NHS

Croydon Clinical Commissioning Group

Draft
Risk Management and Assurance Strategy and Policy

24 October 2012 Rev. V5

CONTROL AND AMENDMENT RECORD

Version	Date	Details of reason for review or update	Author / Reviewer	Approving Committee (s)	Date of Approval
V5	24 Oct 2012	Review against authorisation requirements. Update reflects: - KPIs - SIRO responsibilities - Link of this policy to the incident reporting policy	F Harrington		

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1. Risk Management and Assurance Strategy

1.1 Introduction

The NHS Croydon Clinical Commissioning Group (CCG) is committed to a policy of continuously improving the health and quality of healthcare for the population of Croydon. In order to commission high quality care, the CCG will ensure that all risks arising from its activities or events, threatening the well-being of patients, staff and other stakeholders, are effectively and efficiently identified, minimised or mitigated against.

The principles of this policy are to:
- be **open** and **fair** in our approach to managing risks
- be **consistent** in how we assess and manage our risks throughout the organisation;
- seek to gain **public & staff** trust in the policy areas by following and communicating a safety approach;
- have a **robust methodology** to risk management - aiming to identify, assess, address, review and report on risks in a way that can stand scrutiny, building on best practice and protecting the interests of our stakeholders

The CCG is responsible for delivering health improvements and reducing health inequalities and we are developing our three year Integrated Strategic and Operating Plan (ISOP) and how we aim to achieve our vision of the best possible health and well-being for people in Croydon. We recognise that the behaviour of stakeholders and their risk priorities will impact on the activities of the CCG and similarly, the activities of the CCG will impact upon those of the stakeholders. Consequently, the CCG will do its reasonable best to work with stakeholders in commissioning services which are safe and of a high quality.

Through all its corporate plans and the way it operates, the CCG aims to continuously improve the quality of commissioned services. However, it is acknowledged that delivering these improvements and embracing the creation of positive advantages, benefits and opportunities will involve taking risks. We cannot create a risk free environment, but rather one in which risk is considered as an integral part of everything we do and is appropriately identified and controlled. The Risk Management and Assurance Strategy and Policy (referred to as Risk Management Strategy) demonstrates the CCG's commitment to putting in place a proactive approach to risk management that aims to identify, assess and prioritise risk so that we can minimise the negative consequences.

The Policy sets out how the management of risks will be integrated into the governance arrangements for the CCG. The risk management approach will support and enhance staff's ability to make decisions, provide senior management with a clearer understanding of potential risks, the impact of these risks and what we need to do to mitigate them.

By having a systematic and consistent approach towards managing risks, the organisation will continue to support creativity and innovation and respond to new threats as well as opportunities. Ultimately, it will enable the organisation to deliver its vision of the best health and well being for people in Croydon.

1.2 Scope

This risk management strategy will apply to all staff employed by the CCG as well as commissioned services including Independent Contractors.

However, there is a distinction between theCCG's responsibilities for its own operations, assets and staff where the CCG has direct liability, and its responsibilities for commissioned services including Independent Contractors.

Risks in commissioned services will be managed through a collaborative approach by working closely with partner agencies and having robust governance arrangements in place, whereas each commissioned organisation and contractors will retain liability for its staff and operations.

The responsibilities of independent contractors i.e. General Practitioners, General Dental Practitioners, Community Pharmacists and Optometrists for identifying and managing their own risks will be clarified through contractual arrangements monitored by the NHS Commissioning Board (NHSCB). The CG will support the NHSCB to do this, if required.

As commissioners, the CCG will keep an overview of high risks in commissioned services and monitor that these services continue to put appropriate controls in place to mitigate those risks.

1.3 The Context

The Risk Management Strategy is developed in context of the following Department of Health publications as well as publications of expert bodies on governance and risk management:

- Guidelines for managing risk in the healthcare sector
- An Organisation with a Memory (2000)
- Managing Poor Performance in the NHS
- First class Service: Quality in the NHS
- Building the assurance Framework: A practical Guide for NHS Boards March 2003. Gate log Reference1054
- Making a Difference – Review of Controls Assurance Gateway Ref. No. 4222
- Clinical Governance
- NHS Litigation Authority – CNST Risk Management Standards
- Governing the NHS: A guide for NHS Boards (2003)
- Integrated Governance Handbook 2006

- The Healthy NHS Board: Principles for Good Governance (2010)
- National Patient Safety Publications on Patient Safety
- Risk Management Matrix for Risk Managers (2008)
- A Vision for World Class Commissioning; adding life to years and years to life (2008)
- Australia New Zealand Standard AS/NZ 4360:2004
- Recommendations of the Audit Commission (2007) report "Improving quality and safety - Progress in implementing clinical governance in primary care: Lessons for the new Primary Care Trusts"
- Principles and framework contained in the legislation including:
  - Health and Safety at Work Act 1974
  - Data Protection Act 1998

1.4 The Purpose

The purpose of Risk Management Strategy of the CCG is to:
- Ensure commissioning of high quality and safe patient care
- Protect patients, staff, visitors and all stakeholders from harm
- Support the delivery of organisational objectives, both strategic and operational
- Minimise the CCG's financial liability
- Ensure maintaining a system of internal control across the organisation

1.5 Definitions

Risk may be defined as "the possibility of incurring misfortune or loss". Anything that threatens, impairs and prevents the CCG from achieving its clinical, organisational and financial targets is known as risk.

Risk is the "uncertainty of outcome whether positive opportunity or negative threat".

Risk is measured as the product of likelihood of that hazard causing harm and the severity of harm. In other words Risk = Hazard x Exposure (Likelihood x Severity)

Hazard is anything with the potential to cause harm e.g. faulty equipment, torn carpets, most drugs or cleaning and disinfecting solutions etc.

Harm is the physical injury and/or damage to health, property or assets

Safety is the freedom from unacceptable risk of harm or loss

Risk Management is the "culture, processes and structures that are directed towards the effective management of risks".

The **risk management process** is defined as the process by which an organisation systematically identifies, analyses and reduces its exposure to risks. It also includes effective management of events and incidents when they occur.

Risk Management processes:
- Identification of hazards and risks and their communication to stakeholders.
- Risk analysis and control including prevention and reduction of loss.
- Developing and maintaining a risk register.
- Developing and maintaining an Assurance Framework.
- Managing, reporting and recording of near misses and Incidents
- Investigation of serious incidents and applying "Root Cause Analysis" where appropriate.
- Complaints and claims management.
- Ensure staff and providers of Commissioning Support
  - Educate staff on safety awareness including feedback from incidents, complaints and claims.
  - Ensure compliance with law and professional or other relevant standards.
  - Train staff in order to become competent in their jobs.
  - Train staff in relation to risk assessments and risk management processes

Proactive risk management is about dealing with risks before the losses happen and includes:

- Assessing clinical and non-clinical activities of the CCG
- Identifying hazards and risks
- Assessing hazards/risks for potential severity and frequency
- Analysing the contributory factors
- Eliminating the risks, which can be eliminated
- Reducing the chance of happening and its effect when it cannot be eliminated

Inherent Risk: Exposure arising from any risk before any controls are put in place. It relates to the uncertainty of outcome of process or activities that comprise the process - that exists if nothing is done to control/mitigate/eliminate the risk.

Risk level without consideration of any controls designed effectively.

