Quality Impact Assessment (QIA) Policy – Including Equality and Health Inequalities Impact Assessment (EHIA)

Department / Service:	Corporate
Originator:	Deputy Chief Nursing Officer (DCNO)
Accountable Director:	Chief Nursing Officer (CNO)
Approved by:	Trust Management Board (TMB) Quality Governance Committee
Date of approval:	31st July 2024
First Revision Due:	31st July 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments:	All
Target staff categories	All

Policy Overview:

Worcestershire Hospital Acute Trust is committed to designing and implementing services that improve

- patient safety
- clinical effectiveness
- Patient experiences

Thereby, are committed to ensuring that change schemes as detailed below: are evaluated for their impact on quality:

- commissioning decisions,
- organisational Cost and Productivity Improvement Plans (CPIP),
- business cases,
- any other plans for change,

This Policy details the obligatory steps to be undertaken when completing a Quality Impact Assessment (QIA) in order to assess the impact of change schemes in conjunction with an Equality and Health Inequalities Impact Assessment. This Policy illustrates the required reporting governance for Clinical Executive sign off; providing an assurance that all relevant stakeholders have been consulted and enabled to contribute to completing the QIA. That all benefits, risks, hazards and issues have been acknowledged and appropriate controls or actions have been identified to mitigate or remove potential impact on the Quality elements of the QIA. This process also involves predicting and assessing the implications of a change scheme on a wide range of people. Therefore, this Policy must be associated with the Trusts Equality Diversity and Inclusion Policy: Equality Diversion and Inclusion policy WAHT-HR-445

Key amendments to this Document:

Date	Amendment:	By:
22/02/19	Amendments to highlight the role of the clinical lead in leading the responsibility and sign off when satisfied to proceed.	Vicky Morris Marsha Jones
13/03/19	Amendments re: Governance arrangements at Divisional Level	Vicky Morris Marsha Jones
17/05/19	Amendments re: QIA accountability and Clinical lead role and support	Vicky Morris Marsha Jones
23/05/19	Amendments re: steps to be more obvious following DDN feedback	Jackie Edwards
04/07/19	Amendments re: TME requests: “be clear that we will incorporate the Equality Impact assessment template into the QIA document and process, so that we include that consideration in the QIA process, and need to make adequate reference in the policy and also include the escalation process expected if clinical leads and then Divisions cannot sign off the QIA based on their assessment of risk post mitigation.”	Vicky Morris
22/02/19	Amendments to highlight the role of the clinical lead in leading the responsibility and sign off when satisfied to proceed.	Vicky Morris Marsha Jones
13/03/19	Amendments re: Governance arrangements at Divisional Level	Vicky Morris Marsha Jones
10/06/24	Originator of the document changed to DCNO Section 4: Changed from divisional manager to directorate manager Amendments re: inclusion of Equality and Health Inequalities Impact Assessment being added within this policy HEIA added to appendices QIA template added to appendices	Sarah Shingler Sue Smith
14/11/25	Amendments to Equality Impact Assesment form Logos	Sue Smith

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1. Introduction

A Quality Impact Assessment (QIA) and an Equality and Health Inequalities Impact Assessment (HEIA) are essential processes that should be completed and clinically led. This will ensure the benefits and risks that impact on Quality and Equality are determined and identify whether any change scheme affects quality and all groups equally or unfavourably: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and marriage and civil partnership.

The QIA and HEIA allow the Trust to better assess, measure and quantify the impact on quality and therefore the effectiveness of change schemes. Any significant change is considered and documented and where necessary risks are mitigated so that changes do not have a negative effect on complying with:

- The NHS Constitution,
- Internal and external stakeholders,
- Safeguarding children or adults,
- The duty to promote quality,
- The duty to promote equality and inclusion.

Worcestershire Acute Hospital Trust is committed to ensuring this. Therefore, this Policy details the required steps to assess the impact of any change scheme. The purpose of this policy is to set out the responsibilities, process and format to be followed when undertaking a QIA and HEIA at a macro and micro level to assess against quality and safety standards.

