The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

RISK MANAGEMENT POLICY (1)

Author and Contact details:	[redacted]	
Responsible Director:	**Director of Nursing & Governance**	
Approved by and date:	**Patient Safety Group**	**February 2019**
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Target Audience:	All trust employees.	
Document Approval, History/Changes	**See Appendix 8** For further information contact the Governance Department on [redacted]	

Think of the environment…Do you have to print this out this document? **You can always view the most up to date version electronically on the Trust intranet.**

Executive Summary

The purpose of the Policy is to define the framework and systems the Trust will use to identify, manage and eliminate or reduce to a reasonable level risks that threaten the Trust's ability to meet its objectives and achievement of its values.

This document should be read in conjunction with the Trust Risk Management Strategy.

Contents

1. Introduction

The Trust is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Trust's governance framework and system of internal controls.

The Risk Management Policy is regularly reviewed and updated to ensure it continues to be consistent with the **Trust Risk Strategy** and reflects national guidance and legislation.

1.1. Aims and objectives

1.1.1 The overarching aim of the Policy is to provide assurance that the Trust is providing high quality care in a safe environment, that it is complying with legal and regulatory requirements and that it is meeting its strategic objectives and promoting its values.

1.1.2 Policy objectives are:

- To embed risk management systems and processes within the organisation and to promote the ethos that risk management is everyone's business.
- To clearly define roles and responsibilities for risk management.
- Create an environment which is safe as is reasonably practicable by ensuring that risks are continuously identified, assessed and appropriately managed i.e. where possible eliminate, transfer or reduce risks to an acceptable level.
- To establish clear and effective communication that enables a comprehensive understanding of risks at all levels of the organisation by developing the use of Divisional, specialist and trust-wide risk registers.
- To maintain continued compliance with national standards, regulatory requirements and legislation.
- In line with the Trust's commitment to integrated governance, to adopt an integrated approach to risk management which includes risks related to clinical care, health and safety, financial and business planning, workforce planning, corporate and information governance, performance management, project/programme management, education and research.
- To foster an organisational culture of openness and willingness to report risks, incidents and near misses that is used for organisation-wide learning.
- To ensure training is provided to ensure effective implementation of this Policy as set out in the Training Needs Analysis.

2. Scope

The Policy applies to all staff including contractors and agency staff. The Policy applies equally to all areas of the Trust with regard to all types of risk, both clinical and non-clinical.

3. Definitions

See Appendix 5.

4. Duties

4.1. The Board of Directors

- are responsible for ensuring the Trust has effective systems for managing risk

4.2. The Chief Executive

- as the Trust's Accounting Officer, is personally responsible for maintaining a sound system of internal control including risk management

4.3. Director of Nursing & Governance Strategy and Planning

- has delegated responsibility for ensuring effective systems for risk management are in place across the Trust
- develop and oversee the effective execution of the Board Assurance Framework and ensure effective processes are embedded to rigorously manage the risks therein, monitoring the action plans and reporting to the Board and relevant Committee
- develop and implement the Risk Management Strategy

4.4. The Deputy Director of Nursing & Governance

- work closely with the Chair, Chief Executive, Executive Directors, Divisional Directors and Deputy Directors to implement and maintain appropriate risk management strategies and processes, ensuring that effective governance systems clinical and non-clinical risk processes are in place to assure the delivery of Trust objectives
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a Trust-wide basis
- work closely with the Chief Executive and Directors to support the provision of corporate, and directorate level risk registers

4.5. Senior Information Risk Owner (SIRO)

- the Director of Finance is the SIRO and is the nominated executive lead to ensure the Trust's information risk is properly identified and managed and that appropriate assurance mechanisms exist

4.6. Executive Directors and Deputy Directors have delegated responsibility for:

- managing risks in accordance with their portfolios
- ensuring effective systems for risk management, compatible with this Policy, are in place within their Division, specifically, they must ensure:
  - staff are familiar with the policy and aware of their responsibility for risk
  - staff attend appropriate risk training (including induction and mandatory training)
  - risks (strategic and operational) are effectively managed i.e. identified, assessed and that action plans to mitigate risks are developed, documented and regularly reviewed

4.7. Clinical Directors, Divisional Directors of Operations/General Managers and Lead Nurses are responsible for ensuring:

- that there are effective systems for risk management are in place within their Divisions
- their staff are aware of this policy

4.8. Ward Sisters/Charge Nurses, Heads of Department and Departmental Managers are responsible for:

- the operational implementation of this policy within their departments, wards and/or other clinical and non-clinical areas
- reviewing clinical incidents

4.9. Clinical Governance Lead

- ensures that there are effective systems in place to effectively manage risk across the Trust
- co-ordinates and updates the Trusts Board Assurance Framework (BAF)
- ensures the Trust has a comprehensive and dynamic Risk Register and working with Divisional Management Teams to ensure that they understand their accountability and responsibilities for managing risks in their areas
- ensures Risks management reports including the Quarterly and annual governance and risks reports are available

4.10. Divisional Risk/Governance Leads are responsible for:

- coordinating the risk management processes in their Division and maintaining the Divisional Risk Register

4.11. Staff must ensure:

- they are familiar and comply with the Trust's risk-related policies and relevant professional guidelines and standards
- if they identify a risk, they must escalate this to their line manager

5. Organisational arrangements

The organisational management of risk forms part of the Trust's overall approach to governance. The key forums for the management of risk in the Trust are outlined below.