Residual Risk: Residual risk is a risk that theoretically remains after mitigation i.e. after controls have put in place, assuming that controls are all working as planned. The risk you face with existing controls in place.

It is important for the decision makers to be well informed about the nature and extent of the residual risk. For this purpose, residual risks should always be documented and subjected to regular monitor-and-review procedures.

Target Risk: Target risk is the residual risk we are aiming for i.e. the amount of exposure we are planning to accept. It is the desired risk level after planned actions are implemented to improve risk response

Acceptable risk: It is neither possible nor desirable to eliminate every risk. Some risks are accepted or tolerated in exchange for the benefits arising from those activities in confidence that the risk is being properly controlled. To tolerate risk does not mean to disregard it but rather we review it and aim to reduce it further. Where risk control measures cannot bring the risk exposure to below an unacceptable level, the activity must be referred to senior managers.

For practical purpose all risks which are coloured green in the Risk assessment matrix (Risk Analysis Framework, Appendix 1) would be considered controlled risks and therefore, acceptable. The Governing Body must consider the amount of risk they are prepared to tolerate and therefore the Board sets the risk tolerance levels. If a risk exceeds the 'tolerance line' set by the Board either by impact or probability, the Lead Manager must notify the Governing Body for a decision on the action to be taken. On occasions, the Governing Body may accept medium or high risks, where risk factors are outside the control of senior management but the activity has to be continued regardless.

1.6 Risk Categories

As part of common risk language, similar kinds of risks areas can been grouped together into risk categories for ease of documentation and quick monitoring:

	Risk Category	Definition
1	**Strategic**	These concern the long term strategic objectives of the organisation. They can be affected by external factors such as the economy, changes in the political environment, technological changes, changes in customer behaviour or needs, legal and regulatory changes, missing opportunities and mismanagement risks. The strategic risks are mainly significant risks that can potentially impact the whole organisation. They are also invariably cross-cutting risks that impact across the services rather than just one area.
2	**Governance**	These concern the establishment of an effective

		organisational structure with clear lines of authorities and accountabilities. The risk events can include inappropriate decision making and delegation of authorities and weaknesses related to leadership and Governing Body cohesiveness. All can result in sub optimal performance and poor commission decisions for the CCG.
3	**Financial**	These concern the effective management and control of the finances of the CCG. The risk events can range from insufficient funding, poor budget management, mismanaging assets and liabilities and compensation claims etc.
4	**Legal & Compliance**	These concern risks such as health and safety, consumer protection, data protection, employment practices, failing to comply with employment legislation or industrial action, claims against the CCG and regulatory issues.
5	**Operations & Performance**	These concern the day-to-day issues the CCG is confronted within its operational activities, breakdown in partnerships, failure to manage internal change etc. Operational risks are largely short to medium term where frequency is high/medium likelihood and impact is low to high.
6	**Change / Project Management**	These concern risks that programmes and projects do not deliver agreed benefits on time and within agreed budget and/or introduce new or changed risks that are not effectively identified and managed.
7	**People**	These concern insufficient human capital (capacity and capability) and inappropriate staff behaviour. These risks can have a significant impact on the performance and reputation of The CCG. It may involve risks associated with the environment and health and safety issues.
8	**Clinical / Commissioning**	These concern risks that arise directly from the commissioning of healthcare for patients. This includes clinical errors and negligence, healthcare associated infection, patient safety issues, poor quality of service and patient satisfaction etc.
9	**Information Technology / Information Governance**	These concern the day-to-day issues the CCG is confronted with in relation to information governance and Information technology infrastructure. They can be anything from loss of data to failure of a key IT system. It covers risk events such as technological breakdown, loss of hard or soft copy data, failure by 3rd parties to deliver service, breakdown in partnership,

		breaches of Data Protection Act etc.
10	**Reputational**	These concern issues that impact on confidence in the CCG and the services it commissions

This list is for guidance only and is not exhaustive.

Taking Risks: The CCG acknowledges that taking risk(s) is sometimes necessary in order to develop new technologies and make service improvements. In taking risks, the negative outcomes and benefits should always be carefully balanced. The risk assessments must be carried out and appropriately documented. The controls should be agreed and monitored to minimise negative outcomes. The risk tolerance must be set within the broader framework of public acceptability, available professional guidance, shared understanding of law, ethics, evidence-base and cost effectiveness.

No person (staff, patients or public) should ever be exposed to any risk unless they agree to accept the risk either on an informed basis or by virtue of entering into an employment/job/profession and understanding the risks associated with their activities.

Risk Appetite: Risk appetite, at organisational level, is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept/retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range.

Risk Treatment: Risk treatment is the process of selecting and implementing measures to modify the risk. Risk treatment includes as its major element, risk control/mitigation, but extends further to, for example, risk avoidance, risk transfer, risk financing, etc.

2. Risk Management and Assurance Accountability and Responsibility

2.1 The Governing Body and the Integrated Governance and Audit Committee

The CCG Governing Body is responsible for governing the management of risk within Croydon CCG. It exercises oversight of risk through holding management to account for quality and risk management matters. In addition, the CCG Governing Body will annually review and sign off the commitment to Health and Safety Statement of Intent.

The Integrated Governance and Audit Committee is a Committee of the CCG Governing Body. The committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of organisation's activities, both clinical and non-clinical that supports the achievement of the organisations' objectives.

Some of the main functions of this committee are to receive reports from the auditors and executive officers on the CCG's internal control system and make recommendations to the Governing Body on safeguarding of assets, independence and effectiveness of internal and external audit, effectiveness of internal financial control systems and general control environment.

The Committee is therefore authorised to oversee, review and approve the strategic and annual plans of the internal & external auditors and the co-ordination of their work.

The Committee will review systematic reports and positive assurances from the Senior Management Team and from committee directors and managers on the overall arrangements for governance, risk management and internal control.

The committee will provide strategic direction to support the development of robust governance structures within the CCG and the development of the CCG's governance and risk management strategies.

The committee will provide assurance to the Governing Body that the controls and the assurances identified within the assurance framework are adequate to address the potential risks to the organisation's objectives and ensure that any gaps are monitored. The committee will provide executive support to the development and delivery of robust governance structures within the CCG and in the development of the CCG's governance and risk management strategies. The committee will be responsible for monitoring:
- Effective implementation of the Risk Management Strategy across the CCG.

- That an overview is maintained in respect of the CCG's exposure to risk.
- The development and maintenance of Assurance Framework and Risk Register (see Section 3.1, 3.2 and 3.3)
- Priorities and actions for further action and expenditure in relation to controlling risk.
- Annual objectives for risk management.
- Reporting to the National Reporting and Learning System

Information on risks will be received in the following ways:
- Minutes of subgroup meetings
- Formal reports or minutes from working groups overseeing risk
- Incident reporting and trend analysis
- Serious Incident (including Serious Incidents) reporting
- Safeguarding reporting
- Complaints and PALS reporting
- Claims reporting
- Reports covering the governance and assurance systems and processes.

2.2 The Senior Management Team

The SMT is the executive group whose purpose is to support the Accountable Officer and individual Directors in the fulfilment of their responsibilities and to enable the development and delivery of corporate direction for the management of the CCG.

The Senior Management Team will receive reports on matters relating to the strategic, operational and corporate management of the CCG, including risk management.

The Senior Management Team will be agree Terms of Reference, annual work plan and receive regular reports from specific statutory and other agreed meetings that are accountable to the Senior Management Team.

