Yeovil District Hospital NHS
NHS Foundation Trust

RISK MANAGEMENT STRATEGY

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Table of Contents

1. RISK MANAGEMENT STRATEGY

1.1 Introduction

1.1.1 The Chief Executive and the Board of Directors (BoD) at Yeovil District Hospital NHS Foundation Trust (Trust) is 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.

1.1.2 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 affects 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.

1.1.3 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 is at the heart of all clinical practice and all staff are open to sharing learning from the experiences related to the management of risk.

1.1.4 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 will ensure, on behalf of the Board of Directors that safe systems and robust risk management arrangements are in place for delivering Quality and Safe Care.

1.1.5 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 clinical governance. It is the Trust's aim to ensure that all professionals working within the organisation know that clinical governance and patient safety is part of their daily responsibility and embedded in their working practices.

1.1.6 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.

1.2 Purpose

The purpose of this risk management strategy is:

- to demonstrate an organisational risk management structure that details 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 demonstration of 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 the key individual(s) 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, members, practitioners and managers 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 Monitor

1.3 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, the National Reporting and Learning Service (NRLS) and the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (SIRI) 2010.

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

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

2. ARRANGEMENTS FOR RISK MANAGEMENT

2.1 Yeovil District Hospital NHS Foundation Trust will ensure that the management of risk is established throughout the organisation with guidance on roles, responsibilities, processes and procedures.

2.2 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.

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

2.4 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' Policy in respect of communicating with patients and/or carers about patient safety incidents.

2.5 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.

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

- maintenance of Strategic Business Unit and Service 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)

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

- Audit Committee, NCRAC and CGAC (Assurance Committees)
- Quality Committee
- Formal Committees

For an explanation of the committee responsibilities see Section 5 and **Annex A**.

2.8 Staff are involved in risk management; both through the incident reporting process and the proactive identification and management of risk in the organisation. Staff level responsibilities for risk management are detailed in Section 5.

2.9 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.

2.10 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.

3. RISK REGISTER AND ASSURANCE FRAMEWORK

3.1 Arrangements

3.1.1 The Strategic Business Unit and Service risk registers identifies and lists the risks facing the Trust and the action being taken to mitigate them.

3.1.2 All Lead Directors (including Lead Clinicians responsible for specific work streams), supported by the Trust Risk Manager are responsible for ensuring that risks identified through local mechanisms are included on Business Unit or Service risk registers and the Corporate risk register for those scoring 12+ in line with the risk matrix (matrix). The Director of Nursing and Clinical Governance and the Associate Director for Patient Safety and Quality are responsible for ensuring that Trust-wide clinical risks are included.

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

3.1.4 The Assurance Committees will review the Corporate risk register as part of their meetings agendas to ensure risk treatment plans are being implemented. The Board of Directors will receive the Corporate risk register quarterly. The Audit Committee will have overall oversight of the Assurance process

3.1.5 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**.

3.1.6 When deciding if a risk is acceptable, the risk rating will be considered in the light of controls to reduce the risk. 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.

3.1.7 Within the Trust, the Business Unit and Service 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 Risk Manager, with risk information being received from a variety of sources.

3.2 Definitions of Significant and Acceptable Risk

3.2.1 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.

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

3.2.3 Risk appetite is a threshold – the amount of risk that an organisation is prepared to accept before it takes action.

3.2.4 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.

3.2.5 The **risk appetite** for the Trust is defined as follows:

- **Risk Level – Low / Green - Risk Matrix Scoring 6 or under -** These represent lowest levels of opportunity/threat and actions shall be limited to contingency planning rather than active risk management action. Risks shall be recorded on the Business Units or Service 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 / Amber – Risk Matrix Scoring between 8 and 12 -** These represent moderate levels of opportunity/threat which may have a short-term impact on organisational objectives. 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 Business Unit or Service risk registers and tabled at appropriate meetings, management meetings and relevant committees with responsibility for risk management.

  Risk level shall be monitored as part of the Business Unit or Service managers review together with the status of controls in place and risk treatment.

- **Risk Level – High/Significant/Red – Risk Matrix Scoring 12+ -** These represent higher levels of opportunity/threat which may have a major or long term impact on benefits realisation, 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 Assurance Committees and to the Board of Directors through the Corporate risk register.

3.3 The Assurance Framework

3.3.1 The Assurance Framework (AF) 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.

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

3.3.3 The AF 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 AF is supported by the corporate risk register to identify operational risks.

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

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

4. 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).

- **Principle 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 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.

- **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, operating effectively and its objectives are being achieved.

