NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

RISK MANAGEMENT POLICY

POLICY NO & CATEGORY	RS 01	Risk & Safety
VERSION NO & DATE	15	November 2021
RATIFYING COMMITTEE	Clinical Governance Committee	
DATE RATIFIED	December 2021	
NEXT REVIEW DATE	December 2024	
EXECUTIVE DIRECTOR	Executive Director of Nursing	
POLICY LEAD	Associate Director of Governance	
POLICY AUTHOR *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	Yes	

POLICY CONTEXT

The Policy applies to all staff - **including** HMP Birmingham Healthcare staff and persons engaged in business on behalf of the Trust.

POLICY REQUIREMENT

- All staff members are responsible for ensuring that risks are identified, assessed and managed.
- All staff are responsible for highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role responsibilities.
- All operational service areas and Executive Directors should systematically review risks on their risk registers on a quarterly basis, identify controls for mitigation and evaluate their effectiveness. All risks with a score of 15 and above will be reported to the Clinical Governance Committee on a quarterly basis. All risks with a severity impact of 5 will also be reported. Risk moderation may take place at this Committee to determine whether any of the high scoring local risks will compromise delivery of the Trusts corporate objectives and business plan. All risks which could significantly compromise the Trust's ability to deliver its corporate objectives and business plan will be reviewed on a quarterly basis by the Integrated Quality Committee, People Committee and FPP and will inform the Board Assurance Framework.
- The Trust Board will review the Board Assurance Framework inclusive of the high scoring risks compromising delivery of strategic objectives on a quarterly basis.
- Risks will be assessed against the identified risk scoring matrix, regularly reviewed and appropriate actions taken in line with the Trust risk thresholds.

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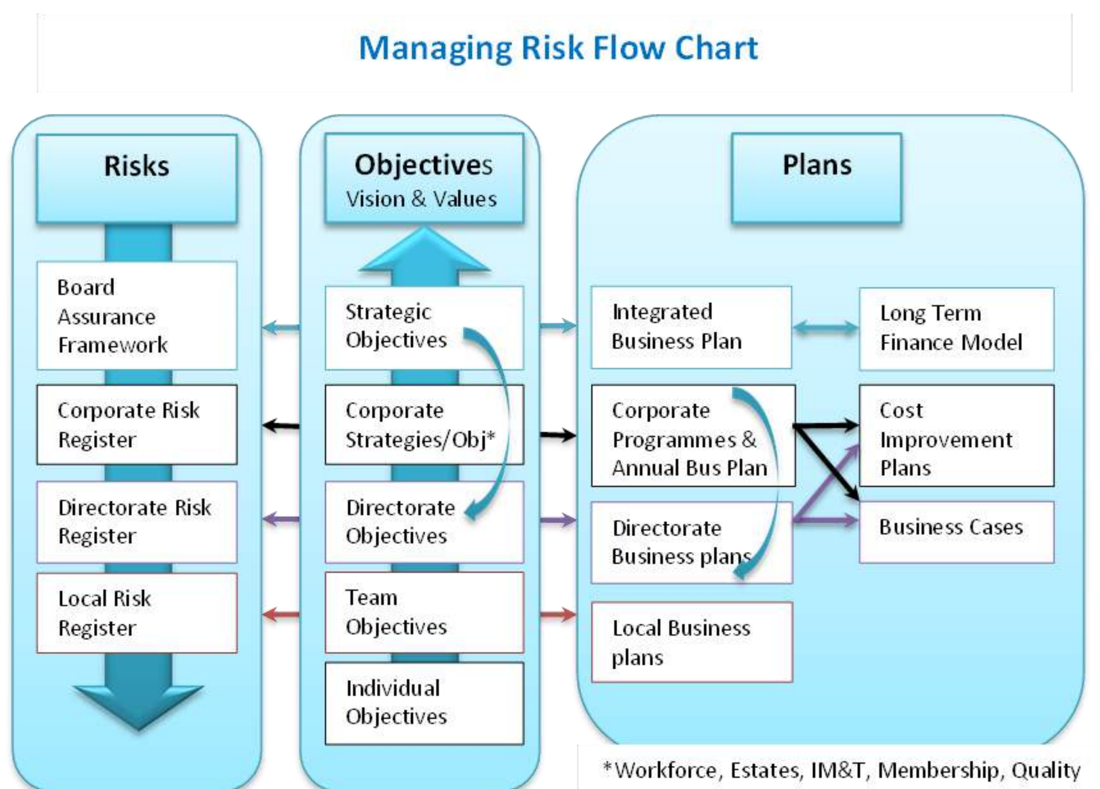
1 Introduction

1.1 Rationale

Risk is the chance that something will happen that will have an adverse impact on the achievement of the Trusts aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity/consequence (impact or magnitude of the effect of the risk occurring)

(Adapted from the Australian/New Zealand Standard AS/NZS 4360:1999)

Culture and leadership in the NHS and its importance in the provision of safe, effective, responsive high-quality care has never been stronger, as is our duty to highlight and close the gap in recognised health inequalities. As a large innovative Trust, we recognise that risk will always be present in the things that we do. The aim of this policy is to ensure that we actively understand risk, recognise risk, and know how to report, review, and manage risks to support the overall aims of the organisation. This means that we look at risk at all levels ranging from the risks to delivery of our most strategic aims, through to the day-to-day delivery of team-based objectives which in turn contribute to the bigger picture. This is demonstrated in the pictorial diagram below: -



Good risk management goes to the heart of what we do in the Trust. We need to be open, honest, and aware of the risks we are facing on a day-to-day level as well as strategically. The consequences for staff, service users, their carers, and families and the wider public when risks are not highlighted and managed were brought into sharp focus following the inquiry into failings at Mid Staffordshire NHS Foundation Trust.