5.1. Trust Board

The Trust Board has overall responsibility for ensuring that the Trust has process and monitoring arrangements in place relating to Governance and Risk from within the Trust.

The two main committees of the Board focusing on Risk Management are the Audit Committee and Quality Committee.

5.2. Quality Committee

- has delegated responsibility for the management of clinical risk within the organisation
- the Quality Committee is responsible for providing assurance to the Board of Directors that the systems of internal control are managing clinical risk appropriately

5.3. Business Performance Committee

- the Business Performance Committee is responsible for providing assurance to the Board of Directors that the systems of internal control are managing non clinical risk appropriately

5.4. Patient Safety Group

- the Patient Safety Group will provide advice and assurance to the Quality Committee on the management of operational risks within the Trust
- the group is responsible for the scrutiny of risks on the operational risk registers to ensure consistency in assessment across the organisation

5.5. Divisional Governance & Risk Groups

- the Divisional Governance & Risk groups are responsible for reviewing and controlling the risks within their divisions

- they will review the Trust Risk Register and escalate those risks which it feels require higher level attention based on the Risk Scoring Matrix

6. Risk management process

6.1. Risk Management covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them and monitoring and reviewing progress. In order for the Trust to manage and control the risks it faces, it needs to identify and assess them.

6.2. Appendix 1 - 5 provide a step-by-step guide to help staff undertake risk management systematically and will ensure consistency of approach across the organisation.

6.2.1 See Appendix 1 for guidelines to identify, assess, action and monitor risks.

6.2.2 See Appendix 2 for guidelines for the use of DATIX web Risk 1 form.

6.2.3 See Appendix 3 for guidelines for the use of the DATIX Web Risk 2 form.

6.2.4 See Appendix 4 for Local Risk Protocol.

7. Risk Registers

7.1. Operational risk register

7.1.1 Operational risks identified from risk assessment must be entered onto the Datix risk management system.

7.1.2 Risks that are graded between 1 and 10 are the responsibility of the local ward/ department.

7.1.3 Risks that are graded 12 to 25 are the responsibility of the Divisional Director of Operations. Risks which are graded from 12 to 25 form the Trust Risk Register.

7.1.4 The operational risk registers will be scrutinised by the Patient Safety Group on a rotational basis and the Executive Team on a quarterly basis.

7.1.5 Risks which the Patient Safety Group considers to be significant will be escalated to the Quality Committee for consideration and may be entered onto the BAF.

7.2. Board Assurance Framework

7.2.1 This is a register of all risks which have the potential to prevent the organisation from achieving its strategic objectives.

7.2.2 The BAF is by the trust Board and by executives on a quarterly basis.

8. Specific risk assessments

8.1. Within the trusts Health & Safety Policy there is a risk assessment process for general environmental risk assessments.

8.2. For specific risk assessments see the following policies:

- Health & Safety Policy
- Fire Safety Policy
- COSHH Policy
- Risk Management Strategy
- Violence and Aggression Policy
- Manual Handling Policy
- Display Screen Equipment Policy

- Stress Management Policy

9. Training

9.1.1 Please refer to the Trusts Training Needs Analysis that can be located within the Corporate Induction and Mandatory Training Policy.

10. Monitoring

Minimum requirement to be monitored	Process for monitoring e.g. audit/ review of incidents/ performance management	Job title of individual(s) responsible for monitoring and developing action plan	Minimum frequency of monitoring	Name of committee responsible for review of results and action plan	Job title of individual/ committee responsible for monitoring implementation of action plan
Risks entered onto the risk register are completed according to Trust methodology	Audit	Line managers	Quarterly	Divisional Governance & Risk Groups	• DATIX Lead • Divisional Governance & Risk Groups
All risks are graded accordingly	Audit	As above	Quarterly	As above	• As above
All risks have action plans	Audit	As above	Quarterly	As above	• As above
Risks are entered onto Datix risk register.	Audit	As above	Quarterly	As above	• As above
Risk registers and associated action plans are monitored at the Divisional Governance & Risk Groups	Audit	Relevant chair of Divisional Governance & Risk Groups	Quarterly	As above	• Relevant chair of Divisional Governance & Risk Groups

11. References

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1999
- Code of Conduct for NHS Managers Department of Health. (2002)
- Risk Management Standards NHSLA
- Code of Governance Monitor

11.1. Supporting policies/documents

- Risk Management Strategy
- Incident Reporting Policy
- Health & Safety Policy
- Fire Safety Policy
- COSHH Policy
- Risk Management Strategy
- Violence and Aggression Policy
- Manual Handling Policy
- Display Screen Equipment Policy
- Stress Management Policy