- **Assurance Framework**: The 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.

5. RESPONSIBILITIES FOR RISK MANAGEMENT

The organisational structure chart is shown in **Annex A**.

5.1 Board of Directors

5.1.1 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

5.2 Audit Committee

5.2.1 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.

5.2.2 The Committee will:

- oversee the Risk Management Strategy and process
- review the Corporate risk rregister 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
- 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
- embed risk management throughout the organisation

5.3 Assurance Committees

5.3.1 The Assurance Committees act as focus for the management of clinical, non-clinical risks receiving reports and recommendations from the Patients Safety Steering Group, Clinical Standards, Patient Experience, Quality Committee and other committees agreed through the Assurance Committees.

5.4 Quality Committee

5.4.1 The Quality Assurance Committee (QC) 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 Audit Committee and NCRAC / CGAC on topic areas to support the assurance process.

5.5 Formal Committees

5.5.1 There are a number of committees / groups that report to the Assurance Committee who are responsible to keep under review and manage the risks under their remit in line with their terms of reference.

Staff Responsibilities for the Management of Risk

5.6 Chief Executive

5.6.1 The Chief Executive as the accountable officer, has overall responsibility for ensuring the implementation of risk management strategy, including organisational controls and reporting arrangements.

5.7 Director of Nursing and Clinical Governance

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

- ensuring implementation of risk management standards and reporting to the 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 clinical governance
- ensuring systems for reporting incidents, investigation of serious incidents and external reporting arrangements are managed effectively

5.8 Chief Finance and Commercial Officer

5.8.1 Responsible for progressing financial and performance risk management. The Chief Finance and Commercial Officer is the nominated Security Management Director (SMD), the nominated Senior Information Risk Owner (SIRO) and the executive director responsible for Fire, Health and Safety.

5.9 Senior Director Risk Leads

5.9.1 The Senior Risk Management leads are:

- Chief Finance and Commercial Officer
- Director for Elective Care
- Director for Urgent Care and Long Term Conditions

5.9.2 They are responsible for:

- communicating the Risk Management Strategy
- carrying out the risk management processes set out in Section 6
- 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

5.10 Company Secretary

5.10.1 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.

5.11 Trust Risk Manager

5.11.1 The Trust's Risk Manager is responsible for maintaining the Trust's risk register and risk management arrangements, working in collaboration with the Company Secretary for identifying corporate risks for reporting to the Board of Directors from the operational risk registers. The trust risk manager provides risk register arrangements for the Business Units and departments to identify and manage their risk. The risk manager is also responsible for maintaining a system for providing assurance against CQC regulations and standards.

5.12 Managers / Heads of Departments

5.12.1 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 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

5.13 All Staff

5.13.1 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.

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

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

6. OPERATIONAL RISK MANAGEMENT

Implementation of this policy and 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

6.1 Risk Management Process

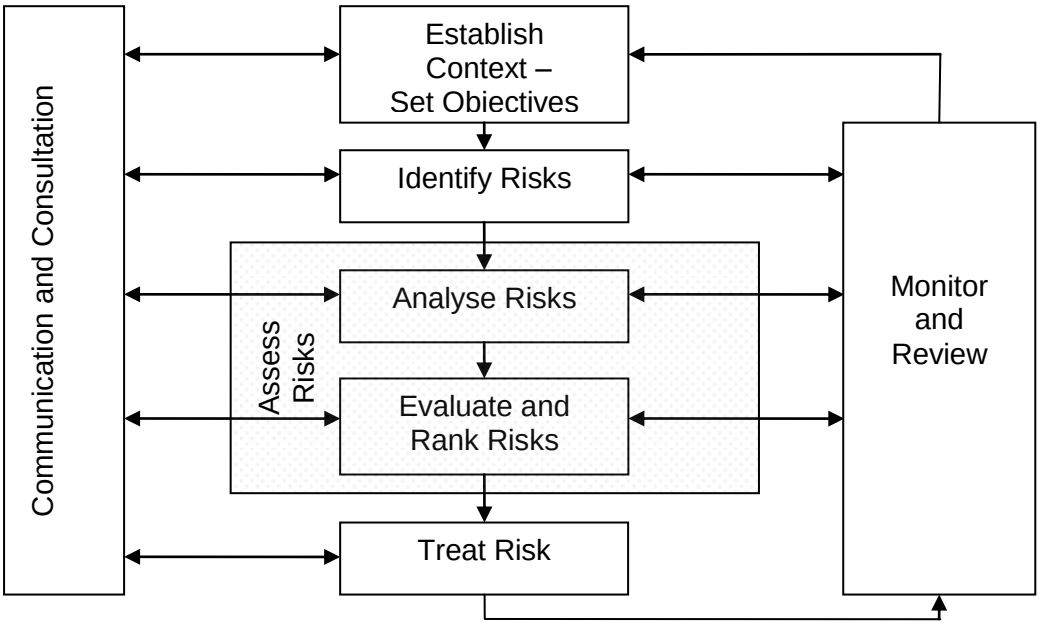
6.1.1 The Trust promotes the establishment of an open and fair, blame-free culture for reporting incidents. There will be clear guidance for all staff regarding staff roles in risk management and this will be clearly communicated at all levels.