2.3 The Accountable Officer

As the Accountable Officer (AO), the overall responsibility for risk management lies with the AO, ensuring that the CCG has appropriate risk management arrangements in place throughout the organisation.

2.4 The CCG Directors

All directors, as part of the Senior Management Team and Governing Body have responsibility for identifying and managing strategic risks for the organisation. Additionally, the executive directors are accountable for managing operational risks associated with their areas of responsibility.

Each Director will, as part of their personal objectives:

- Ensure the Assurance Framework reflects key risks, controls and assurances related to strategic objectives, and that these are reviewed regularly.
- Ensure that there is a risk register in their directorate which incorporates risks, controls and assurances and is reviewed regularly.
- Ensure that all policy papers submitted to the Governing Body and the management team from their areas of responsibility make specific reference to risks in their options appraisal.
- Ensure that adequate resources are made available for minimising risks
- Ensure that the investigation process is activated for incidents falling within their area of responsibility in accordance with the Incident Reporting Policy and Procedures.
- Ensure that Risk Management is robust across all commissioning support services

The <u>Director of Quality and Governance</u> is the designated accountable Director for risk management, including complaints, and for circulating relevant legislation and guidance relating to risk management. They will:

- Delegate managerial responsibilities to those Heads of Service/managers set out in the Commissioning Support Unit (CSU) offer and the Integrated Commissioning Unit (ICU) offer with responsibility for quality including patient safety, PPI, IM&T and Corporate Risk Management to ensure that the CCG has necessary arrangements in place to facilitate risk management.
- Ensure that appropriate resources are available for risk management functions within the CCG.

In addition to these delegated accountabilities the Director of Governance and Quality carries responsibility as the CCG Governing Body's nominated Senior Information Risk Officer (SIRO).

The **Serious Information Risk Officer (SIRO)** is responsible for:
- Understanding how the strategic business goals of the CCG may be impacted by information risks; acting as an advocate for information risk on the Board and in internal discussions
- Ensuring the Board is adequately briefed on information risk issues
- Overseeing the development of an Information Risk Policy, and a Strategy for implementing the policy within the CCG" s Information Governance Framework
- Reviewing the annual information risk assessment to support and inform the Statement on Internal Control (SIC)
- Taking ownership of risk assessment processes for information risks, supported by the Information Governance Manager, Information Security lead (via SLCSS IT), Records Manager and the Caldicott Guardian
- Reviewing and agreeing action in respect of identified information risks

- Providing a focal point for the resolution and/or discussion of information risk issues

The Chief Finance Officer is accountable for financial and recovery risks. The Chief Finance Officer has responsibility for investment decisions (including capital), and financial management, including the management of financial risks. In addition, he is responsible for corporate governance, countering fraud, and IT investments.

The Director of Commissioning is accountable for risk associated with commissioned services, primary care services i.e. independent contractors, Children and Adult Safeguarding and commissioning activities (hosted via the CSU and ICU)

2.5 Responsibilities of Heads of Services (CSU/ICU)

Senior managers are responsible for implementing the CCG Risk Management Strategy and Policies.

Heads of Service are also responsible for:
- Ensuring that appropriate and effective risk management processes are in place within scope of responsibility and their designated area(s) of work; and that all staff are made aware of the risks within their work environment and of their personal responsibilities.
- Preparing specific policies and guidelines to ensure all necessary risk assessments are carried out.
- Developing and implementing risk management plans that support the organisation's overall risk management plan.
- Implementing and monitoring appropriate Risk Management control measures within their designated area(s) and scope of responsibility.
- In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, Heads of Service are responsible for bringing these risks to the attention of their Director and the Corporate Risk Manager
- Encouraging staff in the identification and reporting of hazards and risks.
- Investigating or activating investigations for incidents falling within their area of responsibility in accordance with the Incident Reporting Policy and Procedures.
- Ensuring that all staff are able to access training and necessary information to enable them to work safely. These responsibilities extend to anyone affected by The CCG's operations including sub-contractors, members of the public and visitors.

2.6 Responsibilities of All Managers (CSU/ICU)

Risk Management is an integral part of all the CCG activities including business planning and commissioning. As part of the business planning process each

year, managers are required to identify and record main risks associated with the CCG objectives in their area of responsibility.

A standard Risk Analysis process (tool) will be used throughout the CCG to identify, assess and control all risks. This process will apply in prioritising actions and allocating resources. See Appendix 1.

All managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) and scope of responsibility. In areas where significant risk has been identified and where local control measures are considered to be potentially inadequate, managers are responsible for bringing these risks to the attention to the relevant Assistant Director/Director.

All managers have the same general responsibilities as staff for risk management; in addition, managers (including supervisors and team leaders) have the following responsibilities:

- To ensure that staff understand risks within their department
- To report all risks to an appropriate senior manager within their department for which they are unable to take action.
- To assess all risks those are reported to them by staff and complete appropriate risk assessment forms.
- To investigate incidents falling within their area of responsibility in accordance with the Incident Reporting Policy and Procedures.
- To ensure that all staff are aware of all CCG policies and procedures that relate to risk management and their department.

2.7 Responsibilities of Corporate Affairs Manager (CSU)

The Corporate Affairs Manager will facilitate and oversee the risk management processes. The Health and Safety Manager, Infection Control AD, Fire Safety Advisor, and Governance teams in commissioning directorates will provide additional support to staff in relation to managing risks in their areas of work.

The Corporate Affairs Manager is not the risk owner but facilitates risk management processes. It is acknowledged that risk management remains an integral part of the normal management processes for all managers.

The Corporate Affairs Manager will receive and collate information on risks related to the CCG, monitor new developments in risk management, develop knowledge and expertise and act as liaison point for risk management issues, both within the CCG and with external bodies. The role includes monitoring of proposed developments and initiatives and checking that they are likely to be compliant with good risk management practice. The Corporate Affairs Manager is also responsible for the maintenance and development of the corporate risk register and Assurance Framework.

The Corporate Affairs Manager will work closely with the Deputy Director of Integrated Governance to ensure that appropriate arrangements for implementation of the risk management strategy are developed and will:

- Act as a central reference point resource for all risk management issues within the CCG.
- Co-ordinate corporate risk management activities ensuring that risk assessments are conducted on a regular basis.
- Establish close links with committees and working groups overseeing risk management to ensure that information on risks is available to the Integrated Governance & Audit Committee, Senior Management Team, and the Governing Body.
- Ensure that all committees and working groups within the CCG incorporate Risk Management issues.
- Agree and implement risk management training.
- Establish and oversee the corporate risk register and the status of control for all major risks.
- Work with Directors and managers to ensure appropriate policies and procedures are in place and monitored.

2.8 Responsibilities of Health and Safety Manager (CSU)

The Health and Safety Manager has the following responsibilities:

- Ensure that the CCG remains compliant with the Health and Safety legislation and/or other statutory requirements
- Work with the Corporate Risk Manager to ensure all Health and Safety risks are assessed.
- Ensure that the CCG has appropriate Health and Safety polices in place.
- Ensure the CCG systems for incident reporting meet the requirements of the Health and Safety Executive (HSE)
- Ensure guidance is provided to staff on Health and Safety issues
- Ensure appropriate health and safety training is agreed and delivered
- Ensure health and safety policies and procedures are in place and reviewed regularly
- Ensure that health and safety incidents are investigated, when required
- Ensure that Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) and other health and safety related incidents are reported to the appropriate agencies

2.9 All staff members, volunteers and persons acting on behalf of the CCG

All the CCG employees and contractors are required to play an important role in the day-to-day management of risks. This should reflect in their actions, decision-making processes, business planning or any other activity they are involved in. In order to achieve this goal, all staff will need to maintain high level of awareness, critical evaluation of risks ensuring compliance with acceptable standards.