The following legislation that underpins this policy is:

- Equality Act 2010
- Health and Social Care Act (Safety and Quality) Act 2015
- Health and Social Care Act 2012
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2. Scope of this document

This Policy is to guide accountable persons to achieve a statement of intent that those responsible for any significant change are satisfied to proceed.

When and how often a QIA and HEIA should be undertaken?

This Policy states the required course of actions that must be adopted: pre, peri and post any significant change for likely impact, such as:

- Commissioning decisions,
- Cost and Productivity Improvement Plans (CPIP),
- Business Cases,
- Workforce redesign,
- Pathway or Service redesign.

The list above is not exhaustive therefore any significant change should be evaluated for its impact on quality or equality and also the case for any significant change that is primarily driven by the desire to improve quality for safer care, clinical effectiveness or patient experience. For example

through better use of assets such as equipment or new technologies, any of which might have unintended consequences on quality, equality or inclusion, and should as a minimum be screened for quality impact and equality impact.

For potential negative impact, this should be part of local risk management processes. Where a positive impact is sought, this process may be part of proactive efforts to realise the benefit of a specific change project.

A QIA is an iterative process that will require monitoring

This Policy is not restrictive and should be employed by any organisational employee who is leading any change scheme. This Policy is to ensure that identified mitigating actions or controls are put in place and actioned, that any ongoing potential risks are considered and further necessary mitigations outlined.

Impact Assessments: i.e. QIA and HEIA must be undertaken as part of the development and proposal stage of developing change schemes and should also be reviewed on a regular basis by the project leads. Reviewing the actual impact throughout the implementation stage, during the final review and after the scheme change plan has been implemented. The frequency of review will be dependent on the level of risk identified (but will be a minimum of six monthly) and will be documented in the quality impact assessment document.

3. Definitions

3.1 **Quality Impact Assessment**: An impact assessment is a continuous process to ensure that possible or actual business plans are assessed and the potential consequences on quality are considered and any necessary mitigating actions are outlined in a uniformed way.

3.2. **Equality and Health Inequalities Impact Assessment (EHIA):** An EHIA is a tool to explore the potential for a policy, strategy, service, project or procedure to have an impact on a particular group, groups or community. This includes the impact on one or more of these groups: protected characteristics groups (as outlined in the Equality Act 2010).

3.3 **Quality Improvement**: Quality within health care can be defined in different ways. In recent years many have sought to define quality. Such works reveal a wide range of domains on which to assess Quality. The often cited dimension across these quality domains is: patient experience (Kings Fund 2016) following Darzi NHS Next Stage Review (Department of Health 2008) which defined quality in the NHS in terms of three core areas:
• patient safety
• clinical effectiveness
• The experience of patients.

3.4 **Accountable Clinical Lead**: The most senior clinician: identified by the division/directorate/team as being clinically competent to lead and monitor the QIA process; and with the authority to sign off that they are satisfied to proceed with the proposed significant change. Importantly this person will be on an official register for practitioners e.g. NMC/GMC/HCPC and use their GMC/NMC number: supporting their professional sign off of the QIA.

4. Responsibility and Duties

Project Manager/Directorate Managers:

- The project management lead supported by the directorate manager will identify the accountable clinical lead to screen and assess for the impact on quality and equality as soon as any significant change is identified/commissioned.

- The role of the project manager and directorate manager will be to support the process of engagement from key clinical and administrative staff. They will also make any operational arrangements to facilitate key stakeholder engagement, at the beginning of the process, collate key issues arising and identify the mitigations required that have to be documented in the QIA.

- Both the project manager and directorate manager will have to sign off the QIA prior to presenting at the QIA Panel. This is once they are assured that the QIA is fully completed and all process followed. However, they are not accountable for final sign off of the QIA which is the responsibility of the Clinical lead prior to going to QIA Panel.

Accountable Clinical Lead:

- The accountable clinical lead will be responsible for following the required steps to complete the QIA: achieved through a collaborative and inclusive approach with all relevant stakeholders.

- The accountable clinical lead will be responsible for following the required steps to complete the HEIA: achieved through a collaborative and inclusive approach with all relevant stakeholders.

- The accountable clinical lead will be responsible for identifying and recording issues raised by Clinical team members and facilitating a rounded conversation with colleagues to ensure that all issues/ risks and mitigations/ controls and alternatives are discussed, and a record of the outcome and risk score and which risks need to be added to their local or corporate risk register for active management.