6.1.2 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) and NHS England. Partnership working with these organisations is of key importance in terms of reporting and managing risk.

6.1.3 The Trust's risk management process is based on the Risk Management Standard AS/NZS 4360:2004 published by Standards Australia. 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 AS/NZS 4360:2004



6.2 Key Principles of the Risk Management Process

6.2.1 The risk management process observes the following principles:

- a culture where risk management is considered an essential and positive element in the provision of healthcare
- a risk management approach should provide 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
- recognise that resources may sometimes be required to address risk and business plans should reflect this

6.3 Identifying Risk

6.3.1 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.

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

6.3.3 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.

6.3.4 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.

6.3.5 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

6.3.6 Risk assessment formats and guidance is provided through the Clinical Governance team site on YCloud. For specific risks assessments such as Fire, Health and Safety refer to the appropriate YCloud page.

6.4 Risk Assessment

6.4.1 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:

- Associate Director for Patient Safety and Quality
- Trust Risk Manager
- Maternity Risk Manager
- Fire, Health and Safety Advisor
- Radiation Protection Advisor
- Local Security management Specialist (LSMS)
- Local Counter Fraud Specialist
- Information (IG) Lead

6.4.2 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 or Moderate)) are appropriately managed at a local level
- **AMBER** rated risks (rated 8 to 12 (Significant)) that cannot be treated locally should be referred to the relevant Lead Director, or Service lead.
- **RED** rated risks (rated 12+ (Significant and High Risk)) should be referred directly to the Lead Director, Service lead and Trust Risk Manager for consideration and inclusion in the Corporate Risk Register.

6.5 Managing Risk

6.5.1 Risk assessments should identify controls or mitigating actions, 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 manager lead should ensure these are reviewed and maintained for reference against risk mitigation.

6.5.2 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.

6.5.3 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, Green (RAG) rating

6.5.4 The Trust has an incident reporting policy and maintains a risk management data base (Safeguard) which provides web-based reporting of clinical and non-clinical incidents and near misses.

6.5.5 The Trust will upload patient safety incidents through the National Reporting and Learning System (NRLS) and Security Incidents through the Serious Incident Reporting (SIRS) system to NHS Protect.

6.5.6 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 Serious Incidents requiring investigation (SIRI) policy is followed when identifying and reporting Serious incidents externally

6.6 Minimising Risk

6.6.1 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.

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

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

6.7 Managing Residual Risk

6.7.1 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

6.8 Monitoring Risks

6.8.1 The risk management process is monitored by the risk management committees and through the Assurance Committees reviews up to the Board of Directors.

6.9 Quality Impact Assessments

6.9.1 Quality Impact Assessments 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 consideration of 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.

7. INCIDENT REPORTING

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.

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 everyday practice. The reported incidents are investigated where necessary and all the information entered onto the risk management database.

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 policy.

7.1 Serious Untoward Incident Reporting and Learning from Incidents

Incidents that meet the criteria of a Serious Incidents Requiring Investigation (SIRI) are reported externally. This includes all "Red" incidents (Refer to the Incident Reporting policy), plus a number of other incidents as defined by the lead commissioner.

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

All serious incidents requiring investigation will be escalated through the incident reporting process to be brought to the attention of the Associate Director of Patient Safety and Quality who will escalate risk to the appropriate level.

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

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

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 policy.

7.2 'Being Open' and 'Duty of Candour'

The Trust will ensure through processes set out in the 'Being Open' policy and the Incident Reporting policy. The Duty of Candour is a contractual requirement coming from the recommendations from the Mid Staffs Enquiry http://www.midstaffspublicinquiry.com/report

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

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).

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 (MSO) and a Medical Devices Safety Officer (MDSO) reporting to the Director of Nursing and Clinical Governance with responsibilities reported through the Patient Safety Steering group.