The responsibility for risk management specific to staff jobs will be set out in their job descriptions. All staff will be personally responsible for complying with the Risk Management Strategy and associated policies and procedures.

All staff are responsible for ensuring that they:

- Are aware of the risks associated with their actions
- Develop ways of integrating risk management in their every day practice and making informed decisions influenced by appropriate risk assessment.
- Minimise risks wherever possible, in a managed way. All staff are responsible for their actions and work towards minimising risks were ever possible.
- Report incidents / near miss and unsafe occurrences, in accordance with the risk management strategy.
- Actively involve themselves in identifying risks, their assessment and management as required by their teams and the CCG
- Co-operate with the CCG on arrangements for minimising risks such as by following policies and procedures.
- Are available for training opportunities for risk management.

2.10 Responsibilities of Commissioned Services

All commissioned services Independent Contractors are responsible for maintaining at all times their registration with the Care Quality Commission (CQC) including aspects of risk management and patient safety.

The monitoring of risk management arrangements of commissioned services remains an integral part of the governance framework of the CCG. The monitoring may take place via contract monitoring meetings, SUI reports, complaints, CQC reports or other sources in the public domain.

All incidents and identified risks, either identified during visits or assessments, or those associated with contractual arrangements, should be reported to the CCG.

2.11 Responsibilities of Agency Staff and Contractors and their Staff

All agency staff, contractors and contractors' staff have the following responsibilities:

- Be aware of the risks associated with their actions
- Undertake appropriate risk assessments
- Minimise risks wherever possible, in a managed way. All staff are responsible for their actions and work towards minimising risks wherever possible.

- In accordance with the CCG risk management strategy, report risks to their line manager as they become aware of them
- Co-operate with the CCG on arrangements for minimising risks.
- Ensure that they are fully aware of all appropriate the CCG policies and procedures that impact on their work.

3. Risk Assessment and Risk Management Framework

Risk assessment is a formal and systematic analysis technique, which helps in the identification and quantification of probabilities and consequences of risk. The CCG Risk Assessment Framework is based on the National Patient Safety Agency (NPSA) guidance and the Australia New Zealand Standard AS/NZS 4360:1999 and provides guidance on identifying, evaluating and controlling risks. This is a generic risk assessment method and can be applied in various contexts to assess any type of risk in a consistent manner.

The CCG will ensure training of the Governing Body and expect the provider of its commissioning support have a risk management training programme in place. The responsible managers will analyse work practices in these areas and review them to reduce unnecessary risks. The risk controls (risk treatment) will enable The CCG to determine whether the risks are being managed effectively through:

- Policies/guidelines
- Education and training
- Equipment
- Staff Competency
- Induction programme
- Or any other measures deemed necessary

Risk Assessment will be carried out by all services/departments to identify the significant risks arising out of all CCG procedures (environment, financial, health & safety, clinical) and assess their potential to cause injury, result in litigation, cause damage to the environment or property, result in delays or loss of reputation. These will be the basis of prioritising risk (and in turn the services, procedures etc.). High-risk issues will be given paramount importance. The risk assessment framework (appendix 1) sets out the process in detail.

The Risk Management Process

3.1 Assurance Framework (AF)

According to the Department of Health guidance, all CCGs are required to submit an annual Statement on Internal Control signed by the Accountable Officer and underpinned by a supporting Assurance Framework. This should provide the CCG Governing Body confidence that safe systems are in place, are subject to appropriate scrutiny and that the Governing Body is able to demonstrate that they have been informed about key risks affecting the CCG.

Additionally, the guidance given out in the NHS Governance Handbook (2006) states that the Assurance Framework should provide the organisations with a simple but comprehensive method for effective and focused management of the principal risks that arise in meeting its objectives. This simplifies Governing Body reporting and prioritisation which in turn allows more effective performance management.

The purpose of establishing an Assurance Framework is to ensure that:
   a) The CCG Governing Body is confident that its principal objectives can be achieved
   b) Has a process in place for identifying, minimising and prioritising risks that may prevent the achievement of principal objectives
   c) Strategic controls are in place to manage those risks
   d) Governing Body is satisfied with assurance it receives that these controls are effective and risks are managed appropriately

Process

In order that a robust system of assurance can be established the following steps are being followed:

- Principal objectives at strategic level are set out with involvement of the Governing Body
- Risks to the achievement of these objectives are identified and recorded on the Assurance Framework
- Key controls intended to manage these risks are identified
- Assurances available to cover these objectives and risks are evaluated and any gaps identified
- Action plans to address any gaps are identified, owned and regularly
- monitored

Principal Objectives

The principal objectives are reviewed each year as they are likely to change over time as the strategic imperatives of the CCG change focus. Those identified on the Assurance Framework are linked to other key plans so that they are consistent with local, regional and national strategic objectives, including the NHS Plan, the Integrated Strategic and Operating Plan, compliance with

governance and risk management standards, staff focus and partnership working.

Principal risks

Principal risks are those which threaten the achievement of the organisation's objectives. It is important to recognise that these need to be managed proactively rather than the organisation solely reacting to the consequences of risk exposure. Good governance requires that principal risks should be identified on a continuous basis using the CCG's risk management processes and Governing Body and Senior Management Team discussions and are reviewed through appropriate committees.

Key controls

The key controls to be identified are those which, when taken together, support our staff in the achievement of the organisation's objectives and include, for example:

- Management structure and accountabilities
- Integrated Governance processes including clinical governance and corporate governance arrangements
- Incident reporting and risk management processes
- Patient and public feedback procedures, including complaints
- Staff recruitment, retention, training and education
- Statutory frameworks, for instance the Standing Orders, Standing Financial Instructions and associated Scheme of Delegation
- Communications processes
- Compliance with Healthcare Commission, risk management and other quality standards
- Partnership Board reports

Internal Assurances

Internal sources of assurance on the effectiveness of the CCG's key controls include:

- Management reports to monitoring committees and Governing Body such as monthly, quarterly or annual reports
- Internal audit arrangements

Independent Assurance

Independent sources of assurance on the effectiveness of the CCG's key controls include:

- External audit (Audit Commission)
- External inspection bodies, such as Audit Commission and Care Quality Commission

Monitoring and Reporting

The Governing Body have agreed the following arrangements for ensuring that both the Risk Register and Assurance Framework are proactively monitored so that the processes are embedded within the organisation and link to key business, planning and investment decisions:-

Assurance Framework Monitoring
- Monitored for fitness of assurances and controls by Integrated Governance and Audit Committee each quarter
- Monitored by Governing Body once a year

3.2 Corporate Risk Register (CRR)

Maintaining a risk register is central to the CCG's Risk Management Strategy, which record information on key risks within the CCG and their controls. The Corporate Risk Register will be regularly updated as nature and severity of risks change over time. The register will also record the residual level of current risk and target risk. The register will provide basis for reporting on the status of risks within the CCG.