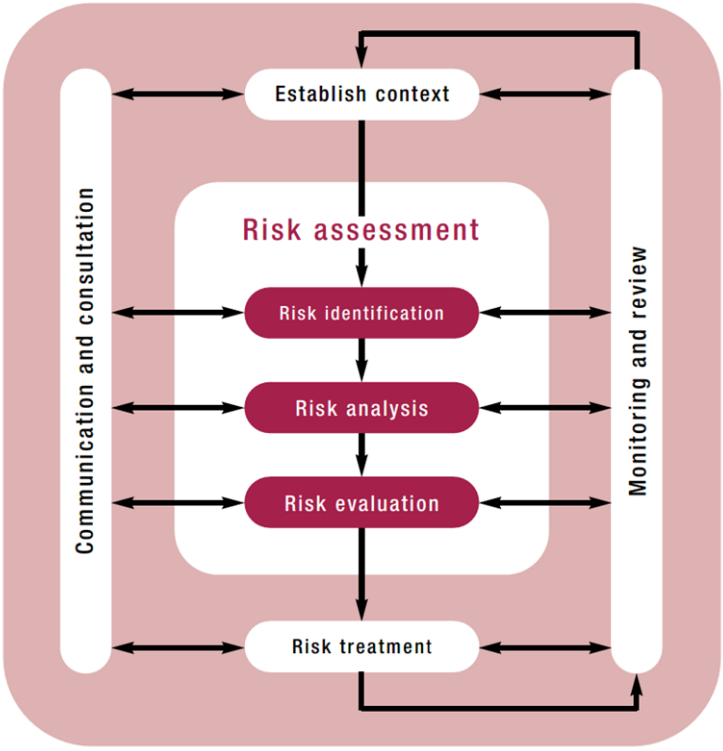
Appendix 1 - Guidelines to identify, assess, action and monitor risks

1. Introduction

This document provides a step-by-step guide to help staff undertake risk management systematically and will ensure consistency of approach across the organisation.

Risk Management covers all the processes involved in assessing, identifying, analysing and the treatment of risks.

The diagram below provides a simplified version of the essential steps in the implementation and ongoing support of the risk management process.



2. Establish the context

The first stage of the risk management process requires the organisation to establish the context of the risk assessment as it relates to both internal and external factors e.g:

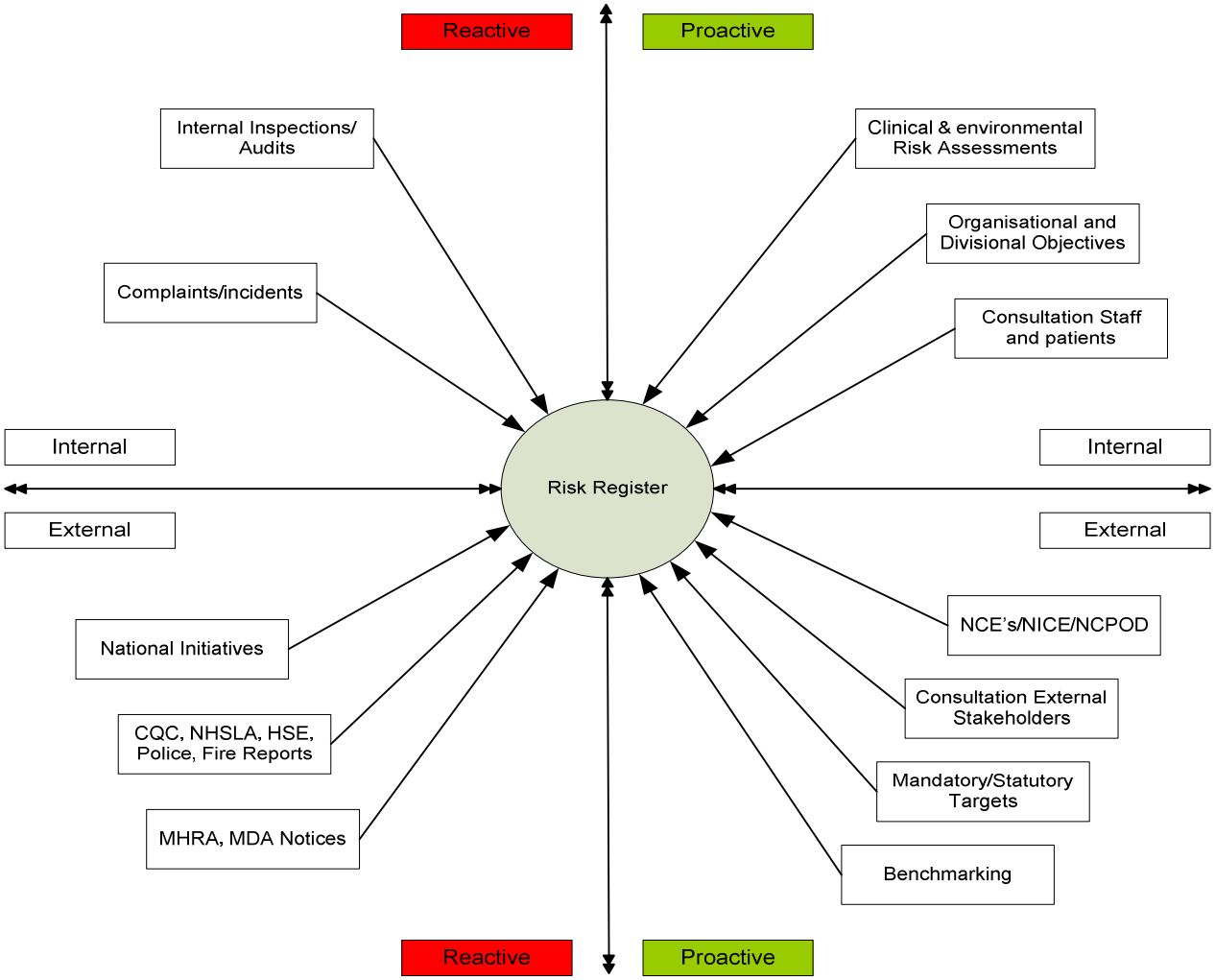
- internal factors include the organisational structure, corporate governance, business processes and technologies
- external factors include legal and regulatory environment, political considerations, economic circumstances and the views of external stakeholders

