QUALITY IMPACT ASSESSMENT

Project/Proposal Name	Shaping Care Together	Date of completion	8th January 2026
Programme Manager	Alexandra Kopec	Clinical Lead	Kate Clark

Background and overview of the proposals (can be copied from PID on Verto or from National/Regional commissioning guidance)

For the populations of Southport, Formby, and West Lancashire, adult A&E services are provided at Southport DGH, while paediatric A&E services are available at Ormskirk DGH. Since April 2020, Ormskirk A&E has experienced a temporary reduction in operating hours from midnight to 8 am due to a shortage of appropriately skilled staff. During these hours, paediatric patients are redirected to Alder Hey Children's Hospital to ensure safe care.

As outlined in the Shaping Care Together case for change, there are a number of challenges the Trust face in providing emergency care for the populations of Southport, Formby and West Lancashire;

- Workforce: The NHS in Southport, Formby, and West Lancashire struggles with recruitment and retention, leading to costly reliance on temporary staff, and despite additional investment, shortages persist due to insufficient training programs and an aging population increasing demand for complex care.
- Infrastructure: Continuous investment in healthcare facilities is essential to avoid costly repairs and ensure they are suitable for patient care, especially for older individuals, to provide high-quality, safe services now and in the future.
- Quality: MWL strive to offer safe, sustainable services focused on excellent patient care, but the latest Care Quality Commission report highlights the need for future adaptations and the challenges of operating across two main hospital sites, which can strain staff.
- Financial: MWLs challenge is to deliver high-quality, safe services with current resources by finding innovative and efficient ways to address inefficiencies and eliminate duplication, as new funding is not available.
- Ageing population: The population in Southport, Formby, and West Lancashire is aging faster than the national average, with a significant increase in those over 65 expected by 2036. This has led to higher demand for healthcare services, especially for emergency and long-term care, and more people living with complex health conditions. To maintain a healthier population, it is crucial to focus on preventing and managing diseases effectively. Future care models must include strong prevention programs to ensure safe and excellent care.

Furthermore, there remain a number of support service risks – spanning emergency care, emergency blood tests, transfusion, trauma and orthopaedics, anaesthetics, general surgery, radiology and pharmacy – arising from the current A&E configuration, most of which would be resolved if the project progressed, and which are currently mitigated through measures such as the overnight closure of the paediatric A&E and additional on-call/clinical pathway arrangements, with further detail included within the clinical section of the PCBC.

The Shaping Care Together programme looks to address these challenges with a single co-located adult and paediatric A&E department for this population, at either Southport DGH or Ormskirk DGH. These options are a result of a rigorous options appraisal process and have been subject to a full public consultation conducted between 4th July to 3rd October 2025.

Maternity and neonatal services are interdependent services but currently out of scope of the SCT programme and remain the subject of interconnected but separate ongoing regional and national reviews and service change programmes.

In addition, the North West Spinal Cord Injuries Centre (NWSCIC), which is co-located with the adult ED at Southport and serves a broad regional population, may be at risk of relocation should services be co-located at Ormskirk.

Reason For Change/Proposal
To address the challenges outlined within the case for change, as noted above.

Who is likely to be Impacted?	Public	✔	Patients	✔	Workforce	✔	Other parts of the system	✔
Please provide additional details, including scale	*(No. of people affected - Consideration of Protected groups/characteristics)* As outlined in the pre-consultation business case (PCBC) this proposed changed will impact the populations of Southport and Formby (128,393) and West Lancashire (118,000).							
Who has been consulted with as part of the QIA development	*(Patient engagement, Provider or partner organisations, Place Quality Teams, Healthwatch)* The original QIA was prepared for the PCBC in collaboration with the SCT Clinical UEC Sub-Group, which includes clinical and operational leads from MWL, C&M ICB, L&SC ICB, Alder Hey, Merseycare, NWAS, and HCRG Care Group (the current providers of the Ormskirk UTC and Skelmersdale Walk-in Centre). The QIA has since been updated following the full public consultation on the proposals for the future A&E, as outlined in the PCBC.							
Financial Considerations	Current Costs	£0	Proposed Costs	Proposed capital costs: £33,136,000 *(please note: the route to funding will be through national/central funding via the capital business case process)*				

