Forgotten Feet Charity

Helping Homeless Feet

Registered Charity 1179671

A Charitable non-profit making organisation

Policies and Procedures

Thank you for your kind generosity in offering your valuable time and skills as a volunteer for our Registered Charity. This project was set up in 2013 to bring a free podiatry and foot health service to those probably most in need and with the least means of being able to obtain such treatment. In addition it is set up in homeless centres so it is easily accessible for this community. In 2018 we gained Charitable status and we now have over 60 services across the UK. There is an open-door policy whereby anyone using such a centre is welcome to treatment; this will include homeless, socially isolated and vulnerable people. Shoes and socks subject to availability are given to service users following treatment.

1. It is currently governed by 7 Trustees, three of whom have designated committee roles. Deborah Monk, Founder and Chairperson; Lydia Patterson, Vice Chair and Secretary; Adam Constable, Treasurer; Belinda Longhurst, volunteer co-ordinator; Dave James, Trustee; Wendy Richards, Trustee and Sarah Dainter, Trustee; and all decisions and changes are made by the committee and trustees.

2. The three committee members are signatories to the bank account.

3. Any subsequent amendments made to these rules and regulations will be agreed by the committee and trustees

4. The Forgotten Feet name and logo can only be used with permission from the committee or trustees, by podiatrists and Foot health practitioners running Forgotten Feet clinics. This may extend to other bodies connected with fundraising or collecting donations for Forgotten Feet and may also be used for promotional and educational purposes.

5. Any funds raised or donated will be deposited in the bank account and used to cover the cost of setting up the charity eg any professional/legal fees, trademarking the logo, setting up new clinics and subsequently used to cover the material cost of running or maintaining clinics.

6. Clinics should preferably be run by at least one podiatrist and helped by one or more others, including Foot Health Practitioners, all of which are operating as autonomous volunteer/practitioners under their own professional indemnity insurance.

7. Students may attend clinics or help under supervision (by prior arrangement), but only if the service user is consenting and it is deemed appropriate. Higher Education Institutes (HEI) must agree to student placement, and as such must be covered by the training Institutes` insurance. Due to the high-risk nature of our clinics, only competent second- or third-year podiatry students may be involved in treating, or observational placement if appropriate. Arrangements for this are at the discretion of the main practitioner at a given venue and the HEI placement officer. Not all locations are suitable for students.

8. All professionals involved must be suitably qualified and insured (professional indemnity insurance) with HCPC registration for all podiatrists. Proof of insurance will be required. Forgotten Feet is not responsible for the actions of any individuals (clients or practitioners), nor the consequences of any treatment given, but is the responsibility of the individual practitioner based on his/her professional opinion. Volunteers treating clients or service users do so at their own risk.

9. Foot Health Practitioners and podiatrists are working together with a mix of skills and knowledge. Whilst a podiatrist may be able to offer advice, he or she is not responsible in any way for supervising or responsible for the actions of a Foot Health Practitioner. Everyone involved must practice within their scope of practice/competencies. Treatment in this environment should be conservative and basic; with risks kept a minimum.

10. It is the responsibility of everyone involved to keep up with policies and procedures and check for updates. Significant amendments will be emailed to everyone as a matter of priority. Therefore it is important for volunteers to ensure trustees have contact emails.

11. When a start date is known for a clinic, if not before, all volunteers must forward the following information if they wish to continue as Forgotten Feet volunteers.

    Name
    Contact email
    Proof of insurance (professional body membership number)
    Venue Name
    Area (Town/City and County)

12. Appropriate clothing must be worn and safety guidelines adhered to, all service users must be treated as high risk and necessary precautions must be taken. Guidelines will be given to all volunteers. (*See `Treatment Guidelines` in this handbook).* Safety of volunteers is paramount, but it is at the risk of the individual.

13. Patient confidentiality must be upheld, basic records are to be maintained for each person and every treatment; this needs only to have the name and date of birth for each individual as a minimum. Medical history is preferred but may be difficult to obtain, assume all are high risk and treat as such. Permission to treat must be documented on the notes.

Permission must be obtained prior to publishing any pictures or videos on social media or elsewhere, this must be clearly explained, and written consent/signature obtained. Sharing of conditions, treatments and experiences are to be encouraged for the benefit of the practitioners, and ultimately the service users; expanding knowledge and learning is important for all involved.

14. Upon leaving Forgotten Feet, practitioners must return any items and/or instruments, funded or donated to the Forgotten Feet project for future use by others.

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Setting up a Forgotten Feet Service

1. Enlist the help of another podiatrist or FHP, where there are several volunteers in an area the clinic could be run more often or on a rota basis, so teams do alternate sessions.

2. You will need a Domiciliary bag – basically treat as Domiciliary but high risk – see separate guidelines for treating in a homeless clinic. Instruments and consumables will be supported depending on supplies.

3. Locate homeless drop-in centres near where you are via the internet. Some of the larger organisations in towns or cities may well be covered by an NHS podiatrist, but there will be plenty of other places in the same city or town without any podiatry services. We are looking to help maybe some of the smaller charities who operate a drop-in service for homeless, socially isolated, or vulnerable people, although, for example, the Salvation Army in many places don't have a podiatry service. Some organisations have access to a local clinic/health centre and are potentially covered, though homeless people are less likely to use this. Getting the ball rolling can take quite a while, it may be that you need to email or phone a couple of places and response can be very slow to begin with, do not give up!

