinical care, including clinical audit, evidence based medicine and national and local guidelines in commissioned services
- reporting to the Somerset CCG Governing Body on patient safety, safeguarding, and quality governance and assurance
- ensuring systems for reporting incidents, investigation of serious incidents and external reporting arrangements are managed effectively

7.3 The Deputy Chief Executive, Chief Nurse and Director of People is the nominated Security Management Director (SMD).

Chief Finance Officer

7.4 The Chief Finance Officer is responsible for progressing financial risk management and is the nominated Senior Information Risk Owner (SIRO).

Chief Information Officer

7.5 The Chief Information Officer is responsible for progressing information risk management.

Senior Director Risk Leads

7.6 The Senior Risk Management leads are:

- Deputy Chief Executive, Chief Nurse and Director of People
- Chief Finance Officer
- Chief Medical Officer
- Chief Operating Officer
- Director of Operations
- Chief Information Officer
- Director of Transformation

7.7 They are responsible for:

- communicating the Risk Management Strategy
- carrying out the risk management processes set out in Section 8
- ensuring that effective risk management processes are in place within their areas of responsibility
- initiating action within their area to prevent or reduce the adverse effects of risk
- managing the treatment of risk until it becomes acceptable to the organisation
- ensuring that learning from events and risk assessments is disseminated throughout the organisation

Company Secretary

7.8 The Company Secretary is responsible for managing the governance arrangements at the Board of Directors level including maintaining the Assurance Framework, ensuring it drives the Board agenda with quarterly reports to the Board of Directors. The role of Company Secretary will also review the assurance and risk Committees structure ensuring it meets the needs of the Trust in line with the governance arrangements.

Deputy Director Quality Governance and Patient Safety

7.9 The Deputy Director Quality Governance and Patient Safety is responsible for monitoring clinical incidents, serious incidents requiring investigation and the maintenance of strategic level reporting to ensure that the Executive Team is fully aware of all clinical risks within the Trust.

Head of Risk and Litigation

7.10 The Head of Risk and Litigation is responsible for maintaining the Trust's risk register and risk management arrangements, working in collaboration with the Company Secretary and Chief Executive to identify corporate risks for reporting to the Board of Directors from the operational risk registers. The Head of Risk and Litigation provides risk register arrangements for the Strategic Business Units and departments to identify and manage their risks.

Managers/Heads of Departments

7.11 Managers are responsible for:

- carrying out risk assessments and risk management processes, including identification, assessment and treatment of risks and communicating risk to those affected, escalating to the risk register as necessary
- maintaining Fire and Health and Safety Risk Assessments locally and developing safe systems of work when significant or high risks are identified that are communicated and monitored
- ensuring that staff accountable to them understand their responsibilities in respect of risk management
- ensuring incidents are reported and managed, and concerns are raised where poor practice, or safety concerns are identified

All Staff

7.12 All staff are responsible for risk management from participation in risk assessment to following the safe working practices that involve their work. Staff are responsible for abiding by policies and procedures and the findings of risk assessment and may be subject to disciplinary action for non-compliance. All staff are responsible for helping to maintain a safe working environment, for using the Trust incident reporting system and for informing their line manager of issues of concern, which may affect safety and quality.

7.13 Staff should report such risks (or potential risks) to their line manager in the first instance and raise concerns as they arise.

7.14 There is a link on the YCloud site for raising views and concerns for staff to access to report their concerns.

8 OPERATIONAL RISK MANAGEMENT

8.1 Implementation of this strategy is essential to achieving a robust risk management system throughout the organisation on which the quality of care to patients and the safety of staff and members of the public ultimately depends. It therefore has important and far-reaching implications. It is recognised that this requires detailed knowledge and understanding of risk management.

Risk Management Process

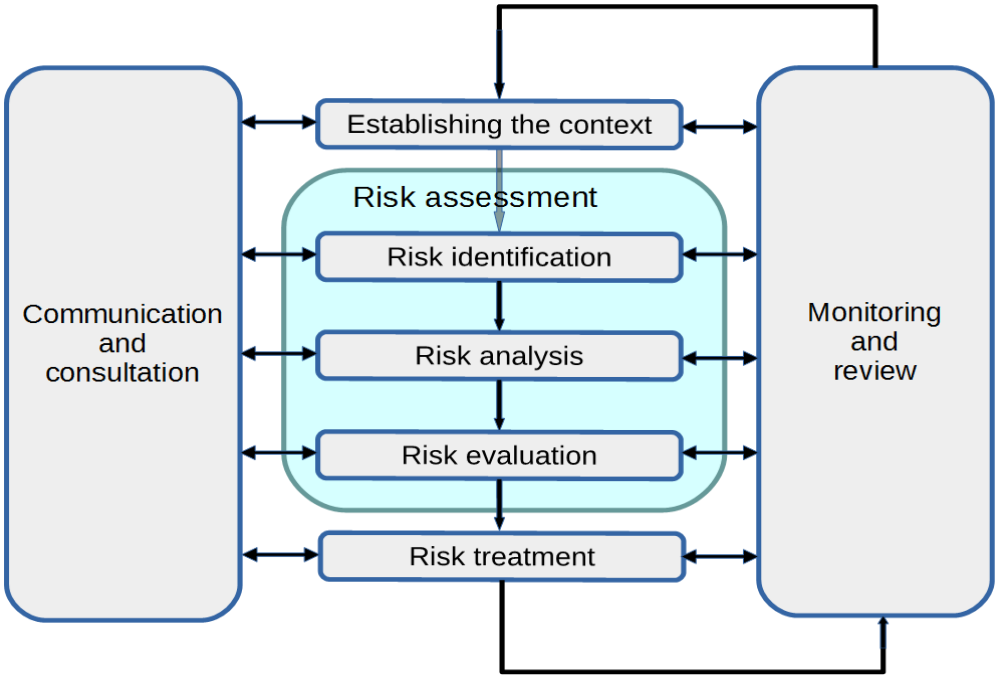
8.2 The Trust promotes the establishment of an open and fair, blame-free culture for reporting incidents. There will be clear guidance for all staff regarding staff roles in risk management and this will be clearly communicated at all levels.

8.3 There are many partner organisations involved in the provision of health services for the Risk Management Strategy. These include the Local Authorities, voluntary

organisations, non-statutory health service providers, patient, carer and user groups, as well as the Clinical Commissioning Group (CCG),NHS England and NHS Improvement. Partnership working with these organisations is of key importance in terms of reporting and managing risk.

8.4 The Trust's risk management process is based on the UK standards ISO 31000 – Application of Risk Management Standards. This model is internationally recognised and has been adopted by the Trust as a risk management model, which is effective at managing risk at any level. Risk management is a continual improvement cycle where objectives are set, risk is identified, assessed and managed proactively. Fig 1 demonstrates the risk model:

Figure 1 - Risk Management Overview from ISO 31000



8.5 The key principles of the risk management process:

- a culture where risk management is considered an essential and positive element in the provision of healthcare
- provision of a supportive structure for those involved in adverse incidents or errors by enabling a no-blame culture, openness and transparency
- processes should be strengthened and developed to allow for better identification of risk, identifying opportunities as well as threats
- managing risk is both a collective and an individual responsibility
- recognition that resources may sometimes be required to address risk and business plans should reflect this

Identifying Risk

8.6 The Trust identifies risk through both reactive and proactive methods. Reactive methods include complaints, significant events and incident reporting; proactive methods include risk assessment and implementation of recommendations arising

from risk assessment and risks raised through external organisations such as the MHRA.

8.7 Risk should identify the potential risks associated with activities including, for example, delivering service targets redesigning projects, managing patient services, consultations, medicine managements, patient consent to treatment and so on.

8.8 Risk may be experienced from a variety of sources internal and external; changes in legislation; theft; losses; attack on IT systems; changes in legislation and standards etc.

8.9 Internal systems have been developed and implemented for the prevention and management of risks. For example, use checklists and protocols, significant incidents, serious untoward incidents, near miss incidents and education to raise staff awareness.

8.10 Systems for risk assessment will provide a structured method to:

- identify hazards (potential to cause harm, or losses)
- establish who will be affected by the hazard and the frequency of exposure
- establish the level of risk (likelihood of harm, or losses occurring)
- assess whether existing controls are adequate
- identify actions to meet any shortcomings
- check that controls and mitigating actions are working

8.11 Risk assessment formats and guidance are provided through the Quality Governance and Assurance team site on yCloud. For specific risks assessments such as Fire, Health and Safety (managed by Simply Serve Ltd) refer to the appropriate yCloud page.

Risk Assessment

8.12 The Trust will implement an approach to risk assessment with the intention that relevant members of staff are given the power and systems to deal with risks relevant to the services for which they are responsible. The Trust has designated posts with responsibilities for risk management support and advice including:

- Senior Information Risk Owner
- Deputy Chief Nurse
- Deputy Director Quality Governance and Patient Safety
- Head of Risk and Litigation
- Maternity Risk Manager
- Fire, Health and Safety Advisor
- Radiation Protection Advisor
- Local Counter Fraud Specialist

- Data Protection Officer

8.13 Risk assessments are the responsibility of Directors, Service Leads and Managers who will keep a register of active risks managed through on-line risk registers ensuring that:

- **GREEN** rated risks (scoring 6 or below (Low)) are appropriately managed at a local level

- **YELLOW** rated risks (rated 8 – 10 (Moderate)) are appropriately managed at a local level but should be referred to the relevant Specialty Lead and if appropriate, referred to the relevant Lead Director

- **AMBER** rated risks (rated 12 – 15 (Significant)) should be referred directly to the Lead Director, Service Lead and Head of Risk and Litigation for consideration and inclusion in the Corporate Risk Register

- **RED** rated risks (rated 16+ (High Risk)) should be referred directly to the Lead Director, Service Lead and Head of Risk and Litigation for consideration and inclusion in the Corporate Risk Register

Managing Risk

8.14 Risk assessments should identify controls or mitigating actions and managed with actions as necessary to reduce risk down to an acceptable level through management teams. Action plans should be used to demonstrate key priorities against risks with delegation of actions and responsibilities identified. The Specialty Lead should ensure these are reviewed and maintained for reference against risk mitigation.

8.15 Risks entered onto the risk registers that have been reduced, where no further controls or actions can be taken to mitigate a risk, may be archived on the risk register to include all evidence to demonstrate mitigating actions at a later date for inspection, or monitoring.