Stage 1 Place/Local Sign off:						
Direct Approval given? Rationale:	Yes – scored at 4 post mitigation.	Brief description of any identified actions at Stage 1	QIA to be submitted wih Business Case	Post mitigation risk score *(Likelihood x Consequence)*	Safety	1
					Effectiveness	1
					Experience	4
					Workforce & Well Led	1
					Sustainability / Performance / Strategic Objectives	1
Sign off group	Sefton Place Quality Team	Date of meeting	21/01/2026	Recommend QIA Panel	N/A	
Has an EIA been completed?	Yes	Has a DPIA been completed?	Yes	Have identified risks been added to risk register?	N/A	

Risk scores above 12 in any area of quality, including patient safety, clinical effectiveness or experience will be taken to QIA panel and must be included within the corporate risk register for the programme of work / Place.

Patient safety						
Will the project or proposal impact on patient safety?	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level	Pre-mitigation Identified Risk Score (Prior to Mitigations)		
				I	L	Total I x L
Please consider… • Will this impact on the organisation's duty to protect children, young people and adults? • Impact on patient safety? • Impact on preventable harm? • Will it affect the reliability of safety systems? • How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced? • Does the change impact on medicines safety or medical devices safety?	The clinical models, developed in line with NHS England Emergency Care guidance, RCEM and RCPCH standards, NICE guidance, and CQC frameworks, align with national best practice. Through collaboration with ICBs and urgent care providers, the programme has established a clinically robust model, approved by key oversight groups to ensure evidence-based, high-quality emergency care. A co-located adults and paediatric A&E will minimise the risk of harm and impact to patients as the workforce would be more sustainable to allow for a safe 24hr A&E department for adults and children. With a 24hr paediatric A&E, the current risk to patients who are in the department between midnight and 8am will be reduced. A&E services are currently being provided for both adults and children with the appropriate safeguarding process in place within MWL. Estates plans will ensure children have a separate waiting area and treatment rooms and be fully compliant with standards referenced within RCPCH guidance. With the benefits to the workforce of a co-located adult and paediatric A&E, safe staffing levels should support the reduction and prevention of patient harms and healthcare associated infections. The programme will ensure compliance with regard to estates configuration.	As either option may require additional travel for patients to access emergency care, there is a risk in delay of care and the increased risk of patient harm, however this should be balanced against the current risk.	N/A	1	1	1

Mitigations (Proposed mitigations to reduce any negative impacts. Please re-score risk of impact once expected mitigation are accounted for)					
Action	**Owner**	**Expected date of completion**	**Date completed**		
N/A	N/A	N/A	N/A		
Outline KPIs which will be used to monitor positive and negative impacts on domain		**Post Mitigation Risk Score**	1	1	1
Positive and negative impacts on the domain will be monitored via the current UEC metrics and the quality schedule which will be monitored via established governance routes.					

Clinical Effectiveness						
Please confirm how the project uses the best, knowledge based, research	The programme follows the relevant guidance set out by the professional bodies and NHS England.					
Will the project or proposal impact on Clinical effectiveness?	Positive impact Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	Neutral Impact May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level	Identified Risk Score (Prior to Mitigations)		
				I	L	Total I x L
Please consider… • How does it impact on implementation of evidence based practice? • How will it impact on clinical leadership • Does it reduce/impact on variation in care provision? • Does it affect supporting people to stay well? • Does it promote self-care for people with long term conditions? • Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting? • Does it eliminate inefficiency and waste by design? • Does it lead to improvements in care pathways? • Will the change impact on avoidable readmission rates? • Will the change impact on the • timeliness of access to care? • Will the change impact on any reported effectiveness outcomes?	Better use/flexibility of the workforce resource, supporting improvements in waiting times and increasing stability, and better accessibility for patients during out of hours; which will reduce patient time in ED and support hospital flow and improve length of stay. A co-located ED aspires to reduce waiting times in ED due to a co-located competent workforce. Particularly with paediatric ED due to the reduced staffing during twilight and late shifts (in line with the European Working Time Directive) and recruitment challenges. Activity modelling enables us to map the workforce against demand to help improve waiting times through resource flexibility with a co-located ED. Consolidation of support services (such as anaesthetics) and reduction in duplication may result in better use/flexibility of the workforce resource (e.g. reduced driving between sites), supporting improvements in waiting times, increasing stability, and better accessibility for patients during out of hours – particularly paediatrics as the current paediatric ED is not 24/7; which aid to improve clinical outcomes.	Further work around clinical interdependencies may impact workforce requirements, particularly regarding paediatric and neonatal workforce.	N/A	1	1	1

