Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

RISK MANAGEMENT POLICY

POLICY NO & CATEGORY	**RS 01**	**Risk & Safety**
VERSION NO & DATE	**14**	**November 2017**
RATIFYING COMMITTEE	**Trust Board**	
DATE RATIFIED	**November 2017**	
NEXT REVIEW DATE	**November 2020**	
EXECUTIVE DIRECTOR	**Executive Director of Nursing**	
POLICY LEAD	**Associate Director of Governance**	
POLICY AUTHOR *(if different from above)*		
FORMULATED VIA	**Audit Committee, November 2017**	

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 on local service area risk registers with a score of 15 and above will be reported to the Clinical Governance Committee on a quarterly basis. Risk moderation may take place at this Committee to determine whether any of the high level 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 and FPP and will inform the Board Assurance Framework.
- The Trust Board will review the Board Assurance Framework inclusive of the high level 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.

Contents **Page Number**

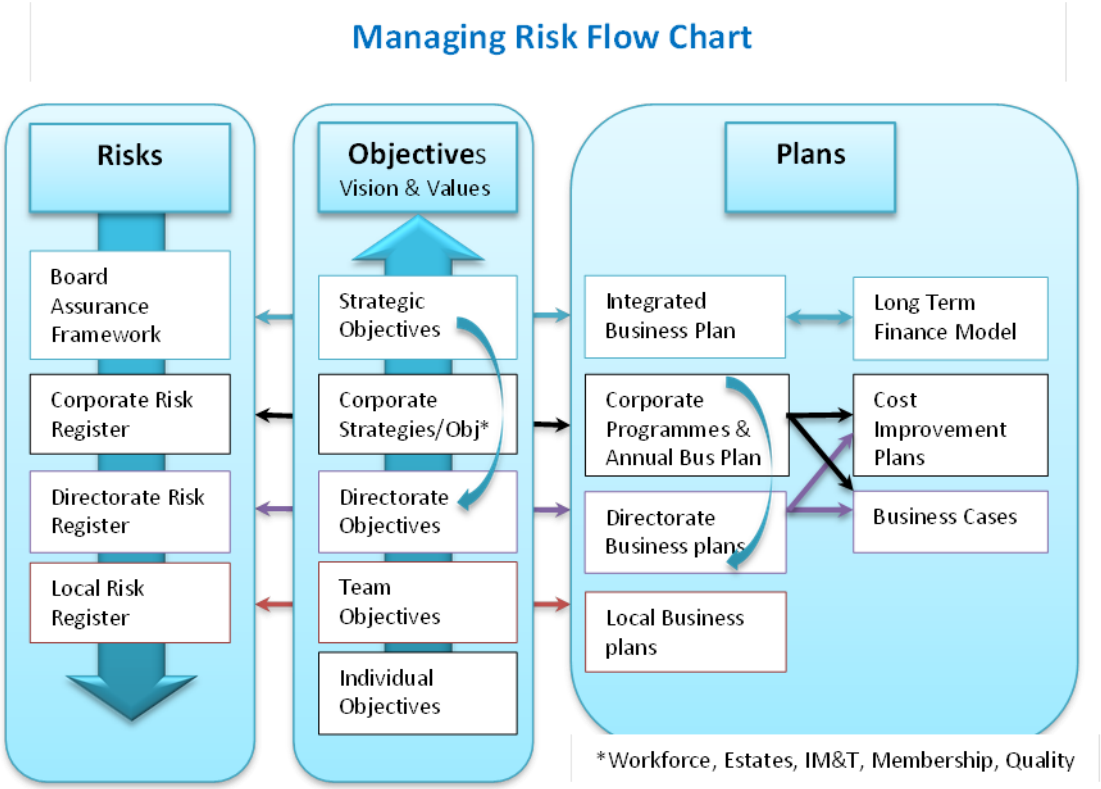
1 Introduction

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 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 Trustwide 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, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order 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 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.