8.16 Risk Assessments for health and safety, fire, security etc. should be maintained locally by the department manager with risk escalated as appropriate in line with the Red, Amber, Yellow and Green (RAG) rating.

8.17 The Trust has an Incident Reporting and Investigation Management Policy and maintains a risk management database (Ulysses) which provides web-based reporting of clinical and non-clinical incidents and near misses.

8.18 The Trust will upload patient safety incidents through the National Reporting and Learning System (NRLS).

8.19 The Trust will ensure the implementation and embedding of safe practice by:

- promoting the use of guidelines and protocols (accessed on the Policies database via the Intranet)

- ensuring safe systems of work are documented and followed when there are significant risks identified

- ensuring that staff undertake continuing professional development activity

- ensuring that the Somerset CCG Reporting and Learning from Serious Incidents (SI) Policy is followed when identifying and reporting serious incidents externally

Minimising Risk

8.20 The Trust will ensure that learning takes place from clinical and non-clinical incidents and risk assessment findings, depending on the seriousness, and share learning with other services.

8.21 Safety alerts will be acted upon in line with the requirements of the alert and monitored for effectiveness.

8.22 Staff will be engaged in the learning process through governance arrangements and through raising awareness and training.

Managing Residual Risk

8.23 Residual risk represents a risk that remains after considering the controls in place to manage the risk and after further actions have been taken to reduce the risk to an acceptable level. In practice this means constantly monitoring the effectiveness of control measures. This will be achieved by:

- reviewing outcomes
- sharing best practice
- evidence based practice
- reflective practice
- clinical supervision
- appraisal
- learning from the patient experience, complaints, claims and mistakes
- inspections and monitoring

Monitoring Risks

8.24 The risk management process is monitored by the risk management Committees and through the Executive Committee and Assurance Committees reviews up to the Board of Directors.

Quality Impact Assessments

8.25 Quality Impact Assessments (QIA) should be conducted on the same principle as risk assessment. The impact on business, finance, provision of clinical and non-clinical services and patient access to services for equality reasons should be assessed and managed. A QIA demonstrates that the wider implications to services have been considered, especially in relation to making savings through Cost Improvement Plans (CIP). The Trust has a QIA process for reference that should be used alongside the development of a QIA framework.

Data Protection Impact Assessments

8.26 The General Data Protection Regulations 2016 and Data Protection Act 2018 introduced a new obligation to undertake a Data Protection Impact Assessment (DPIA) before carrying out types of processing likely to result in high risk to individuals' rights and freedoms. DPIAs are risk assessments that are concerned with the use of personal data within an organisation. They are designed to assist organisations to

consider whether data is secure, whether there is or could be any risk to individuals' privacy, and whether organisations are meeting their obligations. The focus is on the potential for harm – to individuals or to society at large, whether it is physical, material or non-material. To assess the level of risk, a DPIA must consider both the likelihood and the severity of any impact on individuals. For more information please refer to the Trust's DPIA Policy.

9 INCIDENT REPORTING

9.1 Incident reporting underpins an effective Risk Management Strategy. The positive benefit here is that the material provides a rich source of information from which to learn and improve systems and processes and reduce risk.

9.2 A standard format for reporting all types of incidents has been implemented across the Trust. The incident on-line web based form reflects the reporting requirements of the NRLS. Staff receive training at induction and bespoke training to ensure that they are familiar with the reporting requirements. The aim is to ensure that incidents, including near misses, are reported as part of routine practice. The reported incidents are investigated where necessary and all the information entered onto the risk management database.

9.3 As part of the mechanism for handling the reporting of incidents and near misses there is a scoring system which enables an assessment of risk to be made as to the actual impact. This is outlined in the Incident Reporting and Investigation Management Policy.

Serious Untoward Incident Reporting and Learning from Incidents

9.4 The Trust supports the concept of learning from incidents and sharing information in a blame free culture.

9.5 Incidents that meet the criteria of a Serious Incidents Requiring Investigation (SIRI) are reported externally.

9.6 All SIRIs will be escalated through the incident reporting process to be brought to the attention of the Deputy Director Quality Governance and Patient Safety who will escalate risk to the appropriate level and be reviewed at the Senior Incident and Safety Review Group.

9.7 Root cause analysis investigations determines how and why adverse incidents happen, the risk management issues involved and how they can be prevented.

9.8 Changes in practice if necessary will be identified through the investigation process.

9.9 The mechanism for sharing and learning from incidents is through the reporting processes to the Patient Safety Steering Group and through Strategic Business Unit and Governance meetings in line with the Incident Reporting and Investigation Management Policy.

'Being Open' and 'Duty of Candour'

9.10 The Duty of Candour is a statutory and contractual requirement under Regulation 20 of the Health and Social Care Act 2008. The Trust will ensure compliance through processes set out in the Being Open and Duty of Candour Policy and the Incident Reporting and Investigation Management Policy.

Reporting to the Medicines and Healthcare Products Regulatory Agency (MHRA) and the National Reporting and Learning Service (NRLS) to NHS England

9.11 The Trust has a module on the risk management database for the distribution of the Central Alert System (CAS), Medical Device Alerts (MDAs), Patient Safety Alerts and other such clinical alert notifications in line with the Safety Alerts Management Policy. Reporting is through the CAS Liaison Officer (CASLO).

9.12 The CASLO is responsible for reporting to the MHRA, Health and Safety Executive (HSE) and NHS England using information held on the risk management database. In addition, the Trust has nominated a Medicines Safety Officer (MSO) and a Medical Devices Safety Officer (MDSO) reporting to the Deputy Chief Executive, Chief Nurse and Director of People with responsibilities reported through the Patient Safety Steering Group.

10 APPLICABILITY

10.1 This strategy document applies to all staff employed by the Trust, whether on a permanent or temporary basis. Failure to comply with fundamentals of this strategy may lead to exposing the Trust and its patients, staff and the public to unnecessary risk. All staff are responsible for risk management and for reducing risks and acting upon risk assessment and following safe systems of work. Failure to carry this out may lead to disciplinary action being taken against individuals.

11 IMPLEMENTATION, TRAINING AND SUPPORT

11.1 The effective implementation of this Risk Management Strategy will facilitate the delivery of high quality service and, alongside staff training and support, will provide an awareness of the measures needed to prevent, control and contain risk. The Trust will:

- ensure all staff and stakeholders have access to a copy of this Risk Management Strategy
- produce a Corporate Risk Register which will be subject to regular review by the Executive Committee, Assurance Committees and the Board of Directors
- communicate to staff any action to be taken in respect of risk issues
- develop policies, procedures and guidelines based on the results of assessments and all identified risks to assist in the implementation of this Strategy
- monitor and review the performance of the organisation in relation to the management of risk and the effectiveness of the systems and processes in place to manage risk

11.2 Training is essential for the implementation and success of the Risk Management Strategy. The Head of Risk and Litigation and Deputy Director Quality Governance and Patient Safety will work in collaboration with the Academy Team to deliver a training programme for staff with risk management responsibilities. The Head of Risk and Litigation will provide risk management advice and support to Managers and Risk Leads to facilitate local risk management. The Head of Risk and Litigation will provide ad hoc risk management support or advice to Trust staff, including staff members of YDH subsidiary companies as and when needed. All new managers should undergo induction to risk with the Head of Risk and Litigation within the first month of employment.

12 MONITORING THE EFFECTIVENESS OF THE STRATEGY

12.1 Reporting on the effectiveness of the Risk Management Strategy within the Trust based on all available relevant information will be through the Deputy Director Quality Governance and Patient Safety the Company Secretary and the Head of Risk and Litigation.

13 REFERENCES

- NHS Improvement Serious Incident Framework (March 2015) https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf

- NHS Improvement Never Events https://improvement.nhs.uk/resources/never-events-policy-and-framework/

- Department of Health (February 2006) *Integrated Governance Handbook: A Handbook for Executives and Non-Executives in Healthcare Organisations* [Online] Department of Health. Available from: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4128739

- Good Governance Institute: The New Integrated Governance Handbook 2016 https://www.good-governance.org.uk/wp-content/uploads/2017/04/The-new-Integrated-Governance-Handbook-2016.pdf

- NHS Foundation Trusts: Code of Governance (July 2014). Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf

- Financial Reporting Council: The UK Corporate Governance Code (July 2018) https://www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0-d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.pdf

- Department of Health (2002) *Assurance: The Board Agenda* Department of Health. Available from: http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006064

- Good Governance Institute: Board Assurance Frameworks (March 2009) https://www.good-governance.org.uk/wp-content/uploads/2017/04/Board-Assurance-Framework.pdf

- HM Treasury (March 2016) Audit and Risk Assurance Committee Handbook https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf

- NHS Improvement: Learning from Patient Safety Incidents https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

14 ASSOCIATED POLICIES

- YDH Risk Management Arrangements

- Incident Reporting and Investigation Management Policy

- Somerset CCG – Reporting and Learning from Serious Incident (SI) Policy

- Health and Safety Policy

- Raising Concerns (Whistleblowing) Policy
- Being Open and The Duty of Candour Policy
- Infection Prevention Control Policy
- Policy for the Development and Management of Procedural Documents
- Data Protection Impact Assessment Policy

15 SUBSIDIARY COMPANIES OF YEOVIL DISTRICT HOSPITAL (YDH)

15.1 The various subsidiary companies of YDH have responsibility for risk management within their entity; this will be overseen by their respective Board of Directors through their own Risk Management Strategies. YDH, as the parent company, has oversight of risk management across the Yeovil District Hospital NHS Foundation Trust Group and the subsidiary companies are responsible for providing assurance to YDH that suitable and adequate risk management processes are in place.

16 EQUALITY IMPACT ASSESSMENT

16.1 This policy has been assessed and implemented in line with the policy on procedural documents and an equality impact has been carried out to ensure the policy is fair and does not discriminate any staff groups. A completed Equality Impact Assessment can be found at **Annex C.**

1. Introduction

The aim of Yeovil District Hospital NHS Foundation Trust is to provide safe, high quality and effective services that improves the health, wellbeing and independence of the population it serves. The Trust's vision statement outlines this aim:

'To care for you as if you are one of our family'

The Board recognises that risk is inherent in the provision of healthcare, and therefore a defined approach is necessary to identify risk context, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of the Trust's aims and objectives. This Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds. The Risk Appetite Statement does not negate the opportunity to potentially take decisions that result in risk-taking that is outside of the risk appetite. Where this is considered to be the case, it is proposed that these decisions will be referred to the Board.