- The accountable clinical lead: alongside their clinical and managerial colleagues will need to determine the key performance Indicators which need to be monitored. This is to ensure that there is no negative impact on the Quality of the service. These will be outlined in the QIA to ensure that these cover the full range of issues/ mitigations to ensure that any impact can be monitored.

- The Clinical lead (not managerial lead) will determine the required frequency of where and when these are monitored and provide professional assurance that the frequency of the review and indicators will provide early warning of any negative impact.

- The accountable clinical lead will be responsible for signing off the QIA only if they are satisfied of the level of risks/ mitigations put in place, ensuring submission to the Divisional triumvirate team who are required to then review and sign that they are satisfied that the above criteria meet the requirements. If after a comprehensive process all parties have signed the scheme QIA to precede then this will need to go to the QIA Panel for sign off.

- If professional concerns arise following the completed QIA process then a face to face discussion between the Clinical lead and Divisional leadership/ corporate team leads should take place to agree the evidence base for the QIA and opportunities for more controls or mitigation.

- For any scheme where there are still concerns or the Clinical lead is very clear about the inability to sign off the QIA they should engage their Divisional colleagues at an early stage to work through those concerns. The Clinical Executives should also be informed so that they can support where required.

- The Divisional triumvirate are required to endorse and support the Divisional / Directorate Governance arrangements for the regular review and tracking of KPI's required from the QIA and will be held to account for that process.

Divisional Governance Teams and Divisional Directors of Nursing:

- The Divisional Governance lead and Divisional Director of Nursing (DDN), when not identified as the accountable clinical lead, will align with the accountable clinical lead and collectively be responsible for ensuring the QIA is logged and a QIA database maintained.

- Therefore, this requires a divisional governance process to be in place for monitoring: to certify that any identified actions or mitigations have been achieved, and no unintended consequences have occurred.

- If clinical leads and divisions cannot sign off a QIA based on their assessment of post mitigation risk/s the escalation process will be to inform and present the QIA to the Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) in a QIA Panel. If the CNO and CMO do not have assurance that mitigating actions are sufficient to reduce an identified risk, the QIA will not be approved and will be formally reported back to DMT with a recommendation that the overall scheme is modified (if possible).

- Where risks identified within a QIA for a scheme that has been approved for implementation, cannot be mitigated further, the nature of the risk must be clearly documented on the Divisional Risk Register by the scheme lead prior to consideration by the CNO and CMO.

- The CNO will ensure the escalation through to TMB and to the Board if the scheme is required to proceed and the risks are high and may need to be placed on the Corporate Risk Register (CRR) or included into the Board Assurance Framework (BAF) if the risks would materially impact on the delivery of strategic objectives.

- This process will require formal consideration by TMB and then sub- Committees of the Board or the Board directly where risk appetite levels will need discussion and consideration based on the professional advice provided if risks remain too high.

- If CMO/ CNO professional sign off is not able to proceed, then the relevant Committee will be advised accordingly.

- Discussion regarding sub Committee / Board sign off will be required as the last stage of the QIA escalation process.

Associate Director of Clinical Governance, Patient Safety and Risk:

- Each Division will be responsible for reviewing the potential risks and issues arising from a QIA, identifying the mitigations of risks, with associated KPI's to monitor. If however, there are identified potential risks which need to be recognised in the Directorate/ Divisional risk register then these need to be agreed within the Divisional Governance arrangements. This may require support from the Patient Safety Team.

The Executive Team:

- The CNO and CMO will have overall responsibility for final approval and provide an assurance to the Board on any concerns arising from QIA's and HEIAs. Regular updates to the Quality Governance Committee (QGC) for service reconfigurations will be required.

- For major service reconfigurations, QIA's and HEIAs, will need to be formally reviewed at TMB and any concerns with an ability to proceed with a scheme of CPIP will need to be considered at the appropriate sub–Board Committee on behalf of the Board.

- QIA's require the CNO and CMO to sign-off: they will review QIAs and HEIA at a QIA Panel administrated by an Executive PA. Divisional Directors of Nursing, Project Leads and Clinical Leads will be required to attend the QIA Panel to present the QIA.

