

CEREDIGION & MID WALES NHS TRUST
HEALTH INSPECTORATE WALES ACTION PLAN 2005

Draft version 6

2.11.2005

RECOMMENDATION 1

The Trust needs to put in place systems that ensure that the delivery of patient care in its various settings is regularly reviewed to ensure patient needs are met in the most appropriate manner and setting.

ACTIONS:

- 1a** To risk stratify all recommendations from Hospital Patient Environment review
To agree an action plan with Community Health Council
To build actions into Facilities Directorate BSC
Reassess against agreed action plan
- 1b** All health professionals to identify involvement in clinical audit during their annual appraisal
- 1c** Develop and implement detailed cancer standards plan
- 1d** To monitor implementation of NICE guidance including financial impact
- 1e** For Welsh Risk Pool Standard leads to continue to develop and implement action plans for each of the standards
- 1f** For each directorate to identify areas where the Fundamental of Care Standards are applicable, and to undertake annual audit. Changes to practice need to be demonstrated as a result of the audits undertaken
- 1g** Implement the Infection Control Action Plan

IMPROVEMENT OUTCOMES

The Trust Board will have documented evidence regarding the quality of care across the organisation and will be able to monitor improvements by monitoring improvements against each action point.

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
1a 1b 1c	April 2006 March 2006 Sept. 2005	Consequences 3 Likelihood 2	Mid way review to be built into Quarterly Review meeting with the Regional Office	1a Clinical Governance Committee 1b Clinical Governance Committee 1c Clinical Governance Committee	1a Director of Nursing 1b Clinical Directors 1c Clinical Director Medicine/ Divisional Manager	Hospital Patient Environment Inspections. Capital Allocation. Clinical Governance Strategy. Welsh Risk Pool. Infection Control Action Plan. Trusts Estate Strategy
1d 1e	Ongoing February each year	Risk assessment 6		1d Clinical Governance Committee 1e Risk Management Committee	1d Director of Nursing 1e Director of Nursing	
1f	March 2006			1f Clinical Effectiveness Steering Committee	1f Director of Nursing	
1g	March 2006			1g Infection Control Committee	1g Clinical Directors	

RECOMMENDATION 2

Specific services identified as requiring attention as part of the review were:

1. The treatment and transfer of service users with acute mental health problems to beds staffed and managed by Pembrokeshire and Derwen NHS Trust.
2. A long term solution for the provision of dermatology services' should be identified for patients in Ceredigion, following the cessation of services previously provided by Carmarthenshire NHS Trust.

ACTIONS:

- 2a** To re-establish liaison group between the two Trusts and develop documented protocols for the transfer of patients which will be regularly monitored
- 2b** To determine the feasibility of Ceredigion and Mid Wales NHS Trust continuing to provide this service. Following this review to take appropriate action to ensure information is communicated to all relevant parties in order not to compromise patient safety.

IMPROVEMENT OUTCOMES

Protocols for the transfer of patients are developed, in use and audited on an annual basis
The result of the feasibility exercise will be implemented in collaboration with the Ceredigion LHB

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
2a	March 2006	2a. Consequences 4 Likelihood 3	Re-establish liaison group and commence work on transfer protocols	2a Clinical Governance Committee	Director of Nursing	LTA/SAFF
2b	November 2005	Risk assessment 12 2b. Consequences 4 Likelihood 3 Risk assessment 12	Identify current patients on the list and plan to have their care provided Close list to new patients	2b Clinical Governance Committee	Divisional Manager/ Clinical Director for Medicine	

RECOMMENDATION 3

The Trust needs to put systems in place, supported by training for staff, to ensure patients, carers and GPs are provided routinely with all information relevant to patients' care. Areas identified as requiring attention as part of the review were information relating to:

1. Consent
2. Information to patients about their care plans and discharge.

ACTIONS:

- 3a** Working with Medical staff ensure patients receive a copy of the consent form, if patients do not wish to receive a copy this should be documented. This will be achieved through ensuring all new staff attend induction programme which included a session on consent. Providing additional teaching for existing staff on consent
- 3b** As part of the Unified Assessment Process Patients are to receive a copy of their summary record on discharge, this includes ongoing information relating to care

IMPROVEMENT OUTCOMES

Patients will receive a copy of their consent form outlining risks and benefits of the procedure they are/have undergone. This will be evidenced through clinical audit

Patients will be fully informed regarding their ongoing care following discharge from hospital, the implementation of the discharge policy will be reviewed annually

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
3a	March 2006	Consequences 4 Likelihood 2	Training with medical staff is commenced by February 2006. Discharge documentation is reviewed and process established for patients/carers to receive this by April 2006	3a Clinical Governance Committee	Director of Nursing/ Medical Director	Welsh Risk Pool Unified Assessment Process
3b	September 2006	Risk assessment 8		3b Clinical Governance Committee	Director of Nursing	

RECOMMENDATION 4

The Trust should finalise and implement the strategy and action plan for equality and human rights to ensure:

1. The Trust meets legislative requirements by 31 May 2005
2. Staff are trained on promoting fair and equal treatment of colleagues, patients and the public.

ACTIONS:

- 4a** Action plan agreed by Equality Forum – now needs to be formatted into 5 strategic headings provided by CEHR
- 4b** Development and approval of formal Equality and Human Rights strategy by the Trust Board
- 4c** Trust to revise Race Equality Scheme by 31st May 2005
- 4d** Core Training programme to be developed with Centre for Equality and Human Rights and then roll out to the rest of the Trust. Attendance at training events against annual targets will be monitored

IMPROVEMENT OUTCOMES

Staff will be fully informed and engaged in the equality and human rights agenda and as a result all patients will be treated with respect and dignity relevant to their particular circumstances. Information from complaints, patient's stories and feedback questionnaires will be monitored for evidence in improvements in the way patients are treated.

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
4a	December 2005	Consequences 5 Likelihood 1	Action plan to be ratified December 2005	4a Trust Board	4a – 4d Director of Human Resources and Director of Nursing	Equality and Human Rights strategy
4b	August 2006	Risk assessment 5	Draft to Equality Forum June 2006 Achieved May 2005. Launch of revised scheme Dec 2005 Training to commence Autumn 2005	4b Trust Board		
4c	May 2005			4c Trust Board		
4d	Ongoing			4d Trust Board		

RECOMMENDATION 5

The Trust needs to put in place systems that ensure that the results, findings and learning from public and patient involvement activities are routinely reported and disseminated across the Trust.

ACTIONS:

- 5a** Review the role and function of the Public and Patient Involvement Steering Group to ensure it actively supports the dissemination of information and learning opportunities from public and patient involvement activities.
- 5b** For the Public and Patient Involvement Steering Group which includes membership from all directorates to develop and implement systems for information and learning to be reported and shared across the Trust and to the wider NHS

IMPROVEMENT OUTCOMES

Directorates can demonstrate how they have learnt from public and patient involvement activities undertaken elsewhere in the Trust and which have been shared across the organisation. Changes in practice will be reported to the public and patient involvement steering group.

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
5a and 5b	January 2006	Consequences 3 Likelihood 2 Risk assessment 6	At the next PPI steering group review the groups terms of reference and input from the Directorates	5a Trust Board 5b Trust Board	Director of Nursing/ Public Patient Involvement Officer	PPI Action Plan

RECOMMENDATION 6

The delays within the Public and Patient Involvement Annual Action Plan are assessed and corrective actions defined and implemented.

ACTIONS:

6a The action plan is reviewed by the Public and Patient Involvement Steering Group and corrective actions identified and implemented

IMPROVEMENT OUTCOMES

The action plan is fully implemented and the outcomes identified with the plan are achieved

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
6a	January 2006	Consequences 2 Likelihood 2 Risk assessment 4	Action to be completed by completion date	6a Clinical Governance Committee	Director of Nursing/ Public Patient Involvement Officer	PPI Action Plan

RECOMMENDATION 7

The role of the Public and Patient Involvement Officer should be strengthened to ensure all activities are coordinated across the Trust, to raise the profile of the training workshops and to demonstrate the Trust's commitment to involving patients and the public.