In large complex organisations such as ours, managing risk can seem a daunting task. It is, however, inherent in everything that we do, and we largely manage risk successfully every day. It is not a new challenge and because it forms a part of our everyday work, the key is to manage risk at all levels in a simple, effective, transparent, and consistent way. This Risk Management Policy provides a clear framework for the effective and timely management of risks. Sound recording and escalation mechanisms are described for departmental risks, wider locality service area risks and Trust wide risks. The policy also describes the roles and responsibilities of individuals in delivering good risk management as well as the overarching governance structure for reporting of risks.

1.2 Scope

The Policy applies to all staff including HMP Birmingham Healthcare staff and persons engaged in business on behalf of the Trust.

The Trust works in partnership with Birmingham Community Healthcare to ensure individuals with learning disabilities have full and equal access to the full range of mental health services. Therefore, all aspects of this policy equally apply to service users with learning disabilities. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately to support this.

1.3 Principles

The Trust's approach recognises

- The need to ensure that risks are openly discussed and reported within a culture of improvement, honesty, and reality.
- The need to strike a balance between stability and innovation. In a changing and challenging environment, risk management helps to create and seize opportunities in a managed way e.g. by considering alternative actions to those originally intended. Some risks will always exist and will never be eliminated; all staff must understand the nature of risk and accept responsibility for the management of risks associated within their area of authority.

2 POLICY

2.1 All staff members are responsible for ensuring that risks are identified, assessed and managed.

2.2 All staff are responsible for highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role responsibilities.

2.3 The consequence and likelihood of risk occurrence will be assessed against the Trust wide risk scoring matrix (Appendix 1). This matrix is based on best practice and supported by the National Patient Safety Agency. Risks will be recorded on risk registers via the Eclipse electronic risk management system.

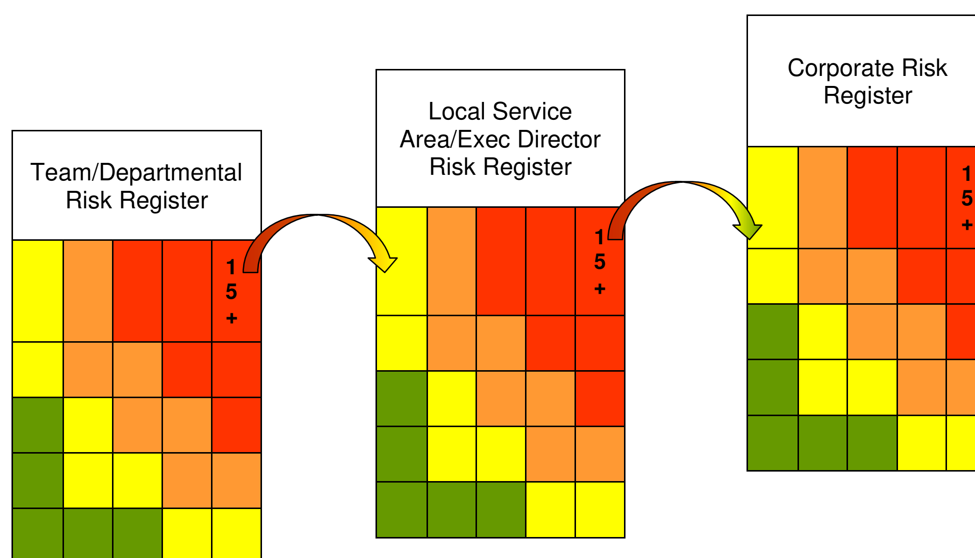
2.4 All local service areas and Executive Directors should systematically review risks on their risk registers on a quarterly basis and provide assurance that the risks are being managed through their local clinical governance committees. Where

risks cannot be managed this should be escalated to line managers. Local service areas and corporate support teams will report on any risks with a score of 15 or above on a quarterly basis through the Clinical Governance Committee. The Clinical Governance Committee will consider risk moderation to any risks with a score of 15 and above to determine whether these could impact on the delivery of the Trust's corporate objectives and business plan.

2.5 All risks which could significantly compromise the delivery of the Trust's corporate objectives/business plan will be recorded onto the Corporate Risk Register. The Corporate Risk Register will be presented in full to the Integrated Quality Committee, People Committee and FPP on a quarterly basis.