The Trust needs to be aware of its risk appetite because if the organisation's collective appetite is not clear and the reasons for this unknown, this may lead to erratic or inopportune risk-taking, thereby exposing the organisation to a risk it cannot tolerate. Conversely, an overly cautious approach could be taken which may stifle growth and development.

The Trust is committed to ensuring patient safety across all services provided by the organisation and therefore the Trust is strongly averse to any risk that may jeopardise it. There is recognition that the provision of healthcare services carries some risk and wherever possible, the Trust will ensure that it does all it can to deliver harm free care for every patient, every time, everywhere.

The Trust is strongly averse to any risks that could result in the non-compliance with legislation, or any frameworks provided by professional bodies.

2. Risk Appetite Categorisation

The risk appetite categories[1] are as follows:

Avoid	Avoidance of risk and uncertainty is a key organisational objective
Minimal	Minimal (as little as reasonably possible). Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
Seek	Eager to be innovative and choose options offering potentially higher business rewards (despite greater inherent risk)
Mature	Confident in setting high levels of risk appetite because of controls, forward scanning and responsiveness systems are robust

[1] Source: Risk Appetite for NHS Organisations (Good Governance Institute)

3. Risk Appetite Statement

Key Element	Risk Appetite	Risk Tolerance
Quality and Governance (All quality related risks)	Minimal (as little as reasonably possible) – Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Low** **(Risks rated: 1-6)**
The Trust prefers safe delivery options that have a low degree of inherent risk. The Trust is only willing to accept ultra-safe delivery options which will not adversely affect the quality and governance of services.		
Business Risk (Loss of referrals, loss of support from CCG, Providers etc.)	Cautious – Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	**Moderate** **(Risks rated: 8-10)**
The Trust is eager to be innovative and to choose options offering potentially higher rewards despite greater possible inherent risks.		
Compliance and Performance (Risks with compliance to licence requirements, data privacy etc.)	Minimal (as little as reasonably possible) – Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Low** **(Risks rated: 1-6)**
The Trust is willing to consider all potential delivery options whilst also providing an acceptable level of reward. The Trust would want to be confident that it is able to meet any regulatory requirements and is able to demonstrate robust process underpinning its compliance. The Trust has no appetite that may result in a breach of patient confidentiality, non-compliance of the General Data Protection Regulations etc.		
Continuity of Service (Risks to the Trust being able to provide services that are required of it)	Minimal (as little as reasonably possible) – Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Low** **(Risks rated: 1-6)**
The Trust prefers to only accept options which have a low degree of inherent risk and will not adversely affect the ability to continue to provide the services which are required of it.		
Operational Risks (Risks covering staffing, health and safety, security, fire, IT, etc.)	Minimal (as little as reasonably possible) – Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Low** **(Risks rated: 1-6)**
The Trust is not willing to accept risks which will affect the operational delivery of the organisation and is committed to ensuring safe services within a robust setting.		

Financial Risks (Accounting risk, credit risk, market risk, liquidity risk and budget risks)	Minimal (as little as reasonably possible) – Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Low** **(Risks rated: 1-6)**
In light of the current financial climate within the NHS and Somerset, the Trust prefers to adopt a cautious approach and only consider safe delivery options which have a low degree of inherent risk. The Trust will focus on meeting its statutory duties of maintaining expenditure within strict limited resources and adherence to financial controls.		
Reputation Risks (Damage to reputation through bad publicity etc.)	Minimal (as little as reasonably possible) – Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Low** **(Risks rated: 1-6)**
The Trust is willing to consider decisions that may bring scrutiny of the Trust, however the potential benefits outweighs the risks i.e. an acceptable level of reward. The Trust will always seek to have a positive reputation that aligns with its *Vision Statement.*		

4. Review of Appetite

The Trust Board will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances against the seven key risk categories outlined within the Trust's Risk Management Strategy. Risks throughout the organisation should be managed within the Trust's Risk Appetite, or where this is exceeded, action taken to reduce the risk.

The Trust's Risk Appetite will be communicated to relevant staff involved in the management of risk.

RISK ASSESSMENT SCORING GUIDELINES

1. INTRODUCTION

1.1 Risk management is a systematic and effective method of identifying risks and determining the most cost effective means to minimise or remove them. It is an essential part of any risk management programme and it encompasses the processes of risk analysis and risk evaluation.

1.2 The Board of Directors ensures that the effort and resource that is spent on managing risk is proportionate to the risk itself. The Trust has in place efficient assessment processes covering all areas of risk.

1.3 To separate those risks that are unacceptable from those that are tolerable should be evaluated in a consistent manner. Risks are assessed by combining estimates of consequence and likelihood in the context of existing control measures. The rating of a given risk is established using a two dimensional grid or matrix with consequence as one axis and likelihood as the other.

1.4 The following properties are essential for a risk assessment matrix:

- simple to use
- provides consistent results when used by staff from a variety of roles or professions
- capable of assessing a broad range of risks including clinical, health and safety, financial risk or reputation

1.5 This guidance can be used on its own as a tool for introducing risk assessment or for improving consistency or scope of risk assessments already in place within the organisation and for training purposes. In particular the organisation should use this guidance only within the framework of its strategic risk appetite and risk management decision making process.

2. GUIDANCE ON CONSEQUENCE SCORING

2.1 When undertaking a risk assessment the consequence or how bad the risk being assessed is must be measured. In this context, consequence is defined as the outcome or potential outcome of an event. Clearly there may be more than one consequence of a single event.

2.2 Consequence scores can also be used to rate the severity of incidents and there are some advantages to having identical or at least parallel scoring systems for risk and incidents.

2.3 This guidance does not give detailed guidelines on incident scoring but gives a brief explanation of how this scoring system can be used for scoring incidents.

2.4 Consequences can be assessed and scored using qualitative data. Whenever possible, consequences should be assessed against objective definitions across different domains to ensure consistency in the risk assessment process. Despite defining consequence as objectively as possible it is inevitable that scoring the consequences of some risk will involve a degree of subjectivity. It is important that effective, practical based training, and use of relevant examples form part of the implementation of any assessment system to maximise consistency of scoring across the organisation.

2.5 The information in **Table 1a** should be used to obtain a consequence score. First define the risk explicitly in terms of the adverse consequence that might arise from the risk being assessed. Then use the table to determine the consequence score of the potential adverse outcomes relevant to the risk being evaluated. The examples given in Table1a are not exhaustive.

How To Use Consequence Table 1a

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

Consequence scoring

1 – Negligible
2 – Minor
3 - Moderate
4 - Major
5 - Catastrophic

2.7 Many issues need to be factored into the assessment of consequence. Some of these are:

- does the organisation have a clear definition of what constitutes a minor injury
- what measures are being used to determine psychological impact on individuals
- what is defined as an adverse event and how many individuals may be affected

2.8 A single risk area may have multiple potential consequences and these may require separate assessment. It is also important to consider from whose perspective the risk is being assessed because this may affect the assessment of the risk itself, its consequences and the subsequent action taken.

2.9 By implementing these guidelines we will benefit from having more detailed definitions or samples for each consequence score. Table 1b shows a number of examples to use at a local level to exemplify various levels of consequence under the domain that covers the impact of the risk on the safety of patients, staff or public.

2.10 More examples have been added to the consequence categories in this revised version (**Table 1b**) as it is felt that extra guidance is required for risk assessment procedures and for training purposes.

RISK ASSESSMENT SCORING GUIDELINES

Table 1a – Assessment of the Severity of the Consequence of an Identified Risk: Domains, Consequence Scores and Examples of the Score Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patient, staff or public (physical / psychological harm)	Minimal injury requiring no / minimal intervention or treatment. No time off work required.	Minor injury or illness requiring minor intervention. Requiring time off work for <7 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 7-14 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 sub-optimal. Informal complaint / inquiry.	Overall treatment or service sub-optimal. Formal complaint (stage 1). Local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint (stage 2). 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.	Incident leading to 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 levels that temporarily reduces service quality <1 day	Low staffing level that reduces service quality.	Late delivery of key objectives / 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 objectives / service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attendance for mandatory / key training.	Non-delivery of key objectives / 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.

RISK ASSESSMENT SCORING GUIDELINES

Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach of statutory duty. Challenging external recommendations / 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.	Non-compliance with national 10-25 % over project budget. Schedule slippage. Key objectives not met.	Incident leading >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 per cent of budget. Claim less than £10,000	Loss of 0.25-0.5 per cent of budget. Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective / loss of 0.5-1.0 per cent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective / loss of >1 per cent of budget. Failure to meet specification / slippage. Loss of contract / payment by results. Claim(s) >£1 million.
Service / business interruption Environmental impact	Loss / interruption of >1 hour. Minimal or no impact on the environment	Loss / interruption of >8 hours. Minor impact on environment.	Loss / interruption of >1 day. Moderate impact on environment.	Loss / interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

Table 1b – Consequence Scores (Additional Guidance and Examples Relating to Risks Impacting on the Safety of Patients, Staff or Public)

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on safety of patients, staff or public (physical / psych-ological 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 <7 days. Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention. Requiring time off work for 7-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable event. 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.
Additional examples	Incorrect medication dispensed but not taken. Incident resulting in a bruise / graze. Delay in routine transport for patient. Category 1 pressure ulcer. Laceration, sprain, anxiety requiring occupation al health counselling (no time off work required).	Wrong drug or dosage administered, with no adverse effects. Physical attack such as pushing, shoving or pinching, causing minor injury. Self-harm resulting in minor injuries. Category 2 pressure ulcer. Slip / fall resulting in injury such as a sprain.	Wrong drug or dosage administered with potential adverse effects. Physical attack causing moderate injury. Self-harm requiring medical attention. Category 3 pressure ulcer. Healthcare – acquired infection (HCAI). Incorrect or inadequate information / communication on transfer of care. Vehicle carrying patient involved in a road traffic accident. Slip / fall resulting in injury such as dislocation / fracture (e.g. #NOF) / blow to the head resulting in a bleed.	Wrong drug or dosage administered with adverse effects. Physical attack resulting in serious injury. Category 4 pressure ulcer. Long-term HCAI. Retained instruments / material after surgery requiring further intervention. Haemolytic transfusion reaction. Slip / fall resulting in permanent injury Loss of a limb. Post-traumatic stress disorder. Failure to follow up and administer vaccine to baby born to a mother with hepatitis B.	Unexpected death. Suicide of a patient known to the service in the past 12 months. Homicide committed by a mental health patient. Large-scale cervical screening errors. Removal of wrong body part leading to death or permanent incapacity. Incident leading to paralysis. Incident leading to long-term mental health problem. Rape / serious sexual assault.