	In addition, the opportunity to optimise functionality of the walk-in-centre (Skelmersdale) and the urgent treatment centre (Ormskirk), can provide greater access to urgent care services for the local population, as well as the opportunity to maximise efficiencies in the clinical model to improve clinical outcomes and effectiveness due to a stabilised clinical model. It is expected that this will be monitored via clinical audit. Improved utilisation of workforce and skill mix to improve waiting time and decision making in ED, which will support ED performance and hospital flow metrics. With regard to interdependencies, reduction of duplication and access to other workforce resources available may positively impact elective recovery. The SCT programme is working closely with Lancashire & South Cumbia ICB whilst the ICB undertake an integrated urgent care redesign, as noted as an interdependency to the programme, and the aforementioned organisations are core members of the SCT clinical UEC sub-group which have developed the SCT models of care and will contribute to the future detailed pathways.					

Mitigations (Proposed mitigations to reduce any negative impacts. Please re-score risk of impact once expected mitigation are accounted for)					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Outline KPIs which will be used to monitor positive and negative impacts on domain		**Post Mitigation Risk Score**	1	1	1
Positive and negative impacts on the domain will be monitored via the current UEC metrics and the quality schedule which will be monitored via established governance routes.					

Patient Experience, Equality & Equity						
Will the project or proposal impact on patient experience, or equality and equity for the ICB population?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				I	L	Total I x L
Please consider… • What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience? • What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys / complaints / PALS / incidents)? • How will it impact on the choice agenda? • How will it impact on the compassionate and personalised care agenda? • How might it impact on access to care or treatment? • Will the change enable care to be provided closer to home? • Will people using services and their unpaid carers	A full equalities and health inequalities impact assessment (EHIIA) was conducted on the proposed options with the PCBC (Appendix 25) prior to public consultation. Furthermore, a detailed post-consultation EHIIA is being developed for the decision-making business case which considers the impact on protected characteristics. The proposed changes should align with the need to offer patients choices about their care. This includes ensuring that any reconfiguration does not limit the options available to patients. A 24h paediatric ED will be available which will mean patients will have care closer to home instead of travelling to Alder Hey during the overnight closure. Through better joined up working across the UEC pathway and a fit for the future newly designed ED, this could improve patient ED waiting times. The SCT programme conducted a 10-week period of pre-consultation during July to October 2024, to gain feedback and insights from the public/patients, staff and	Co-location of adult and paediatric A&E services at either Southport DGH or Ormskirk DGH will require one of these A&E departments to move to a different site. Co-location at Ormskirk will potentially see an adverse impact on patient and carer experience for those within the Southport and Formby population for both urgent and emergency care due to lack of UTC provision in Southport. Co-location at either Southport or Ormskirk Hospital will require the relocation of at least one clinically co-dependent service alongside the respective A&E department - one for the Southport option and seven for the Ormskirk option. During the implementation of these moves, and the associated adjustments to other potentially impacted services, there may be an adverse effect on patient and carer experience. The risk of disruption is greater for the Ormskirk option due to the higher number of co-dependent services that would need to relocate.	A proportion of the population will need to travel further depending on the co-location site; i.e. patients from Southport and Formby will need to travel to Ormskirk if co-located at Ormskirk DGH and patients from West Lancashire will need to travel further if co-located at Southport DGH. There could be an increased cost and travel time for patients travelling by public transport.	2	3	6