2.6 Risks scores of 15 or above on the Corporate Risk Register will be reported to the Trust Board on a quarterly basis as part of the Board Assurance Framework

Escalation in the Risk Register Hierarchy



3 Procedure:

The Trusts overall approach to risk management reflects three key stages:

- Risk Identification
- Risk Analysis
- Risk Control

3.1 Risk Identification:

The identification of risk needs to be dynamic process, which involves all staff and ensures that action is taken before incidents/actual loss or harm have occurred. Risks may be clinical or non-clinical risks, including financial risks and reputational risks. Risks can become apparent from many sources, included but not limited to:

Internal sources

- risk assessment including work place assessment,
- clinical risk assessment,

- organisational objectives, KPI’s,
- consultation of staff and patients,
- incidents, complaints, and review of litigation cases
- incident or complaint trends
- serious incident recommendations
- Family and Friends Test feedback
- internal inspections and audits,
- infection control,
- safeguarding
- information governance

External sources

- Regulatory standards and inspection feedback (CQC)
- Central Alerting System (CAS),
- Mandatory and statutory targets,
- National enquiry reports
- External audit reports and findings,
- External safeguarding reviews
- Health and Safety Executive (HSE)
- National Survey Results
- NHS Improvement
- NICE
- National Benchmarking Exercises
- Audit Commission, National Patient Safety Agency (NPSA),
- Coroner reports
- Failings in other organisations

Managed change

- Any managed change generated within the Trust should be risk assessed before, during and after the change occurs. Significant Projects will be managed through the Project Management Office where risk & issue logs and Clinical Quality and Equality impact assessments are documented, assessed, and managed by the project teams. All projects are reviewed by the Transformation Committee who provide oversight, assurance and governance of all risks and impact assessments relating to the Projects. Risk assessments should be undertaken using the 5x5 risk scoring matrix.
    - Risks with a score of 9 or above should be reported to the Transformation Committee who will undertake a review of the risk and its impact on the delivery of Trust corporate objectives and the business plan. Risk moderation will take place at this stage to determine those risks to be included on the Corporate Risk Register for escalation to the Integrated Quality Committee and Trust Board.
    - Risk with a score of 3 or above should be formally documented on local project risk registers and reviewed by relevant Project Boards/teams.

3.2 **Risk Analysis:**

Key risks identified in line with 3.1 above will be recorded on local risk registers which are accessible on the Trust wide electronic Eclipse system.

3.3 **Risk Control**

Following identification and analysis of any risk, a decision will need to be made as to whether the Trust can avoid, reduce, eliminate, accept/retain or transfer the risk.

Avoid: Whether a particular task can be undertaken a different way so that the risk does not occur.

Reduce: Whether action can be taken to reduce, as far as possible, the probability or impact of the risk exposure.

Eliminate: Whether definitive action can be taken to eliminate the risk exposure.

Accept/Retain: Whether the level of risk is acceptable as no further mitigating actions can be taken, or the extent of actions to be taken outweighs the consequence of the risk occurring. Risks that are accepted will continue to form part of our review and reporting processes.

Transfer: Whether the risk can be transferred to another organisation

Where further actions are required to avoid, eliminate or reduce the risk, these actions must be entered onto the risk register along with the date by which the action will be implemented and the individual responsible for assuring delivery of the action.

4 Responsibilities

Post(s)	Responsibilities	Ref
All Staff	All staff should be aware of risk assessment findings and risk management measures, which affect their practice and professional needs. They must inform their line managers of risks deemed to be unacceptable and / or outside of their ability to manage. In addition, all staff (permanent and temporary) must • Report incidents/accidents and near misses in a timely manner and in accordance with Incident reporting policies via eclipse • Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of others who may be affected by the Trust's business. • Comply with all Trust policies and procedures and any other instructions / guidelines to protect the health, safety, and welfare of anyone affected by the Trust's business	
Executive Director & Trust Board	**The Chief Executive** maintains overall accountability for risk management within the Trust	

	but will delegate responsibility to nominated Executive Directors of the Trust Board. **The Director of Nursing (on behalf of the Chief Executive)** is the Executive Director responsible for co-ordinating the management of risk and for ensuring that risks are escalated through the risk management governance structure. The Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management. **The Director of Finance** has delegated responsibility for internal financial controls and the implementation of financial risk management, procurement, information management systems, information governance, communications, the programme management office, and estates and facilities (managed within the subsidiary organisation SSL). **The Director of Operations** has overall responsibility for the management and co-ordination of all operational risks including business continuity and emergency planning **The Director of Strategy, People and Partnerships** has overall responsibility for risks relating to People, Organisational Development and Capability, Learning and Development, Business and Strategic Planning and Strategic Partnerships. The **Company Secretary** has overall responsibility for the reporting to Trust Board of the assurance framework, reflecting the high scoring risks identified in Trust risk registers. **Associate Directors of Operations/Clinical Directors/ Heads of Service/Associate Directors of Corporate Support Services will be responsible for** • Implementing Trust approved operational policies, standards, guidelines, and procedures within their area of responsibility and ensuring these are understood by staff. • Ensuring that risk assessments are undertaken liaising with appropriate professionals as appropriate. • Ensuring that an up-to-date record of staff's attendance at, and compliance with, statutory and mandatory training is maintained as per the Risk Management Training Policy. • Implementing and monitoring any identified, and appropriate, control measures to mitigate risk within their scope of responsibility.	