3. GUIDELINES ON LIKELIHOOD SCORING

3.1 Once a specific area of risk has been assessed and its consequences score agreed, the likelihood of that consequence occurring can be identified by using **Table 2.** Note that the Table is intended as guidance and we have attempted to populate the table with descriptions of our own probability and frequency descriptions. As with the assessment of consequence, the likelihood of a risk occurring is assigned a number from 1 to 5 the higher the number the more likely it is the consequence will occur:

Likelihood Scoring

1 - Rare
2 - Unlikely
3 - Possible
4 - Likely
5 - Certain

3.2 When assessing likelihood it is important to take into consideration the controls already in place. The likelihood score is a reflection of how likely it is that the adverse consequence described will occur. Likelihood can be scored by considering:

- frequency (how many times will the adverse consequence being accessed actually be realised?), or
- probability (what is the chance the adverse consequence will occur in a given reference period?)

Table 2 – Likelihood Scores (Broad Descriptors of Frequency)

Likelihood Score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency How often might it/does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur, but it is not a persisting issue / circumstances	Will undoubtedly happen / recur, possibly frequently

Table 3 – Likelihood Scores (Time-Framed Descriptors of Frequency)

Likelihood Score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

3.3 It is possible to use more quantitative descriptions for frequency by considering how often the adverse consequence being assessed will be realised. A simple set of time framed definition for frequency is shown above in **Table 3**.

3.4 However frequency is not a useful way of scoring certain risks, especially those associated with the success of time limit or one off projects such as a new IT system that is being delivered as part of a three year programme or business objective. For these risks the likelihood score cannot be based on how often the consequence will materialise. Instead it must be based on the probability that it will occur at all in a given period. In other words, a three year IT project cannot be expected to fail once a month and the likelihood score will need to be assessed on the probability of adverse consequences occurring within the project's time frame.

3.5 With regard to achieving a national target, the risk of missing the target will be based on the time left during which the target is measured. The Trust might have assessed the probability of missing a key target as being quite high at the beginning of the year but nine months later if all the control measures have been effective, there is a much reduced probability of the target not being met.

3.6 This is why specific "probability" scores have been developed for projects and business objectives – see **Table 4**. Essentially, likelihood scores based on probability have been developed from project risk assessment tools from across industry. The vast majority of these agree that any project which is more likely to fail than succeed (that is, the chance of failing is greater than 50 per cent) should be assigned a score of 5.

Table 4 - Likelihood Scores (Probability Descriptors)

3.7 **Table 4** can be used to assign a probability score for risks relating to time-related or one-off projects or business objectives. If it is not possible to determine a numerical probability, the probability descriptions can be used to determine the most appropriate score.

Likelihood Score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability Will it happen or not?	<0.1 per cent	0.1-1 per cent	1-10 per cent	10-50 per cent	>50 per cent

4. RISK SCORING AND GRADING

4.1 Risk scoring and grading as follows:

- Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk
- Use **Table 1a** to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated
- Use **Table 2** to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If a numerical probability cannot be determined, use the probability descriptions to determine the most appropriate score
- Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

4.2 The risk matrix in **Table 5** shows both numerical scoring and colour bandings. The Trust's risk management processes are used to identify the level at which the risk will be managed in the Trust, assign priorities for remedial action, and determine whether risks are to be accepted, on the basis of the colour bandings and/or risk score.

Table 5 - Risk Matrix

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

KEY: Low risk | Moderate risk | Significant risk | High risk

4.3 For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1-6 = Low Risk
8-10 = Moderate Risk
12-15 = Significant Risk
16-25 = High Risk

4.4 This model risk matrix has the following advantages:

- commonality across the NHS with a five by five matrix
- it is simple yet flexible and therefore lends itself to adaptability
- it is based on simple mathematical formulae and is ideal for use in spreadsheets
- equal weighting of consequence and likelihood prevents disproportionate effort directed at highly unlikely but high consequence risks. This should clearly illustrate the effectiveness of risk treatment
- there are four colour bandings for categorising risk
- even if the boundaries of risk categorisation change we are able to compare "scores" to monitor whether risks are being evaluated in a similar manner

5. RISK RATINGS

5.1 The Trust adopts the standard three risk ratings as described below:

INITIAL risk rating (also known as 'inherent risk score')	The risk score before any mitigating actions had been implemented. This would also be the score which articulates how severe and likely the risk is to occur if the controls in place are found to be ineffective, or absent.
CURRENT risk rating (also known as the 'residual risk score')	This is the score at time of writing, taking account of existing controls and mitigating actions.
TARGET risk rating	The keyword here is "target". This is the future (or prospective) risk score assigned to any risk after gaps in control measures have been addressed, and outstanding actions implemented. It is the level of risk which can be tolerated.

6. RELATIONSHIP WITH INCIDENT SCORING

6.1 One of the features of the risk scoring system described here is that it includes a mechanism for directly scoring the consequence of an adverse event. When assessing risks, the consequence score is used to grade the consequence of events that might occur because of the risk in question. A certain amount of care is required when applying a score to an incident as there is danger that the incident might be given an overall actual impact score of 4 or 5 Consequence which could make the incident a "red" incident (see model risk matrix).

6.2 Refer to the Incident Reporting and Investigation Management Policy for detailed guidance.

7. CONCLUSION

7.1 As the Trust embeds risk management into respective governance arrangements, it has become more important than ever to make risk assessment easier and more consistent. It is essential that risks can be rated in a common currency within the NHS and other organisations, allowing financial, operational and clinical risks to be compared against each other and prioritised. Lastly, there needs to be confidence that tools for assessing risk can be used easily and consistently by a range of different professionals.

Somerset Equality Impact Assessment

Before completing this EIA please ensure you have read the EIA guidance notes – available from your Equality Officer			
Organisation prepared for	**Yeovil District Hospital NHS Foundation Trust**		
Version	**1**	**Date Completed**	**April 2021**
Description of what is being impact assessed			
Policy for the Development and Management of Procedural Documents			
Evidence			
What data/information have you used to assess how this policy/service might impact on protected groups? Sources such as the Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles,, should be detailed here			
No impacts on protected groups			
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?			
Equality & Diversity Lead			

Analysis of impact on protected groups				
The Public Sector Equality Duty requires us to eliminate discrimination, advance equality of opportunity and foster good relations with protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the Public Sector Equality Duty. Based on this information, make an assessment of the likely outcome, before you have implemented any mitigation.				
Protected group	**Summary of impact**	**Negative outcome**	**Neutral outcome**	**Positive outcome**
Age	• n/a	☐	✓	☐
Disability	• n/a	☐	✓	☐
Gender reassignment	• n/a	☐	✓	☐
Marriage and civil partnership	• n/a	☐	✓	☐
Pregnancy and maternity	• n/a	☐	✓	☐
Race and ethnicity	• n/a	☐	✓	☐
Religion or belief	• n/a	☐	✓	☐
Sex	• n/a	☐	✓	☐
Sexual orientation	• n/a	☐	✓	☐

Other, e.g. carers, veterans, homeless, low income, rurality/isolation, etc.	• n/a	☐	✓	☐

Negative outcomes action plan
Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.

Action taken/to be taken	Date	Person responsible	How will it be monitored?	Action complete
n/a	Select date			☐
	Select date			☐

If negative impacts remain, please provide an explanation below.

n/a

Completed by:	**Samantha Hann**
Date	**April 2021**
Signed off by:	**Bernice Cooke**
Date	**April 2021**
Equality Lead/Manager sign off date:	**Not required as no significant service change as a result of this policy**
To be reviewed by: (officer name)	**Not required as no significant service change as a result of this policy**
Review date:	**n/a**

MATERNITY DEPARTMENT
RISK MANAGEMENT STRATEGY

Version Number	8.1	Version Date	April 2021
Policy Owner	Chief Executive		
Author	Head of Midwifery		
First approval or date last reviewed	The Risk Management Policy was first approved in July 2007, reviewed in September 2011 up to Version 4.1, reviewed in September 2014 (version 5), reviewed in October 2017 (version 6), reviewed in February 2018 (version 6.1), reviewed in July 2019 (version 7), reviewed October 2019 (version 8)		
Staff/Groups Consulted	Clinical Director of Obstetrics Maternity Risk Manager Deputy Director Quality Governance and Patient Safety Head of Risk and Litigation Clinical Directors of Patient Safety & Governance Practice Educator		
Approved by the Audit Committee on behalf of the Board of Directors	05 May 2021		
Next Review Due	October 2022		
Equality Impact Assessment	April 2021		

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MATERNITY DEPARTMENT
RISK MANAGEMENT STRATEGY

1 INTRODUCTION

1.1 The Maternity Risk Management Strategy and Framework defines how the Maternity Unit, within Yeovil District Hospital NHS Foundation Trust (the Trust), supports a systematic approach to risk management. It sets out how the Maternity Unit embeds and implements the risk management processes, with an underpinning ethos of a continuing positive learning culture (Standards for Better Health, 2004).

1.2 The Maternity Unit has a duty of care to women and their families, staff and the local population and the aim of the Strategy is to minimise risks to mothers and infants through the implementation of a risk management framework which:

- Identifies the principal risks to the achievement of the Trust's objectives for Maternity Services
- Evaluates the nature and extent of the risks
- Manages them efficiently, economically and effectively

1.3 This Strategy and Framework is an annex to the Trust's Risk Management Strategy and should be read in conjunction with the Trust's Incident Reporting and Investigation Management Policy, Complaints and Concerns Management Policy, Claims Management Policy and Trust HR Manual.

2 MATERNITY DEPARTMENT RISK MANAGEMENT PHILOSOPHY

2.1 The Maternity Risk Management Strategy underpins the ethos of effective risk management within the maternity services, which is seen as an integral part of quality governance and assurance. The maternity service will take all steps reasonably practicable in managing both clinical and non-clinical risks with the overall objective of protecting mothers and their babies, staff, and members of the public**.** The primary concern is the provision of a safe, risk free environment together with working policies and practices that take account of assessed clinical and non-clinical risks, minimise them to promote a 'no blame, learning culture' which encourages all team members to participate and empower others.