ACTIONS:

- 7a Guidance to be developed and endorsed by the Trust Board regarding the coordination role of the PPI Officer
- 7b For the Public and Patient Involvement Officer to present to the Trust Board on achievements to date and areas of future work in order to highlight the importance of involving patients and the public
- 7c Training in PPI to be widely advertised across the Trust and to be fully endorsed by the Trust Board

IMPROVEMENT OUTCOMES

The Trust can demonstrate a coordinated approach to PPI activities across the Trust demonstrated through reduction in duplicated effort, learning lessons and sharing best practice across individual directorates and areas
The number of staff undertaken training in PPI is increased year upon year

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
7a 7b 7c	Nov. 2006 October 2006 April 2006	Consequences 3 Likelihood 2 Risk assessment 6	Action to be completed by completion date	7a Trust Board 7b Trust Board 7c Trust Board	Director of Nursing/ Public Patient Involvement Officer	PPI Action Plan PPI Strategy Clinical Governance Strategy

RECOMMENDATION 8

The Trust Board should routinely draw together and document the range of performance indicators that underpin the Board's discussions and decision making

ACTIONS:

- 8a In reviewing the Trusts Corporate Balanced Score Card for 2005/6 the Trust Board is to decide what additional performance indicators it wish's to review in relation to those included in the suggested template published by the Welsh Assembly Government. This should be completed in conjunction with the Trusts Audit Committee and Clinical Governance committee
- 8b For the Trust Board to receive regular reports on performance against the agreed indicators identified in the balanced score card

IMPROVEMENT OUTCOMES

For the Trust Board to have clear information on agreed key areas of the Trust's performance. This will enable the Trust Board to monitor performance and take appropriate action

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
8a and 8b	April 2006	Consequences 3 Likelihood 2 Risk assessment 6	Trust Board to consider the new Balanced Score card and to determine additions to this by November 2005	8a Trust Board 8b Trust Board	Chief Executive	Balanced Score Card/ SAFF

RECOMMENDATION 9

The Trust should work towards integration of all data sources (verbal, written and electronic) to maximise capture of the whole patients' experience.

ACTIONS:

- 9a Undertake a review of the Information Strategy to ensure integration of data sources is included in the Strategy
- 9b Implement recommendations highlighted from the review

IMPROVEMENT OUTCOMES

Information from all sources is readily available and integrated and benefits to patient experience are demonstrated. There will be a reduction in the number of stand alone information systems within the Trust.

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
9a and 9b	April 2006	Consequences 3 Likelihood 2 Risk assessment 6	Review group established to consider the information strategy	9a Information Management Steering Committee 9b Information Management Steering Committee	Director of Finance	Communication Strategy IM&T Strategy

RECOMMENDATION 10

The Trust needs to ensure that the latest version of policies, procedures and reports are available on the web site and the intranet.

ACTIONS:

10a For the Policy Review Group to develop a detailed plan outlining timescale for this to be completed and the process for ensuring regular updating

IMPROVEMENT OUTCOMES

To establish a process whereby all policies are regularly reviewed and the Trust intranet site holds all the current version of policies
For all policies to be up to date and available on the internet and intranet

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
10a	April 2006	Consequences 3 Likelihood 2 Risk assessment 6	Action to be completed by completion date	10a Clinical Governance Committee	Deputy Director of Nursing	WRPMS PPI Strategy

RECOMMENDATION 11

The Trust should report upon existing learning programmes and expand the sharing of learning with external bodies

ACTIONS:

- 11a Collate and document all existing joint learning activities (NHS and Non – NHS)
- 11b Ensure active participation in all Wales events e.g. All Wales Quality Events
- 11c Develop annual joint education plan with other local organizations
- 11d To develop a plan for 'teleconferencing' education events