8. APPLICABILITY

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.

9. IMPLEMENTATION, TRAINING AND SUPPORT

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 risk committees, 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
- ensure that all training programmes raise and sustain awareness throughout the Trust of the importance of identifying and managing risk. There is an internal course for managers that should be undertaken once every 5 years. All new managers should undergo induction to risk with the Trust Risk Manager.
- 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

10. MONITORING THE EFFECTIVENESS OF THE STRATEGY

Reporting on the effectiveness of the risk management strategy within the Trust based on all available relevant information will be through the Associate Director of Quality and Patient Safety, the Company Secretary and the Risk Manager.

11. REFERENCES

- Department of Health (2011) The “Never Events” List for 2013/14 – Policy Framework for Use in the NHS [Online]. Available at http://www.england.nhs.uk/wp-content/uploads/2013/12/nev-ev-list-1314-clar.pdf
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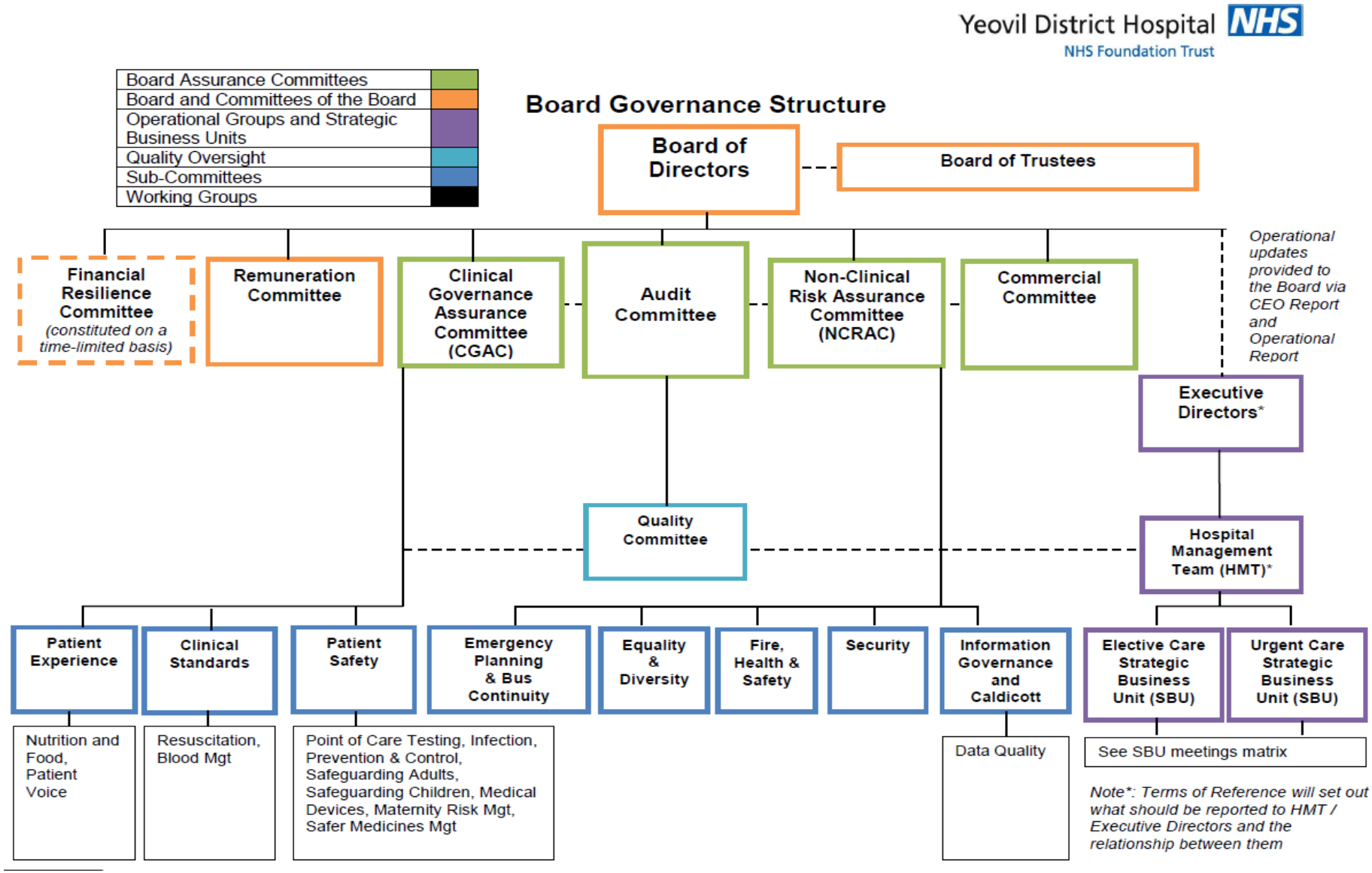
12. ASSOCIATED POLICIES