The risks may be identified from information received through various internal and external sources and recorded on the CRR. These include:

Internal	External
Regular risk assessments	Changes in National priorities
Adverse Incidents and Near miss reports	Public inquiries
Complaints (Public perceptions)	Changes in law
Claims	Hazard and Safety notices (HSE, MHRA, NPSA etc)
Training	Media
Whistle blowing	National reports (Expert Groups etc)
Audits	National inquiries
Patient satisfaction surveys	Assessment by external bodies
Research/ new technologies / service development	The CCG's strategy/operational plan
Note: This is not an exhaustive list	

The review of key risks on the risk register and directorate based registers will be monitored at the relevant governance group meeting. The risk registers will be used for establishing priorities for resources and supporting capital bids.

Monitoring Corporate Risk Register

The Integrated Governance and Audit Committee and sub-groups: Monitors high and extreme risks (15-25) as well as receives the risk register once a year.

Management Team: Monitors high and extreme risks (15-25) in more detail quarterly; with any changes to risk register each month

The Governing Body: Monitors Extreme risks (15-25) at every Governing Body meeting

3.3 Link between the Assurance Framework and Corporate Risk Register:

The high risk areas from the Assurance Framework should be further drilled down to include operational details in the Corporate Risk Register e.g. if poor implementation of a strategy is identified as a principal risk in the AF, then operational risks which can contribute to the implementation of that strategy e.g. compliance risks, governance risks or clinical risks should be added to the Corporate Risk Register along with control measures and actions to be taken.

4. Risk Management and Assurance Management

4.1 Serious Untoward Incidents

Responsible Director: *Director of Governance and Quality*

Responsible Manager: *Corporate Affairs Manager (CSU)*

The Corporate Affairs Manager is responsible for management of incidents and SIs. The CCG's Reporting, Management and Investigation of Incidents (including Serious Incidents) provides further clarity on working arrangements The SMT will receive quarterly reports on SIs.

4.2 Major Incident Planning

Responsible Director: *Director of Governance and Quality*

Responsible Manager: *To be confirmed*

The Integrated Governance and Audit Committee takes an overview of the risks facing the CCG and decides how Major Incident Planning fits in with other risk management activities such as business continuity planning. Local emergency planning arrangements should be informed by information regarding major adverse events and 'near misses'.

4.3 Claims Management

Responsible Director: *Director of Governance and Quality*

Responsible Manager: *Corporate Affairs Manager (CSU)*

The Corporate Affairs Manager is responsible for handling claims and works closely with the NHSLA and the CCG solicitors. The CCG's Claims Handling and Management Policy & Procedure will provide further clarity on working arrangements between claims handling, risk management and complaints. Any risks identified through claims and actions needed to minimise those risks should be reported to the responsible committees. The SMT receives quarterly reports on claims.

4.4 Complaints Management

Responsible Director: *Director of Governance and Quality*

Responsible Manager: *Quality and Clinical Governance Manager (CSU)*

Complaints and PALs team (CSU) is responsible for handling complaints and queries from members of public. The team will follow local policy based on national guidelines that have been updated in light of new legislation. Complaints can provide a useful insight into organisational risk areas. The SMT monitors complaints data and receives regular reports on the way they feed into strategies for managing organisational risks.

4.5 Information Governance and Senior Information Risk Officer (SIRO)

Responsible Director: *Director of Governance and Quality*

Responsible Manager: *Information Governance Manager (CSU)*

Effective information Governance is based upon the core principles of risk assessment and management. In order to make the best use of resources, each information system should be secured to a level appropriate to the measure of risk associated with it.

Information Security Management Standard ISO270001 is a key step in ensuring that the CCG has appropriate controls in place to protect the confidentiality, integrity and availability of person identifiable data so that the risk of data loss is minimised.

The Information Governance (IG) Toolkit is a standards-based self-assessment process across six IG domains. The toolkit compliance scores is electronically submitted to NHS Connecting for Health.   The results are subsequently forwarded to the Healthcare Commission and also to the National Information Governance Board.

Once identified, information security risks must be managed on a formal basis. Risks will be recorded within the CCG risk register and action plans put in place to demonstrate effective management of the risks.

4.6 Performance Management

Responsible Director: *Director of Governance and Quality*

Responsible Manager: *Business Intelligence Manager (CSU)*

Performance management is the process of evaluation against specific objectives, standards, other organisations or historical data enabling judgement to be made on the relative position or progress of the CCG's priorities, services and responsibilities.

It is important that the CCG's performance management system provides timely information about achievement of business objectives and functions with a sharper focus on effective planning and developments. The risk management strategy / policy supports the performance management process by identification of risks to achieving individual objectives, controls in place, action plans and provision of assurances.

4.7 Training and Development

Risk management education and training of all staff is an essential element of developing safety culture. The CCG will train its Governing Body and expects its commission support services to ensure mandatory induction programmes, include a module of introduction to risk management and to make available a

range of training programmes for risk assessment and management, health and safety, fire, infection control, manual handling and incidents reporting and handling, investigation and Root Cause Analysis. An ongoing risk management-training programme needs to be in place, based on staffs' training need analysis.

The Governing Body members will be appropriately trained and skilled in risk management and in carrying out risk assessment through management seminars.

Raising general awareness of staff regarding specific risk areas will also be undertaken through staff briefings, targeted email shots, induction programme and inclusion of relevant documents on the CCG Intranet and/or public drive.

All professional staff will be responsible for ensuring that they undertake necessary training to maintain their accreditation.

The Corporate Affairs Manager (CSU), in consultation with all directorates will develop and implement annual training programme for core risk management areas across the CCG.   This will include training to new governing Body members and arranging risk management seminars for the Governing Body and senior managers. The training will include the risk assessment tools used by the CCG.   All managers are responsible for ensuring that appropriate / designated staff attends these training sessions.

4.8 Policies and Procedures

The importance of up to date easily understood policies; procedures, guidelines and standards cannot be over emphasised in relation to risk reduction. The Senior Management Team will monitor that policies and procedures remain up to date and are available to those who need to use them. The Corporate Affairs Manager (CSU) is responsible for maintaining continuous programme of reviewing all policies and procedures. Regular audits will be undertaken to ensure compliance with policies and procedures. A consistent framework will be developed to produce and ratify policies and procedures.

Links with other relevant policies

Incident / Near Miss Reporting and Managing Policy Including SUIs. Procedures for Reporting and Managing Incidents/Near Miss including SUIs.

The former document provides policy aspects of incident reporting and managing whereas, the second document provides an account of detailed and step-by-step guidance to deal with and investigate incidents. All staff and particularly managers should familiarise themselves with these procedures.

Quality Strategy

The Quality Strategy will set out the CCG's arrangements as a commissioner to ensure that a framework exists for contracting and monitoring high quality, world

class innovative and safe services which are cost effective. The reporting, analysing and learning from incidents is an essential element of improving patient safety and quality of care.

Serious Incidents

SIs in healthcare are uncommon but when they occur the NHS has a responsibility to ensure there are systematic measures in place for safeguarding people, property, NHS resources and reputation. The CCG is required to ensure effective governance and learning following all incidents and seeks to work closely with all provider organisations as well as commissioning staff members to ensure all incidents are reported and managed appropriately. The Reporting, Management and Investigation of Incidents (including Serious Incidents) Policy provides further clarity on working arrangements.