	• Ensuring that identified risks are recorded on the risk register as appropriate within their domain and reported through local governance structures to the Clinical Governance Committee on a quarterly basis. • Overseeing the development and monitoring of an action plan to mitigate identified risks on the risk register. It is fundamental that risk management is accepted as a line management responsibility. Managers at all levels must adopt this approach, own the process, and act, both proactively and retrospectively, to identify, assess, and manage any risk issues affecting their unit, departments, wards or services. It is also important that managers stimulate the interest of their staff in the identification and reporting of hazards and risk and those managers respond positively to this. **Clinical Nurse / Service Managers / Team Managers, Matrons and Ward Managers** have a responsibility to ensure that they and their staff group / teams are fully aware of the Trust approach to risk management. They will • Ensure that risk assessment findings are disseminated to team members and action plans are developed and implemented to eliminate/ reduce /isolate /control the identified risks. • Identify risks on the risk register and contribute to the development and implementation of mitigation actions to reduce the likelihood of the risk occurring **Clinicians / practitioners will** • Provide safe clinical practice • Maintain professional registration with the relevant governing professional bodies • Adhere to relevant professional Codes of Practice • Maintain - and keep records to evidence - up to date competencies, skills and knowledge • Assess clinical risk using Trust approved clinical risk assessment tools • Contribute to the identification of risks which may need to be included on local risk registers **Freedom to Speak Up Guardian *will*** • Escalate any risks associated with FTSU activity • Work with relevant leaders to ensure that these are registered and managed in line with this policy	

Joint Working Responsibilities	It is often at the interface between organisations that the highest risks exist, and clarity about responsibilities and accountabilities for those risks can be most difficult to ascertain. Only by working closely and collaboratively with a wide range of partner organisations can these risks be identified and properly managed. The Trust currently works closely with key stakeholders and will endeavour to involve partner organisations in all aspects of risk management. Key partners include: • Governors • Clinical Commissioning Groups • NHS Improvement/England • Birmingham City Council • Solihull Metropolitan Borough City Council • Safeguarding Boards (Birmingham & Solihull) • West Midlands Police • Statutory and voluntary bodies • Service user and carer groups. • HMP Birmingham • Other NHS organisations Providers of shared service to the Trust (including collaborative partners e.g. Reach Out)	

Associate Director of Governance	• Has delegated responsibility for risk management and governance systems and processes and reports to the Executive Director of Nursing • Coordinates the Risk Register reports for escalation to Committees Is responsible overall for functions of Clinical Governance, Risk Management, Health and Safety, Regulatory Compliance, Quality Improvement, Clinical Effectiveness, Legal Services, Patient Safety and Governance intelligence	
Head of Health, Safety and Regulatory Compliance	• Supports the Associate Director of Governance in the delivery of the non-clinical risk management agenda across the Trust • Acts as the Trust central contact for safety alerts (CAS, NPSA etc.) • Manages the Risk and Safety Team including Health & Safety/ Fire Safety, LSMS and Manual Handling and supports the delivery of individual objectives • Develops health & safety / fire / risk management Policies • Provides specialist health & safety advice and assessment in connection with refurbishment schemes and new developments/projects / change to use of premises • Gives advice on making reasonable adjustments to the workplace for staff with special requirements / returning to work following sickness absence • Investigates health & safety incidents / accidents • Alerts the Trust to, and advises on compliance with, legislation in Health & Safety • Provides specialist advice and support for health & safety risk assessments / inspections Ensures that the Trust complies with statutory standards & training in relation to fire safety.	
Patient Safety Specialist	• Manages the Serious Incident investigation process including external reporting arrangements and support to individual reviews. • Provides monthly confidential reports on serious incidents for the Trust Board and key committees. • Identifies key patient safety risks at an organisational level • Responsible for the oversight of the Eclipse system that hosts the Trust risk registers. Through the reporting of incident and SI data and learning, supports the Trust at every level to identify emerging risks associated with patient safety.	

Health, Safety and Fire Advisor	• Develops fire safety policies • Provides safety training, advice, and support to operational staff • Undertakes fire safety risk assessments • Develops fire safety strategies • Ensures that the Trust complies with statutory standards & training in relation to fire safety • Liaises with fire services, police & statutory bodies • Develops manual handling policies and delivers manual handling training • Undertakes moving & handling risk assessments – people and objects Provides advice & expertise on the manual handling of individuals & the use of manual handling equipment (i.e. hoists, assisted baths etc.,)	

Head of Quality Improvement and Clinical Effectiveness	Overall responsible for co-ordination of clinical governance arrangements and management of **Divisional / Local Governance facilitators**. Individual Governance facilitators are responsible for provision of support Clinical Directors in the local risk management arrangements and particularly support for local operational risk registers in relation to their allocated areas.	
Local Security Management Specialist	• Investigates, incidents of violence and aggression towards Trust Staff - supporting managers and staff affected • Provides Crime Prevention advice as required and acts as a focal point for contact with external agencies • Develops security management policies, preventative and management strategies related to security risks • Undertakes security risk assessments Complies with the requirements of the role as set out in the directions to NHS Bodies on Security Management Measures issued in 2004	
Head of Infection Prevention and Control	• Provides specialist infection control advice to all staff across the Trust • Develops infection prevention & control policies • Collaborates with external providers for Infection prevention & control • Develops contingency plans • Investigates / reviews infection control incidents / outbreaks /ward closures • Reports infection control outbreaks / liaises with external agencies Undertakes and monitors an annual programme of work	