5. Quality Impact Assessment Process

This Policy defines the Trusts **commitment to Improving Quality** and views that the completion of both a QIA and HEIA will ensure scrutiny of all proposed schemes for change across WAHT.

This Policy provides guidance and directs the accountable clinical leads through the steps required to complete a QIA, thereby ensuring that all aspects of: patient safety, clinical effectiveness, and the experience of patients and staff are safeguarded**.**
All QIAs must be accompanied by a HEIA. Stand-alone HEIAs should be used for Polices and Strategies.

Completing a QIA will aid to inform and enable appropriate decision making to:

- analyse what the impact is (positive and negative),
- the likelihood of impact,
- the degree of impact,
- actions or controls to manage and mitigate the risks and,
- potential for benefits.

A QIA is an iterative process that requires close monitoring and managing and will be the responsibility of the accountable clinical lead, and responsible divisional manager will support any clinical decision making if the clinical lead is not satisfied to proceed with any proposed significant change.

The process requires the accountable clinical lead to identify significant stakeholders to support the completion of the QIA, and the sequential steps followed to ensure that there is no omission or any unintentional consequence.

STEPS TO BE TAKEN TO COMPLETING A FULL QIA:

A proposed significant change has been identified/commissioned:
Lead in time (Project scoping)

Divisional Manager to identify accountable clinical lead to progress the QIA

Step 1:

Quality Impact Screening Tool (see Appendix 1) is to be completed before the full details of the business case/proposal is agreed**:** this will be led by the identified accountable clinical lead. Equality and Health Inequalities Impact Assessment to be completed (See supporting documents)

ONE OR MORE QUALITLY ELEMENTS IDENTIFIED THAT WILL BE IMPACTED

NO IMPACT IDENTIFED

Step 2:

The accountable clinical lead will be responsible for ensuring a fully completed QIA as per screening indicates

The completed QIA and HEqIA Screening Tool will be presented with proposed business case/case for change along with the EIA and guided by the Trusts Risk MATRIX

Step 3:

The accountable clinical lead will:

1. Identify the required stakeholders to complete a **stakeholder analysis** and **scoping exercise** of the proposed changes: if required support can be sought from the Improvement Team to facilitate.
2. To identify the opportunities from the proposed change: of which they will be evidence based
3. Define and scope the current situation through brainstorming
4. Consider and collate the benefits and impacts
5. Identify controls, mitigations and concerns.

Step 4: The information will be gathered and populated into the QIA document

Step 5:

The Divisional Governance Team and DDN will support the accountable clinical lead with the calculation of consequences across a number of **Domains:** to establish the potential consequences and the potential likelihood.

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Step 6:

The Divisional Governance Team and DDN will support the accountable clinical lead with the completion of the QIA to calculate the overall risk. The assessment of *consequence x likelihood* will be performed against the status quo, and following any actions or controls to mitigate risks.

Step 7:

All other associated risk assessments will be completed e.g. Ward Environment risk assessments

6. Implementation

a. Plan for implementation

A copy of the policy will be uploaded to the organisations Key Documents intranet page.

b. Dissemination

The CNO will be responsible for ensuring a communication is issued via a memo: to all managers to inform them of the updated policy and thereby the requirements to complete a QIA for any change scheme that could have a positive or negative impact.

c. Training and awareness

The training will enable all relevant stakeholders to contribute and complete a QIA aligned with any newly written document for any change scheme that could have a positive or negative impact. This can be performed by the Deputy Chief Nursing Officers / Chief Nursing Officer.

7. Monitoring and compliance

All QIA's will be monitored locally (within Divisions) to identify how any scheme is impacting on quality across: patient safety, clinical effectiveness, and the experience of patients. This will be achieved by the accountable clinical lead taking responsibility for the scheme; maintaining and monitoring all mitigating actions as per QIA until all actions or controls are achieved. Monitoring compliance of any added to local/directorate or corporate risk registers should be managed by the Divisional Governance Teams and DDN with support from the Associate Director of Clinical Governance, Patient Safety and Risk retrospectively. This will be required as a standing agenda item for each division.