Major Incident Plan

The CCG has a duty to protect and promote the health of the community, including at times of emergency. It is committed to ensuring it can respond quickly and effectively to any major incident. The CCG's Major Incident Plan details how it will do this.

Complaints Policy

Sometimes an incident may give rise to a complaint. The CCG Complaints policy sets out the procedure for handling and responding to complaints received from patients or their relatives. It clarifies which serious complaints may be investigated as SUIs. In case a serious complaint is investigated as a SUI, the policy also describes the process for informing the patient and/or relatives about the investigation process to be followed.   The Corporate Affairs Manager (CSU) will need to be kept fully informed with the progress of the investigation of individual complaints.

Legal Claims

The CCG is liable for the actions of its employees in the legitimate course of their employment. It is essential that the Corporate Affairs Manager is given early warning of incidents, which may lead to potential negligence claims. Civil Litigation Reforms require that the CCG must investigate incidents in preparation for litigation. The incident reporting system is therefore crucial to the good management of claims.

The Claims Policy and Procedures outline the key principles and process by which claims will be handled by the CCG ensuring best professional practice at local level. This includes clinical negligence, employer's liability and third party claims. This is keeping in line with civil litigation requirements and NHSLA guidelines issued by the NHS Litigation Authority. The Claims Policy ensures that health care governance issues are addressed and robust investigations are carried out as required by the principles set out in the Reporting, Management and Investigation of Incidents (including Serious Incidents) Policy.

Disciplinary and Appeals Incorporating Suspension Policy and Procedure

The aim of this policy and procedure is to uphold the high standards of conduct required by the CCG and to provide a fair and consistent method of dealing with breaches of these standards.

Health and Safety at Work Policy

The policy promotes a safe environment for staff and patients, and provides guidance and procedures for the organisation. The principles of this policy apply to reporting health and safety incidents and near misses.

Procedure for Raising Concerns (Whistle Blowing)

This procedure was introduced to enable staff to raise concerns at an early stage if they have concerns at work. Usually these concerns are easily resolved. However, when they are about unlawful conduct, financial irregularity or concern about the clinical competence of another clinician, it can be difficult to know what to do. This procedure provides guidance for staff in these circumstances.

Being Open Policy: When Patients are harmed

Being open, as defined by the National Patient Safety Agency (NPSA), simply means apologising and explaining to patients and/or their carers as to what happened if someone was harmed receiving treatment.

Being Open policy compliments the CCG's current Policy and Procedure for Reporting and Managing Incidents including Serious Untoward Incidents (SUIs), and reaffirms our commitment to openness, as well as clarifying the process for staff on extending apologies to patients and /or their carers who are harmed as a result of their treatment. Being Open policy aims to improve the quality and consistency of communication with patients and/or their carers. In doing so, it can reduce trauma suffered by patients and potentially reduce complaints and claims.

4.9 Monitoring, Reviewing and Auditing

The Integrated Governance and Audit Committee will agree and monitor an annual risk management work plan. Progress on delivery will be reported to the Governing Body on annual basis covering:

- Regular reports on progress in meeting risk management targets
- A annual review of the Risk Management Plan
- The major risk areas on the risk register
- Incident and Near miss trends

This risk management strategy/plan will be reviewed annually as part of review of Quality strategy whereas this policy will be reviewed every three years unless there was an overriding reason for reviewing it.

4.10 External Assurances

The internal Audit and the Audit Commission will provide independent assurance to the Audit Committee and Governing Body on key aspects of the risk management system.

4.11 Key Performance Indicators

The CCG will measure risk management performance through:

- Progress against risk management action plan
- Implementation of lessons learnt from SUIs, complaints and claims
- Achievement of risk related performance targets as detailed in the CCG's business plan
- Uptake of training which have direct impact on reducing risks

Key Performance Indicators are proposed in the table below.

Risk Management KPIs

Key Indicator	Purpose	Construction	Use of the indicator / action required	Frequency of review	Review body(ies)
BEING PRO-ACTIVE: IDENTIFYING AND MANAGING RISK *Note: Mandatory fields within the risk register ensure that the Trust process for assessing risks of all types is followed (min. data set in accordance with NHSLA requirements)* ***(NHSLA Criterion 1.5 a)***					
Total number of risks on register	Provides a quantification of the number of risks that are subject to control which can be „benchmarked" with other management units etc.	Sum of all risks on the unit risk register.	Compare with other management units and if the number is considered low in comparison then establish whether the process of risk identification needs improving	Quarterly	Integrated Governance and Audit Committee
Number of risks opened in the reporting period	Provides a quantification of the number of risks that were identified within the reporting period which can be benchmarked against other management units	Sum of all risks with open date falling in the reporting period	Compare with other management units and with relevant performance data (incident/ complaints/claims/ audit/ targets etc) and if number is considered low in comparison establish whether process of risk identification needs to be strengthened	Quarterly	Integrated Governance and Audit Committee
% training in risk management carried out as identified in training needs analysis	Provides a quantification of compliance with the risk management training needs analysis which can be benchmarked against the target (indicator of risk management capability)	Number of staff trained as a % of the total number who require to be trained	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Quarterly	Integrated Governance and Audit Committee
% of local risk assessments with review(s) in date @ time of reporting	Provides a quantification of the number of risks that are subject to monitoring in accordance with planned arrangements which can be compared with target	Sum of all risks where the „Next review date" is greater than the report date expressed as a % of the total number of open risks	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Quarterly	Integrated Governance and Audit Committee
% of risk management actions completed on time	Provides a quantification of the number of planned controls which have been implemented on time (in accordance with planned timescales) which can be benchmarked against target	Sum of all actions completed on time as a percentage of the total number of actions due for closure in the reporting period (actions which are carried forward in breach from the previous reporting period are included in the calculation)	Performance and record plan for improvement	Quarterly	Integrated Governance and Audit Committee
LEARNING FROM EXPERIENCE: INCIDENT REPORTING, INVESTIGATION AND SAFETY IMPROVEMENT					
Number of SIs occurring	Provides a quantification of the number of serious incidents which have occurred which can be benchmarked against other units/commissioned services/specialties and trends monitored over time	Sum of all SIs with opened date falling in the reporting period	Compare with other management units and monitor trends over time; if the number is considered high consider the following: – Need for aggregate analysis to identify recurring themes / root causes – Need for improved monitoring of safety improvements and shared	Quarterly	Integrated Governance and Audit Committee

Key Indicator	Purpose	Construction	Use of the indicator / action required	Frequency of review	Review body(ies)
			learning from incidents – Possible high reporting rate		
% SI investigations completed within 45/60 day deadline	Provides a quantification of the number of serious incident investigations which have been completed on time which can be benchmarked against the target	Sum of all investigations due for closure within the reporting period which are closed within 45/60 working days expressed as a % of the total number of investigations due for closure in that period	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement, where appropriate	Quarterly	Integrated Governance and Audit Committee
% SI actions completed on time	Provides a quantification of the number of planned improvements which have been implemented on time which can be benchmarked against target safety	Sum of all actions completed on time as a percentage of the total no. of actions due for closure in the reporting period (actions which are carried forward in breach from the previous reporting period are included in the calculation)	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Quarterly	Integrated Governance and Audit Committee
Percentage of SI action plans that are compliant with due dates	Provides a quantification of the % of serious incident action plans which are on target for completion, in line with due dates	Sum of action plans with all actions compliant with due dates at the time of reporting, expressed as a % of the total number of open action plans	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Quarterly	Integrated Governance Committee
Incident reporting rate (IRR)	Provides a quantification of the rate of reporting which can be benchmarked against the target (mean national IRR? Other CCGs?). A higher IRR is indicative of a better safety culture	Number of incidents reported per ……	Compare with target and if rate is low consider need for: – Local awareness raising – Improved feedback and learning from incidents	Quarterly	Integrated Governance Committee
Incident notification lag	Provides a quantification of the time from incident to local management review of the form and return to the Risk Dept	Mean difference between the incident date and the date of receipt of the incident form in the Risk Management Office	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Quarterly	Integrated Governance Committee

