South East Coast Ambulance Service NHS
NHS Foundation Trust

Lone Worker Policy

Contents

1. Statement of Aims and Objectives

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) takes the health, safety and welfare of all staff extremely seriously. The Trust recognises that some staff are required to work by themselves for significant periods of time without close or direct supervision in the community, or in isolated work areas throughout the 24-hour period, seven days a week.

1.2. As a result, staff who are lone working are potentially more vulnerable to risk of violence or abuse whilst carrying out their duties.

1.3. The Trust considers that violence or abuse towards staff is completely unacceptable and the aims and objectives of this policy are to protect staff, so far as is reasonably practicable, from the risks associated with, or exacerbated by, lone working. It will do this by ensuring that the risk of working alone is assessed in a systematic and on-going manner, and that safe systems and methods of work are put in place to eliminate risks to staff working alone or to reduce those risks to the lowest practicable level.

1.4. The Trust also recognises that vulnerability and isolation when lone working, can affect people at a personal level.

1.5. The Policy is designed to assist accountable management to ensure that appropriate support is available to staff who have to work alone.

1.6. Lone working environments present unique health and safety challenges. With the exception of the issues reference in section 2.6, there is no specific legal guidance on working alone. However, under the Health and Safety at Work Act 1974, and the Management of Health and Safety Regulations 1999, the Trust must organise and control the health and safety of Lone Workers, as it must with all employees.

1.7. The HSE have published 'Protecting Lone Workers' a health and safety guidance on the risks of lone working (INDG73 rev4). Additional guidance can be found within https://www.nhsemployers.org/publications/improving-personal-safety-lone-workers.

1.8. This policy applies to all staff employed by the Trust and also includes temporary staff, agency staff, contractors, bank workers and volunteers.

2. Principles

2.1. The following principles will be applied to all situations involving lone working that arise in connection with any duties and authorised activities of Trust staff, regardless of whether it is directly connected to the treatment of patients or takes place on NHS property.

2.2. The Trust acknowledges its obligation under the Health and Safety at Work Act (1974) and the Management of Health and Safety at Work Regulations (1999), for the health, safety and welfare at work of its staff.

2.3. They require the Trust to identify hazards, assess the risks and put measures in place to avoid or control these risks.

2.4. The Trust takes into account the NHS Violence Reduction Standards on protecting healthcare staff and the directions given to take action against those who abuse or assault them.

2.5. Staff have a responsibility themselves, and to their colleagues, not to place themselves or others at risk of injury or harm (S.7 Health and Safety at Work Act 1974).

2.6. **Identifying Lone Workers:** Trust Managers will ensure working practices and systems are in place for all employees (including themselves). They will account for the whereabouts of all lone working employees. **These will include, but not be limited to:**

- The Trust will have indicative call signs on the Computer Aided Dispatch System (CAD) for operational lone workers, that relate to responding vehicles.

- Examples of this includes “C” as the first letter of the call sign for all Single Response Vehicles and distinctive call signs for Community First Responders.

- Non-operational lone workers, including those lone working for periods as part of their role, must also be identified by their Line Manager.

- Non-operational lone workers and supervisors should refer to the Agile Working Policy for advice.

2.7. **Working Environments:** There are some circumstances which under the Management of Health and Safety Regulations 1999 can be identified as higher risk environments that require a full risk assessment to ensure there are suitable and sufficient controls to allow individuals to lone work. **These situations relevant to Trust staff are:**

- People who work in confined spaces: it must be borne in mind that a confined space means any place, which by virtue of its enclosed nature creates a reasonably foreseeable specified risk (i.e. lack of clean air / oxygen). This could mean any environment a crew responds to where there is a confined space, examples may be a sewer, trench, cellar, mechanic workshops and pits, boiler room, hold of a boat, garage workshop, lift shaft and other examples as stated by the Health and Safety in Confined Spaces Regulations 1997.

- Persons who work at or near electrical conductors, as defined by the Electricity at Work Regulations 1989.

- Persons who work at height, as defined by the Working at Height Regulations 2005.