4. In your initial email or phone call introduce yourself, ask whether they may be interested in a free podiatry (foot-health) service run at 6 – 8 week intervals, or whatever your work load allows. Explain that they do not need to provide anything other than a couple of chairs – anything else is a bonus! If there is a separate room that can be used that is great, otherwise a corner or area in a large room is fine. Mention that we aim to provide socks and donated footwear when available. Also mention

that Forgotten Feet is a Registered Charity, your professional qualification, and the fact you are insured.

5. If the response is positive – (you may have to prompt an initial response), arrange a time to meet up and explain in more detail how the service works. Sometimes these places have funds that can cover the cost of consumables but not often! You can refer service providers/hub co-ordinators to the website www.forgottenfeet.org where there is some information as to how things work and what to expect. There are numerous services across the UK with great benefits to service users ranging from direct benefit from podiatry, boosting self- esteem by listening to peoples stories and taking an interest, helping to resolve foot related issues which in turn can help someone back to work. It has been noted that service users who engage with podiatry are far more likely to engage with other health care professionals – all of which has a positive impact on mental and physical health.

6. The number of people you see at a session may vary tremendously. Most sessions are just 2 to 3 hours every 6 – 8 weeks. At the smaller venues you can expect to see between 1 and 8 people (just an approximate guide based on what we see at other services). It can take a few sessions to build trust and encourage people through, but once word gets round it gets busier! Often the service users with the worst feet are slowest on the uptake, often through sheer embarrassment or distrust/suspicion. It is a great feeling to break through those barriers, everyone benefits.

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Treatment Guidelines

Below are some commonly asked questions and topics. Information is based on experience within the homeless and socially isolated settings. There is a higher level of mental illness (around 45%), within this population along with drug and alcohol abuse producing behaviour which can at times be quite challenging. Generally the homeless/rough sleepers are quite a transient population making any continuity of treatment almost impossible. The podiatry service we offer through the forgotten feet project is very basic and aims primarily to alleviate pain, replace worn out or ill-fitting footwear to prevent further problems, help with simple biomechanical issues and show some compassion! People we see range from rough sleepers, sofa surfers, those in shelter and people who have recently moved into accommodation, as well as those considered socially isolated and on the poverty line.

As a broad overview of the homeless population; often the men have come from broken relationships/marriages and forced to leave the marital home then spiralled downhill toward alcoholism, younger men commonly we find have been in and out of prison for crimes relating to drugs, women very often are victims of abuse at home or in the care system, have run away and turned to drugs and prostitution to support the habit. Women living on the streets are often abused by male rough sleepers. People put into accommodation often do not like it and will return to the streets where their friends are. A minority are entrenched homeless and prefer that way of life. There are numerous other factors relating to homelessness, these are a few of the ones we commonly encounter. People can end up homeless for a variety of reasons, it often follows that alcohol or drugs are consumed to blot out the reality of a desperate situation.

Sign Posting – It has been shown that those taking up the offer of a podiatry service are far more likely to see other health care professionals. People often want to talk about other serious issues they may have, therefore it is useful to have some local phone numbers of for example Rape Crisis, Emergency Shelter,

local GP, Drug and Alcohol advisory service to name but a few. A well set up drop-in centre should have these numbers to hand and staff to deal with them.

Gaining consent now requires a signature, or if easier for the client a tick box (some may not be able to write), medical history taken if possible, but can be difficult as quite often people don't want to tell you any more than their name and date of birth. They are generally quite suspicious or mistrusting at first, medical histories are often if given not accurate, people will lie about infectious disease; therefore treat everyone as high risk. On the notes ensure you have date, treatment given, anything given out and your signature, we currently just use postcards for each person. Always ask permission and gain written consent/signature for photos or video footage, some will refuse, and some will not want their faces in the shot. Ensure any noticeable scarring, tattoos or amputations are not shown, these could identify people who don't want to be found. Also be aware of anything around such as boxes/bags or belongings, with names on that could identify the whereabouts of a person.

Anonymised sharing of foot-health conditions is to be encouraged for the benefit of the practitioners and ultimately the service users; expanding knowledge and learning is important for all involved.

Treatment – Treat as high risk and conservatively. Sharp debridement if necessary, do not over debride reduce the risk of cutting anyone – reduce likely hood of blood contamination, also reduce possibility of them getting an infection which is highly likely due to unsanitary conditions. We use dry dressings if needed, extra care to be taken with possible ulcers – treatment will vary according to patient compliance and whether they are willing to seek further help if required.

Commonly seen complaints – Pitted keratolysis (use plenty of antibacterial spray on this – debride well if necessary), corns, callous (heavy) often with extravasation, fungal skin and nail infections, long thick nails, along with an array of other conditions including quite a few vascular/neurovascular conditions related to drug and alcohol abuse.

Equipment - A basic domiciliary bag is adequate, a headlamp is often useful, plastic aprons and couch roll. Two chairs for operator and patient, a footstool if you have one. It is essential that a suitable decontamination process is adhered

to which includes the use of an autoclave. Chemical sterilisation is neither acceptable nor best practice. Dispose of sharps and single use instruments carefully and appropriately.