2.2 The Maternity Department is committed to providing a mother, baby and family centred service that is flexible and comprehensive. Excellent communication systems are vital, both verbal and written, to ensure we continue to strive to improve the care we provide for mothers, babies and their families.

2.3 A proactive approach to risk management is supported by the Clinical Directors and managers at all levels within the department. There are clear, identified links with Quality Governance team, clinical audit, the Patient Advisory Liaison Service (PALS), complaints service and legal department via the Trust Quality Governance Department.

2.4 This strategy and framework for risk management will be disseminated through the local induction process and staff briefing sessions.

3 MATERNITY DEPARTMENT RISK MANAGEMENT OBJECTIVES

3.1 These objectives are complementary to the Trust's overall risk objectives and are supported by the recommendations of national documents and guidelines such as the

National Institute for Health & Clinical Excellence (NICE), MBRRACE Mothers & Babies Reducing Risks through audit and confidential enquiries across the UK, Each Baby Counts and Safer Maternity Care.

3.2 The Maternity Service will:

- Promote a culture which values risk management, learns from experience and is just and supportive of staff involved in risk management issues

- Embrace a philosophy of continuous improvement in order to achieve a standard of excellence in health care and education

- Ensure all staff adopt a proactive approach to risk management within the maternity services through identification and assessment, and reporting as dictated by the Trust Incident Reporting Policy which includes:

  - Identifying near misses, non-clinical and clinical risks. (Utilising the Clinical Incident Maternity Trigger List – see Annex 2)

  - Reporting incidents promptly through the Trust incident reporting system 'Ulysses'

  - Being Open and following the statutory 'Duty of Candour'

  - Investigate complaints and serious incidents promptly

  - Following up and acting on recommendations

  - Change in policies, guidelines and practices where necessary

  - Communicating changes to staff promptly

  - Monitoring common trends and perform regular audits

  - Providing feedback to all individuals through various mediums, encapsulating every single group

  - Review and implement action plans

- Manage all risks within the maternity services emerging from various sources such as the identification and reporting process, complaints, claims or other sources. The Trust Risk Register will be the tool employed to score such risks and regular reviews are essential

- Ensure that designated individuals are responsible for areas of risk management and appropriate action plans are implemented, communicated and reviewed

- Look to embrace a philosophy of continuous improvement in order to achieve maximum patient and staff safety. This supports the Trust's legal duty under the Health and Safety at Work Act 1974, and the Management of Health and Safety at Work Regulation 1999 in relation to risk assessment

- Educate all levels of staff in risk management and complaints, putting measures in place to ensure lessons are learnt

- Ensure that a model of clinical supervision is in place which supports midwives in practice and acts as a catalyst to improving care

- Ensure a robust and holistic approach to risk management incorporating all relevant disciplines and departments

- Ensure that evidence based policies, guidelines and safe systems of work are in place

4 STRUCTURE LEAD ROLES AND RESPONSIBILITIES

4.1 The Chief Executive as Accountable Officer holds ultimate responsibility for all areas of risk management within the Trust. The maternity service sits within the Elective Care Strategic Business Unit led by the Deputy Chief Executive, Chief Nurse and Director of People.

4.2 The responsibilities for risk management within the maternity services rest with a number of individuals within the Department who report within an agreed framework to the Deputy Chief Executive, Chief Nurse and Director of People as a member of the Board of Directors led by the Chief Executive. They are responsible for leading and managing risk and ensuring risk management arrangements are in place across the maternity unit:

- Clinical Director for Obstetrics & Gynaecology

- Head of Midwifery

- Consultant Obstetrician with Designated Lead for Labour Ward

- Midwifery Matron

- Maternity Risk Manager

4.3 Within the maternity speciality there is a designated Maternity Risk Manager, who is responsible for leading a co-ordinated approach to managing risk in the maternity unit in conjunction with the Clinical Director for Obstetrics and Gynaecology, the Head of Midwifery and the Midwifery Matron. The Maternity Risk Manager is responsible as the chair of the Maternity Risk Management Committee for escalating issues of concern to the Clinical Director of Obstetrics and Gynaecology and the Head of Midwifery and maintaining an up to date risk register. They are in turn responsible for escalating to the Deputy Chief Executive, Chief Nurse and Director of People and the Chief Medical Officer to the Board of Directors and Chief Executive through the Governance and Quality Assurance Committee.

4.4 Other roles contributing to the maternity risk management process include:

- Clinical Director Paediatrics

- Consultant Lead for Obstetric Anaesthesia

- Head of Risk and Litigation

- Practice Educator Midwife

- Professional Midwifery Advocates

- Midwifery clinical leaders

- All other Staff

Deputy Chief Executive, Chief Nurse and Director of People

4.5 They are responsible for:

- Communicating the Trust Risk Management Strategy
- Carrying out the risk management processes set out in Section 6 of the Trust Risk Management Strategy
- Ensures that effective risk management processes are in place within their areas of responsibility
- Initiates action within their area to prevent or reduce the adverse effects of risk
- Manages the treatment of risk until it becomes acceptable to the organisation
- Ensures that learning from events and risk assessments is disseminated throughout the organisation

Head of Midwifery (HoM):

4.6 They are responsible for:

- Ensuring that maternity services comply with legislation, Trust and Department policies and guidelines in respect of all risk management activities and the Trust Risk Management Strategy
- The implementation of this strategy, thus ensuring effective operational management of risk within the Department
- Sharing joint responsibility with the Clinical Director for Obstetrics and Gynaecology for risk management issues
- Ensuring that risks scored as significant or higher are managed and reviewed at departmental level and escalated as appropriate in the organisation
- Co-ordinating investigations into incidents and complaints
- Attending the Strategic Business Unit meeting on behalf of the Maternity Services
- Reporting directly to the Deputy Chief Executive, Chief Nurse and Director of People who is the Lead Executive at Trust Board level with responsibility for the Maternity Services
- Reporting on the Maternity RCOG dashboard and the quarterly Maternity Risk Management Report to the Strategic Business Unit
- Ensuring the completion of departmental action plans including recommendations from completed investigations, internal and external inspections
- Undertaking annual monitoring and review of this strategy in conjunction with the Clinical Director for Obstetrics and Gynaecology

Maternity Risk Manager

4.7 They are responsible for:

- Implementation of this strategy thus ensuring effective operational management of risk within the Department
- Compliance with legislation, Trust and Department policies and guidelines in respect of all risk management activities
- Clinical risk co-ordination
- Reviewing incident forms
- Co-ordinating the undertaking of internal level 0, 1, 2 and 3 investigations liaising with the Quality Governance department as appropriate
- Provision of risk management feedback to the Patient Safety Steering Group to enable the monitoring of the maternity services
- Communicating recommendations to all staff
- Ensuring incidents are investigated and appropriate actions taken in a timely manner
- Co-ordinating the completion of the Maternity RCOG dashboard as a monitoring and reporting mechanism which informs the Maternity Risk Management Committee, Maternity Clinical Governance Meeting and the Trust Patient Safety Steering Group
- Chairing the Maternity Risk Management Committee
- Reporting to Maternity Clinical Governance Meeting and Labour Ward Council meetings
- Attending on behalf of the Maternity Risk Management Committee and reporting to the Patient Safety Steering Group
- Ensuring the Obstetric and Maternity Risk Register is constantly updated
- Ensuring the implementation of “Duty of Candour”
- Working closely with the all members of the team to reduce operational risk and complaints
- Considers recommendations and advice arising from the national confidential enquires, other national guidance (i.e. NICE) and findings from the Health Service Investigation Branch (HSIB) and health circulars, for the purpose of agreeing and ratifying implementation plans for practice, via the Maternity Clinical Governance meeting and the monthly Maternity Risk Management meeting

Role of Maternity Risk Manager as Risk Co-ordinator

4.8 It is the responsibility of the Risk Co-ordinator to:

- Facilitate and manage an effective process for identification of hazards and other factors that have implications for clinical standards and delivery of care to women in line with national standards and legislation

- Initiate immediate action to a higher level in the Trust regarding urgent risk issues through immediate communication with the Head of Midwifery, the Deputy Chief Executive, Chief Nurse and Director of People and the Clinical Director for Obstetrics and Gynaecology

- Undertake and complete a comprehensive Maternity Service Risk Assessment, identifying risks for inclusion within the Trust Risk Register

- Ensure that individuals undertaking risk assessments are competent to do so by attendance for suitable training and guidance

- Ensure the maternity risks included on the Trust Risk Register are reviewed on a quarterly basis by the Maternity Risk Management Committee and update the register as required at other times

- Ensure risk training programmes are attended to promote risk analysis, including root cause analysis investigations

- Ensure that all incidents are graded according to severity and likelihood of recurrence and that risk assessments are reviewed after incidents

- Identify any trends in incident and near miss reporting across the Department and communicate effectively with the Head of Midwifery, consultant medical staff, clinical leads and midwives

- Instigate any reviews of identified trend analysis to provide the department with an overall view to base any recommendations in change of practice

- Delegate investigation of incident reports to clinical leads where appropriate

- Work with the Head if Risk and Litigationto identify and control risks that cannot be dealt with at department level

- Liaise with all relevant departments where incidents have been recognised as potential for litigation for the Trust

- Notify the Trust Legal Services department within 14 days of a notifiable severe brain injury incident under the Early Notification Scheme has occurred using the Early Notification report form

Clinical Director:

4.9 They are responsible for:

- Ensuring compliance with legislation, Trust and Department policies and guidelines in respect of all risk management activities

- Working with the Head of Midwifery and Maternity Risk Manager to foster a robust risk management structure

- Sharing joint responsibility with the Head of Midwifery for risk management issues

- Being the Professional lead for obstetric and labour ward matters or delegates this role to another Consultant Obstetrician within the team

- Sharing joint responsibility for chairing the Clinical Governance Meeting with the Head of Midwifery

- Leading the formulation of, and changes to, policies and guidelines

- Ensuring that all obstetrician team members follow policies and remain competent in their roles

Consultant Obstetrician with Designated Lead for Labour Ward:

4.10 They are responsible for:

- Providing clinical leadership for all labour ward matters

- Ensuring that labour ward practice remains safe and is in line with national guidelines and recommendations