- The Trust and those in control of any work at height activity, must make sure work is properly planned, supervised and carried out by competent people.

2.8. **Issues of Lone Working**: The Trust recognises and is cognisant that **hazards facing Lone Workers include:**

Violence and personal safety	The nature of the work of the Trust often involves staff visiting patients in their home, which can lead to an increased risk to personal safety.
Fire / Arson	It may be difficult for an isolated worker to evacuate a building when the fire alarm activates.

Moving and handling	Moving and handling tasks may pose more risk to an individual member of staff.
Isolated areas	Undertaking work within isolated areas where help is not available.
High risk areas	Undertaking work within known high risk areas.
Violence and/ or aggression	Working with people who may threaten staff including road rage.
Carrying medication	Equipment or valuables.
Vulnerable people	Student Paramedics, staff with disabilities or pre-existing medical conditions.
Isolation	Staff health and wellbeing potentially affected by long periods lacking interaction.
Fatigue	Working and/or travelling, including long periods of intense concentration.
Wellness & personal injury.	
Travelling alone or between sites / offices / meetings.	
Handling cash and / or banking.	
Vulnerability to false allegations about their conduct and behaviour.	

2.9. Trust Managers will carry out risk assessments, or refer to ones already in existence, via the processes defined in the Risk Management Strategy Policy and Procedure for either types of Lone Worker, or the specific risks they face. **This will include;**

- Trust Managers being cognisant of the risks that individual workers within their area of work face and where necessary institute appropriate and Trust recognised control measures to reduce or remove the risk.

- Trust Managers putting into practice processes and systems of work in accordance with Trust policy and procedures which are designed to eliminate or reduce risks associated with working alone.

- Trust Managers must include lone working risks through the appraisal process and should conduct an annual review updating the risk assessment to ensure it is suitable and sufficient.

- If circumstances or risks change, this assessment must be reviewed with immediate effect.

- Dynamic Risk Assessments are the basis that ALL Trust staff must use in addition to all other documented risk assessments to make informed decisions for entering or removing themselves from any substantiated and credible threats.

- This same process applies also to Lone Workers who must consider all aspects of their safety at all times, in conjunction with an awareness of their increased vulnerability as lone workers.

2.9.1. (Please refer to the Security Management Policy and Security Management Procedure.) Refer to Appendix A- Lone working example role risk assessment form.

2.10. **Calling for assistance:** Lone workers by definition are a vulnerable group.

2.10.1. Therefore, all Lone Workers must have a means of raising assistance or calling for help; **Within the Trust this will be via:**

Fixed telephone

Fixed panic button

Mobile telephone

Radio

2.10.2. These devices will not prevent incidents from occurring but do provide a means of calling for assistance and obtaining aid to minimise the severity of incidents.

2.10.3. **Welfare Checks will be carried out on staff while they are lone working, including, but not limited to:**

- There will be regular contact, determined by the risk assessment, between the Lone Worker and any form of supervision (by telephone or face to face).

- Other types of welfare check appropriate to the location of the Lone Worker, their duties and specific Trust policies / procedures regarding them.

- Staff in the Emergency Operations Centre (EOC) must be aware of the whereabouts of Operational Single Responders whilst responding and must observe lengthy periods without communication with a view to follow up and confirm the well-being of Operational Single Responders, with welfare checks for timed reminders and extended times on scene or at hospital.

- Line Managers are also responsible for confirming the location of their staff, their whereabouts and wellbeing as determined from their risk assessment.

- There is a requirement that Line Managers cascade this information to any duty managers where applicable.

2.10.4. It is recognised that whilst Trust staff may not always have access to their immediate line manager, they must have a means of access to individuals of responsibility and an appropriate level of seniority within the Trust management structure who can take responsibility for their wellbeing. Therefore, office staff, contractors etc. who attend or remain on site and are lone working in a building with an EOC, should notify the duty Emergency Operations Centre Manager (EOCM) that they are present and when they are leaving to ensure, in emergency (e.g. evacuation) that individual is known to be in the building to be accounted for. The same principle applies to other Trust sites where a Duty Operational Manager should be notified.