Medicaments – Medicated products, including but not limited to Antifungals, Antibacterial and Antimicrobial dressings, creams and powders are supplied when possible, for use by the practitioner only when deemed appropriate under clinical judgment. These products are for use in the treatment environment and are not to be issued to service users.

Safety – Treat all as high risk, beware mental illness isn't always apparent straight away, don't trap yourself in a corner, keep an escape route. If you are on your own keep the door open. Never have anyone between you and the door. Keep only what you need on show, NEVER leave a scalpel with a blade on within easy reach. People are desperate and may try to steal items of value to sell – never leave doms bag unattended and try to ensure a member of staff is within earshot if you are ever on your own. We have treated in a secluded corner of a church as well as in separate rooms. Almost anywhere is possible to offer a simple service, it doesn't need to be in a smart clinic.

It is advisable that you are covered by vaccinations and are up to date with tetanus and Hep B. Take extra care when handling sharps.

Always be kind, this remains one of the most rewarding things you will ever do

Forgotten Feet Charity

Performing a Risk Assessment in your Forgotten Feet service venue

You will need to regularly Risk Assess the venue where your Forgotten Feet team provide a service.

The Royal College of Podiatry has compiled some guidance to assist you with this process. This is combined with the national Health and Safety Executive (HSE) guidance.

Health and Safety Panel 2014

Five steps to risk assessment

This is a web-friendly version of leaflet INDG163(rev3), revised 06/11

This leaflet aims to help you assess health and safety risks in the workplace

A risk assessment is an important step in protecting your workers and your business, as well as complying with the law. It helps you focus on the risks that really matter in your workplace – the ones with the potential to cause real harm. In many instances, straightforward measures can readily control risks, for example ensuring spillages are cleaned up promptly so people do not slip, or cupboard drawers are kept closed to ensure people do not trip. For most, that means simple, cheap and effective measures to ensure your most valuable asset – your workforce – is protected.

The law does not expect you to eliminate all risk, but you are required to protect people as far as 'reasonably practicable'. This guide tells you how to achieve that with a minimum of fuss.

This is not the only way to do a risk assessment, there are other methods that work well, particularly for more complex risks and circumstances. However, we believe this method is the most straightforward for most organisations.

What is risk assessment?

A risk assessment is simply a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm. Workers and others have a right to be protected from harm caused by a failure to take reasonable control measures.

Accidents and ill health can ruin lives and affect your business too if output is lost, machinery is damaged, insurance costs increase or you have to go to court. You are legally required to assess the risks in your workplace so that you put in place a plan to control the risks.

How to assess the risks in your workplace

Follow the five steps in this leaflet:

Step 1
Identify the hazards

Step 2
Decide who might be harmed and how

Step 3
Evaluate the risks and decide on precautions

Step 4
Record your findings and implement them

Step 5
Review your assessment and update if necessary

Don't overcomplicate the process. In many organisations, the risks are well known and the necessary control measures are easy to apply. You probably already know whether, for example, you have employees who move heavy loads and so could harm their backs, or where people are most likely to slip or trip. If so, check that you have taken reasonable precautions to avoid injury.

If you run a small organisation and you are confident you understand what's involved, you can do the assessment yourself. You don't have to be a health and safety expert.

If you work in a larger organisation, you could ask a health and safety advisor to help you. If you are not confident, get help from someone who is competent. In all cases, you should make sure that you involve your staff or their representatives in the process. They will have useful information about how the work is done that will make your assessment of the risk more thorough and effective. But remember, you are responsible for seeing that the assessment is carried out properly.

When thinking about your risk assessment, remember:

- a **hazard** is anything that may cause harm, such as chemicals, electricity, working from ladders, an open drawer etc;
- the **risk** is the chance, high or low, that somebody could be harmed by these and other hazards, together with an indication of how serious the harm could be.

Step 1
Identify the hazards

First you need to work out how people could be harmed. When you work in a place every day it is easy to overlook some hazards, so here are some tips to help you identify the ones that matter:

- **Walk around** your workplace and look at what could reasonably be expected to cause harm.
- **Ask your employees** or their representatives what they think. They may have noticed things that are not immediately obvious to you.
- **Visit the HSE website** (www.hse.gov.uk). HSE publishes practical guidance on where hazards occur and how to control them. There is much information here on the hazards that might affect your business.
- If you are a member of a **trade association**, contact them. Many produce very helpful guidance.
- **Check manufacturers' instructions** or data sheets for chemicals and equipment as they can be very helpful in spelling out the hazards and putting them in their true perspective.
- Have a look back at your **accident and ill-health records** – these often help to identify the less obvious hazards.
- **Remember to think about long-term hazards to health** (eg high levels of noise or exposure to harmful substances) as well as safety hazards.

Step 2
Decide who might be harmed and how

For each hazard you need to be clear about who might be harmed; it will help you identify the best way of managing the risk. That doesn't mean listing everyone by name, but rather identifying groups of people (eg 'people working in the storeroom' or 'passers-by').

In each case, identify how they might be harmed, ie what type of injury or ill health might occur. For example, 'shelf stackers may suffer back injury from repeated lifting of boxes'.