3. Risk Assessment

The risk assessment phase has three phases: risk identification, risk analysis and risk evaluation. During the risk identification phase, the organisation develops a comprehensive list of the risks that might prevent it from achieving its objectives, as well as the causes and possible outcomes of those risks materialising. This information is considered carefully during the risk analysis, where the organisation conducts qualitative and/or quantitative assessments of those risks. The risk assessment stage culminates in the risk evaluation step, where the organisation decides which risks are significant enough to require active management and prioritises that list.

3.1 Risk identification

There is no unique method for identifying risks. Risks may be identified in a number of ways and from a variety of sources, the diagram below illustrates common areas of information that can be used to identify both reactive and proactive risks.



3.3 Risk Analysis/evaluation

Addresses the likelihood and consequence. Currently the DATIX web Risk Management system is used to collect information to enable simple risk analysis.

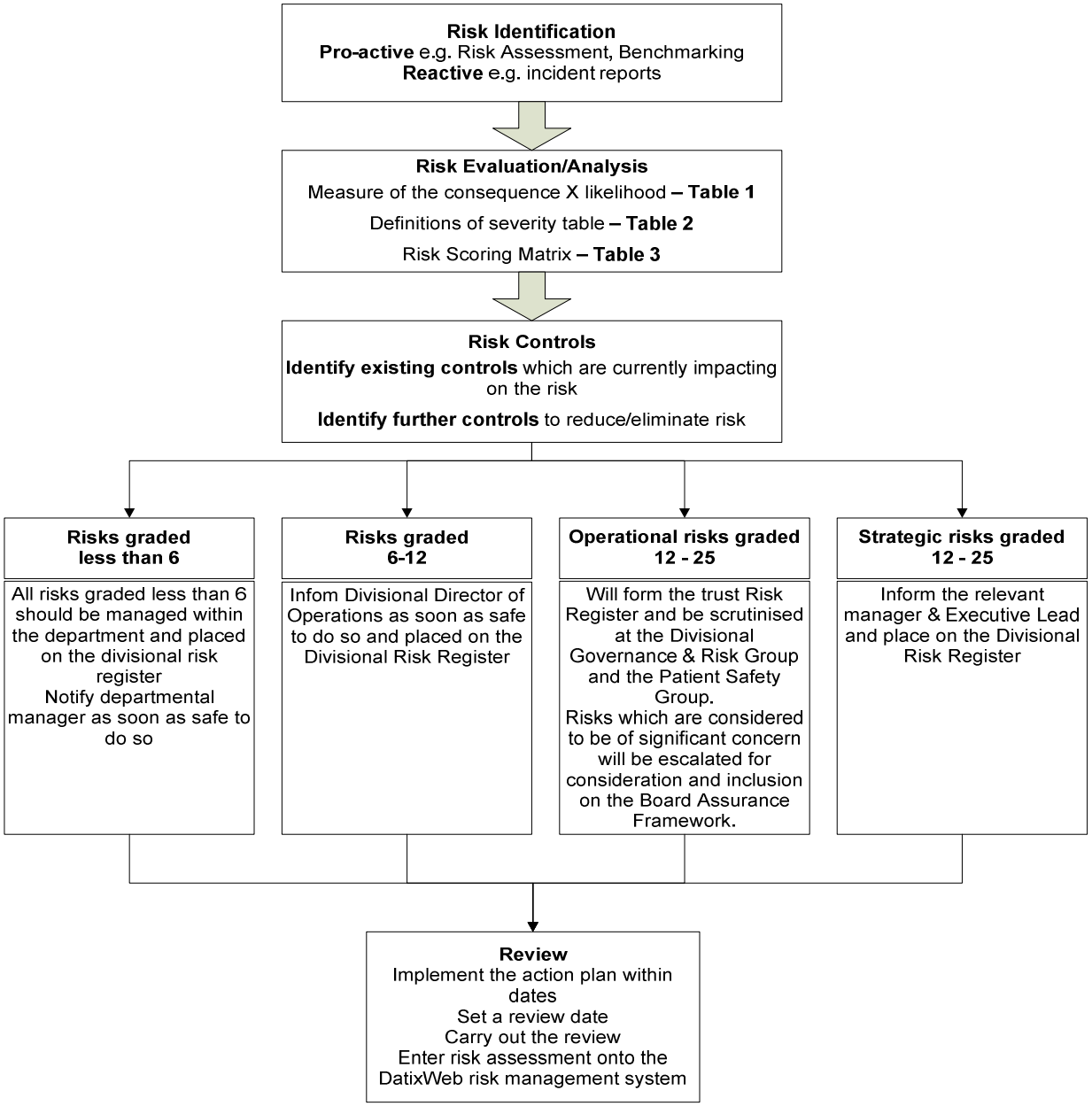
3.5 Risk treatment

Is the activity of selecting and implementing appropriate actions to reduce/control the risk. Risk treatment includes as its major element, risk control (or mitigation), but extends further to, for example:

- risk avoidance is the elimination of hazards, activities and exposures that can negatively affect an organisation's assets
- risk transfer the purpose of this action is to take a specific **risk**, which is detailed in the insurance contract, and pass it from one party who does not wish to have this **risk** (the insured) to a party who is willing to take on the **risk** for a fee, or premium (the insurer)
- risk financing is concerned with providing funds to cover the financial effect of unexpected losses experienced by a trust

4. Procedure

The following procedure is used by all staff to ensure a continual systematic approach to risk assessments throughout the Trust.