- Ensuring that all obstetrician team members follow policies and remain competent in their roles

- Leading on the review of labour ward practice and recommend subjects for audit

- Providing advice and guidance to the Maternity Risk Management Committee about unit issues

Midwifery Matron:

4.11 They are responsible for:

- Ensuring the operational implementation of risk management systems and processes in each area of responsibility

- Midwifery Matron is the professional midwifery lead for labour ward matters

- Midwifery Matron shares joint responsibility for chairing Labour Ward Council with the Consultant Labour Ward Lead

- Working closely with the Maternity Risk Manager to reduce operational risk and complaints

- Being actively involved in developing and updating maternity policies and guidelines based on current evidence

- Investigate and respond to incidents / near misses as soon as possible and, where appropriate, within 24 hours of occurrence

- Identifying resultant actions within a Department Action Plan. Any Action Plan key points will be discussed at the departmental meetings, where any change of practice / guideline will be ratified

- Providing feedback to individuals and arrange appropriate training where need is identified

- Ensuring action guidance will be completed in accordance with the Trust Incident Reporting system

- Working with colleagues and junior doctors and midwives to ensure changes in practice and polices are complied with and are maintained

- Undertaking competency-based assessment of clinical skills for midwives

Practice Educator Midwife:

4.12 They are responsible for:

- Development and provision of Training Needs Analysis and on-going mandatory training programmes which reflect the requirements of the CQC and professional registration, taking into account training needs identified through critical incident reporting and risk management

- Working with new midwives within the clinical setting and providing training for new staff in line with Trust's policy and CQC standards to maintain and improve standards and skills

Clinical Director Paediatrics:

4.13 They are responsible for:

- Being the Professional lead for neonatal and SCBU matters

- Providing expert advice to the maternity risk management committee for those matters linked with the management of the neonate and neonatal risks identified in pregnancy

- Ensuring all paediatric team members follow policies and remain competent in their roles

- Reviewing the paediatric guidelines that link to maternity

Consultant Lead for Obstetric Anaesthesia:

4.14 They are responsible for:

- Being the Professional lead for obstetric anaesthesia

- Providing expert advice to Labour Ward Council and the Maternity Risk Management Committee for matters relating to obstetric anaesthesia

- Co-ordinating the referral of high risk pregnant women to the anaesthetic service prior to delivery

- Ensuring that all anaesthetic team members follow policies and remain competent in their roles

- Reviewing the anaesthetic guidelines that link to maternity

Head of Risk and Litigation:

4.15 The Head of Risk and Litigation acts as a support and advisor to the maternity services on risk management issues.

Employees

4.16 Employees at all levels of the Trust need to understand the importance of risk management and the part they play in its development and implementation. All staff have an individual responsibility and professional accountability to:

- Report near-misses, incidents and adverse events using the Trust incident reporting system 'Ulysses'. If the impact is serious and requiring an immediate response, the incident should be reported to a member of the Maternity management team and named Consultant. Reporting will be to the Trust 'on-call manager' and consultant out of hours

- Actively encourage other members of staff to identify risk and assist in the risk management process. All staff are encouraged to highlight the Maternity Risk Management Strategy and Framework during local induction for new staff and to attend any relevant briefing sessions when the strategy is updated

- Be actively involved in developing and updating maternity policies and guidelines based on current evidence

- Be aware of personal responsibilities for maintaining a safe environment

- Attend all mandatory training sessions as required by the Maternity Department and Trust, keeping all relevant documentation as to their attendance

- Be aware of their legal duty to take reasonable care for their own safety and the safety of others who may be affected by their work

- Provide safe clinical practice

- Be familiar with Trust and Department policies, protocols and guidelines.

Responsibility for implementation of this strategy is shared by the Clinical Director, the Head of Midwifery and the Maternity Risk Manager:

4.17 It is their responsibility to:

- Ensure that serious risk issues are escalated in the Trust through direct reporting to the Deputy Chief Executive, Chief Nurse and Director of People (Lead Executive at Trust Board Director level with responsibility for the Maternity Services and risk management)

- Monitor the implementation of and compliance with this policy through the regular presentation of the RCOG dashboard at the monthly Risk Management meeting

- Review results of investigations and recommendations from incident reporting and monitoring the results of action plans at the Maternity Risk Management Meeting and Maternity Clinical Governance meeting

- Give expert clinical advice within the Maternity Risk Management Committee

- Ensure that recommendations/outcomes are communicated within the Department, Labour Ward council, Maternity Clinical Governance meeting and Trust Patient Safety Steering Group

- Work in partnership to provide a co-ordinated approach across Obstetrics and Midwifery

- Ensure that all medical staff comply with appropriate risk management processes

- Liaise regularly with the Deputy Director Quality Governance and Patient Safety and Head of Risk and Litigation in order to meet the Trust and Directorate risk management objectives

4.18 Different groups have delegated responsibilities for risks with maternity services as per the Terms of Reference for these meetings:

- Maternity Risk Management Committee

- Labour Ward Council

- Rolling Maternity Clinical Governance meeting

- Friday Lunchtime Review and Education Sessions

- Obstetric Interventions

- Perinatal Mortality and Morbidity

- Senior Safety Huddle

- Avoiding Term Admission into Neonatal Unit (ATAIN)

- Saving Babies' Lives

4.19 The maternity services recognise that in assuring effective and comprehensive risk management, there must be links between risk management and the system for legal claims, complaints management, clinical audit and clinical guideline development.

5 TRAINING

5.1 To monitor training and ensure that all staff are trained in risk management, this is done by appropriate instruction, information and teaching within Trust and local induction days. All new staff are required to attend a Trust – wide induction which includes risk management issues; at Department level, a local induction process is provided. All midwives, healthcare assistants and clerical workers undergo a period of preceptorship and receive written induction / orientation packs which include risk management information. Medical staff receive local induction training which includes consent training and information on risk management. Locum medical staff or staff beginning out of rotation will receive an induction pack prior to commencing work. In addition, further information is provided on the maternity rolling mandatory training and education programme days, medical junior staff training sessions, drills and skills training, Obstetric Intervention meetings and ad hoc meetings as appropriate.

Maternity Mandatory Training

5.2 The maternity training needs analysis sets out the specialist training required for each staff group and the frequency of the training. The training needs analysis informs the Staff Passport which incorporates both Trust and specialist requirements.

Responsibilities

5.3 Head of Midwifery is accountable for:

- Ensuring that all permanent and temporary staff attend the training appropriate to their role as set out in the training needs analysis
- Informing in writing by the practice educator if a staff member is out of date for training by 3 months
- Receiving a copy of the action plan drawn up by the staff member and the line manager if the staff member is out of date for training for more than 3 months
- Taking whatever action is considered appropriate if a staff member does not comply with repeated requests to attend or complete mandatory training

5.4 Line Managers are responsible for:

- Assisting the Head of Midwifery in the achievement of their role to ensure that all staff attend specialist mandatory training as identified in the maternity training needs analysis, and that this links to the staff personal development plan and appraisal
- Informing in writing by the practice educator within 1 month if a staff member is out of date with their mandatory training. They will be expected to contact the staff member and ensure that the training needs are addressed
- Line managers will be informing in writing by the practice educator if the staff member is still out of date after 3 months. They will be expected to meet with the staff member and draw up an action plan with a copy to the Head of Midwifery and practice educator to ensure that training is given priority

5.5 The staff are responsible for ensuring that they attend all training for their staff group as determined by the maternity training needs analysis, and as identified in the Staff Passport. Bank and temporary staff are personally responsible for ensuring they attend all training required by the Trust and the maternity training needs analysis as identified in the Staff Passport. All staff will be issued with a Staff Passport detailing the Trust and Departmental mandatory training specific to their post. The Staff Passport will include the frequency of the training requirement and will encourage the staff member to record their training attendance. This passport will be used as evidence, in association with electronic attendance records held by the Yeovil Academy and HR, for the purposes of staff appraisal.

5.6 The Midwifery Practice Educator is responsible for:

- Developing and delivering a programme of training as identified in the maternity training needs analysis that reflects the needs of the different staff groups
- Collaborating with the consultant obstetrician responsible for training and education and the Clinical Lead for Obstetrics to ensure that such a programme is wherever possible and appropriately delivered in a multi-professional setting

- Maintaining accurate records of attendance and non-attendance, identifying when staff members are due for their training and those who are out of date

- Informing the staff member and their line manager within 1 month if they are out of date

- Informing the line manager and Head of Midwifery if a staff member is 3 months out of date

- Publishing lists of training dates in sufficient time to allow managers to plan attendance

- Providing monthly reports to the Maternity Risk Manager detailing the training status of all staff

Attendance Standard

5.7 The Trust Maternity Department expects all staff to comply with mandatory training requirements. For the purpose of the Royal College of Obstetricians and Gynaecologists (RCOG) maternity dashboard the standards are set as follows:

- Green 90%
- Amber 80%
- Red 65%

5.8 Maternity and Trust mandatory training will be considered together and reported to the Maternity Risk Manager on a monthly basis.

5.9 Wherever possible staff will be allocated protected paid time to attend mandatory training. If staff are nominated to attend and fail to do so, the midwifery practice educator will inform their line manager in writing. The staff member must make every effort to attend the next appropriate training session. It is inevitable that some members of staff will be unable to attend through sickness and annual leave. In these circumstances it remains the responsibility of the individual to ensure that they make a specific request for study leave for the following training session.

5.10 It is occasionally necessary to withdraw staff from training for purposes of providing cover for clinical areas. In this case the staff member must be given priority on the following session and should not be withdrawn on consecutive training sessions. Line managers will be notified in writing within 1 month of members of staff who do not attend planned training or who are out of date.

5.11 Staff will be provided with 7.5 hours protected time a year to complete their mandatory e-learning package. Staff will be rostered this time and can be completed at home with the use of an external link, however evidence must be provided to the Practice Educators detailing the modules completed.

5.12 The Trust fully supports continuing professional development and lifelong learning for all staff. Individual midwives may identify post registration training needs through appraisal. Line managers may help identify specific course or study days that meet the individual's needs, however all final decisions regarding training allocation should be referred to the Head of Midwifery and funding for agreed training will be sought via a training funding application form to the Yeovil Academy.

5.13 All new members of staff are met during the induction process, training requirements are assessed and training plans will be implemented in accordance with the individual's needs.