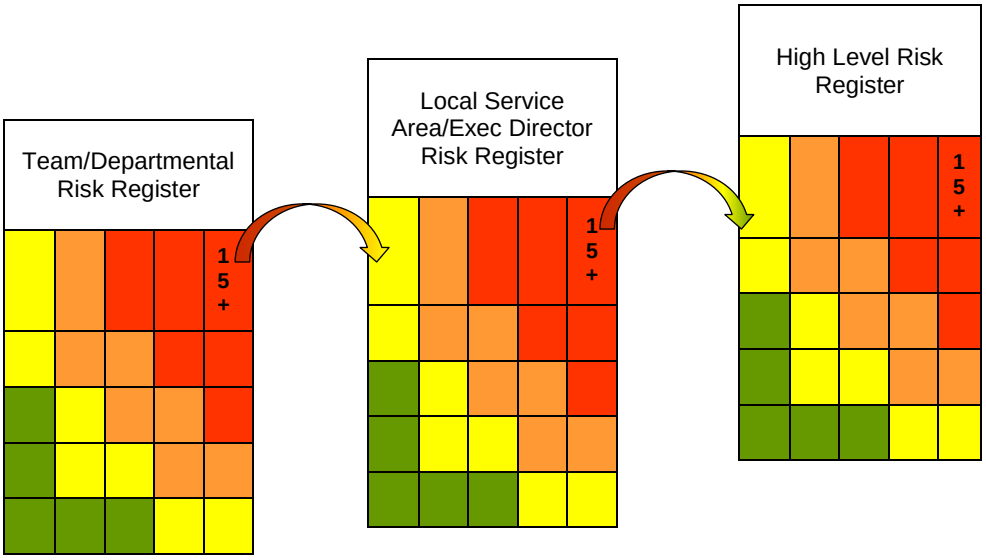
2.3 The consequence and likelihood of risk occurrence will be assessed against the Trustwide risk scoring matrix (Appendix 1). This matrix is based on best practice and supported by the National Patient Safety Agency. Risks will be recorded on risk registers via the Eclipse electronic risk management 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 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 high level risk register. The high level risk register will be presented in full to the Integrated Quality Committee and FPP on a quarterly basis.

2.6 Risks scores of 15 or above on the High level 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 etc.;

External sources;

- Regulatory standards and inspection feedback (CQC)
- Central Alerting System (CAS),
- Mandatory and statutory targets,
- National enquiry reports,
- Health and Safety Executive (HSE)
- 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 Programme Management Board 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 Programme Management Board 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 High Level 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 Trustwide 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 Risk Management Accountabilities and Responsibilities

4.1 Executive & Trust Board Level

4.1.1 The **Chief Executive** maintains overall accountability for risk management within the Trust, but will delegate responsibility to nominated Executive Directors of the Trust Board.

4.1.2 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.

4.1.3 The **Medical Director** and the **Director of Nursing** have joint delegated responsibility for clinical risk management.

4.1.4 The **Director of Resources** has delegated responsibility for internal financial controls and the implementation of financial risk management, information management systems, business planning, information governance, communications, the programme management office, organisational development and facilities.

4.1.5 The **Director of Operations** has overall responsibility for the management and co-ordination of all operational risks. Risks relating to human resources and staffing also sit with the Director of Operations.

4.1.6 The **Company Secretary** has overall responsibility for the reporting to Trust Board of the assurance framework, reflecting the high level risks identified in Trust risk registers*.*

4.1.7 **Associate Directors of Operations/Clinical Directors/ Heads of Service** 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.

4.1.8 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 take action, both proactively and retrospectively, to identify, assess, and manage any risk issues affecting their unit, departments, wards or services.

4.1.9 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.

4.1.10 **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

4.1.11 **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

4.2 Key Responsibilities of *all* Staff

4.2.1 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.

4.2.2 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

4.3 Joint Working Responsibilities

4.3.1 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.

4.3.2 The Trust currently works closely with key stakeholders The Trust will endeavour to involve partner organisations in all aspects of risk management.

4.3.3 Key partners include

- Governors
- Clinical Commissioning Groups
- NHS 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

4.4 Roles & Responsibilities of key staff with responsibility for managing risk

4.4.1 Risk management support will be provided by staff with responsibilities for specific areas of risk management, a brief summary of which is given below.