A Local DATIX Web protocol (**Appendix 4**) is available and in operation for each division. This protocol describes the arrangements, responsibilities and processes to be followed in order to populate a risk onto the DATIX Web system.

3.1 Risk Assessment

An assessment of the risks associated to a particular practice or activity may be undertaken using the Trust's Generic Risk Assessment Tool see **Appendix 5.**

- Table 1 (below) provides examples of consequence by domain
- Table 2 provides information on likelihood
- Table 3 provides information to assist in determining the risk grading or score.
- Table 4 provides information for Risk Rating (including responsibilities & accountability to manage risk).

Table 1 – Measuring the of Consequence

Domain	Consequence Score and Descriptor				
	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury or Harm Physical or Psychological	No / minimal injury requiring no / minimal intervention or treatment No time off work required	Minor injury or illness, requiring intervention Requiring time off work for < 4 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring intervention Requiring time off work for 4 -14 days Increase in length of hospital stay by 4 -14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects
Quality of the Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Unsatisfactory patient experience directly related to clinical care – readily resolvable	Mismanagement of patient care, short term effects < 7 days	Mismanagement of patient care, long term effects >7 days	Totally unsatisfactory patient outcome or experience
Statutory	Coroners verdict of natural causes, accidental death, open No or minimal impact on legal	Coroners verdict of misadventure Breech of statutory legislation	Police investigation. Prosecution resulting in fine >£50k Issue of a statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in fine >£500k	Coroners verdict of unlawful killing Criminal prosecution (incl Corporate manslaughter) > imprisonment of Director/ Executive
Business/ Finance & Service Continuity	Minor loss of non-critical service Financial loss <£10K	Service loss in a number of non-critical areas <2 hours or 1 area or <6 hours Financial loss £10 - 50k	Loss of services in any critical area Financial loss £50 - 500k	Extended loss of essential service in more than one critical area Financial loss £500k to £1m	Loss of multiple essential services in critical areas Financial loss > £1 m
Potential for Complaint or Litigation / Claims	Unlikely to cause complaint or litigation	Complaint possible Litigation unlikely Claim(s) < £10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100k - £1m	High profile complaint(s) with national interest Multiple claims or high value single claim >£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care / service quality (<1 day) Concerns about competency / skill mix	Ongoing low staffing level that reduces patient care / service quality Minor error(s) due to levels of competency (individual / team)	Ongoing problems with levels of staffing that results in late delivery of key objective/service Moderate error(s) due to levels of competency (individual / team)	Uncertain delivery of key objective/service due to lack of staff. Major error(s) due to levels of competency (individual / team)	Non-delivery of key objective/service due to lack of staff / lloss of key staff. Critical error(s) due to levels of competency (individual / team)
Reputation or Adverse Publicity[1]	Within the Trust Local media 1 day e.g. inside pages, limited report	Local media <7 day coverage e.g. front page, headline Regulator	National media <3 day coverage Regulator action	National media >3 day coverage. Local MP concern. Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets.	Minor non-compliance with standards / targets. Minor recommendations from report	Significant non-compliance with standards / targets. Challenging report	Low rating. Enforcement action. Critical report	Loss of accreditation / registration. Prosecution. Severely critical report

[1] Organisational reputation risks can relate to impact on how the organisation is viewed by staff within the organisation, by other organisations in the health and social care economy, by elected representatives and by patients and the general public.

Table 2 - Measuring the likelihood

Descriptor	Score	Frequency/How Likely is it to happen?
Rare	1	This probably will never happen/recur
Unlikely	2	Do not expect it to happen/recur, but it is possible it may do so
Possible	3	Might happen or recur occasionally
Likely	4	Will probably happen/recur, but is not a persisting issue or circumstance
Almost Certain	5	Very likely to happen/recur; possibly frequently