Remember:

- some workers have particular requirements, eg new and young workers, new or expectant mothers and people with disabilities may be at particular risk. Extra thought will be needed for some hazards;
- cleaners, visitors, contractors, maintenance workers etc, who may not be in the workplace all the time;
- members of the public, if they could be hurt by your activities;
- if you share your workplace, you will need to think about how your work affects others present, as well as how their work affects your staff – talk to them; and
- ask your staff if they can think of anyone you may have missed.

Step 3
Evaluate the risks and decide on precautions

Having spotted the hazards, you then have to decide what to do about them. The law requires you to do everything 'reasonably practicable' to protect people from harm. You can work this out for yourself, but the easiest way is to compare what you are doing with good practice.

There are many sources of good practice, for example **HSE's website** (www.hse.gov.uk).

So first, look at what you're already doing, think about what controls you have in place and how the work is organised. Then compare this with the good practice and see if there's more you should be doing to bring yourself up to standard. In asking yourself this, consider:

- Can I get rid of the hazard altogether?
- If not, how can I control the risks so that harm is unlikely?

When controlling risks, apply the principles below, if possible in the following order:

- try a less risky option (eg switch to using a less hazardous chemical);
- prevent access to the hazard (eg by guarding);
- organise work to reduce exposure to the hazard (eg put barriers between pedestrians and traffic);
- issue personal protective equipment (eg clothing, footwear, goggles etc); and
- provide welfare facilities (eg first aid and washing facilities for removal of contamination).

Improving health and safety need not cost a lot. For instance, placing a mirror on a dangerous blind corner to help prevent vehicle accidents is a low-cost precaution considering the risks. Failure to take simple precautions can cost you a lot more if an accident does happen.

Involve staff, so that you can be sure that what you propose to do will work in practice and won't introduce any new hazards.

Step 4
Record your findings and implement them

Putting the results of your risk assessment into practice will make a difference when looking after people and your business.

Writing down the results of your risk assessment, and sharing them with your staff, encourages you to do this. If you have fewer than five employees you do not have to write anything down, though it is useful so that you can review it at a later date if, for example, something changes.

When writing down your results, keep it simple, for example 'Tripping over rubbish: bins provided, staff instructed, weekly housekeeping checks', or 'Fume from welding: local exhaust ventilation used and regularly checked'.

We do not expect a risk assessment to be perfect, but it must be suitable and sufficient. You need to be able to show that:

- a proper check was made;
- you asked who might be affected;
- you dealt with all the significant hazards, taking into account the number of people who could be involved;
- the precautions are reasonable, and the remaining risk is low; and
- you involved your staff or their representatives in the process.

There is a template at the end of this leaflet that you can print off and use.

If, like many businesses, you find that there are quite a lot of improvements that you could make, big and small, don't try to do everything at once. Make a plan of action to deal with the most important things first. Health and safety inspectors acknowledge the efforts of businesses that are clearly trying to make improvements.

A good plan of action often includes a mixture of different things such as:

- a few cheap or easy improvements that can be done quickly, perhaps as a temporary solution until more reliable controls are in place;
- long-term solutions to those risks most likely to cause accidents or ill health;
- long-term solutions to those risks with the worst potential consequences;
- arrangements for training employees on the main risks that remain and how they are to be controlled;
- regular checks to make sure that the control measures stay in place; and
- clear responsibilities – who will lead on what action, and by when.

Remember, prioritise and tackle the most important things first. As you complete each action, tick it off your plan.

Step 5
Review your risk assessment and update if necessary

Few workplaces stay the same. Sooner or later, you will bring in new equipment, substances and procedures that could lead to new hazards. It makes sense, therefore, to review what you are doing on an ongoing basis. Every year or so formally review where you are, to make sure you are still improving, or at least not sliding back.

Look at your risk assessment again. Have there been any changes? Are there improvements you still need to make? Have your workers spotted a problem? Have you learnt anything from accidents or near misses? Make sure your risk assessment stays up to date.

When you are running a business it's all too easy to forget about reviewing your risk assessment – until something has gone wrong and it's too late. Why not set a review date for this risk assessment now? Write it down and note it in your diary as an annual event.

During the year, if there is a significant change, don't wait. Check your risk assessment and, where necessary, amend it. If possible, it is best to think about the risk assessment when you're planning your change – that way you leave yourself more flexibility.

Some frequently asked questions

What if the work I do tends to vary a lot, or I (or my employees) move from one site to another?
Identify the hazards you can reasonably expect and assess the risks from them. This general assessment should stand you in good stead for the majority of your work. Where you do take on work or a new site that is different, cover any new or different hazards with a specific assessment. You do not have to start from scratch each time.

What if I share a workplace?
Tell the other employers and self-employed people there about any risks your work could cause them, and what precautions you are taking. Also, think about the risks to your own workforce from those who share your workplace.

Do my employees have responsibilities?
Yes. Employees have legal responsibilities to co-operate with their employer's efforts to improve health and safety (eg they must wear protective equipment when it is provided), and to look out for each other.

What if one of my employee's circumstances change?
You'll need to look again at the risk assessment. You are required to carry out a specific risk assessment for new or expectant mothers, as some tasks (heavy lifting or work with chemicals for example) may not be appropriate. If an employee develops a disability then you are required to make reasonable adjustments. People returning to work following major surgery may also have particular requirements. If you put your mind to it, you can almost always find a way forward that works for you and your employees.