2.11. **Records of attendance:** To prevent criminal or misconduct allegations and to protect both staff and patients, with the exception of a disposition from a 999 call or associated clinical attendance, staff must ensure their attendance has been communicated appropriately to EOC prior to attending any private residence. Any non-operational attendance (e.g. a Serious Incident duty of Candour contact meeting) should be attended with a work colleague. Any arrangements can be identified and documented within the risk assessment.

2.11.1. Details of all attendances must either be added to an existing CAD record (if a live incident) or recorded via an appropriate method to suit the purpose of the attendance, such as through a Complaints record.

2.11.2. The record must also include who attended, dates and times, and relevant details of the content of the visit and its purpose.

2.11.3. If it is necessary to make a call to a member of the public (i.e. a welfare phone call or video calling to a patient), this must be undertaken on a recorded line. If this is not possible, the call must be made from a Trust telephone and details of it added to the record (see 2.11 and 2.12. above).

2.12. **Reporting Incidents:** Where a Lone Worker or Operational Responder suffers any form of adverse incident, whether or not related to their lone working at the time of the incident, a Datix Report Form must be fully completed submitted.

2.12.1. Trust Managers will ensure that all information regarding concerns or incidents that may affect the safety of Lone Workers – be it health and safety risks, history marking requests or information referred from other agencies (i.e. the Police) is passed on in written format (such as by email or on the appropriate Trust form, e.g. a Datix to the relevant group / individual within the Trust (i.e. the History Marking Review Group, the Risk Department etc.) for action.

2.12.2. Recording, reporting, and investigating any incidents involving a Lone Worker and making recommendations to prevent recurrence, will be carried out in accordance with the Incident Reporting and Investigation Manual.

2.12.3. The Trust Line Managers will ensure that all adverse incidents, including those involving Lone Workers, are recorded on the Trust's incident reporting database (DATIX), investigated where appropriate and if necessary reported to the appropriate statutory authority (i.e. RIDDOR, etc.) by the Health and Safety Manager(s).

2.12.4. Investigations into physical or non-physical assaults.

2.12.5. The Trust lead on Security will provide advice and guidance to local managers investigating physical or non-physical assaults on members of staff, sustained during the course of their duties, and support investigations, including liaising with staff and Police to where necessary to support sanction and redress.

3. Competence

3.1. To support this policy, operational/response capable staff must be provided with information, instruction and training, including training at induction annual updates and refresher training (i.e. conflict resolution training) as defined by their roles and the Trust Training Needs Analysis.

3.2. On induction that all operational staff, including Operational Single Responders, Community First Responders and Response Capable Managers, must be trained in Conflict Resolution, and that this is refreshed yearly.

3.3. In accordance with the Health and Safety at Work Act 1974 requires staff to take reasonable care of themselves and other people who may be affected by their actions. Staff responsibilities and actions relating to the implementation of this policy are given in more detail in Section 4.

4. Definitions

4.1. The Trust defines a Lone Worker as ‘any individual who, in the process of carrying out their duties on behalf of the Trust, may find themselves working alone or in an area isolated from colleagues’.

4.2. Operational Single Responders are considered a specialist type of lone working that requires additional consideration and staff / management should consult the appropriate associated guidance for that area.

4.3. The Trust recognises that **ANY** member of staff may spend a limited amount of their working time alone.

4.4. The Trust recognises that there are specific staff types who are regular Lone Workers, and that **this may include but not limited to:**

- Community First Responders.
- Staff making operational use of single response vehicles (as above).
- Fleet Technicians.
- IT / Comms Engineers.
- Make Ready Operatives.
- Production Desk Drivers.
- Operational Managers / Team Leaders.
- Non-Operational Managers / Senior Managers.
- Trust Directors.
- Support Services staff.
- Reception Staff.
- Call handlers with an agile working agreement.
- Administrative staff with an agile working agreement.
- Individuals who travel between Trust sites as part of their role.
- Contractors (e.g. Estates, Make Ready, Cleaning, Agency staff)

4.5. This policy refers to the term Managers in a generic sense to refer to individuals holding positions of responsibility within the Trust.