6 INCIDENT / EVENT / TRIGGER REPORTING

6.1 All staff are to follow the Trust incident management process as outlined in the Trust Risk Management Strategy and Incident Reporting and Investigation Management Policy (accessible on the Trust intranet). All staff are to be made aware of this strategy though various means:

- Newsletter
- Induction for new staff
- Near miss, Labour Ward Council, and Obstetric Intervention meetings
- Intranet
- Personal Email
- Notice Boards and focus board on labour ward

6.2 The risk management process must be followed for all incidents, whether clinical or non-clinical. Report the incident and maintain safety in the situation.

6.3 Maternity 'Triggers' are used for the identification of specific maternity orientated clinical risks, which are reported on the Trust Incident Form as per the Trust Risk Management Strategy with all other identified incidents and near misses. Access to the Trust incident reporting system 'Ulysses' is available in all work areas. All incident forms are reviewed for the purpose of trend analysis with the aim of identifying areas of practice for review and to provide an overview of the incidents reported. This involves scoring each incident in line with the Trust Risk Management Strategy using the Likelihood versus Consequence scoring method. The list of triggers is included as Annex 2.

6.4 The Maternity Risk Management Committee meets monthly to review reported incidents from Ulysses and to review the maternity dashboard. This review group identifies and instigates follow up action to manage and reduce risk. The outcomes of the Maternity Risk Management Committee are reported to the Trust Patient Safety Steering Group addressing any emerging themes or trends and learning. This wider group will also review investigations from incidents and near misses and monitors progress on action plans. The department participates in the quarterly Trust Wide Governance Agenda when appropriate to enable sharing of lessons learned in maternity across the organisation.

Serious Incidents Requiring Investigation (SIRI)

6.5 SIRIs in line with the National framework for reporting and learning from serious incidents requiring investigation (for example, unexpected deaths or actual injury to a patient) must be reported immediately to:

- The Head of Midwifery
- Clinical Director of Obstetrics & Gynaecology
- Midwifery Matrons

- On call Consultant Obstetrician

- Clinical Site Manager, who will inform the Manager on call who in turn will inform the Director on call for the Trust if the event occurs out of hours and some of the above personnel are not immediately available

6.6 Such incidents are communicated as soon as reasonably practicable to the Deputy Chief Executive, Chief Nurse and Director of People and the Chief Medical Officer. Investigation into adverse events is carried out using the Serious Incident Framework 2015. A Trust wide register of all investigations is maintained by the Quality Governance Department and monthly reports are made to the Trust Patient Safety Steering Group.

6.7 Direct lines of communication exist between this Department and the Trust Quality Governance department, and Patient Advisory and Liaison services.

6.8 Serious Incidents should be reported to Somerset Clinical Commissioning Group (CCG) and through to NHS England by the Quality Governance Department if appropriate through STEIS reporting. As a Foundation Trust, Yeovil District Hospital is also ultimately responsible to NHS England and Improvement.

6.9 Initial risk assessment is carried out on receipt of an incident form. The Clinical Director, Head of Midwifery, Obstetric Labour Ward Lead, Maternity Matron and Maternity Risk Manager meet to make an initial assessment of any immediate action required and further risk assessment of near miss and harm level of 3 incident reports at a weekly Senior Safety Huddle. The Serious Incident and Safety Review Group will nominate an independent investigator(s) to undertake the investigation if required. However, this will also include specialist Maternity personnel, as maternity is a highly specialised area. Other specialist personnel are asked to advise on investigation of incidents as appropriate, for example the infection control team.

6.10 The investigation and resulting action plan is presented at the Maternity Clinical Governance Meeting or appropriate departmental meeting. This approach enables learning for those involved in the incident as well as the rest of the department and allows more in depth analysis of events. It is envisaged that this will also prevent a repetition of the incident. In some cases, a Trust wide approach is advocated, thereby sharing the learning from an incident that may have wider implications to the Trust.

6.11 The investigation action plan is incorporated into the Departmental action plan monitored by the Clinical Director and Head of Midwifery.

7 ANTENATAL & NEWBORN SCREENING INCIDENT MANAGEMENT

7.1 National screening programmes are public health interventions, which aim to identify disease or conditions in defined populations in order to reduce incidence, or morbidity, or mortality from that disease/condition, or to provide improved choice and information to individuals and families. The characteristics specific to screening programmes mean that incidents require special attention and management:

- There is potential for incidents in screening programmes to affect a large number of individuals/users of the service. This means that seemingly minor local incidents can have a major service and population impact

- As individuals respond to an offer of screening in the expectation that it will be beneficial, there is an added ethical imperative to prevent and respond effectively to quality problems

- Poor quality screening can do more harm than good – it can harm individuals and /or have no benefit to the population

- Incidents often affect the whole screening pathway and not just the local department or provider organisation in which the problem occurred

- Local incidents can affect public confidence in a screening programme beyond the immediate area involved

- Investigation and dissemination of learning from local incidents, "potential" incidents and near misses should be shared with the rest of the national screening programme in order to help prevent incidents elsewhere

Definition of a Screening Incident

- A screening incident is any unintended or unexpected incident(s) that could have or did lead to harm to one or more persons who are eligible for NHS screening; or to staff working in the screening programme. A screening incident can affect populations as well as individuals

- It is an actual or possible failure in the screening pathway and at the interface between screening and the next stage of care

- Although the level of risk to an individual in an incident may be low, because of the large numbers of people offered screening, this may equate to a high corporate risk. It is important to ensure that there is a proportionate response based on an accurate investigation and assessment of the risk of harm. Due to the public interest in screening, the likelihood of adverse media coverage with resulting public concern is high even if no harm occurs

Definition of a Serious Screening Incident

7.2 Whether a "serious incident" should be declared is a matter of professional judgement on a case by case basis. It should be a joint decision by the key stakeholders informed by QA advice. In distinguishing between a screening incident and a serious screening incident, consideration should be given to whether individuals, the public or staff would suffer avoidable severe (ie permanent) harm or death if the problem is unresolved. "A *serious incident is an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following:*

- Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public

- A never event – all never events are defined as serious incidents although not all never events necessarily result in severe harm or death

- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services including data loss, property

7.3 The stimulus to declare a serious screening incident can come from a number of organisations such as the provider, NHS England and QA. A serious incident can be declared at the outset and scaled down as appropriate.

7.4 Please see Annex 3 for a flow chart determining the management of antenatal and newborn screening incidents.

8 BEING OPEN AND DUTY OF CANDOUR

8.1 The ethical responsibility of the NHS to acknowledge failings and resolve them openly is emphasised in the NHS Constitution. From April 2013, the NHS standard contract includes a duty of candour. The *Francis Report* emphasised the need to put NHS users at the centre of services, have effective governance and investigate quality problems rigorously. The Trust will ensure this takes place through processes set out in the 'Being Open' and Duty of Candour Policy and the Incident Reporting and Investigation Management Policy, the Head of Midwifery will ensure this takes place within maternity. The Duty of Candour is a contractual requirement coming from the recommendations from the Mid Staffs Enquiry http://www.midstaffspublicinquiry.com/report

9 PERINATAL MORTALITY REVIEW TOOL

9.1 MBRRACE-UK were appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'. The PMRT programme was commissioned by HQIP on behalf of the Department of Health (England) and the Welsh and Scottish Governments; as a consequence the tool is free for use by Trusts and Health Boards in England, Wales and Scotland.

9.2 The PMRT had been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

9.3 The aim of the PMRT programme is to introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death from 22 weeks gestation, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews

- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports, a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care

10 COMPLAINTS AND LITIGATION

10.1 All complaints are centrally managed under the Trust's Complaints and Concerns Management policy but locally investigated. This process encourages local ownership of complaints and ensures local implementation of service improvements.

10.2 Any litigation claims are managed centrally and investigated in conjunction with the Quality Governance Department under the Trust's Claims Management process.

10.3 Any identified learning will be incorporated into an action plan discussed at the maternity bi monthly rolling Clinical Governance Meeting where any relevant action is agreed.