Elements of the Policy that will be monitored will be consistency checks of all schemes: through business cases and/or Project Initiation Documents approval process. The QIAs will be formally audited annually to include QIAs associated with any CPIP schemes.

The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

8. Policy Review

This policy will be reviewed every 3 years and approved by the Trust Management Board and Quality Governance Committee

9. References

References: Code:

Kings Fund (2016). Improving Quality in the NHS. [Online] London. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf [Accessed 11 Feb. 2019].	N/A
Darzi, A. (2008). High Quality Care for All NHS Next Stage Review Final Report. [online] The Stationery Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf [Accessed 11 Feb. 2019].	N/A
NHS Providers, Good practice Quality Impact Assessment [online] Available at: https://nhsproviders.org/media/1160/prepprog-good-practice-qias-2.pdf [Accessed 2 Feb.2019]	N/A

10. Background

a. Equality requirements

The completion of the EAI screening has not identified any discrimination or impact for any of the 9 protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and marriage and civil partnership. A copy of the completed assessment is included as Supporting Document 1.

b. Financial risk assessment

The completion of Financial Risk Assessment has not identified any risk that could impact on the implementation of this Policy. The financial risk assessment is included in Supporting Document 2.

c. Consultation

Consultation took place with the senior executive team who have organisationally responsibility for quality and governance. The governance leads, quality assurance leads, safeguarding leads and risk managers have all been consulted.

Supporting Document 1 - Equality Impact Assessment Tool

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality and Health Inequalities Impact Assessment (HEIA) Form
Please read HEIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust	
Other (please state)			

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Sue Smith	**Deputy Chief Nursing Officer**	**susan.smith137@nhs.net**
Date assessment completed	**10/06/2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Quality Impact Assessment (QIA) Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	This Policy details the obligatory steps to be undertaken when completing a Quality Impact Assessment (QIA) in order to assess the impact of change schemes.			
Who will be affected by the development & implementation of this activity?	❑✓ ❑✓ ❑✓	Service User Patient Carers Visitors	❑✓ ❑✓ ❑ ❑	Staff Communities Other _____

	❑✓			
Is this:	❑ ✓Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	n/a			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	This is a review and update of the existing policy			
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

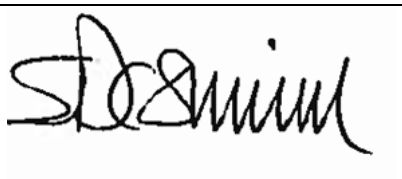
Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this HEIA? (e.g in a service redesign, this HEIA should be revisited regularly throughout the design & implementation)	In line with policy review			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing HEIA	
Date signed	02/09/2024
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	NO
2.	Does the implementation of this document require additional revenue	NO
3.	Does the implementation of this document require additional manpower	NO
4.	Does the implementation of this document release any manpower costs through a change in practice	NO
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	NO
	Other comments:	.

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Divisional Director before progressing to the relevant committee for approval

Appendix 1:
Quality Impact Screening Tool

The following assessment screening tool will require judgement against all listed areas of risk in relation to quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations.

Where an adverse impact score greater than eight is identified in any area, this will require a more detailed Quality Impact Assessment to be carried out, using the escalation proforma.

Insert your assessment as positive (P), negative (N) or neutral (N/A) for each area.
Record your reasons for arriving at that conclusion in the comments column.
If the assessment is negative, you must use the Organisations Risk Scoring Matrix: Risk Management Strategy CG-007-12 embedded at the end of this document to calculate the score for the harm / consequence and likelihood of occurrence. Multiply the two figures together to provide the overall risk score. Insert the total of the overall risk score in the Risk Score if Potential Risk column.

Please refer to Section 4 of the Organisations Risk Scoring Matrix: Risk Management Strategy CG-007-12 to assess if a full Quality Impact Assessment is required. If the risk score is below 6, no QIA is required, if the risk score is above 8, a full QIA will be required.