5. Responsibilities

5.1. The Chief Executive Officer is the Executive member of the Board with overall accountability in relation to meeting the 'duty of care' under health and safety legislation and is responsible for the health, safety and welfare of all Trust employees and that of any third party who may be affected by the Trusts undertakings. This includes Lone Workers.

5.2. The Director of Quality and Safety is the Director delegated with the responsibility for health and safety and, in conjunction with the Director of Finance and Corporate Services, will develop standards for the organisation, specific to Lone Workers.

5.3. Trust Managers are responsible for the implementation and management of lone working standards in their services / localities.

5.4. The Trust Lead on Security (ASMS) is responsible for advice and guidance to local management and that governance processes exist to risk assess staff who may be lone working.

5.5. The Head of Learning and Development Department is responsible for ensuring that staff receive information, instruction and training in accordance with this policy, as defined by their roles and the Trust Training Needs Analysis.

5.6. The Health and Safety Manager is responsible for the auditing and external reporting (where applicable) and monitoring of adverse incidents.

5.6.1. **All staff are responsible for:**

- Taking reasonable care of themselves and other people who may be affected by their actions.
- Familiarising themselves with relevant health and safety policies and procedures.
- Co-operating with directives by following rules and procedures designed for safe working.
- Considering and assessing potential risks to their health and safety as a result of their working practices and environment, particularly when lone working.
- Understanding and being sufficiently aware of the risks of their role and implementing appropriate and reasonable precautions to safely carry them out.
- Acquainting themselves with procedures, policies, equipment and practices designed to maintain Lone Worker safety.
- Ensuring a dynamic risk assessment, as defined by the Security Management Policy, is carried out by individual workers to assess where their working practice or environment may make them vulnerable when lone working.
- Reporting all lone working incidents however minor, to their manager via an Incident Report Form (IWR-1).
- Attending all training designed to meet the requirements of this and other relevant Trust policy.
- Not interfering or misusing anything provided for their, or others' safety.

- Being aware of the hazards and risks to which they are exposed to as Lone Workers.

- Being aware of the processes to follow in the circumstances of any type of adverse event or incident (such as man down facilities and ambient listening).

6. Competence

6.1. The Trust has employed a trained Security Management Specialist (Lead on Security) to advise on all matters relating to the security of staff. The Lead on Security is qualified in delivering safety and security advice to staff and to establish safe systems of work, including that for lone workers.

6.2. All operational staff are given conflict management training as part of their initial training and refresher training as part of their yearly key skills training.

7. Monitoring

7.1. The Health and Safety Manager will produce reports and statistics for every Central Health and Safety Working Group (CHSWG) meeting of ALL incidents from the Trust's incident reporting system (including those pertaining to Lone Workers) on the number and type of incidents.

7.2. The CHSWG will ensure that lessons learnt from incidents are managed in a pro-active fashion, cascaded effetely through the Trust and embedded to prevent reoccurrence. The Group can also escalate corporate risks to the Quality & Safety Committee.

7.3. The Health and Safety Manager will monitor the results of health and safety investigations and recommendations for improvement to prevent recurrence and ensure that learning from incidents is spread throughout the Trust through training, the intranet, posters and publications. If trends develop these will be reported to the CHSWG for remediation to ensure action plans are developed and implemented. The CHSWG will, if necessary, make recommendations for improvements, or elevating risks to the appropriate Committee or the Executive Team.

8. Audit and Review

8.1. The Trust will audit and review this policy every three years, in partnership with its staff, Patient and Public Involvement Groups, Trade Union Colleagues and Safety Representatives.

8.2. This review will be brought forward should changes to national guidance, legal requirements or Trust responsibilities change, or in conjunction with other Trust policies which concerns lone workers.