Context:	Source: (Project, Vital Sign, Key objective, Serious Incident, Compliance etc.)	**NHS**
Key Objective ((*Specific, Measurable, Agreed, Realistic and Time bound*)		Croydon Clinical Commissioning Group
Responsible Director:	**Lead Manager:**	**Risk Register Record**
Which Principal objective in the Assurance Framework is this linked to:		
Date Assessed (Opened):	**Date signed off by Lead Director:**	**Date last Reviewed:** **Record No.**

Risks and Controls

Risks	Controls	
(Please state what could possibly go wrong? how could it go wrong? Any reasons that could prevent you achieving the objective stated above.)	Please describe below what controls are currently in place to manage risks stated in the left hand column	Are there any gaps in control i.e. what other controls are needed to mitigate the risks?
1.		
2.		
3.		
4.		
5.		

Consequences / Impact

What will be the consequences or impact of risks that have been identified above? *(For guidance please use Risk Assessment Matrix)*

Original (Inherent) Risks Score				*Residual Risk*				*Target Score*		
Impact (Consequences)	**Likelihood (Probability)**	*Risk Score*		**Impact** (Consequences)	**Likelihood (Probability)**	*Risk Score*		**Impact** (Consequences)	**Likelihood (Probability)**	*Risk Score*

Action Plan – Where gaps in controls are identified above, please state the actions which will be employed for addressing those gaps (The actions should be SMART i.e. specific, measurable, Agreed, Realistic and time bound)	*Expected date of completion*	*Date when completed*
1.		
2.		
3.		
4.		
5.		

Internal Assurances

Positive Assurance – Has the Governing Body and other committees received/will receive assurances?	**Please state when this was sent and what method of reporting was used:** Governing Body / Governing Body committees (e.g. quarterly/ annual reports, minutes)	**Gaps in Assurances:** Assurances which need to go to Governing Body/ relevant committees

External Assurance

Positive Assurance – Has the Governing Body and other committees received/will receive assurances?	**Please state when this was sent and what method of reporting was used:** Governing Body / Governing Body committees (e.g. quarterly/ annual reports, minutes)	**Gaps in Assurances:** Assurances which need to go to Governing Body/ relevant committees

For risk scoring please use the Risk assessment Framework.

Likelihood / Consequences	1. Rare	2.Unlikely	3.Possible	4. Likely	5.Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15

2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

1 - 3 Low	4 – 6 Moderate	8 – 12 High	15 – 25 Extreme

Please complete all sections electronically. After completing the form please retain a copy in you local risk register. For organisational risks, please send a copy to Risk Manager irrespective of the risk score. For operational / team risks, only send it to the Corporate Risk Manager if it is an extreme risk (15-25) and has been signed off by your lead director.

Risk Assessment Framework

Introduction

Risk assessment is a formal and systematic analysis technique, which helps in the identification and quantification of probabilities and consequences of risk. The consequences may be in the form of loss, failures of services or harm to staff, patients and users. The process involves defining preventative measures to reduce the chances of recurrence and/or impact of consequences.

To simplify, Risk Assessment is an examination of your work or those you are responsible for and identifying what could cause harm or loss and how to minimise recurrence and/or impact.

Risk assessment consists of four steps:

- **Identification:** Defining or listing of activities or a risk area/category such as fall, equipment failure, medication errors etc.
- **Risk Evaluation:** the evaluation of frequency and potential consequences;
- **Risk Treatment or Control:** a process of determining appropriate measures to reduce risk; and
- **Risk Communication:** the sharing of risk information in simple language to all stakeholders.

Aim

The aim of risk assessment process is to identify and evaluate risks in a consistent way which may be related to business planning, clinical activities, services delivery and the environment; and to implement appropriate controls to minimise those risks.

Risk Assessment Process

Risk assessment involves determining chances as well as negative consequences of intended actions, decisions or activities. This can be carried out at two levels.

a) In making every day, minute-to-minute decisions, conscious or subconscious weighting of reasonable actions against their possible consequences,

b) Involving a systematic and formal process, which is applied to more important decisions and needs working together with group/s of people. This process is commonly referred to as the Risk Assessment Process. When risks are identified, they should be explicitly assessed and systematically recorded including:

    The process and outcome of assessment
    The process and outcome of decision-making
    The evidence base or reasons for the decision

All services are required to carry out initial risk assessments related to key areas of their functions, followed by ongoing assessments as risks are identified through other sources. All risk assessments should be carried out in teams and/or groups except the Health and Safety

assessments, which should be carried out by competent person/s. This systematic approach to risk management will be based on the model below.

Depending on grade of the risk, the designated manager (Head of service/Assistant Director/ Director) will sign off the Risk Assessment, ensuring appropriate control measures and action plans are in place. The risk assessments will be recorded on risk register and action plans will be monitored as part of management responsibilities**.**

Once the mitigating actions to reduce the risks have been completed, they should be noted in the risk register along with the residual risk score and the grade.

What will be assessed and recorded on the Corporate Risk Register:

All risk assessments will be graded and scored using the risk assessment matrix and added to the risk register.

Risks associated with the following will be assessed and recorded on risk register:

- Strategic and business plan targets
- Adverse incidents and near misses
- Complaints
- Claims
- New projects
- Research and trials
- Environmental risk including Health & Safety Risks
- Fire safety
- Security
- Red Risks from the directorate risk registers

The source of the risk must be recorded on the Risk register. For assessing specific risks the generic risk assessment framework may be used in conjunction with other risk assessment tools specific to those areas.

The score generated by the risk assessment matrix will be used to prioritise actions and allocation of resources.

Key Steps For Risk Assessment

Establish the context	-	Define the activity or objective What are the goals and objectives
Risk identification	-	What can possibly go wrong How can it happen
Risk Assessment	-	What would be the consequences or impact What are the contributing factors What are the chances of that risk being realised
Evaluation and Ranking	-	Evaluate options for reducing risks looking at the contributing factors Quantify costs of actions to reduce risks

Risk Treatment or Control	-	Identify actions, which reduce total, cost /impact of risk and give best value for money
	-	Address the issues identified at the risk-assessment stage, which could threaten the achievement of targets Compare costs against benefits
	-	*Avoid:* not proceeding with activity likely to generate the risk
	-	*Reduce:* reducing or controlling the likelihood and consequences of the occurrence
	-	*Transfer:* arranging for another party to bear or share some part of the risk through contracts, partnerships, joint ventures, etc.
	-	*Accept:* some risks may be minimal and retention acceptable.
Monitor and review	-	Monitor Risk Impact Review effectiveness of action Has the risk priority changed
Communicate	-	Who needs to know (internal/external stakeholders)

Risk Assessment Matrix

The risk assessment matrix is a risk grading system which enables quantification of risks by considering quantitative and qualitative measures of severity (impact or consequences) and likelihood (frequency or probability) using a colour coded, 1-5 rating system. The risk score is obtained by multiplying <u>likelihood x severity.</u> Details of the risk assessment matrix are given below. Risks can be graded as green, yellow, brown or red.