Table 3 - Rating the Risk/Risk Matrix

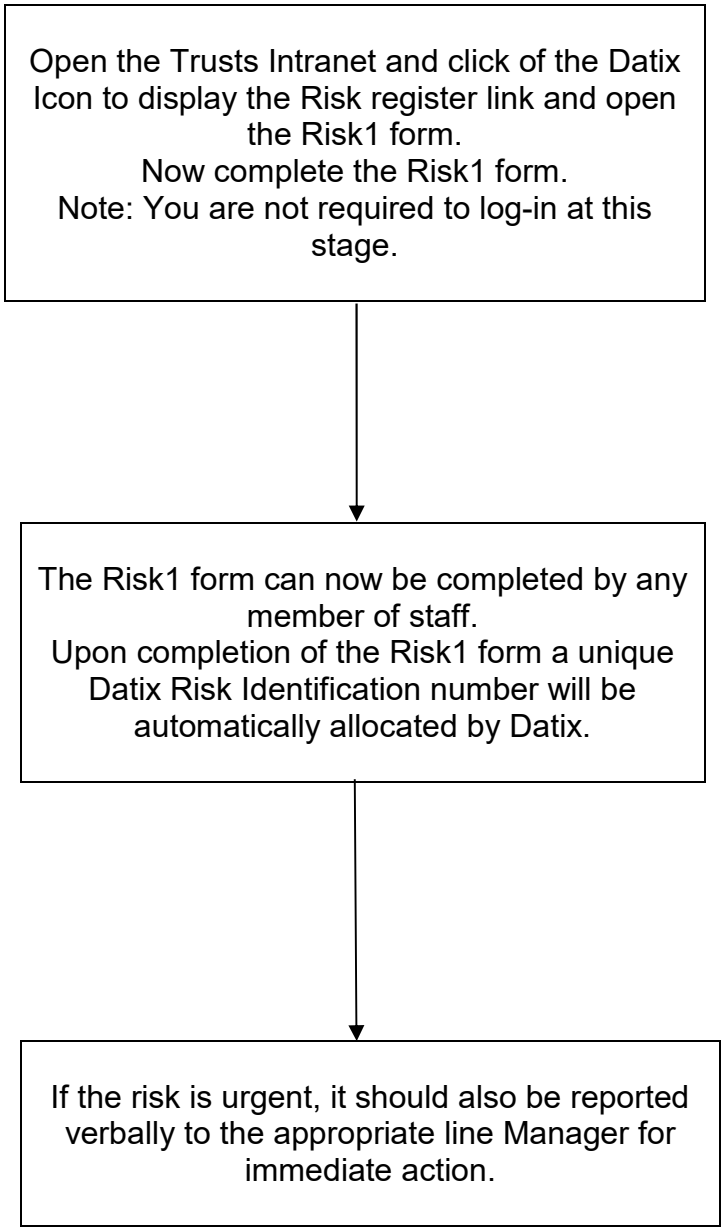
	Consequences				
Likelihood	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost Certain	**5**	**10**	**15**	**20**	**25**
Likely	**4**	**8**	**12**	**16**	**20**
Possible	**3**	**6**	**9**	**12**	**15**
Unlikely	**2**	**4**	**6**	**8**	**10**
Rare	**1**	**2**	**3**	**4**	**5**

To determine the level of risk (Risk Rating) of an event use the 5x5 risk scoring matrix above by assessing the Likelihood of the event happening and assessing the most likely Consequence of that event, this will give you a score and a colour. Formula: L x C = Risk Rating

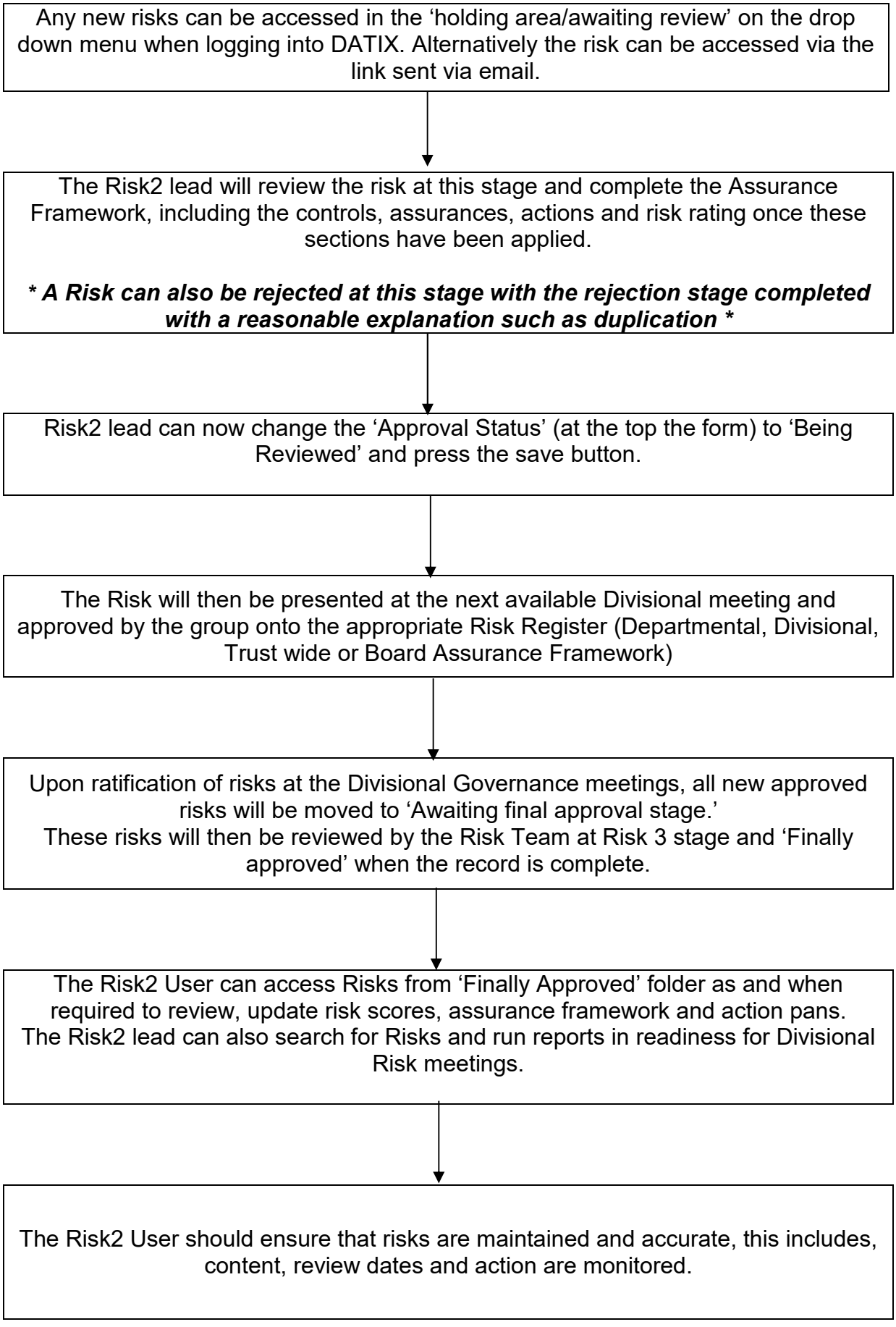
Table 4 - Risk Rating (including responsibilities & accountability to manage risk)

