Risk assessment: what might be the consequences to your service?

Risk of reduction in quality or absence of specialist nursing service

Include what is currently offered, for example:

- specialist knowledge
- nurse/AHP led clinics
- symptom management and control
- appropriate and timely referrals
- autonomous prescribing
- drug titration and medication reviews (non-medical prescribing qualifications)
- DMD screening and starting on treatment
- DMD monitoring
- support for infusions
- management of relapse
- referral for DMD escalation
- prevention of secondary complications
- telephone support/telephone clinics
- home visits
- training
- education
- supervision
- management of staff/budget
- liaison with and referrals to other health and social care professionals
- safe guarding and case management

Describe what you cannot offer if the service is reduced, for example:

Clinical issues

- autonomous prescribing (if appropriate)
- autonomous practice eg nurse led clinics
- impact on DMD management
- maintaining safety of pwMS who are taking DMDs
- medication reviews, titration
- problems resulting from inadequately managed symptoms/inappropriate medication reviews eg UTIs, falls
- increase in secondary complications
- compliance with national guidelines such as NICE guidance and Quality standards
- risk of unsafe care
- risk of increase in emergency admissions and readmissions within 28 days due to lack of specialist preventive care
- unmanageable caseloads
- risk of not updating specialist knowledge in all areas, leading to unsafe care. In addition:
    - include ongoing annual costs
    - study leave requirements

- cover requirements while training is completed

Patient experience

- Longer waiting times
- risk of inequity – patients whose condition you are familiar with may more focus than patients with a condition new to you
- some pwMS will be unable to access the service – either due to a lack of provision for those not on DMDs and/or a lack of ability to provide home visits or satellite clinics (or both)

Management issues

- managing/mentoring staff
- budgetary management (if any)
- education/training
- clinical supervision
- liaison with local patient groups and input into courses (e.g. newly diagnosed)
- specialist advice to generalist staff eg inpatient assessments, GP support, district nurse support
- any other duties eg negotiating with commissioners
- who will take on these aspects of the role?

Risk of loss of specialism

- risks to patients if there are fewer opportunities to keep up to date – out of date practice, advice, medications etc
- risks to the employing organisation if there are fewer opportunities to keep up to date, for example offering best practice, failure to comply with national guidelines, potential for unsafe care and increase in costs due to increased use of emergency care and potential loss of revenue through a reduction in clinic slots (if your Trust is on a tariff system)
- risk to service of loss of existing specialist staff

Risks to neurology service

- estimate increase in time required for neurologists to undertake the basics, eg one two-yearly review for every active patient in your caseload = increase of how many hours in the neurology service?
- risk of incurring fines for breaching waiting times such as 18 week referral to treatment target because of increased caseload
- what will be the impact on DMD prescribing – costs of non-completion of Bluteq forms
- estimate loss of nurse-led income (link to nursing service description) from transferring these activities or increased costs to community
- risk of losing other income that neurologists might have generated otherwise
- risk of unmanageable caseload for neurologist

Risk of complaints

- from patients
- from relatives

- from GPs
- from other NHS organisations (nowhere to refer to, loss of supervision, education)
- include admin costs - eg increase in PALS workload, managers having to respond
- include potential for legal costs

Risks around patient management and admissions

- risk of reduction to planned and managed admissions with timely discharge
- risk of increase in unplanned admissions – include pressure on A&E (the MS Trust can help you find out about the number of emergency admissions etc. locally if you don't have ready access to this information in-house)
- risk of increased length of stay, if possible estimate average bed days
- risk of readmissions within 28 days without specialist nurse input
- risk of admissions due to loss of specialism e.g. complex medication regimes no longer managed in clinic due to loss of autonomous prescribing
- reduced ongoing monitoring, with associated risk of untreated side effects

Downbanding

Ensure that the risks are documented and responsibility of any identified risk is allocated. You may wish to discuss with the appropriate line manager who is going to be the person who will take the responsibility for risks identified, if the post will continue at a lower band.

The biggest risk to the downbanded individual is that they will continue to offer the same service but with fewer resources. The purpose of this risk assessment is to demonstrate that the service is reduced. You need to identify what skills and services will disappear if roles are downbanded, as it is likely that existing postholders will leave once their period of pay protection ends

- Check your current job description and competences - ask HR if you never received one.
- Check lower band job description and competences – ask HR for one if necessary.
- Use these to evidence your current practice and to compile your risk assessment – what will you not be able to offer if working at a lower band that you currently do offer to your patients?
- Ensure you match or exceed every part of your current job description.

Describe what will be lost if your role is downbanded: risk assess your current service against the lower band competences and description. Who will take on the additional services currently offered?