Head of Safeguarding	• Promotes good professional practice in relation to safeguarding and promoting the welfare of children and young people, together with that of adults at risk of abuse/neglect with care and support needs • Conducts investigations for serious case reviews involving statutory reviews relating to safeguarding • Provides education & training to Trust and inter-agency staff on all aspects of Safeguarding and Domestic Abuse • Provides individual expertise and advice to practitioners • Acts as the central reference point for the Trust in relation to Safeguarding • Ensures Trust compliance with legislative requirements in relation to safeguarding • Manages the Safeguarding Team • Identifies organisational safeguarding risks Supervision and staff appraisal arrangements will be utilised for the purposes of ensuring that dedicated roles in all areas of managing risks are carried out effectively and in line with individual job descriptions and KSF outlines. Annual Reports will be provided for Health & Safety / Fire Safety, and Security Management, in addition to Safeguarding and Infection Control Annual Reports will go to the Clinical Governance Committee and to the Trust Board.	

Risk Management Committee Structures	The committees of the Trust responsible for the management of risk are set out in Appendix 7. Terms of reference for committees reporting directly to Trust Board will be approved by Trust Board. Similarly sub-committee terms of reference will be approved by their appropriate senior reporting committee. This appendix may be updated when committee changes occur and a note of the changes made will be reported to the Audit Committee. Core risk management responsibilities sit with: **The Trust Board are responsible for:** • approving the overall framework for Risk Management across the Trust including approval of the Risk Management Policy • Reviewing risks with a score of 15 and above as part of the Board Assurance Framework and providing robust constructive debate on the effectiveness of risk mitigation **The Audit Committee are responsible for:** • reviewing the effectiveness of the system of internal control for risk management • producing the Annual Governance Statement for approval by the Trust Board **The Integrated Quality Committee are responsible for:** • Reviewing the full Corporate Risk Register to ensure that this is reflective of quality, safety, and experiential outcomes for the Trust • Reviewing the effectiveness of mitigating controls in managing risk • Providing assurance of the credibility of the risk register content to the Trust Board via the Board Assurance Framework **The Finance, Performance and Productivity Committee (FPP) are responsible for:** • Reviewing the full Corporate Risk Register to ensure that this is reflective of performance and financial sustainability outcomes for the Trust • Reviewing the effectiveness of mitigating controls in managing risk • Providing assurance of the credibility of the risk register content to the Trust Board via the Board Assurance Framework	

	The People Committee are responsible for: • Reviewing all high scoring risks relating to the workforce • Reviewing all high scoring risks relating to Organisational Development and capability • Reviewing all high scoring risks relating to Learning and Development • Reviewing the effectiveness of mitigating controls in managing risks • Providing assurance of the credibility of the risk register content to the Trust Board via the Board Assurance Framework **The Clinical Governance Committee are responsible for:** • Reviewing all local service area risks with a score of 15 or above and for applying risk moderation to determine the level of impact that these risks may have on delivery of corporate objectives. Where a significant impact is identified, the Clinical Governance Committee will escalate such risks to the Corporate Risk Register **Transformation Committee are responsible for:** • Reviewing all programme group risks linked to change programmes with a score of 15 and above and for applying risk moderation to determine the level of impact that these risks may have on delivery of corporate objectives. Where a significant impact is identified, the Transformation Committee will escalate such risks to the Corporate Risk Register **Local Clinical Governance Committees/Trust wide Governance Groups/ Programme Groups are responsible for:** • Reviewing all local and service/project specific risks and ensuring that these are documented on local risk registers • Identifying and tracking the implementation and effectiveness of risk mitigation actions to demonstrate dynamic risk management Escalating risks with a score of 15 and above to the Clinical Governance Committee or Programme Management Board as appropriate	
Learning and Development	• The Trust will support and train staff in developing their skills of managing clinical and non-clinical risk	

	as part of a statutory and mandatory training programme. A risk register management training programme is provided to all Clinical Directors, Associate Directors and Executive Directors, and those required to oversee risk registers at a service level.	

5 Development & Consultation Process

Consultation summary	
Date policy issued for consultation	April 2021
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**
PDMG	November 2021
Trust Clinical Governance Committee	
Integrated Quality Committee	
Finance, Performance and Productivity Committee	
People Committee	
Local Clinical Governance Committees	
Transformation Committee	

6 Reference Documents

Australian/New Zealand Standard AS/NZS 4360:1999

7 Bibliography

None

8 Glossary

None

9 Audit and assurance

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
Risk Management structure (App 7)	Ass Director of Governance	Committee reporting structure.	Qtr	Reports to each senior committee on a quarterly basis minimum.	Committee chair.	As identified.
Review of risk register by Trust Board (App 5)	Company Secretary	Assurance Framework .	Qtr	Report to Trust Board.	Directors as identified.	As identified.
Review of Risk Register by Integrated Quality Committee, People Committee and FPP	Associate Director of Governance (IQC) Director of Finance (FPP) Director of People, Strategy and Partnerships	Risk Register Report	Qtr	Integrated Quality Committee, People Committee and FPP	Directors as identified	As identified

	(People Committee)					
Local risk management arrangements (App 2)	Clinical Directors	Risk Register report	Qtr	To local Clinical Governance Committees, with high scoring risks reported quarterly to Clinical Governance Committee	Associate Director or Clinical Director.	As identified.