Scores	Risk Grade	Responsibilities & Accountability
1 - 5	**Low**	This level of risk has been authorised to be managed Locally at Departmental Level and will sit on the appropriate Departmental Risk Register.
6 - 12	**Moderate**	This level of risk has been authorised to be managed at Divisional Level and will sit on the appropriate Divisional Risk Register. The Divisional Director of Operations will be responsible for the management and control of all Moderate Risk for their Division.
15 +	**High**	This level of risks has been authorised to be managed at either on the Divisional Risk Registers as a HIGH operational Risk or by the Executive Directors as a HIGH strategic Risk affecting the Trust achievement of Strategic Aim/Objectives.

Appendix 2 - Guidelines for the use of DATIX web Risk 1 form



Appendix 3 - Guidelines for the use of the DATIX Web Risk 2 form



Appendix 4 - Divisional Risk Protocol

The Walton Centre NHS Foundation Trust

EXAMPLE Divisional Procedure	
Title:	*Example* Divisional Risk Procedure
Aim:	To underpin the Risk Management Policy
Authored / Developed by:	[redacted]
Review date:	
Reference / Supporting Documents:	Risk Management Policy
Implementation:	Copy to all managers, requesting receipt and assurance that all staff in area of responsibility are aware of, understand, have access to and implement the contents of the procedure.

Contents

1. Introduction

It is vital that the local process for assessing and managing risks is systematic and constant across the Trust and reflects the requirements of the Trust Risk Management Policy. Services are required to agree and implement an agreed DATIX Risk Procedure in conjunction with the Risk Department.

2. Definitions

- Risk1 User - Person who identifies the risk
- Risk2 User - Person who attends Divisional Risk Meeting (or designated Deputy in Risk 2 absence).
- Risk 3 User - Member of staff from the Risk Team

3. Duties

The following Managers have been identified to utilise Datix Web Risk Register for the Division.

Risk 2 User		
Name	**Initial**	**Title**

4. Entering a Risk on DATIX Web

4.1 Completion of Risk 1 Form

To access Datix simply go to the Trust Intranet home page, and click the Datix icon, which will take you to the appropriate link for the Risk 1 Form.

Complete the Risk1 form with as much information as possible (fields marked* are mandatory). If you are unsure about some areas of the form just complete as much as you can, further detail can be added at the next stage.

4.2 Completion of Risk 2 Form

- The Risk2 user will then log into DATIX and find the risk in holding area awaiting review click on the risk to open and complete the risk form in full.
- The Risk2 user will then need to complete the risk grading, identify controls, assurances, gaps in controls and gaps in assurance.
- The Risk2 user should also attach relevant documents, use Email Communication section and set up an Action Plan, if required.
- Once the Risk2 Form has been completed the Risk2 lead will be required to change the ***"Approval Status"*** field to **"*being reviewed*"** where all reviewed risks will be held ready for discussion at next Divisional Risk Meeting.

4.3 Searching for Records & Producing Reports in Datix

Risk2 users will be able to produce "packaged reports" which will be set up on the system by the Risk Team. Alternatively, the Risk 2 Managers will have access to search for their own records and produce reports in Datix.

4.4 Requesting Risks to be closed on Datix

When the Risk is completed and requires closing on Datix, Risk2 user's will need to send an email from the Risk record to the Risk Team requesting the closure of the risk, this will provide an audit trail against the risk record.

5.0 Training Requirements

Training for the use of the Datix Risk Management Risks Module will be provided by the Datix Project Lead.

6.0 Supporting Documents / Trust Policies

- The Trusts Risk Management Policy

Appendix 5 - Definitions

- ***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.
- ***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.
- ***Hazard*** - the HSE defines a hazard as "anything that may cause harm."
- ***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).
- ***Strategic 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. Strategic risks must be reported to the Board of the Directors and should be managed at executive level, directly or by close supervision.
- ***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.
- ***Board Assurance Framework*** - Board Assurance Frameworks - this is a register of all risks which have the potential to prevent the organisation from achieving its strategic objectives.
- ***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 department or division which is responsible for delivering services.
- ***Risk appetite*** - is the type and amount of risk that the Trust is prepared to tolerate and explain in the context of its strategy.
- ***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.