IMPROVEMENT OUTCOMES

The Trust Board is fully aware of learning opportunities provided within the Trust and those provided externally which staff have been supported to attend
The Trust regularly shares with others its experiences and takes opportunities to learn from others

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
11a, 11c and 11d	April 2006	Consequences 3 Likelihood 2	Establish systems for collating learning activities	11a Clinical Governance Committee	11a, 11b and 11c Director of Nursing and Director of Human Resources	Training Strategy
11b	March 2007	Risk assessment 6	Discuss with local organisations the possibility of developing joint educational plans/ having shared learning opportunities	11b Clinical Governance Committee 11c Clinical Governance Committee 11d Clinical Governance Committee	1d Telemedicine Manager	Communication Strategy PPI Strategy IM&T Strategy

RECOMMENDATION 12

Health Inspectorate Wales seeks reassurance that the role of Quality Improvement Manager will be filled in the near future.

ACTIONS:

12a The post has been advertised during June 2005 - no applicants

12b To review how this role can be delivered given that the Trust has been unsuccessful in recruiting following two national adverts

IMPROVEMENT OUTCOMES

The function's included within the Job Description of Quality Improvement Manager are fulfilled and the quality improvement agenda is actively taken forward

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
12a and 12b	Nov. 2005	Consequences 3 Likelihood 3 Risk assessment 9	Role has been reviewed and alternative solution identified	12b Clinical Governance Committee	Director of Nursing	Clinical Governance Strategy Risk Management Strategy

RECOMMENDATION 13

The Trust needs to ensure it acts on all incidents and gives feedback to the staff members concerned in order to encourage appropriate incident reporting.

ACTIONS:

- 13a** Directorates lead on the review of incidents and provide feedback to staff. Quality Improvement Manager to undertake a review of current arrangements, identify areas where this is not occurring and working with directorates identify actions to correct this.
- 13b** Undertake an audit of randomly selected IR1 forms to ensure they are appropriately completed and to determine whether the originator received feedback on an annual basis

IMPROVEMENT OUTCOMES

For 95% or more staff to have received feedback on completed incident forms from the data collected for the audit

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
13a 13b	March 2006	Consequences 3 Likelihood 3 Risk assessment 9	Audit to be scheduled prior to Christmas	13a Risk Management Committee 13b Risk Management Committee	13a Director of Nursing 13b Director of Facilities	Risk Management Strategy

RECOMMENDATION 14

The Trust needs to ensure that staff are encouraged to perform clinical audits within the remit of a Trust-wide audit programme

ACTIONS:

- 14a All health professionals are to identify involvement in clinical audit during their annual appraisal
- 14b Employment contracts to include requirement for health professionals to be involved in clinical audit
- 14c To develop a trust wide annual audit programme

IMPROVEMENT OUTCOMES

All health care professionals can demonstrate involvement in clinical audit through their annual appraisal.
 New and existing employment contract includes requirement for all health care professionals to be involved in clinical audit
 There is a Trust wide audit programme in place and there is evidence to demonstrate this has been influenced by incidents, complaints etc.
 An annual audit programme is developed and published

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
14a	March 2006	Consequences 3 Likelihood 2	Actions to be completed by completion date	14a Management Board	Clinical Directors	Human Resource Strategy
14 b	March 2006	Risk assessment 6		14b Management Board	Director of Human Resources	
14c	November 2005			14c Clinical Governance Committee	Chair of Clinical Effectiveness Steering Committee	

RECOMMENDATION 15

The Trust needs to develop a programme of training in respect of clinical effectiveness to ensure that patient care is provided in line with good/best practice guidelines

ACTIONS:

- 15a** Establish a group to develop a training programme for clinical effectiveness, this will include coordinating existing training activities in this area
15b Publish and circulate the availability of the training for clinical effectiveness

IMPROVEMENT OUTCOMES

Existing training is coordinated across the organisation and new specific training has been developed and implementation commenced. To demonstrate this an annual training programme will be published.
Staff knowledge and skills in this area will be increased.