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	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/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

		unresolved	findings are not acted on		
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing 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 >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Projects/	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Objectives	Key 'political' target is being achieved and impact prevents improvement	Key 'political' target is being achieved but impact reduces performance marginally below target in the near future or Performance currently on target, but there is no agreed plan to meet the target	Key 'political' goal is marginally below target or is soon projected to deteriorate beyond acceptable limits or There is an agreed plan but it does not yet meet the rising target	Key 'political' target not being achieved and impact prevents improvement, or substantial decline in performance trend	Key 'political' target is not being achieved and the impact further deteriorates the position
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract /

				million Purchasers failing to pay on time	payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

With some risk assessments, you may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	1	2	3	4	5
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	**Low risk**
	4 - 6	**Moderate risk**
	8 - 12	**High risk**
	15 - 25	**Extreme risk**

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 34) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (Page 36) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L   (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Further Actions

Following grading of risks further actions will be required:

Red: █ 15 - 25

Extreme risk, urgent action required. Notify the line manager and relevant Director immediately. Send a copy of risk assessment form to the Corporate Risk Manager within 24 hours of formal assessment. The risk will be recorded on the Risk Register and the relevant committees will be informed. Action plan is to be monitored by the Senior Management Team and the Integrated Governance and Audit

Amber: █ 8 - 12

High Risk, Notify the Assistant Director/Director who will inform the Executive Team. The risk will be recorded on the Risk Register and the relevant committees informed. The Senior Management Team, and the Integrated Governance & Audit Committee will monitor the action plan

Yellow: █ 4 - 6

Moderate risk needs attention of line managers. Action plan required to be monitored within Directorates and must be discussed at the Directorate Management meetings. These risks should be recorded on the Directorate Risk Register.

Green █ 1 - 3

Low-level risk within acceptable limits, Line manager responsibility as it needs to be managed by routine procedures.

Risk Treatment Methods / Options

For each risk, determine treatment options. The objective of this stage of the risk assessment process is to develop cost effective options for treating the risks. Treatment options are driven by outcomes that include:

- Avoiding the risk,
- Reducing the risk,
- Transferring the risk, and
- Retaining the risk.

Avoiding the risk - not undertaking the activity that is likely to trigger the risk.

Factors to consider the validity of this option include:

- What will happen if the activity is not undertaken?
- Is the risk level too high to proceed / continue with the activity?
- Is the cost of the required controls higher than the benefit of the activity?
- Will the failure of the activity have critical consequences for other areas of the business?

Reducing the risk - controlling the likelihood of the risk occurring, or controlling the impact of the consequences if the risk occurs.

Factors to consider for this risk treatment strategy include:

- Can the likelihood of the risk occurring be reduced? (through preventative maintenance, or quality assurance & management, change in business systems and processes), or
- Can the consequences of the event be reduced? (through contingency planning, minimising exposure to sources of risk or separation/relocation of an activity and resources).

Transferring the risk totally or in part: This strategy may be achievable through moving the responsibility to another party or sharing the risk through a contract, insurance, or partnership/joint venture. Please be aware that a new risk arises in that the party to whom the risk is transferred may not adequately manage the risk!

Retaining the risk and managing it. Resource requirements feature heavily in this strategy.

Cost/benefit analysis

For risk areas where financial aspects play a predominant part in decision making, the completion of a cost / benefit analysis of each treatment option provides a sound basis for selecting the best option to manage the risk. The following points will assist your analyses.

- Ensure your analysis is broad. Identify the resource implications of the proposed treatments. For example, will a new software system need to be funded, will additional people be required. What are the travel implications?

- Discuss the expected benefits from each option.

Decide which option provides the best cost / benefit outcome. List the agreed costs and benefits of the potential treatment.

Identify which potential risk treatment options will be implemented

Based on the options available, decide which potential treatment option/s should be implemented. There will often be more than one risk treatment for a risk.

Possible Sources which may be used for identifying risks

The risks may be identified from information gathered from number of internal and external sources. Please see the table below:

Possible Internal Sources	Possible External Sources
Regular risk assessments	Changes in National / Local priorities
Adverse Incidents and Near miss reports	Public inquiries
Complaints (Public perceptions)	Changes in law
Claims	Hazard and Safety notices (HSE, MHRA, NPSA etc)
New Projects	Media
Whistle blowing	National reports (Expert Groups etc)
Audits	National inquiries
Patient satisfaction surveys	Assessment /inspection by external bodies
Brainstorming sessions	Service development / new activities

Who is responsible for identifying risks and carrying out risk assessments?

All Staff members	Identifying and reporting hazards, incidents, near miss etc.
	Whistle blowing
Managers /Clinicians	Regular risk assessments and review of existing risks
	Complaints
	Clinical & other audits
	Project risks
	Patient satisfaction surveys
	Hazard Safety Notices
	Any other area in the above list
Directors / Assistant Directors/Service Heads	Changes in local / national priorities /law
	Public / national confidential inquiries
	National reports
	Assessment / inspections by external bodies

Responsibility for Maintaining / Reviewing Risk Register

CCG wide Risk Register and Assurance Framework	
Maintenance:	Corporate Risk Manager
Review and updating:	Lead Managers
Signed off by:	Lead Directors
Monitoring:	Committees overseeing risk management and Governing Body

Directorate Risk Register	
Maintenance:	Designated person by each directorate
Review and updating:	Lead Managers
Signed off by:	Lead Director
Monitoring:	Integrated Governance & Audit Committee.

Frequency of review of risks and controls:

Red Risks	Every month, updated by lead managers and reviewed by Management Team
Amber Risks	Quarterly, updated by lead managers and reviewed by lead directors
Yellow Risks	Quarterly, updated by lead managers and reviewed by lead managers and directors
The whole risk register	Quarterly overview by committees overseeing risk management & Governing Body

Risk Assessment following an adverse incident, Near miss, Complaint or Claim

Risk assessment should be carried out following an SUI, complaint or claim investigation looking at the key root causes leading to that incident.

If the risk has already been identified, please revisit your risk register and review grading and control measures (actions) for reducing that risk. You may need to add further controls.

If it is a new category of risk and has not been identified before, please use the risk assessment procedure.

Risk Assessment and Monitoring Flow Chart:

Hazard /Risk identified at source

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Team/ Designated person assesses risk/s and complete risk assessment form

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Risk assessment form checked and signed off by Head of profession/Assistant Director/ Director

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Is it a significant risk?

Yes → If risk rated Red, forward risk assessment to the Line manager/ Assistant Director/ Director

↓

The designated manager (as above) considers risk control measures, develops an action plan and implements them. Red risks need to be recorded on Corporate Risk Register.

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For Red Risks, a copy of the Risk assessment form sent to the Corporate Risk Manager for Corporate Risk Register as soon as the risk assessment is completed

No ↓

If risk rated Green/ Yellow/Amber, manage locally enter on the Directorate Risk Register

↓

Monitoring and Review

Directorate Risk Register reviewed at the Directorate Management meetings.

Corporate Risk Register to be reviewed by Senior Management Team/ Integrated Governance and Audit Committee/Board