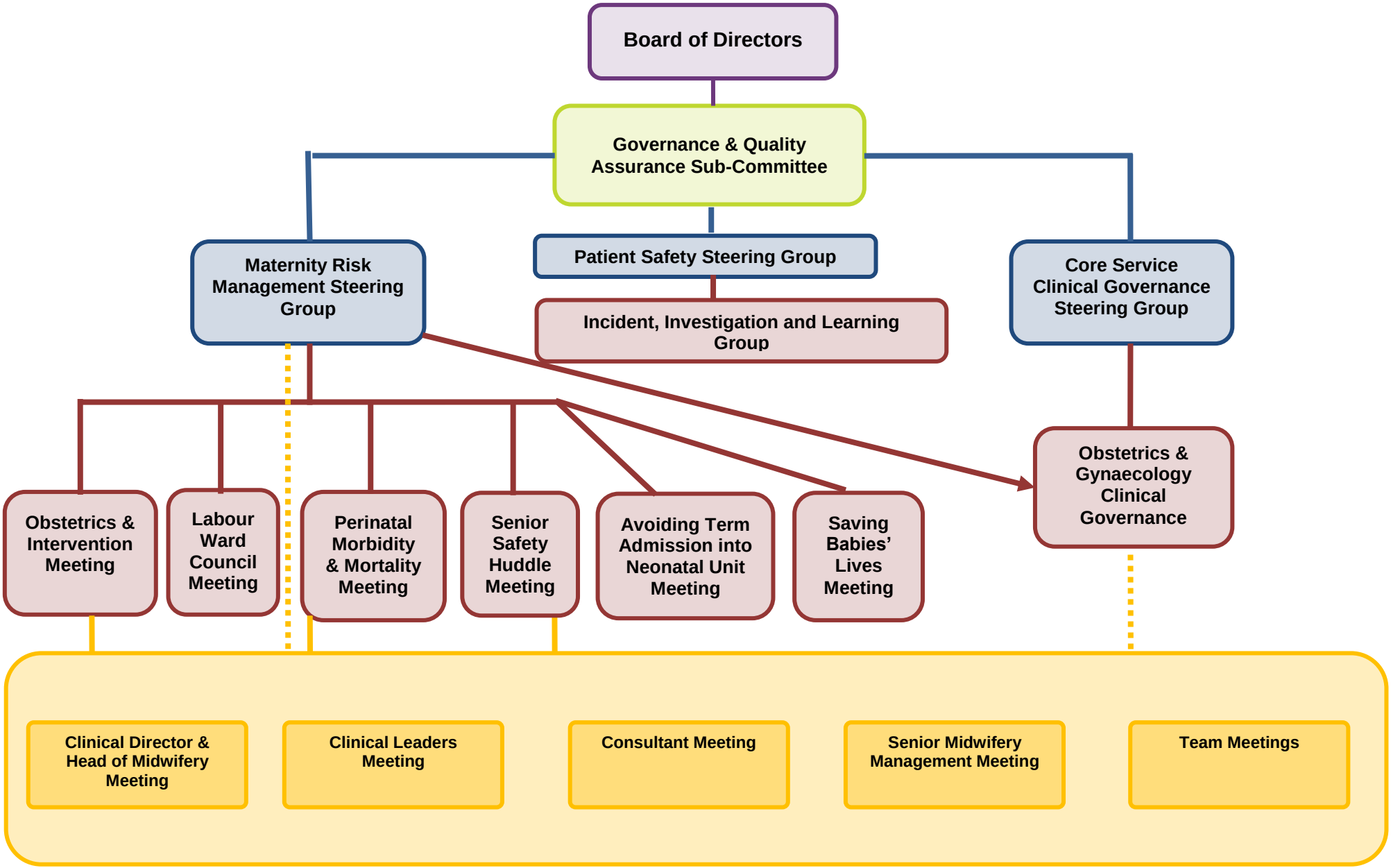
11 PEER REVIEW

11.1 The clinical areas have a system of peer review. This uses a ward monitoring tool that includes assessing and reporting on a range of quality criteria. It is informed by the Trust iCARE (communication, attitude, respect & environment) philosophy and objectives and provides a specific yet dynamic assessment of care delivery and standards. Through this process, opportunities for learning from the information collected and reviewed are provided and implemented. These reports are presented at Maternity Clinical Governance meetings.

12 REFERENCES

- Department of Health Nov 2017 Safer Maternity Care - The National Maternity Safety Strategy - Progress and Next Steps
- Trust Risk Management Strategy for which the Maternity Risk Management Strategy is an appendix to
- Trust Incident Reporting and Investigation Management Policy
- Complaints Policy
- Trust HR Manual which includes Training Policy
- MBRRACE-UK Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15, December 2017
- Fundamental Standards of Care
- Maternity Dashboard Clinical Performance and Governance Score Card Royal College of Obstetricians and Gynaecologists (RCOG) Good Practice No: 7 January 2008
- Perinatal Mortality Review Tool

MATERNITY DEPARTMENT GOVERNANCE STRUCTURE



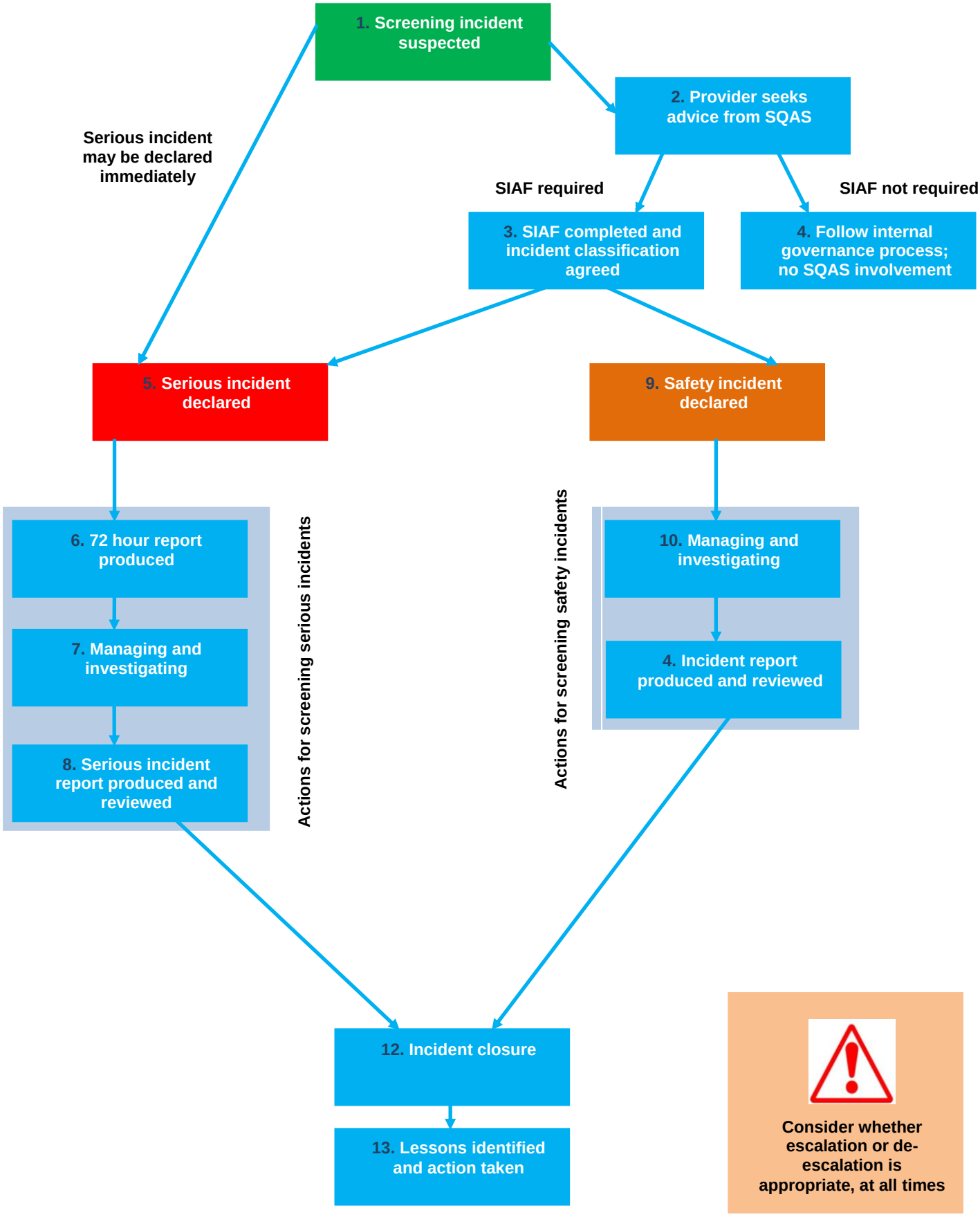
Please complete a Trust incident form for the following maternity related issues:

- Anaesthetic complications
- Baby born below 10th centile
- Baby temperature recorded below 35.5
- Birth injury
- Born before arrival
- Calling in on-call midwives
- Closure of the unit
- Concerns about management of labour
- Congenital anomalies (as per EUROCAT definition)
- Cord accident/prolapse
- Cord Ph below 7.1
- Delay in carrying out emergency LSCS
- Eclampsia
- Hysterectomy
- In-utero transfer out
- Inadequate staffing levels for workload
- Laceration to baby at caesarean section
- Loss of clinical materials eg. Swab
- Low apgars <7 at 5 minutes
- Maternal death
- Maternal resuscitation
- Maternal transfer to intensive care
- Maternity positive COVID 19 test
- Misdiagnosis of antenatal screening test
- Missed antennal /neonatal screening test
- Neonatal death
- Neonatal seizures
- Noncompliance of electronic/maternity trilogy recording
- Pulmonary embolism (PE)
- Postpartum haemorrhage 1000-1499mls
- Postpartum haemorrhage >1499mls
- Premature deliveries up to 36+6
- Readmission of baby
- Readmission of mother
- Return to theatre
- Seriously ill patient
- Shoulder dystocia
- Significant infection
- Stillbirth
- Term baby admitted to SCBU
- Third & forth degree tear
- Transfer in from homebirth
- Trauma to bladder or other organs
- Unavailability of any facility or equipment
- Unavailability of healthcare record
- Undiagnosed breech
- Unplanned homebirth
- Unsuccessful forceps ventouse
- Uterine rupture
- VTE
- Working environment of 30+ for over 3 hours

NB:

- Drug errors should be recorded under main Trust category of medication incidents
- Communication issues should be listed separately in addition to the maternity trigger incident form as these will be recorded under the main Trust category of communication incident

INCIDENT MANAGEMENT FOR ANTENATAL & NEWBORN SCREENING



Somerset Equality Impact Assessment

Before completing this EIA please ensure you have read the EIA guidance notes – available from your Equality Officer			
Organisation prepared for	**Yeovil District Hospital NHS Foundation Trust**		
Version	**1**	**Date Completed**	**April 2021**
Description of what is being impact assessed			
Policy for the Development and Management of Procedural Documents			
Evidence			
What data/information have you used to assess how this policy/service might impact on protected groups? Sources such as the Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles,, should be detailed here			
No impacts on protected groups			
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?			
Equality & Diversity Lead			

Analysis of impact on protected groups				
The Public Sector Equality Duty requires us to eliminate discrimination, advance equality of opportunity and foster good relations with protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the Public Sector Equality Duty. Based on this information, make an assessment of the likely outcome, before you have implemented any mitigation.				
Protected group	**Summary of impact**	**Negative outcome**	**Neutral outcome**	**Positive outcome**
Age	• n/a	☐	✓	☐
Disability	• n/a	☐	✓	☐
Gender reassignment	• n/a	☐	✓	☐
Marriage and civil partnership	• n/a	☐	✓	☐
Pregnancy and maternity	• n/a	☐	✓	☐
Race and ethnicity	• n/a	☐	✓	☐
Religion or belief	• n/a	☐	✓	☐
Sex	• n/a	☐	✓	☐
Sexual orientation	• n/a	☐	✓	☐

Other, e.g. carers, veterans, homeless, low income, rurality/isolation, etc.	• n/a	☐	✓	☐

Negative outcomes action plan
Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.

Action taken/to be taken	Date	Person responsible	How will it be monitored?	Action complete
n/a	Select date			☐
	Select date			☐

If negative impacts remain, please provide an explanation below.

n/a

Completed by:	**Nicola Crouch**
Date	**April 2021**
Signed off by:	**Sallyann Batstone**
Date	**April 2021**
Equality Lead/Manager sign off date:	**Not required as no significant service change as a result of this policy**
To be reviewed by: (officer name)	**Not required as no significant service change as a result of this policy**
Review date:	**n/a**