experience longer or reduced waiting times for services?	stakeholders on UEC services in Southport, Formby and West Lancashire. This consisted of public events, public roadshows, staff events, staff roadshows, focus groups and a survey. This engagement was used to populate the full list of options for the options appraisal process. Patient and public representatives across the main geographical areas were included as appraisers within both the hurdle and evaluation criteria application workshops. The SCT programme has also carried out a 13-week consultation on two proposed options for the future location of adult and paediatric A&E departments in Southport, Formby, and West Lancashire: either co-located at Ormskirk Hospital or at Southport Hospital. The insights gathered are now being used to inform the development of the decision-making business case. An Engagement Process Advisory Group has been established, which consists of public/patient representatives of the local communities of Southport, Formby and West Lancashire, as well as Healthwatch and CVS. Co-location of adult and paediatric A&E services at either Southport DGH or Ormskirk DGH will require one of these departments to move to a different site. Co-location at Ormskirk will see a positive impact on patient and carer experience for those within the West Lancashire population, whilst co-location at Southport will see a positive impact on patient and carer	Co-location at Southport may see an adverse impact on patient and carer experience for those within the population of West Lancashire, although will still have access to the UTC at Ormskirk and WIC at Skelmersdale. Travel and transport emerged as key themes in the consultation feedback. To ensure these concerns are fully addressed, we have established a dedicated Travel Advisory Group. The group's purpose is to identify potential risks, opportunities, and solutions related to travel and transport, and to explore what strategies or investments may be needed to improve patient and staff access to essential services. While this programme cannot address longstanding issues or concerns related to travel and transport, the TAG can highlight these issues to local authority and transport providers as well as contributing to wider health-focused work to improve accessibility of urgent care to local populations.				

	experience for those within the population of Southport and Formby.					

Mitigations (Proposed mitigations to reduce any negative impacts. Please re-score risk of impact once expected mitigation are accounted for)

Action	Owner	Expected date of completion	Date completed
Risk: As co-location of adult and paediatric A&E services onto one site will result in the other site losing their respective A&E service, this will result in a proportion of the population needing to travel further depending on the co-location site; i.e. patients from Southport and Formby will need to travel to Ormskirk if co-located at Ormskirk DGH and patients from West Lancashire will need to travel further if co-located at Southport DGH. There are high levels of deprivation with both the Sefton and West Lancashire patches which will be affected by this, particularly those who require the use of public transport. Mitigation: • A mitigation for this change, regardless of which site the co-location A&E would be, is for the Trust to provide a free-of-charge shuttle bus service between Southport and Ormskirk hospitals. Other options to address travel can be considered within the travel advisory group. • Ensuring that the UTC (Ormskirk) and WIC (Skelmersdale) are utilised effectively, especially, if there is co-location at Southport to reduce travel for the populations of West Lancashire. • Work with West Lancashire colleagues to improve urgent health offer for those populations including wider work aligned to 10 year plan. This will be a greater priority with the preferred option.	SCT programme SRO	By implementation (date tbc – subject to DMBC approvals and capital business case timescales)	TBC

Outline KPIs which will be used to monitor positive and negative impacts on domain	Post Mitigation Risk Score			
Positive and negative impacts on the domain will be monitored via the current UEC metrics and the quality schedule which will be monitored via established governance routes.		2	2	4

Workforce & Well Led						
Will the project or proposal impact on the workforce and well led domains?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				I	L	Total I x L
Please consider… • Will the change impact on the required skill mix of staff? • Will there be any changes in roles or training requirements for existing staff • Will the proposal impact on training provision and availability of placements? • Will there be a change in satisfaction levels reported by staff? • Will there be change to the way in which staff within the service are expected to work, such as number of hours or impact on workload? • Will there be any changes to the oversight and accountability requirements for the service, is it clear where these responsibilities will sit? • Will there be an impact on the recruitment and retention of staff working in the service area?	Skill mix: Enhanced skill mix through consolidation of adult and paediatric A&E, stronger anaesthetic and radiology cover, and more resilient rotas. Roles/training: Opportunities for upskilling (paediatric emergency care, anaesthetics support) and cross-specialty development. Training provision/placements: Likely improved supervision and case-mix exposure on a single site, benefiting learners. Staff satisfaction: Expected improvement due to rota stability, reduced operational pressure, and better access to co-dependent services. Working patterns: Potential for clearer rotas and workload distribution, reducing reliance on agency staff. Recruitment/retention: More sustainable rotas and reduced agency reliance should make roles more attractive. Redundancies: No redundancies signalled; focus is on redeployment rather than reduction.	Skill mix: Adjustment period for staff adapting to new skill requirements and consolidated site. Working patterns: Changes to shift patterns and on-call arrangements could initially disrupt work-life balance. Staff satisfaction: Risk of dissatisfaction if implementation is poorly managed or if staff feel displaced. Recruitment/retention: If relocation or single-site working is unpopular, there could be short-term retention challenges.	N/A	1	1	1

• Could there be any redundancies? • Could there be any opportunities (including staff development)						

Mitigations (Proposed mitigations to reduce any negative impacts. Please re-score risk of impact once expected mitigation are accounted for)					
Action	**Owner**	**Expected date of completion**	**Date completed**		
N/A	N/A	N/A	N/A		
Outline KPIs which will be used to monitor positive and negative impacts on domain		**Post Mitigation Risk Score**	1	1	1
Positive and negative impacts on the domain will be monitored via the UEC metrics and the safer staffing/workforce reports including staff feedback, recruitment and retention as per the quality schedule for the organisation.					