Title of scheme:
Project Lead for scheme:
Senior Manager/ Executive Sponsor:
Accountable Clinical Lead:
Brief description of scheme:
Intended Quality Improvement Outcome/s:

Quality Impact Screening Tool: to be completed at the point of project scoping

		Neg (negative) Pos (positive) Neu (neutral)	Risk Score if Potential Risk	Comments (include reason for identifying impact as positive, negative or neutral)
1.	**Does the proposed significant change impact negatively on one or more of the elements:**			
	• Maintaining Clinical Standards/Duty of Quality			
	• Patient Experience			
	• Staff Experience			
	• Patient Safety			
	• Clinical Effectiveness/Efficiencies			
	• Prevention of Harm			
	• Productivity and Information			

Name of accountable clinician completing assessment:	
Position:	
Based on the Risk Score is a full QIA required (Y/N)	
Signature:	
Date of assessment:	

Use the Organisations Risk Scoring Matrix: Risk Management Strategy CG-007-12

Risk Scoring Matrix

Worcestershire NHS
Acute Hospitals NHS Trust

SECTION 1 –	HARM / CONSEQUENCE SCORING				
	1	2	3	4	5
Descriptor	Insignificant	Minor	Moderate	Major	Catastrophic
OBJECTIVES Achievement of organisational / strategic objectives	Negligible effect upon the achievement of the objective	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty / cost	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty / cost	Significant effect on the objective making it extremely difficult / costly to achieve	Catastrophic effect on the objective making it unachievable.
CLINICAL Impact on the safety of patients (physical/ psychological harm)	Incident prevented / near miss. Incident not prevented but NO HARM was caused	Any patient safety incident that required extra observation or MINOR treatment and cased minimal harm to one or more patients e.g. first aid, additional therapy or additional medication	Any patient safety incident that resulted in a MODERATE increase in treatment and that caused significant but not permanent harm to one or more patients Moderate increase in treatment is defined as: a return to surgery; an unplanned readmission; a prolonged episode of care; extra time in hospital or as an outpatient; cancelling of treatment; transfer to another area such as intensive care - as a result of the incident.	Any patient safety incident that appears to have resulted in permanent (SEVERE) harm to one or more patients Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as: permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.	Any patient safety incident that directly resulted in the DEATH of one or more patients The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) - Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved. Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) - Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Service actively causing patient harm Gross failure of patient safety if findings not acted on Non coronial inquest/ ombudsman inquiry Gross failure to meet national standards
OPERATIONAL Service/ business interruption Environmental impact	Loss/ interruption of >1 hour No impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Impact on staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury requiring minor intervention Requiring time off work but less than 7 days	Moderate injury requiring professional intervention Requiring time off work for 7 -14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident causing death Multiple permanent injuries or irreversible health effects
FINANCIAL	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
INFORMATION GOVERNANCE	Minor breach of confidentiality. Up to 10 individuals affected (scale 0)	Information up to 100 individuals (scale 1&2) Local media coverage	Serious breach of confidentiality e.g. information for 101 – 1000 individuals (scale 3) Local media coverage ICO fine up to £50k	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1001 – 100 000 people affected ICO fine of £50k to £250k	Loss of all systems / data Very sensitive information information about 100,001 + individuals. ICO fine of £250k to £500k. National media attention
REPUTATION	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence	Local media coverage Long-term reduction in public confidence	National media coverage requiring significant action	National media coverage impacting on our ability to function
COMPLIANCE Statutory duty/ Inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty. Improvement notices. Critical report	Multiple breaches in statutory duty Prosecution Severely critical report

Taken from Risk Management Strategy CG-007-12

Appendix 2:
Equality and Health Inequalities Impact Assessment (EHIA) Tool

Herefordshire & Worcestershire STP - Equality and Health Inequalities Impact Assessment (HEIA) Form
Please read HEIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council	
Worcestershire Acute Hospitals NHS Trust		Worcestershire County Council	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust	
Other (please state)			

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:**			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ Service User ❑ Patient ❑ Carers ❑ Visitors		❑ Staff ❑ Communities ❑ Other _____	
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please				

name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				
Race including Traveling Communities				
Religion & Belief				
Sex				
Sexual Orientation				
Other Vulnerable and Disadvantaged				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this HEIA? (e.g in a service redesign, this HEIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing HEIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Appendix 3:

Quality Impact Assessment template

Final QIA bl