10 Appendices

1. Equality Impact Assessment
2. Risk scoring
3. Risk Registers
4. Risk Thresholds / risk level monitoring
5. Assurance Framework
6. Committees

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

<table>
<tr><td>Title of Proposal</td><td colspan="4">Risk Management Policy</td></tr>
<tr><td>Person Completing this proposal</td><td>Rob Grant</td><td colspan="2">Role or title</td><td>Associate Director of Governance</td></tr>
<tr><td>Division</td><td>Nursing</td><td colspan="2">Service Area</td><td>Governance</td></tr>
<tr><td>Date Started</td><td>08.10.2021</td><td colspan="2">Date completed</td><td></td></tr>
<tr><td colspan="5">Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.</td></tr>
<tr><td colspan="5">This policy is designed to ensure that the Trust has effective systems in place to identify, report, mitigate and assure itself of any risks to the effective delivery of all its strategic priorities. These are: Quality, Sustainability, People and Clinical Services</td></tr>
<tr><td colspan="5">Who will benefit from the proposal?</td></tr>
<tr><td colspan="5">The robust identification and management of risk will benefit, staff, service users, visitors and partners across all services and sites.</td></tr>
<tr><td colspan="5">Impacts on different Personal Protected Characteristics – Helpful Questions:</td></tr>
<tr><td colspan="2">Does this proposal promote equality of opportunity?
Eliminate discrimination?
Eliminate harassment?
Eliminate victimisation?</td><td colspan="3">Promote good community relations?
Promote positive attitudes towards disabled people?
Consider more favourable treatment of disabled people?
Promote involvement and consultation?
Protect and promote human rights?</td></tr>
<tr><td colspan="5">Please click in the relevant impact box or leave blank if you feel there is no particular impact.</td></tr>
</table>

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	✓			*please refer to note below
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal?				

Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	✓			*please refer to note below
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	✓			*please refer to note below
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	✓			*please refer to note below
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	✓			*please refer to note below
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	✓			*please refer to note below
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	✓			*please refer to note below
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	✓			*please refer to note below
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being ‘out’ or would office culture make them feel this might not be a good idea?				

<table>
<tr><td>Transgender or Gender Reassignment</td><td>✓</td><td></td><td></td><td colspan="2">*please refer to note below</td></tr>
<tr><td colspan="6">This will include people who are in the process of or in a care pathway changing from one gender to another
Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?</td></tr>
<tr><td>Human Rights</td><td>✓</td><td></td><td></td><td colspan="2">*please refer to note below</td></tr>
<tr><td colspan="6">Affecting someone's right to Life, Dignity and Respect?
Caring for other people or protecting them from danger?
The detention of an individual inadvertently or placing someone in a humiliating situation or position?</td></tr>
<tr><td colspan="6">If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)</td></tr>
<tr><td></td><td>~~Yes~~</td><td>No</td><td colspan="3"></td></tr>
<tr><td rowspan="2">What do you consider the level of negative impact to be?</td><td>High Impact</td><td>Medium Impact</td><td>Low Impact</td><td colspan="2">No Impact</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">✓</td></tr>
<tr><td colspan="6">If the impact could be discriminatory in law, please contact the Equality and Diversity Lead immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the Equality and Diversity Lead before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the Equality and Diversity Lead.</td></tr>
<tr><td colspan="6">Action Planning:</td></tr>
<tr><td colspan="6">How could you minimise or remove any negative impact identified even if this is of low significance?</td></tr>
<tr><td colspan="6">Refer to note below</td></tr>
<tr><td colspan="6">How will any impact or planned actions be monitored and reviewed?</td></tr>
</table>

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Note: Whilst the mechanism of risk registration, mitigation and assurance is silent on equality and inclusion, it does offer a vehicle for the recognition and mitigation of specific risks to equality and inclusion. The effective use of risk registers and their reporting and oversight can offer a positive impact in highlighting risks to equality and support specific approaches to close the gaps where these are identified.

RISK SCORING

The prioritisation and allocation of risk

To ensure that meaningful decisions on the prioritisation and treatment of risks can be made, the Trust will grade all risks using the same tool.

- **The 5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999) will be used to assign risk priority.**

It is essential to have one system for prioritising and rating risks, and this will be used to prioritise risks on the Assurance Framework and Risk Registers, and for rating incidents, complaints, and claims. Risk analysis uses descriptive scales to describe the magnitude of potential consequences and the likelihood that those consequences occur.