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
15a and 15b	March 2006	Consequences 3 Likelihood 2 Risk assessment 6	The components of the training programme are to be developed by January 2006	15a Clinical Governance Committee 15b Clinical Governance Committee	Director of Nursing/ Medical Director/ Director of Human Resources	Clinical Governance Strategy

RECOMMENDATION 16

The role and responsibilities of the named Non-Executive Director with responsibility for child protection needs to be clarified

ACTIONS:

- 16a** Undertake a literature review and clearly document the role and responsibility of the Non-Executive Director in the Trusts Child Protection Policy.
- 16b** Take the revised Child Protection Policy to the Trust Board for approval
- 16c** disseminate the revised Child Protection Policy across the organisation

IMPROVEMENT OUTCOMES

The role and responsibility of the Non-Executive Director for Child Protection is understood by the Trust Board and across the organization. The Non Executive Director meets regularly with the Executive Director and Named Nurse and Doctor for Child Protection

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
16a, 16b and 16c	April 2006	Consequences 3 Likelihood 2 Risk assessment 6	Literature review completed	16a Trust Board 16b Trust Board 16c trust Board	Director of Nursing	Child Protection Strategy

RECOMMENDATION 17

The importance of appraisal and CPD is reinforced. Particular attention should be given to supporting staff in the smaller hospitals, allowing them to participate fully

ACTIONS:

- 17a** The Directorate Management Team for Medicine reinforces through local meetings the importance of appraisal and CPD. As part of the introduction of the Knowledge and Skills framework (Agenda for Change) all staff are to have a personal development plan.
- 17b** An annual audit is undertaken to ensure all staff in community hospitals have an appraisal

IMPROVEMENT OUTCOMES

More than 75% of staff have received an appraisal during the preceding year (to allow for staff turnover)

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
17a and 17b	March 2006	Consequences 3 Likelihood 2 Risk assessment 6	Action to be completed by completion date	17a Management Board 17b Management Board	Clinical Director Medicine	Training Strategy

RECOMMENDATION 18

A system for coordinating, forward planning and advising staff of visits to all sites by Board Members and senior management should be implemented

ACTIONS:

18a Identify Trust Board members with specific links and responsibilities to all areas within the Trust

18b To develop and disseminate a visiting schedule of Trust Board members

IMPROVEMENT OUTCOMES

Individual areas are aware of who their link Board member is and when they will visit. Individual areas will feel able to discuss openly issues with the Board member. Information from the visits will be feedback to the Trust Board on an annual basis

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
18a and 18b	November 2005	Consequences 1 Likelihood 1 Risk assessment 1	Action to be completed by completion date	18a Trust Board 18b Trust Board	Chairman	Communication Strategy

RECOMMENDATION 19

The security arrangements at Bronglias A&E Department should be reviewed. As a first step, 'zero tolerance' posters should be displayed in all public areas, particularly A&E waiting rooms

ACTIONS:

- 19a** To undertake a formal review of security arrangements in A&E
- 19b** To review violence and aggression policy
- 19c** Display 'zero tolerance' posters within the A&E department
- 19d** Commence implementation of the all Wales passport Scheme for Violence and Aggression

IMPROVEMENT OUTCOMES

A review of security arrangements has taken place and action has been completed.
Staff and patients feel secure within the department. This will be monitored through annual review of security arrangements

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
19a	March 2006	Consequences 4 Likelihood 3	Review group established by December 2005	19a Health and Safety Committee	19a Clinical Director Surgery	Violence and Aggression Policy
19b	April 2006	Risk assessment 12	Policy review completed by April 2006	19b Health and Safety Committee	19b Director of Nursing	Health and Safety Policy
19c	December 2005		Zero tolerance posters developed/purchased for use by December 2005	19c Health and Safety Committee	19c Clinical Director Surgery	Clinical Governance Strategy Human Resources Strategy
19d	January 2006			19d Health and Safety Committee	19d Director of Nursing	