9. References

- The Department of Health and Counter Fraud Security Management Service – A Professional approach to managing security in the NHS

- Health and Safety at Work Act 1974

- Health and Safety in Confined Spaces Regulations 1997
- Electricity at Work Regulations 1989
- HSC - Management of Health and Safety at Work Regulations 1999
- HSE – Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013
- NHS employers' publications improving-personal-safety-lone-workers

10. Appendix A

Assessment No.	**Risk Assessment Form**

Completed by and role:	**Initial assessment date:**
Location of the risk: Trust Wide	
Task / Hazard being Assessed: Lone working of **operational** staff frontline	

STEP 1			**STEP 2**	**STEP 3**	**STEP 4**		
REF NO.	**ACTIVITY**	**HAZARD**	**PERSON(S) AFFECTED AND HOW**	**CURRENT CONTROL MEASURES**	**RISK RATING** **L x C = R**		
LW/1	Lone working	Accidents or emergencies arising out of the work being carried out by staff.	Staff injury arising from driving, moving and handling, working with substances hazardous to health, working at height, working with equipment, slipping and tripping and collision with vehicles.	Suitable and sufficient risk assessments have been carried out by the OU to manage the identified risks arising from Safety, Chemical, Biological and Health hazards. Health and Safety Policy and procedure established across the Trust to communicate a set of organisational arrangements to guide actions in order to achieve the goal of keeping our staff safe. Health and Safety E leaning training delivered to all SECAMB staff and additional key skills training to all operational staff.			

				Competent Health and Safety staff trained and identified as the responsible person within each OU for health and Safety. Support from regional health and safety manager Operational staff carry Airwave handset with request speech, priority and crew emergency buttons Where staff cannot be reached their contact details are available on GRS, attempt voice call otherwise physical visit. How do staff raise an emergency alert? How do staff check in? What do you do if staff cannot be raised? How do you escalate missed check in? What first aid provision is available for staff?			
LW/2	Lone working	Sudden Illness	Onset of new and or existing illness to staff.	What first aid provisions are available to staff? Managers should be aware of existing medical conditions and reasonable adjustments applied where appropriate			
LW/3	Lone working	Inadequate provision of rest, hygiene and welfare facilities	Lack of suitable facilities for staff to prepare and take meals during breaks negatively impacting on their wellbeing.	The Trust has identified responsible persons who carry out bi monthly inspections to ensure welfare facilities are suitable and escalate any deficiencies.			

			Lack of facilities for staff to change and clean themselves causing degradation in our infection prevention controls.	In addition, an annual health and safety audit is carried out by the health and safety team and welfare facilities are included within. Cleaning contract in place for welfare facilities and monitored through contract manager.			
LW/4	Lone working	Physical violence from members of The public and/or intruders	Actual bodily harm and or verbal assault whilst attending to service users From members of the public, the service user and service user's family. Actual bodily from trespassers onto SECAMB site.	Staff receive conflict management and breakaway training. Staff carry out a dynamic risk assessment and have authority to withdraw from situations whereby there is a fear of assault until such times as police support is present. Airwave radio provides effective communication as well as urgent alert with passive listening. The Trust LSMS support the active prosecution of offenders. CCTV is fitted to vehicles. History marking. Local intelligence from EOC			
LW/5	Lone working	Contact with stray dogs or cattle, along with other potentially hostile animals and wildlife.	Injury to staff whilst operationally deployed on response duties.	Staff carry out a dynamic risk assessment and have authority to withdraw from situations whereby there is a fear of injury from animals and wildlife until the necessary organisations can make the area safe.			

LW/6	Lone working	Mental wellbeing	Staff stress as result of isolation, and lack of adequate management support.	Appraisal system in place Self and third party referrals for mental health support are accepted by Wellbeing Hub. Referrals can be made to Occupational Health Directory of services available on the intranet to signpost staff with a variety of issues to the appropriate service. Discussion during PADR, 121 and informal meetings.			