4.4.2 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
- Is responsible overall for functions of Clinical Governance, Risk Management ,Health and Safety, Compliance and Governance intelligence

4.4.3 Risk & Safety Manager

- 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 work place 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.

4.4.4 Head of Investigations

- 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.

4.4.5 Clinical Governance Manager

- 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 in local risk management arrangements and particularly support for local operational risk registers in relation to their allocated areas.

4.4.6 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 and 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

4.4.7 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.,)

4.4.8 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

4.4.9 Head of Safeguarding

- Promotes good professional practice in relation to safeguarding and promoting the welfare of children and young people, together with that of vulnerable adults
- Conducts investigations for serious case reviews involving potential / actual serious injury of a child and that of vulnerable adults
- 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

4.4.10 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.

4.4.11 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.

4.5 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 following Audit Committee.

Core risk management responsibilities sit with:-

4.5.1 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

4.5.2 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

4.5.3 The Integrated Quality Committee are responsible for:-

- Reviewing the full high level risk register to ensure that this is reflective of quality, safety, and workforce 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

4.5.4 The Finance, Performance and Productivity Committee (FPP) are responsible for:-

- Reviewing the full high level 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 Audit Committee

4.5.5 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 High level Risk Register

4.5.6 Programme Management Board 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 Programme Management Board will escalate such risks to the High level Risk Register

4.5.6 Local Clinical Governance Committees/Trustwide 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

.

4.6 Learning and Development

4.6.1 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.

4.6.2 A risk management training needs analysis based on risk assessment has identified the areas of training required for staff working in BSMHFT and this is detailed in the Risk Management Training Policy.

5 Development & Consultation Process

Consultation summary	
Date policy issued for consultation	October 2017
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**
Audit Committee	XX November 2017
Version 14 updated to include clarity on governance structures	October 2017
Trust Board	November 2017

6 Reference Documents

7 Bibliography

8 Glossary

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 t.	Qtr	Report to Trust Board.	Directors as identified.	As identified.
Review of Risk Register by Integrated Quality Committee and FPP	Associate Director of Governance	Risk Register Report	Qtr	Integrated Quality Committee and FPP	Directors as identified	As identified
Local risk management arrangements (App 2)	Clinical Directors	Risk Register report	Qtr	To local Clinical Governance Committees, with high level risks reported quarterly to Clinical Governance Committee	Associate Director or Clinical Director.	As identified.

10 Appendices

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

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 An event that impacts on a small number of	Major injury leading to long-term incapacity / disability Requiring time off work >14days Increase in length of hospital stay by >15days Mismanagement of patient care with long term	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
			patients	effects	
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 Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of

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

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
			accident Slip / fall resulting in injury such as sprain		

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 in order 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:

- High Level 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 and FPP** • 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 and FPP level monitoring of these risks • IQC and FPP 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.