RECOMMENDATION 20

The Trust needs to progress service user and public consultation according to Signposts Two guidance

ACTIONS:

20a To develop a work plan outlining actions to be taken

20b See also recommendation 1, 5, 6 and 7 above

IMPROVEMENT OUTCOMES

Work plan has been developed and the actions contained within this are fully implemented

Service users and the public are fully engaged with the organisation and this can be demonstrated through various real examples

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
20a	April 2006	Consequences 3 Likelihood 2	Action to be completed by completion date	20a Clinical Governance Committee	Director of Nursing/ PPI Officer	PPI Action Plan PPI Strategy
20b	As per individual rec.	Risk assessment 6		20b Trust Board		Clinical Governance Strategy

RECOMMENDATION 21

The Board should ensure that this updated Clinical Governance Strategy is updated in line with the review dates and effectively communicated to all stakeholders

ACTIONS:

21a The Clinical Governance Strategy was reviewed in February 2005 and information on this disseminated across the Trust

IMPROVEMENT OUTCOMES

For staff and members of the public to be informed of the Trusts Clinical Governance Strategy

MONITORING PROCESS

Action Ref.	Completion Date	Assessment of Risk	Milestones	Monitored by	Lead Accountability	Relationship to Organisational Plans
21a	April 2005	Consequences 2 Likelihood 2 Risk assessment 4	Action to be completed by completion date	21a Trust Board	Director of Nursing	Risk Management Strategy PPI Strategy

Foot note - Assessment of Risk (the full risk matrix is attached at appendix 1)

The Trust Policy on Incident reporting uses a matrix approach to assessing risk scoring the consequences and likelihood of an incident from 1-5 and then multiplying the score for each to give an overall risk assessment. This can range from 1 – 25. the following scores require the following action

- 0-5 No immediate action required
- 6-10 Action within 12 months
- 12-25 Urgent action required

RISK ASSESSMENTS

LIKELIHOOD:

Taking into account the controls in place and their adequacy, how likely is it that such an incident could occur? Apply a score according to the following scale:

Level	Descriptor	Description
5	Almost Certain	Likely to occur on many occasions, a persistent issue
4	Likely	Will probably occur but it is not a persistent issue
3	Possible	May occur occasionally
2	Unlikely	Do not expect it to happen but it is possible
1	Rare	Can't believe that this will ever happen

SEVERITY:

Taking into account the controls in place and their adequacy, how severe would the consequences be of such an incident? Apply a score according to the following scale.

Level	Descriptor	Actual or Potential Impact on Individual(s)	Actual or Potential Impact on Organisation
5	Catastrophic	DEATH	National adverse publicity. WAG Investigation Litigation expected/certain
4	Major	PERMANENT INJURY: e.g. RIDDOR reportable injury/ ill health retirement/redeployment	RIDDOR reportable Long term sickness Litigation expected/certain
3	Moderate	SEMI-PERMANENT INJURY/DAMAGE e.g. injury that takes up to 1 year to resolve or requires Occupational Health involvement/rehabilitation	RIDDOR reportable Long term sickness Litigation possible but not certain High potential for complaint
2	Minor	SHORT TERM INJURY/DAMAGE e.g. injury that has been resolved within one month	Minimal risk to organisation Short term sickness Litigation unlikely Complaint possible
1	Insignificant	NO INJURY OR ADVERSE OUTCOME	No risk at all to organisation Unlikely to cause complaint Litigation risk remote

RISK MATRIX

LIKELIHOOD	SEVERITY					
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic	
1 - Rare	1	2	3	4	5	No immediate Action
2 - Unlikely	2	4	6	8	10	Action within 12 months
3 - Possible	3	6	9	12	15	
4 - Likely	4	8	12	16	20	Urgent Action
5 - Almost certain	5	10	15	20	25	

Note: You must assess each risk against the likelihood of an incident occurring and should it happen the severity of the consequences.