What if I have already assessed some of the risks?
If, for example, you use hazardous chemicals and you have already assessed the risks to health and the precautions you need to take under the Control of Substances Hazardous to Health Regulations (COSHH), you can consider them 'checked' and move on.

Getting help

If you get stuck, don't give up. There is a wealth of information available to help you. More information about legal requirements and standards can be found on our website at: www.hse.gov.uk, and in particular in our publications (available from HSE Books):

Essentials of health and safety at work (Fourth edition) HSE Books 2006
ISBN 978 0 7176 6179 4

Health and safety made simple HSE 2011
www.hse.gov.uk/simple-health-safety/index.htm

Company name: **Date of risk assessment:**

Step 1 What are the hazards?

Spot hazards by:

- walking around your workplace;
- asking your employees what they think;
- visiting the *Your industry* areas of the HSE website;
- checking manufacturers' instructions;
- contacting your trade association.

Don't forget long-term health hazards.

Step 2 Who might be harmed and how?

Identify groups of people. Remember:

- some workers have particular needs;
- people who may not be in the workplace all the time;
- members of the public;
- if you share your workplace think about how your work affects others present.

Say how the hazard could cause harm.

Step 3 What are you already doing?

List what is already in place to reduce the likelihood of harm or make any harm less serious.

What further action is necessary?

You need to make sure that you have reduced risks 'so far as is reasonably practicable'. An easy way of doing this is to compare what you are already doing with good practice. If there is a difference, list what needs to be done.

Step 4 How will you put the assessment into action?

Remember to prioritise. Deal with those hazards that are high-risk and have serious consequences first.

Action by whom	Action by when	Done

Step 5 Review date:

- Review your assessment to make sure you are still improving, or at least not sliding back.
- If there is a significant change in your workplace, remember to check your risk assessment and where necessary, amend it.

Further information

For information about health and safety, or to report inconsistencies or inaccuracies in this guidance, visit www.hse.gov.uk/. You can view HSE guidance online and order priced publications from the website. HSE priced publications are also available from bookshops.

This leaflet contains notes on good practice which are not compulsory but which you may find helpful in considering what you need to do.

This leaflet is available in priced packs from HSE Books, ISBN 978 0 7176 6440 5. A web version can be found at: www.hse.gov.uk/pubns/indg163.pdf.

SEVERITY CONSEQUENCE INDEX

SEVERITY

"Domains"	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
Objectives and projects	▪ Barely noticeable reduction in scope / quality / schedule	▪ Minor reduction in scope / quality / schedule	▪ Reduction in scope or quality, project objectives or schedule.	▪ Significant reduction in ability to meet project objectives or schedule.	▪ Inability to meet project objectives, reputation of the organisation seriously damaged and failure to appropriately manage finances.
Injury (physical and psychological) to patients staff.	▪ Adverse event leading to minor injury not requiring first aid.	▪ Minor injury or illness, first-aid treatment needed. No staff absence required.	▪ Significant injury requiring medical treatment and/or counselling.	▪ Major injuries or long term incapacity/ disability (loss of limb), requiring medical treatment and/or counselling.	▪ Incident leading to death or major permanent incapacity.
Patient experience or outcome	▪ Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.	▪ Unsatisfactory patient experience / clinical outcome directly related to care provision – readily resolvable	▪ Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery < 1Wk	▪ Unsatisfactory patient experience / clinical outcome, long term effects - expect recovery > 1Wk	▪ Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects.
Complaints / claims	▪ Locally resolved complaint	▪ Justified complaint peripheral to clinical care	▪ Below excess claim. ▪ Justified complaint involving lack of appropriate care.	▪ Claim above excess level. ▪ Multiple justified complaints.	▪ Multiple claims or single major claim.
Staffing and competence	▪ Short term low staffing level (< 1 day), where there is no disruption to patient care.	▪ Ongoing low staffing level results in minor reduction in quality of patient care ▪ Minor error due to ineffective training / implementation of training.	▪ Late delivery of key objective / service due to lack of staff. ▪ Moderate error due to ineffective training / implementation of training. ▪ Ongoing problems with staffing levels	▪ Uncertain delivery of key objective / service due to lack of staff. ▪ Major error due to ineffective training / implementation of training.	▪ Non delivery of key objective / service due to lack of staff. ▪ Loss of key staff. ▪ Critical error due to insufficient training / implementation of training.