- Incident Reporting policy and serious investigation procedure
- CCG Somerset - Serious Incident Requiring Investigation (SIRI) policy
- Health and Safety policy
- Raising Concerns (Whistleblowing) policy
- 'Being Open' policy
- Infection Prevention Control policy
- Procedural Documents policy
- Maternity Risk Management policy

13. EQUALITY IMPACT ASSESSMENT

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**.

ANNEX A – ORGANISATIONAL STRUCTURE



ANNEX B - RISK ASSESSMENT SCORING GUIDELINES

1. INTRODUCTION

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.

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.

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.

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

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

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.

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.

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.

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.

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

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

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 to determine psychological impact on individuals
- what is defined as an adverse event and how many individuals may be affected

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.

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.

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.

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 <3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity / disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality / complaints / audit	Peripheral element of treatment or service 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.	Uncertain delivery of key objectives / service due to lack of staff. Unsafe staffing level or competence (>5 days).	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

			Poor staff attendance for mandatory / key training.	Loss of key staff. Very low staff morale. No staff attendance for mandatory / key training.	mandatory training / key training on an ongoing basis.
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation. Reduced performance rating if unresolved.	Single breech of statutory duty. Challenging external recommendations / improvement notice.	Enforcement action. Multiple breeches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breeches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity / reputation	Rumours. Potential for public concern.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House). Total loss of public confidence.
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1-0.25 per cent of budget. Claim less than £10,000	Loss of 0.25-0.5 per cent of budget. Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective / loss of 0.5-1.0 per cent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective / loss of >1 per cent of budget. Failure to meet specification / slippage. Loss of contract / payment by results. Claim(s) >£1 million.
Service / business interruption Environmental impact	Loss / 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 <3 days. Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable 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. Mismanage-ment 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. Grade 1 pressure ulcer	Wrong drug or dosage administered, with no adverse effects. Physical attach such as pushing, shoving or pinching, causing minor injury. Self-harm resulting in minor injuries. Grade 2 pressure ulcer. Laceration, sprain, anxiety requiring occupational health counselling (no time off work required).	Wrong drug or dosage administered with potential adverse effects. Physical attack causing moderate injury. Self-harm requiring medical attention. Grade 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 a sprain.	Wrong drug or dosage administered with adverse effects. Physical attack resulting in serious injury. Grade 4 pressure ulcer. Long-term HCAI. Retained instruments / material after surgery requiring further intervention. Haemolytic transfusion reaction. Slip / fall resulting in injury such as dislocation / fracture / blow to the head. 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

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 - Almost certain

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

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**.

However frequency is not a useful way of scoring certain risks, especially those associated with the success of time limited of 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.

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.

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)

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

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).

The risk matrix in **Table 5** shows both numerical scoring and colour bandings. The Trusts 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**
Minor - 1	1	2	3	4	5
Moderate - 2	2	4	6	8	10
Significant or Major - 3	3	6	9	12	15
Fatality/Very High- 4	4	8	12	16	20
Multiple Fatalities - 5	5	10	15	20	25

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

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

1-3 = Low Risk
4-6 = Moderate Risk
8-12 = Significant Risk
15-25 = High Risk

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. RELATIONSHIP WITH INCIDENT SCORING

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).

Refer to the Incident Reporting policy for detailed guidance.

6. CONCLUSION

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.

ANNEX C – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Name of Document: **Risk Management Strategy**

1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	**No**	
	• Ethnic origins (including gypsies and travellers)	**No**	
	• Nationality	**No**	
	• Gender	**No**	
	• Culture	**No**	
	• Religion or belief	**No**	
	• Sexual orientation including lesbian, gay and bisexual people	**No**	
	• Age	**No**	
	• Disability	**No**	
2.	Is there any evidence that some groups are affected differently?	**None**	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	**None Identified**	
4.	Is the impact of the policy/guidance likely to be negative?	**No**	
5.	If so can the impact be avoided?	**Not Applicable**	
6.	What alternatives are there to achieving the policy/guidance without the impact?	**Not Applicable**	
7.	Can we reduce the impact by taking different action?	**Not Applicable**	

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Signed: **Adrian Pickles** (Trust Risk Manager) Date: **25th November 2014**