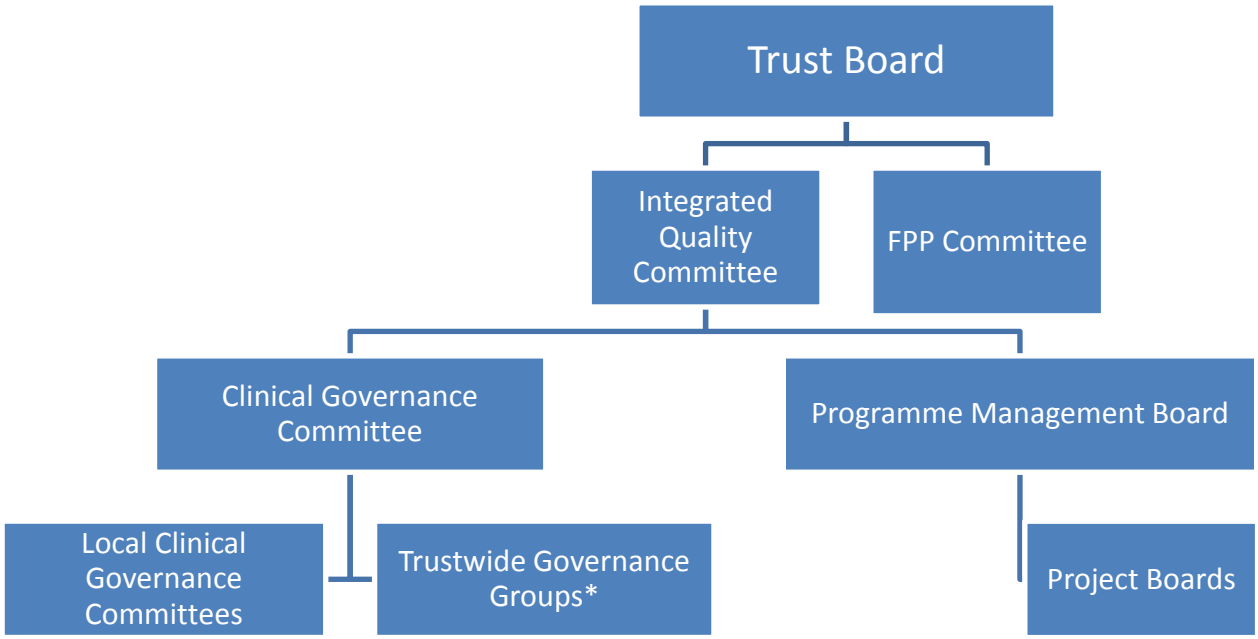
The Board will identify any gaps with regard to controls/sources of assurance or any unacceptable assurance results and ensure that management has actions in place to address them.

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 Committee
- Infection Prevention and Control Committee
- Health and Safety Committee
- Clinical Senate
- Clinical Effectiveness Group
- Workforce Committee

Key Terms of Reference

Birmingham and Solihull Mental Health NHS Foundation Trust

Integrated Quality Committee Terms of Reference

V6

1 Authority

1.1 The Integrated Quality Committee is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment at future Trust Board meetings.

1.2 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

1.3 The committee is authorised by Trust Board to carry out any function within its terms of reference.

2. Purpose

2.1 The primary purpose of the committee is to ensure, on behalf of the Board that the Trust is aiming to achieve the highest standards of quality around safety, patient experience and clinical effectiveness, as outlined in the Well Led Framework, the Quality Strategy and Quality Accounts. The committee will monitor progress against implementation of these key documents and will provide assurance to the Trust Board on the effectiveness of the quality and safety of services, to ensure that there is no negative impact on quality due to financial decision making; and to ensure regulatory compliance in respect of quality.

2.2 The committee is responsible for seeking assurance on people productivity elements of the trusts work – this includes human resources and staff support and experience and the People's Plan

2.3 Seek any and all explanations and information it requires from any employee or contractor of the organisation to achieve the committee's purpose.

2.4 To approve policies identified for sign off at IQC, in line with the Policy Development and Management policy.

3. Duties

3.1 To provide assurance to Trust Board that the quality, safety and effectiveness of clinical services are appropriate.

3.2 To ensure compliance with the regulatory standards of clinical staff.

3.3 To review the top risks from risk registers on a quarterly basis in order to identify those, related to quality and safety, which need to be included on the Board Assurance Framework and to provide assurance to Trust Board that effective structures are in place to measure and continuously improve the effectiveness of care and that effective plans are in place to mitigate risk and ensure plans are implemented effectively.

3.4 To provide assurance to the Trust Board that the Trust is listening to patients about their experience and to take account of issues that might indicate that individuals /groups of patients may be having and poorer experience, including exploring complaints and adverse trends.

3.5 To provide focus on quality and improvement for patients and users of the Trust's services and to provide assurance in relation to quality defined as safety, effectiveness and patient experience

3.6 To ensure that the themes and lessons arising from any investigation and review of serious incident claims and complaints, or homicide reviews are consistently shared across the organisation and the actions arising are effectively implemented and make appropriate recommendations to the Trust Board.

3.7 To review, approve and monitor implementation and impact of the Trust's Quality Strategy and Quality Account.

3.8 To ensure Medical Director and Director of Nursing sign off has been received in respect of impact on quality for all service redesign plans.