Sustainability / Performance / Strategic Objectives						
Will the project or proposal impact on the sustainability, performance or strategic objectives of the organisation and/or wider system?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				I	L	Total I x L
Please consider… • Will there be any impact on capacity and demand on services • Will there be a financial impact from the change? For example, will there be an impact on any elements of the supply chain? • What is the effect on the long-term sustainability of the service or care Pathway? • Will changes to resources (such as staff, time, energy, buildings) be required? • Will changes affect the environmental impact of the service (such as energy demand, increased waste, refurbishment required)? • Will it impact on efficiency and waste? • Is there a likely impact on other contracts or system partners that provide associated services or elements of the pathway? • Will there be an impact on the travel requirements (increases or reductions) and needs for staff, patients and service users as part of the proposal?	Capacity & Demand: Improved resilience and ability to manage peaks through consolidated ED and paediatric services. Financial: Economies of scale, reduced agency costs, and long-term operational savings. Sustainability: Future-proofed urgent care model aligned with NHS integration goals. Resources: Better utilisation of staff and equipment; streamlined rotas. Environmental: environmental impact assessment completed in support of the PCBC. Efficiency & Waste: Higher staff utilisation and reduced duplication of services. Travel: Fewer inter-hospital transfers for complex cases. Full travel impact assessment completed to support the PCBC. Care Pathways: Enhanced continuity of care and reduced handovers.		N/A	1	1	1

• Will the change impact of the services or organisation's ability to meet national and or local performance targets? • Will the change affect the performance of care pathways? • Does the proposal impact on the organisation's strategic objectives? • Does the proposal align with the wider objective and ambitions of the NHS? • Does this proposal impact on the joint forward plan for the ICB, and partnership working across ICBs?						

Mitigations (Proposed mitigations to reduce any negative impacts. Please re-score risk of impact once expected mitigation are accounted for)

Action	Owner	Expected date of completion	Date completed
N/A	N/A	N/A	N/A

Outline KPIs which will be used to monitor positive and negative impacts on domain	Post Mitigation Risk Score			
Positive and negative impacts on the domain will be monitored via the current UEC metrics and the quality schedule which will be monitored via established governance routes.		1	1	1

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget

		Reputation - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	**1**	**2**	**3**	**4**	**5**
Unlikely (2)	**2**	**4**	**6**	**8**	**10**
Possible (3)	**3**	**6**	**9**	**12**	**15**
Likely (4)	**4**	**8**	**12**	**16**	**20**
Almost Certain (5)	**5**	**10**	**15**	**20**	**25**

Low Risk	**Moderate Risk**	**High Risk**	**Extreme Risk**	**Critical Risk**

Risk Proximity

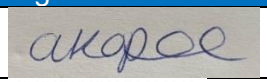
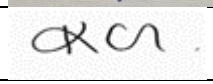
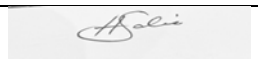
A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Alexandra Kopec	Project lead		19/01/2026
Dr Kate Clark	Clinical lead		19/01/2026
Alexandra Kopec	Programme manager	(as above)	19/01/2026
Halima Sadia	PMO lead		19/01/2026
Once signed off by all above, then the QIA is submitted via qia@cheshireandmerseyside.nhs.uk **to QIA review group**			

PMO receipt					
Verto/PMO reference		Date QIA reviewed PMO		Reviewed by	

Meeting Chair	Date of Meeting	Outcome	Comments/feedback
Mel Spelman Jennie Piet Tracey Forshaw	21/01/2026	Approved	Resubmittted QIA following formal public consultation, business case now being submitted and updated QIA reviewed and approved by Sefton Place Quality Team.
Requested review frequency:	Annual	Date for next submission:	January 2027

Outcome of QIA review:	Approved -mitigations and key performance indicators are appropriate	Requires further information and re-submission	Amendments to project or proposal required to reduce impact on care quality	Project or proposal not approved to proceed, for example, impact on care quality exceeds risk appetite