Date **Signature**	**1st Review date** **Signature**	**2nd Review date** **Signature**	**3rd Review date** **Signature**	**4th Review date** **Signature**	**5th Review date** **Signature**	**6th Review date** **Signature**

Risk scoring: The risk score will be based upon the consequence of a risk and the likelihood of it being realised. The Trust uses the risk scoring methodology and matrix previously published by the National Patient Safety Agency;

Scoring the Consequence: Consequence must be scored using the Table of Consequences as a guide:

Table of Consequences					
	Consequence Score and Descriptor				
	1	**2**	**3**	**4**	**5**
Domain:	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury or harm Physical or Psychological	Minimal injury requiring no / minimal intervention or treatment	Minor injury or illness requiring intervention	Moderate injury requiring intervention	Major injury leading to long-term incapacity/disability	Incident leading to fatality

	No Time off work required	Requiring time off work < 4 days Increase in length of care by 1-3	Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners' verdict of natural causes, accidental death or open No or minimal impact of statutory guidance	Coroners' verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50K Issue of statutory notice	Coroners' verdict of neglect/system neglect Prosecution resulting in a fine >£500K	Coroners' verdict of unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non-critical areas >6 hours. Financial loss £50-500K.	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m.	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient complaint or Litigation / Claim	Unlikely to cause complaint, litigation or claim.	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) £100-£1m.	High profile complaint(s) with national interest. Multiple claims or high value single claims. £1m.

Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality <1day. Concerns about skill mix / competency.	On-going low staffing level that reduces patient care/service quality. Minor error(s) due to levels of competency. (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service. Moderate error(s) due to levels of competency. (individual or team)	Uncertain delivery of key objectives / service due to lack of staff. Major error(s) due to levels of competency (individual or team).	Non-delivery of key objectives / service due to lack/loss of staff. Critical error(s) due to levels of competency (individual or team).
Reputation or Adverse publicity	Rumours/loss of moral within the Trust. Local media 1 day e.g. inside pages or limited report.	Local media <7 days' coverage e.g. front page, headline. Regulator concern.	National Media <3 days' coverage. Regulator action.	National media >3 days' 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.

3. <u>Scoring the Likelihood:</u> Likelihood must be scored using the Table of Likelihood as a guide:

Description	**1** **Rare**	**2** **Unlikely**	**3** **Possible**	**4** **Likely**	**5** **Almost Certain**
Frequency (How often might it / does it occur)	This will probably never happen/recur. Not expected to occur for years.	Do not expect it to happen/recur but it is possible it may do so. Expected to occur at least annually.	Might happen or recur occasionally. Expected to occur at least monthly.	Will probably happen/recur, but it is not a persisting issue/circumstances. Expected to occur at least weekly.	Will undoubtedly happen/recur, possibly frequently. Expected to occur at least daily.
Probability	Less than 10%	11 – 30%	31 – 70 %	71 - 90%	> 90%

Risk Score and Grading: Once the Consequence and Likelihood have been determined, the over-all risk score can be measured using the Risk Score Matrix and should follow a linear pathway:

1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5	10	15	20	25
4	8	12	16	20
3	6	9	12	15
2	4	6	8	10
1	2	3	4	

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

	15 to 25 Extreme Risk
	8-12 High Risk
	4-6 Moderate Risk
	1 to 3 Low Risk

Risk grading: Supports the Trust with setting its risk appetite, with the 'Risk Rating - Actions Table' used to define the guidance on the documentation/ registration of the risk on DATIX, the urgency of action to mitigate the risk and clarifies ownership, reporting and oversight:

Score	Risk Grade	Action *	Risk Owner **	Operational Monitoring ***	Organisation Oversight ****	Escalation Route	Board Assurance
1-3	Low	Risk entered	Principle Risk Lead	Group	Management Group / Committee / Board	Described in each: Group/ Committee/ Board	Quality and Patient Safety Committee

		onto DATIX		(described in each terms of reference)	(described in each terms of reference)	terms of reference	Finance & Investment Committee Workforce and Wellbeing Committee Audit Committee
4-6	Moderate						
8-12	High						
15-25	Extreme						

Additional control measures may well be implemented following the registration of the risk onto the Trusts risk register. Subsequently risk scores may change. If this happens add the control measure to the risk assessment when implemented and update risk scores.

References:

- Health and Safety Policy
- Risk Management policy
- Risk Management procedure