Service / business interruption	▪ Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	▪ Short term disruption to service with minor impact on patient care.	▪ Some disruption in service with unacceptable impact on patient care. ▪ Temporary loss of ability to provide service.	▪ Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	▪ Permanent loss of core service or facility. ▪ Disruption to facility leading to significant "knock on" effect.
Financial	▪ Negligible organisational financial loss (£< 1k).	▪ Minor organisational financial loss (£,1-10k).	▪ Significant organisational financial loss (£,10-100k).	▪ Major organisational financial loss (£,100k-1m).	▪ Severe organisational financial loss (£>1m).
Inspection / assessment / audit	▪ Small number of recommendations which focus on minor quality improvement issues.	▪ Minor recommendations made which can be addressed by low level of management action.	▪ Challenging recommendations but can be addressed with appropriate action plan.	▪ Enforcement Action. ▪ Low rating. ▪ Critical report.	▪ Prosecution. ▪ Zero Rating. ▪ Severely critical report.
Adverse publicity / reputation	▪ No media coverage, little effect on staff morale.	▪ Local Media – short term. ▪ Minor effect on staff morale / public attitudes.	▪ Local Media – long term. ▪ Impact on staff morale and public perception of the organisation.	▪ National Media (< 3 days). ▪ Public confidence in the organisation undermined. ▪ Usage of services affected.	▪ National Media (> 3 days). ▪ MP / MSP Concern (Questions in Parliament).
Organisational / Personal Security, and Equipment	▪ Damage, loss, theft (£< 1k).	▪ Damage, loss, theft ▪ (£,1-10k).	▪ Damage, loss, theft ▪ (£,10-100k).	▪ Damage, loss, theft ▪ (£,100k-1m).	▪ Damage, loss, theft (£>1m).

Likelihood

	1 **Remote**	2 **Unlikely**	3 **Possible**	4 **Likely**	5 **Almost Certain**
Probability	▪ Will only occur in exceptional circumstances.	▪ Unlikely to occur but definite potential exists.	▪ Reasonable chance of occurring – has happened before on occasions.	▪ Likely to occur – strong possibility.	▪ The event will occur in most circumstances.

Risk Rating

LIKELIHOOD	SEVERITY				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
5 Almost Certain	**5**	**10**	**15**	**20**	**25**
4 Likely	**4**	**8**	**12**	**16**	**20**
3 Possible	**3**	**6**	**9**	**12**	**15**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
1 Remote	**1**	**2**	**3**	**4**	**5**

Grade of incident	Risk	Actions
Low (1-3)	Acceptable	No further preventative action is necessary, but consideration should be given to more cost-effective solutions or improvements that impose no additional cost burden. Monitoring is required to ensure that the controls are maintained
Moderate (4-9)	Action Required	Efforts should be made to reduce the risk, but the cost of reduction should be carefully measured and limited. Risk reduction measures should normally be implemented within three to six months
High (10-15)	Immediate Action Required Unacceptable	If a new activity or process, it should not be started until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk. Where the risk involves an existing activity or process, the problem should normally be remedied within one to three months.
Very High (16-25)	Immediate Action Required Intolerable	The activity or process should not be started or allowed to continue until the risk level has been reduced. While the control measures selected should be cost-effective, legally there is an absolute duty to reduce the risk. This means that if it is not possible to reduce the risk even with unlimited resources, then the activity or process must not be begin, or must remain prohibited.

Risk Matrix

Likelihood		Rare	Unlikely	Possible	Likely	Almost Certain
Consequence		1	2	3	4	5
Catastrophic	5	5 Amber	10 DK Amber	15 Red	20 Red	25 Red
Major	4	4 Amber	8 DK Amber	12 DK Amber	16 Red	20 Red
Moderate	3	3 Green	6 Amber	9 DK Amber	12 DK Amber	15 Red
Minor	2	2 Green	4 Amber	6 Amber	8 DK Amber	10 DK Amber
Negligible	1	1 Green	2 Green	3 Green	4 Amber	5 Amber

Grade	Risk Score	Timescales for Implementing Actions and Reducing the Initial Risk Score
Red	15-25	Risks falling into this category require urgent and immediate action. Mitigating actions should reduce the initial risk score within one month. These risks are reported quarterly to Risk Management Board and Board of Directors
Dark Amber	8-12	Mitigating actions to be implemented as soon as possible, but no later than six months. These risks are reported quarterly to Risk Management Board.
Amber	4-6	Mitigating actions to be implemented as soon as possible, but no later than the next financial year
Green	1-3	Quick, easy measures implemented immediately. Further actions planned for when resources permit.

CONSEQUENCE RATING (Severity of impact if it occurs)

Score	Description	
1	**Negligible**	• Adverse event requiring no / minimal intervention or treatment • Short term low staffing level (<1 day) – temporary disruption to patient care • Small financial loss <£1K • Loss / interruption of >1 hour; no impact on delivery of patient care / ability to provide services • Information Governance – Final score less than or equal to zero (<=0) • Potential for public concern
2	**Minor**	• Minor injury or illness – first aid treatment needed • Member of staff off work for <3 days • Increase in length of hospital stay by 1-3 days • On-going low staffing level – minor reduction in quality of patient care • Financial loss <£1K - £50K • Short term disruption, of >8 hours, with minor impact • Information Governance – Final score equal to 1 (=1) • Local media coverage – short term reduction in public confidence
3	**Moderate**	• Moderate injury or illness requiring professional intervention to resolve the issue • RIDDOR / Agency reportable incident • Increased length of hospital stay by 4-15 days • On-going low staffing resulting in moderate reduction in the quality of patient care • Financial loss £50K - £500K • Loss / interruption of >1 day causing an impact on the delivery of patient care • Information Governance – Final score greater than or equal to two but less than five (.=2 and <5) • Local media coverage – long term reduction in public confidence
4	**Major**	• Major injury / long term incapacity / disability (e.g. loss of limb) • Member of staff off work for >14 days • Increased length of hospital stay >15 days • Unsafe staffing level leading to a temporary service closure <5 days • Financial loss £500K - £1M • Loss / interruption of >1 week causing a serious impact on the delivery of patient care resulting in contingency plans being invoked • Information Governance – Final score greater than or equal to five and less than thirteen (>=5 and <13) • National media coverage with <3 days service well below reasonable public expectation
5	**Catastrophic**	• Incident leading to death • Multiple permanent injuries or irreversible health effects • Loss of several significant service critical staff leading to a service closure >5 days • Financial loss >1M • Permanent loss of core services / facility • Information Governance – Final score greater than or equal to thirteen (>=13) • Total loss of public confidence