3.9 To receive exception reports from FPP, and scrutinise these, in relation to financial outcomes or plans which may have the potential to impact on quality and ensure this is discussed at the committee and views fed back by exception report to FPP

3.10 To provide assurance to Trust Board that the Trust has adequate systems and processes in place to ensure and continuously improve patient safety and management of risk from 'Ward to Board'.

3.11 To consider actual Trust performance against external benchmark information in relation to quality and safety, people and HR, as an aid to the overall effectiveness and efficiency of the Trust

3.12 To receive monthly quality dashboard reports around an agreed set of Key Performance Indicators to measure effectiveness, safety and experience to be determined by the Committee.

3.13 To receive reports from Divisions outlining their structures and processes for managing and monitoring Quality, Risk, Safety and quality governance and to assure itself and the Trust Board that divisions are giving appropriate priority to continuous improvement.

3.14 Where performance in respect of quality and patient safety has fallen short of agreed standards, or there has been some other indication of a diminution of standards, the Committee has the delegated authority to request evidence of assurance that the concerns have been investigated, corrective action has been taken and lessons have been learnt.

3.15 To have oversight of mortality information and any associated learning arising from mortality case note review

4. Members

4.1 The membership of the committee will be
Chair - Non-Executive Director

- Deputy Chair - Non-Executive Director
- Non-Executive Director
- Executive Director of Nursing
- Medical Director
- Executive Director of Operations
- Company Secretary
- Associate Director of Governance

Other Directors will attend if they have an agenda item but only for that item.

4.11 All members will have one vote. In the event of votes being equal the Chair of the Committee will have the casting vote.

4.12 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting

4.13 Other Board members will have the right to attend the committee but will be required to advise the Chair of IQC in advance of their intention to do so.

4.14 The Trust Chair and Chief Executive will be non-voting ex-officio members of the Committee and will be entitled to attend any or all committee meetings. They will also receive all Committee reports.

4.15 Where members are unable to attend they are entitled to, and in the case of Executive Directors, expected to nominate a deputy to attend in advance of the meeting. Such a deputy will be expected to be briefed and entitled to utilise the members vote at the meeting.

4.16 Non-members can attend the meeting with the prior agreement of the Committee chair.

4.17 Members are expected to make every effort to attend all meetings of the Committee.

4.18 Meeting attendance will be reviewed by the Committee chair annually.

5. Quoracy

5.1 The meeting will be considered quorate with 3 Committee members, one of which must be a Non-Executive Director and one must be an Executive Director.

6. Declaration of interests

6.1 All members and attending ex-officio members must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

7. Meetings

7.1 Meetings will be held monthly.

7.2 Meeting dates will be agreed annually in advance by the members of the Committee.

7.3 To include as a standing item on every agenda the Committee should review how effectively it has discharged its business at that meeting.

8. Administration

8.1 The meeting will be closed and not open to the public.

8.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

8.3 An action list and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

8.4 Any issues with the action list or minutes will be raised within 7 calendar days of issue.

8.5 The Executive Director of Nursing will agree a draft agenda with the Committee Chair and it will be circulated 7 calendar days after the previous meeting to allow time for input, with the final version circulated with papers.

8.6 The Board Support Officer will be responsible for updating the forward plan with input from the Director of Nursing and Associate Director of Governance, for agreement with the Chair of the Committee

8.6 Any issues with the agenda must be raised with the Committee chair within 4 working days.

8.7 All final Committee reports must be submitted 7 calendar days before the meeting.

8.8 The agenda, minutes and all reports will be issued 6 calendar days before the meetings.

9. Reporting and links to other committees

9.1 The Committee will receive regular reports from the groups reporting into it – the formal timing of these will be outlined on the IQC forward plan and in addition to this exception reports will be provided as required

- Clinical Governance Committee
- Mortality Surveillance Group
- Clinical Senate (by way of quarterly reports)

9.2 The Committee will report to Trust Board at the next meeting reporting on any significant issues.

9.3 The Committee will provide exception reports to the Audit Committee

9.4 To support overlap between IQC and FPP the Chair and CEO will provide this through their frequent attendance at both meetings. Anything involving service changes will require sign off in terms of impact on quality by the Medical Director and the Director of Nursing. Attendees at both IQC and FPP will be expected to have an eye on the need for an integrated approach so that impact issues are not lost, and papers to both committees will need to indicate where there is a potential impact on quality. Where necessary, exception reports will be provided between the two committees.