Measures of likelihood – likelihood scores (non-financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur **at least annually**	Expected to occur **at least monthly**	Expected to occur **at least weekly**	Expected to occur **at least daily**

Measures of Likelihood – likelihood scores (financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur in the current or next year	Unlikely to occur during the current or next year	Could easily occur during the current or next year	Will probably occur during the current or next year	Definitely will occur during the current or next year

Note:

Measures of likelihood have to be applied to actual consequence detailed in the risk, it is expected that there is some evidence of these.

For instance a risk defined in relation to a service user falling leading to a fracture should not be based on the likelihood of a service user falling, but of falling AND this leading to a fracture.

Measures of Consequence – Domains, consequence and examples of score descriptors

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no or minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work <3days Increase in length of hospital stay by 1-2days	Moderate injury requiring professional intervention Requiring time off work 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity / disability Requiring time off work >14days Increase in length of hospital stay by >15days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
			An event that impacts on a small number of patients	Mismanagement of patient care with long term effects	large number of patients
Quality Complaints Audit	Peripheral elements of treatment or service sub-optimal Informal complaint or inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if not resolved Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment or service Gross failure of patient safety if findings not acted on Inquest / Ombudsman inquiry Gross failure to meet national standards
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objectives / service due to lack of staff Unsafe staffing levels or competence	Non-delivery of key objectives due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / Inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable	National media coverage with >3days service well below reasonable

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		Elements of public expectation not being met		public expectation	public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5% over project budget Schedule slippage	<5-10% over project budget Schedule slippage	Non-compliance with national 10-25% over budget project Schedule slippage Key objectives not met	Incident leading >25% over project budget Schedule slippage Key objectives not met
Finance – including claims	Non delivery/Loss of budget to value of <£10K	Non delivery/Loss of budget between £10K and £100K	Non-delivery/Loss of budget between £100K and £500K	Non delivery/Loss of budget between £500K and £2M	Non-delivery/Loss of Budget of more than £2M
Service / Business interruption **Environmental impact**	Loss / interruption of >1hour Minimal or no impact on environment	Loss / interruption of >8hours Minot impact on environment	Loss / interruption of >1day Moderate impact on environment	Loss / interruption of >1week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Measures of Consequence – Additional guidance and examples relating to risks impacting on the safety of patients, staff or public

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise or graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse side effects Physical attach such as pushing, shoving or pinching causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring	Wrong drug or dosage administered with potential adverse side effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2-3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate	Wrong drug or dosage administered with adverse side effects Physical attack causing serious injury Grade 4 pressure ulcer Long-term HCAI Slip / fall resulting in injury such as dislocation, fracture, blow to the head	Unexpected death Suicide of a patient known to the services within last 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Incident leading to paralysis Incident leading to long-term

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		occupational health counselling – no time off work required	information / communication on transfer of care Vehicle carrying patient involved in road traffic accident Slip / fall resulting in injury such as sprain	Loss of limb Post-traumatic stress disorder	mental health problem Rape / serious sexual assault

5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999)

LIKELIHOOD						
	Almost Certain	5 Yellow	10 Yellow	15 Red	20 Red	25 Red
	Likely	4 Yellow	8 Amber	12 Amber	16 Red	20 Red
	Possible	3 Green	6 Yellow	9 Amber	12 Amber	15 Red
	Unlikely	2 Green	4 Yellow	6 Yellow	8 Amber	10 Amber
	Rare	1 Green	2 Green	3 Green	4 Yellow	5 Yellow
		Insignificant	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

RISK REGISTER

Risk Registers
Risk registers are an integral part of the process of managing risk and are used as a repository of risk information to:

- Record risks related to BSMHFT's objectives and express risks in terms of event, consequence and impact
- Store information on significant risks in a meaningful way that can be distributed and used to make better informed decisions
- Rank risks by severity of consequences in order that they may be prioritised for action.

The Trust risk registers will consist of a number of component risk registers which collectively will reflect all responsibilities of the organisation. These will be as follows:

- Corporate Risk Register – reflecting the risks which could significantly compromise the Trust's ability to deliver its corporate objectives/annual plan
- Executive Director registers - reflecting the risks relating to each individual executive director of the Trust
- Local Service Area Risk Registers – reflecting risks that are local to individual services
- Project Risk registers – reflecting significant programmes (e.g. capital schemes)

Each Director will be required to have in place mechanisms for the regular review (at least every quarter) of their risk register ensuring that the risk register is updated and amended to reflect new risks and any changes.

Risk registers should reflect any risk identified, but sources of risk should include:

- Environmental / other risk assessments
- Clinical audit
- Committee risk log
- Complaints
- CQC regulation requirement
- Incident trends
- Internal audit review
- Internal Inspection
- National Publication
- NICE recommendations
- SI recommendation
- Service user / carer feedback
- Staff feedback
- Committee risks