For further descriptors refer to pages 8 – 12 of A Managers Guide to Risk Assessment

General Risk Assessment Form

Trust Site		**Reason for writing a Risk Assessment (please tick box ✓)**		**Date**	
Division		**Hazard Identification**		**Risk Assessor(s) (Name & Designation)**	
		Complaint			
Ward / Department / Service Area		**Incident Report**		**Risk Owner (Name & Designation)**	
		Health & Safety			
		NPSA / NICE Guidance			

Risk ID	

What is the Risk? Description of Hazard (x), Hazardous Event (y) and Result (z)

(Example – please delete when completing the form: Lack of skilled staff often occur at night (x) due to chronic staff shortages (y) resulting in clinical errors (z))

Who or What is at Risk? (Approx. Numbers)	**Possible impact of not addressing the risk**	**Control Measures / Actions already in place *(Mitigation)***	**C**	**L**	**Current Risk Score C x L = RS**

Control Measures / Actions required to eliminate or reduce the risk *(Contingency)*	**Responsibility**	**Completion Date**

Monitoring Group / Committee	**Frequency of Monitoring (will depend on Risk Score)**	**Residual Risk Score – after new controls are implemented**		
		C	**L**	**Risk Score C x L = RS**
Review Date				
Date added to the Risk Register				

Risk Assessment & Action Plan

Clinical Site	**Address of clinic**	**Reason for writing a Risk Assessment Your evidence (please tick box)**		**Date**		**Risk I.D.**	
		Incident report		**Risk Assessor(s)**			
Service Area	**Podiatry**	**Complaint**					
		Health & Safety Audit		**Risk Owner**			

What is the Risk? Description of Hazards and Hazardous Event (Task/activity: Area: Equipment: Individual)

The risk of sharp injury to staff and patient from using a basic Scalpel Handle (no additional safety features)

Who or What is at Risk? (Approx. numbers)	Possible impact of not addressing the Risk	Control Measures/Actions Presently in Place	C	L	Risk Score C X L =Risk Score
? staff ? potential pts	Increased numbers of sharp injury from a surgical blade due to design of Granton retractable blade safety handle. This might be superficial skin injury to the patient or a risk of a blood born pathogen being transferred from patient to staff. This may be a frequent risk should the podiatry department use this product on a regular basis	Stainless steel scalpel handles which need to be loaded and unloaded with a surgical blade using a blade holder. Review processes regularly & review new devices as available.	4	1	4
		Frequency of Monitoring (will depend on scoring)			

Controls/Actions required to eliminate or reduce the risk	Who is responsible	Completion date
Granton retractable safety handle was piloted in the department Handle is a new design as part of EU regulations on sharps. Handle is clumsy to use inappropriately designed for Podiatry debridement. The blade wobbles in the plastic handle which is designed in way that it is difficult to control the blade. If a member of staff is left handed they cannot use the clip to retract the blade as it is on the wrong side which means they have to swap hands with the blade uncovered in order to get to the clip to retract the blade back		

Risk Score after new controls are implemented			Review Date		Date added to the risk register	
C	L	Risk Score C x L = RS	Signature of Risk Assessor(s)		Title	
4	1	4	Signature of Risk Owner		Title	

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Mental Health "Conditions" and "Illnesses"

There is no real difference between an *illness* and a *condition*. Most people with long-term mental health needs will have temporary periods of "illness" in which they experience acute distress / other symptoms, combined with periods of stability when they are symptom-free.

Other people with mental health needs may constantly display symptoms, normally as a result as long-term avoidance of treatment in which their symptoms eventually become enmeshed with their personality. Many people in the homeless community would fall into this category. This might appear to others as a "condition".

Mental Illness and the homeless population

Many people in the homeless community will be experiencing trauma (frequently referred to a PTSD) as a result of negative life experiences, especially in childhood. Very high numbers of people with mental health issues have often experienced childhood sexual abuse. Often their symptoms will present as "flashbacks" to the traumatic event. Whilst medication (prescribed and illicit) can dampen the symptoms, normally a person needs to engage in counselling or longer-term therapy to support their recovery. Unfortunately, the NHS has very long waiting times for therapy.

On a similar note, many people will be experiencing depressive symptoms including feelings of worthlessness, hopelessness, and low motivation. Recent research has suggested that anti-depressant medication is beneficial for many people, especially if combined with a talking therapy such as Cognitive Behavioural Therapy (CBT).

