NHS Bracknell and Ascot Clinical Commissioning Group

NHS Slough Clinical Commissioning Group

NHS Windsor, Ascot and Maidenhead Clinical Commissioning Group

Title of meeting CCG Governing Body Meeting in Public			
Date of Meeting		**Paper Number**	
Title		Risk Management Framework	
Sponsoring Director (name and job title)		Nigel Foster, Chief Financial Officer	
Sponsoring Clinical Lead (name and job title)		n/a	
Author(s)		Christina Gradowski, Head of Corporate Affairs	
Purpose		The Risk Management Framework has been updated to reflect current risk management processes	
The xxx Committee is required to (please tick)			
Approve	X	**Receive**	
Discuss		**Note**	
Risk and Assurance (*outline the key risks / where to find mitigation plan in the attached paper and any assurances obtained)*		The purpose of the Risk Management Framework is to ensure that risks affecting the three CCGs are appropriately identified and managed in order to improve the quality of care for patients, provide a safe and secure environment for staff, patients and visitors and maintain operational effectiveness and achievement of business objectives	
Legal implications/regulatory requirements		Every organisation owes all of its employees a duty of care to ensure that their place of work complies with the Health and Safety at Work Act 1974 and all its subsequent regulations and EU Directives.	
Public Sector Equality Duty		Applies to all staff	
Links to the NHS Constitution (relevant patient/staff rights)		Aligned to **Staff – your rights and NHS pledges to you** It is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High-quality care requires **high-quality workplaces, with commissioners and providers aiming to be employers of choice.**	
Strategic Fit		Risks are aligned to strategic objectives outlined in the CCG's Five Year Plan	

Commercial and Financial Implications *(Identify how the proposal impacts on existing contract arrangements and have these been incorporated?* *Include date Deputy CFO has signed off the affordability and has this been incorporated within the financial plan. Include details of funding source(s)*	Date Deputy CFO sign off …….
Quality Focus *(Identify how this proposal impacts on the quality of services received by patients and/or the achievement of key performance targets* *Include date the Director of Nursing has signed off the quality implications)*	Quality Risks are reported via the Quality Risk Register and included on the Assurance Framework where aligned to strategic objectives Date Director of Nursing sign off…….
Clinical Engagement *Outline the clinical engagement that has been undertaken*	Clinicians are involved in the identification of risks within their work on joint committees
Consultation, public engagement & partnership working implications/impact	Risks are raised during Committee business where patients / public are involved – lay members and Healthwatch
NHS Outcomes *Please indicate (highlight) which Domain this paper sits within by highlighting or ticking below:* *Please note there may be more than one Domain.*	Domain 1 Preventing people from dying prematurely; Domain 2 Enhancing quality of life for people with long-term conditions; Domain 3 Helping people to recover from episodes of ill health or following injury; Domain 4 Ensuring that people have a positive experience of care; and Domain 5 Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Executive Summary

(summary of the paper and sign-posting the reader to the key sections within the report / paper)

The Risk Management Framework covers the three CCGs in east Berkshire (Bracknell and Ascot CCG; Slough CCG and Windsor, Ascot and Maidenhead CCG). As member organisations there is a need to have clarity on the risks that are pertinent to one CCG and all three CCGs strategic objectives, where collaboration takes place (e.g. provider contracts, strategic programmes and projects) and the actions taken to mitigate these risks. This Framework has been updated to take account of current processes and committee structure.

Recommendation(s)

To approve the updated Risk Management Framework

NHS Bracknell and Ascot Clinical Commissioning Group

NHS Slough Clinical Commissioning Group

NHS Windsor, Ascot and Maidenhead Clinical Commissioning Group

NHS BRACKNELL & ASCOT CLINICAL COMMISSIONIG GROUP

NHS SLOUGH CLINCIAL COMMISSIONING GROUP

NHS WINDSOR, ASCOT & MAIDENHEAD CLINICAL COMMISSIONING GROUP

RISK MANAGEMENT FRAMEWORK

FEBRUARY 2015

Version No:	Draft v0.4
Approved By:	CCG Governing Body
Approval Date:	xxx March 2015
Review Date:	February 2017

Amendment History

Date	Paragraph	Author	Version	Summary of Change
May12		Steph Bennett	Draft 0.1	Creation of document
August 2012		Lise Llewellyn	Draft 0.2	Review / streamline for CCG
March 2013		Christina Gradowski	Draft 0.3	Review inclusion of CCG committee structure
Feb 2015		Christina Gradowski	Draft 0.4	Review and updated to reflect current roles, responsibilities and committee structure

1. INTRODUCTION

1.1. The Risk Management Framework covers the three CCGs in east Berkshire (Bracknell and Ascot CCG; Slough CCG and Windsor, Ascot and Maidenhead CCG). As member organisations there is a need to have clarity on the risks that are pertinent to one CCG and all three CCGs, where collaboration takes place (e.g. provider contracts, strategic programmes and projects) and the actions taken to mitigate these risks. Thereafter the three CCGs will be referred to as 'the CCG'.