RISK THRESHOLDS / RISK LEVEL MONITORING

Level of Risk	Risk Scores	Determination of Level, monitoring of Action Plans and acceptability of risk to the Trust	Monitoring Process
Red	• All risks rated 15 + (post moderation) • Unacceptable level of risk exposure which requires immediate corrective action to be taken	• Unacceptable risk • Level determined by **IQC, FPP and People Committee** • Action Plans are approved by the relevant Executive Director • Included in the Assurance Framework • Progress against the Assurance Framework Action plans is monitored by the Trust Board	• IQC, FPP and People Committee level monitoring of these risks • IQC, FPP and People Committee to advise Board on ways of managing high risks that cannot be addressed within existing resources • Included in Assurance Framework • Board level monitoring of assurance framework action plans
Amber	• All risks rated 12+ • Unacceptable level of risk exposure which requires constant active monitoring, and measures to be put in place to reduce exposure	• Unacceptable risk • Level determined by **Executive Director** • Action Plans managed by senior manager • Progress updates via Divisional Leads	• Included in Risk Register and reported to local Clinical Governance Committee/Local FPP • Action plans monitored by Executive Director
Yellow	• All risks rated 4- 10	• Level determined by the **Service Manager** • Action Plans managed locally by named managers on behalf of the Director.	• Action Plans monitored by Directors Management team
Green	• All risks rated 1 - 4		

THE ASSURANCE FRAMEWORK

'The Assurance Framework is a high level report which enables a Board to demonstrate how it has identified and met its assurance needs focused upon the delivery of its objectives' (Healthcare Commission Assurance Standards Unit 2006)

The Board receives assurance on the management of risk via the Assurance Framework, which details the principal risks within the organisation, and also details the Trust strategic objectives that may be subsequently affected.

It is also a tool to enable Board decisions to be made about which risks are to be treated and/or controlled as priorities.

The Assurance Framework gives the Board the required assurance that risks to achieving key objectives are being effectively controlled.

The Assurance Framework will go to the Trust Board for review at least quarterly.

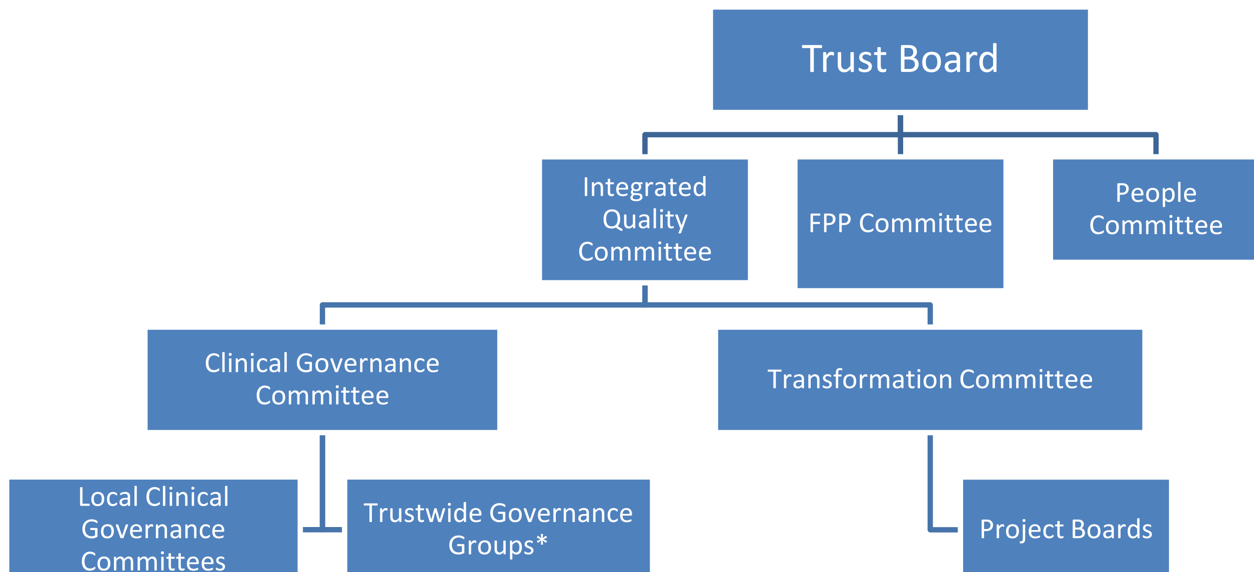
The Board will identify any gaps with regard to controls/sources of assurance or any unacceptable assurance results and ensure that management has actions in place to address them.

Sources of assurance will be assessed with regard to their independence, competence and relevance before considering the implications of the levels of assurance being reported.

Assurance Level Definitions

Assurance Level	Definition	Descriptors
Limited	Urgent improvements needed to mitigate risk Few controls	The organisation is exposed to significant risk that could: • lead to failure to achieve key strategic objectives including the integrated business plan • Lead to failure in achieving key targets • significant loss of reputation • major service disruption • Key controls do not exist or they are limited
Moderate	Controls are in place but further improvements would be beneficial to further mitigate risk	• Non-compliance with key controls • Possible failure to achieve key strategic objectives • Not all integrated business plan targets met • Possible loss of reputation • Mitigating action plans to reduce risk not completed
Significant	Strong controls are in place and are complied with	• The organisation is not exposed to foreseeable risk due to the existence of key controls and mitigating action plans that are being managed effectively and efficiently • Key integrated business plan and targets on track

GOVERNANCE COMMITTEES



***Trustwide Governance Groups include (but are not limited to) –**

- Safeguarding Management Board
- Infection Prevention and Control Committee
- Health and Safety Committee
- Clinical Effectiveness Group