You are likely to meet people who have been diagnosed with a "personality disorder". This can be a controversial diagnosis that is often applied to people who struggle to maintain relationships (emotionally unstable personality disorder) or whose behaviour can be challenging for others (anti-social personality disorder). Again, there are often roots with childhood trauma. Generally, mental health services can be reluctant to support people with a

personality disorder and they are sometimes considered to be “untreatable”. Traditional treatment approaches such as medication or CBT can have limited benefits and frequently people benefit from long-term specialist psychological interventions.

At the acute end of the spectrum, some people will be experiencing “psychotic” symptoms which are defined as experiencing sensory hallucinations or delusional beliefs. Sometimes, these persons may have a diagnosis of Schizophrenia or be experiencing the “manic” phase of a Bi-Polar illness. If these symptoms are severe then effective treatment will normally involve strong tranquiller medication. Many people are reluctant to take this medication due to the numerous side-effects including sedation, weight-gain and muscle spasms.

Diagnosis of these mental health conditions requires specialist psychiatric or psychological assessment. If they are registered, a person’s GP would normally be the initial pathway for accessing further assessment and treatment.

Assessment

We suggest that at the outset of the conversation, you probably need to reassure the person that what they tell you will be confidential. **However, you need to be clear that if they tell you information that indicates that they are a danger to themselves or other people, then you may have to pass this on to other organisations.**

It is advisable to state that it is up to them how much information they wish to share. Explain that you will have to ask some potentially awkward questions, but reassure them that they do not have to answer; “you’re in charge here…” etc

Having done this, I would start with asking open questions…. “how can we help you today?”; “what specific problems are you experiencing”. Once they are talking, you can move on to more direct and closed questions.

If someone is reluctant to speak then it would be appropriate to respect this and back off, whilst gently explaining that it may be difficult to give them to right help without full information.

Risks of Suicide

The best longer-term indication of the risk of suicide is whether the person has made **previous** suicide attempts and the severity of these attempts. This should be combined with directly asking a person whether they have any **current** suicidal ideas and plans (these questions probably need to be gently weaved into the conversation once rapport has been established- see above).

Appropriate questions to ask:

(i) "Do you every feel like hurting or killing yourself?"
(ii) "Do you have a specific plan to act?"
(iii) "What is the likelihood of you acting on this plan in the next …" (week / months)? (Maybe ask for a score 1-10).
(iv) "What has stopped you from acting on this plan so far?" (these are referred to as "protective factors")
(v) "Would you be agreeable to seeking help?"
(vi) "Can you give me an assurance you will keep yourself safe until ….?" (a safety plan can be put in place)

If a person has a clear plan **and** a current intention to act, then they will need to be signposted to urgent mental health support. In most cases and if they are registered, we suggest speaking to their GP or duty Doctor at the surgery to pass on this information and making a written record of the conversations.

If the person is willing to attend A&E, then they will be able to access an assessment from a mental health professional 24/7.

If the person is known and currently open to the local Mental Health Trust, then it may be worthwhile speaking to the local Home-Based Treatment Team (sometimes known as the "Crisis Team") to get advice about managing the situation.

If the person is wholly unwilling to seek help and you have concerns that a person is at immediate risk, then we suggest contacting the police requesting their immediate support. The police have powers under Section 136 of the Mental Health Act to take a person experiencing severe mental distress to a place of safety for an assessment.

Staying safe

In terms of the risks of aggression from people with mental health needs, research would indicate that the main risk factors are a past history of violence, substance use, non-adherence with medication and disengagement from mental health services. These factors may apply to a large proportion of the homeless community.

In terms of behavioural cues, the main ones appear to be intense staring; postural tension; clenching jaw and hands; increasing volume and speed of speech; allied with the clear expression of paranoid ideas about a specific person.

In this situation, try to maintain safe distance from the person and consider exits to the room. Try to de-escalate by using a calm tone and possibly slowing down your speech. Try not to challenge the person if they are experiencing bizarre / psychotic ideas, it may be helpful to empathise with the person's distress … "that sounds very distressing…"; or "I'm really sorry to hear that".

Avoid providing an intervention to someone who is *substantially* intoxicated. Not only from the risk standpoint, but also due to the fact that it is near impossible to gain informed consent.

What can we do if someone doesn't have capacity but has come for treatment?

The Mental Capacity Act Code of Practice 6.34 to 6.35 indicates that if you have *reasonable belief* that a person lacks capacity then you can provide treatment in their "best interests" under the MCA sections 5.

Forgotten Feet Charity

In terms of record keeping, you would need to record what information you have given the person and what evidence there is that they are unable to understand and/or retain and /or weigh the information you have provided. It would still be necessary to record the person's views about the proposed treatment and the views of any other person(s) who provides support for them.

We are looking to ensure Forgotten Feet not only exists but also thrives as a successful charity. In order to do this, we need to prove the value of our service by collecting some data. We have put together a sheet which only requires a few ticks (see the separate document `Forgotten Feet Data Sheet`) and would appreciate it if you could complete this approximately every 6 months. **We are collecting information on 'treatments' provided, rather than patient details to ensure anonymity**. It may require you to check with the service user that you can collect such data and reassure them that it is completely anonymous.

Once again, thank you for your kind generosity in offering your valuable time and skills as a volunteer. It really is appreciated by us as a charity, but more so by the vulnerable people who really do value the care that you will provide.

Our ethos is to always be kind.

The Forgotten Feet Committee

Registered Charity 1179671