Appendix 6 - Equality Impact Assessment (EIA) Form

The Walton Centre NHS Foundation Trust

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Part 1

1. Person(s) Responsible for Assessment: [redacted]

2. Contact Number: [redacted]

3. Department(s): [redacted]

4. Date of Assessment: Jan 2019

5. Name of the policy/procedure being assessed: Risk Management Policy

6. Is the policy new or existing?

Existing

7. Who will be affected by the policy (*please tick all that apply*)?

Staff √ Patients √ Visitors Public

8. How will these groups/key stakeholders be consulted with?
Via Patient Safety Group

9. What is the main purpose of the policy?
Contained within body of policy

10. What are the benefits of the policy and how will these be measured?
See monitoring section

11. Is the policy associated with any other policies, procedures, guidelines, projects or services?

- Risk Management Strategy
- Incident Reporting Policy
- Divisional Risk Protocols

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics?

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation/adjustments already put in place
Age			√	See Next Section	Not applicable
Sex			√	See Next Section	Not applicable
Race			√	See Next Section	Not applicable
Religion or Belief			√	See Next Section	Not applicable
Disability			√	See Next Section	Not applicable
Sexual Orientation			√	See Next Section	Not applicable
Pregnancy/maternity			√	See Next Section	Not applicable
Gender Reassignment			√	See Next Section	Not applicable
Marriage & Civil Partnership			√	See Next Section	Not applicable
Other				See Next Section	Not applicable

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)

This policy is limited to very specific aims relating to Risk Management. It is not a policy concerned with the allocation or provision of particular services to the public, other than to ensure that this is done in accord with relevant legal responsibilities and guidance etc. So, there are no known grounds to suggest that this policy could have any significant risk of it disproportionately impacting on patients or members of the public who have protected characteristics. This policy covers all staff and does not confer direct benefits or impose particular sanctions on any sections of the workforce, nor does it materially affect their normal terms and conditions of work. So, there are no known grounds to suggest that this policy could have any significant risk of it disproportionately impacting on staff who have protected characteristics.

13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? No

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Safeguarding Matron for further support.

Action	Lead	Timescales	Review Date

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken ☑

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality ☐
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended. ☐
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed ☐

Name [redacted] Date: 6/2/19

Signed:

Appendix 7 - Policy approval checklist

The Bed Management Policy is presented to the Patient Safety Group for Approval.

In order for this policy to be approved, the reviewing group must confirm in table 1 below that the following criteria is included within the policy. Any policy which does not meet these criterion should not be submitted to an approving group/committee, the policy author must be asked to make the necessary changes prior to resubmission.

Policy review stage

Table 1

The reviewing group should ensure the following has been undertaken:	**Approved?**
The author has consulted relevant people as necessary including relevant service users and stakeholders.	Yes
The objectives and reasons for developing the documents are clearly stated in the minutes and have been considered by the reviewing group.	Yes
Duties and responsibilities are clearly defined and can be fulfilled within the relevant divisions and teams.	Yes
The policy fits within the wider organisational context and does not duplicate other documents.	Yes
An Equality Impact Assessment has been completed and approved by the HR Team.	Yes
A Training Needs Analysis has been undertaken (as applicable) and T&D have been consulted and support the implementation	Yes
The document clearly details how compliance will be monitored, by who and how often.	Yes
The timescale for reviewing the policy has been set and are realistic.	Yes
The reviewing group has signed off that the policy has met the requirements above.	Yes

Reviewing group chairs name:	**Date:**

Policy approval stage

☐ **The approving committee/group approves this policy.**

☐ **The approving committee/group does not approve the policy.**

Actions to be taken by the policy author:

Approving committee/group chairs name: [redacted]	**Date: Feb 2019**

Appendix 8 - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
2.0	All	Rewrite of existing policy	Nov 2015	[redacted]
2.1	All	Amends by Resilience & Safety Manager	Nov 2015	
2.2	All	Amends by Dep Director of Governance	Nov 2015	
2.3	All	Amends by Dep Director of Governance	Dec 2015	
2.4	5.2 & 5.5	Insert duties for exec team. Update escalation arrangement from PSG to QC	Dec 2015	
2.5	7.1& 7.2	Insert sections for operational risk register and BAF.	Dec 2015	
2.6	4.7	Update Divisional Directors to Divisional Directors of Operations	Dec 2015	
2.7	4	Update of flowchart to take into account transfer of operational risks onto BAF.	Mar 2016	
3.0	4.3	Update title to Director of Nursing & Governance from Director of Strategy and Planning	Feb 2019	
3.0	4.4	Update title Deputy Director of Governance to Deputy Director of Nursing & Governance	Feb 2019	
3.0	4.9	Update title of Datix Lead to Clinical Governance Lead	Feb 2019	

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on [redacted]

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar [redacted]

هذه المعلومات يمكن أن تُتَرْجَم عند الطّلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على [redacted]

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داوابکرێت یان ئەگەر بەباش زاندرا دەکرێت وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是: [redacted]