9.5 The Chair of IQC and the Chair of MHLC will discuss any potential areas of duplication in their remits and ensure this is rectified in work planning and later amendments to their respective TORs.

9.6 The Committee will review their effectiveness on an annual basis, reporting the outcome of the review to Trust Board

9.7 The Committee Chair will present to the Council of Governors annually a report on the work of the Committee.

March 2016

AUDIT COMMITTEE

TERMS OF REFERENCE

1 Authority

1.1 The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2 Purpose

2.1 The Committee is authorised by Trust Board to carry out any function within its terms of reference.

2.2 The Committee is delegated and authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
- Approved the annual report and accounts.

2.3 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

2.4 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

3. Duties

3.1 <u>Governance, Risk Management and Internal Control</u>

3.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

3.1.2 In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with

CQC regulations), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- Annual Report and Accounts
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by the Counter Fraud and Security Management Service

3.1.3 That the Committee will review the top risks identified from risk registers to recommend to Trust Board risks for inclusion within the Trust Board Assurance Framework.

3.1.4 In carrying out its work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it

3.1.5 The committee will have delegated authority from the Board to receive and approve changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

2 Internal Audit

3.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organization
- Annual review of the effectiveness of internal audit

3.3 External Audit

3.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, in order for a recommendation to go to the Council of Governors, whose role it is to appoint the external auditors
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses

3.4 Other Assurance Functions

3.4.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health arms-length Bodies or appropriate regulators/inspectors.

3.4.2 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee, and any Risk Management committees that are established, as well as receiving or seeking assurances as appropriate, from the other board sub committees.

3.4.3 In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

4. Membership

4.1 The membership of the committee will be:

- Chair – Non-Executive Director
- Deputy Chair – Non-Executive Director
- Non-Executive Director
- Associate Non-Executive Director

4.2 Others required to attend the committee will be:

- Executive Director of Resources

- Company Secretary

4.3 Invitations for attendance of others will be issued by the Chair of the committee in line with the requirements of the agenda.

4.4 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control and the Chair of the Board will have an open invitation to attend.

4.5 All members will have one vote. In the event of votes being equal the Chair of the committee will have the casting vote.

4.6 Appropriate Internal and External Audit representatives shall normally attend meetings, although are not entitled to vote. However at least once a year the Committee should meet privately with the External and Internal Auditors.

5. Quoracy

5.1 A quorum shall be two members of the committee.

6. Declaration of interests

6.1 All members and attending officers must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

7. Meetings

7.1 The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members. The Board will appoint one of the members Chair of the Committee. The Chair of the organisation shall not be a member of the Committee but will have an open invitation to attend.

7.2 Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

7.3 Meeting dates will be agreed annually in advance by the members of the committee.

7.4 To include as a standing item on every agenda the Committee should review how effectively it has discharged its business.

8. Administration

8.1 The meeting will be closed and not open to the public.

8.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the committee.

8.3 An Action List and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

8.4 Any issues with the Action List or minutes will be raised within 7 calendar days of issue.

8.5 The Company Secretary will agree a draft agenda with the committee chair and it will be circulated 7 calendar days before the meeting.

8.6 Any issues with the agenda must be raised with the committee chair within 4 working days.

8.7 All final committee reports must be submitted 7 calendar days before the meeting.

8.8 The agenda, minutes and all reports will be issued 6 calendar days before the meetings.

9. Reporting

9.1 The committee will report to Trust Board at the next meeting reporting on any significant issues.

9.2 The committee will review their effectiveness on an annual basis, reporting the outcome of the review to Trust Board.

9.3 The committee Chair will present to the Council of Governors annually a report on the work of the committee

May 2016 approval by the Board