1.2. Risk is described as:

"The chance of something happening that will have an adverse impact on objectives".

1.3. The purpose of the Risk Management Framework is to ensure that risks affecting the three CCGs are appropriately identified and managed in order to improve the quality of care for patients, provide a safe and secure environment for staff, patients and visitors and maintain operational effectiveness and achievement of business objectives.

1.4. Risk is inherent throughout the organisation's activities. The CCG's' Governing Body recognises the need to provide a framework for the development of risk management systems and processes through the creation of an active learning culture in which people can learn from, and respond positively to, incidents and identified weaknesses.

1.5. The organisation will build a system of internal and shared controls and assign responsibility for the assessment and management of risk at all levels of the organisation across the breadth of its responsibilities. The robust management of risk will ensure that high quality, safe and affordable services for the patients of the CCG are commissioned and that business objectives are achieved.

2. SCOPE OF THE RISK FRAMEWORK

2.1. This document relates to the management of risks faced by the CCG. This will include the risks to staff, patients and visitors and also those relating to the CCG's relationships with partner organisations, stakeholders and third parties where these impact on the organisation's objectives.

2.2. The CCG may be exposed to a wide range of potential risks including:

a) Direct risks

i) Strategic business risks

ii) Financial risks

iii) Management risks

iv) Information risks

v) Reputational risks

b) Indirect

i) Patient safety and quality risks – through commissioned services

ii) Health and Safety risks – through commissioned services

iii) Workforce and recruitment risks - through commissioned services

iv) Estates and environmental risks - through commissioned services

c) Commissioned services support

i) Commissioning support risks - delivery core commissioning functions to support local delivery

2.2. The integration of clinical and non-clinical risk is important in making risk management an integral part of the day to day business of healthcare and for creating a holistic approach to risk management. For the purposes of this strategy;

a) **clinical** risk can be described as that which has the potential to impact on diagnosis, treatment, health care outcome, quality and safety of services

b) **non-clinical** risk is that associated with corporate or financial matters, the environment, health and safety, information etc.

3. AIMS AND OBJECTIVES OF THIS FRAMEWORK

3.1. The framework aims to:

a) Identify and minimise risks to the CCG of failing to meet its strategic objectives as set out in its strategic and business plans;

b) Ensure that risks to the quality, improvement and delivery of patient services and patient care are identified and minimised within agreed practical and financial limits;

c) Protect patients, staff and third parties from avoidable risks;

d) Minimise risk to the CCGs assets within agreed practical and financial limits;

e) Raise staff awareness of and use of risk management techniques;

f) Provide compliance with national standards – clinical, financial and organisational.

3.2. The methodology of delivering the risk framework is to:

a) Identify risks;

b) Assess and analyse risks;

c) Provide a sound qualitative assessment system;

d) Identify and consider control measures;

e) Decide appropriate treatment at the correct management level;

f) Manage risks;

g) Monitor known risks;

h) Report and analyse risks and potential near misses;

3.3. The CCG will implement these methodologies by:

a) Having the appropriate strategies, policies, tools and resources

b) Educating and training staff

c) Identifying individual lead responsibilities and establishing appropriate committees and working groups

d) Providing accurate and timely reporting and analysis of accidents, incidents, complaints, claims and losses.

e) Performing audit processes, trend analysis and performance monitoring

3.4. This framework defines the organisation's concept of risk management, its place in corporate governance and the structures and processes needed to ensure that the risks facing the organisation are identified and managed appropriately.

4. ACCOUNTIBILITY AND REPORTING STRUCTURES

4.1. Responsibility of CCG Governing body

4.1.1. The Governing Body has overall responsibility for managing risk associated with the CCG's activities. The Governing Body mitigates this risk by adopting sound and practical governance structures and processes - the system of 'internal control'. It will receive regular assurance that the key risks which potentially threaten the organisation's strategic objectives are being well managed and mitigated via the Governing Body Assurance Framework and Directorate / Committee Risk Registers. These registers will also include the joint (federated) risks so that the Governing Body has overview of risks being managed by joint committees. If the Governing Body is concerned over joint risks the CCG lead will escalate these concerns to the appropriate committee. The Governing Body will produce an annual statement of internal control (or annual governance statement) that it is doing its "reasonable best" to manage the CCG's affairs efficiently and effectively through the implementation of internal controls and the effective management of risk.

4.2. Responsibility of Audit Committee

4.2.1. The Joint Federated Audit Committee is a statutory sub-committee of the CCG Governing Body. It is responsible for reviewing the adequacy of the arrangements put in place for risk management by the CCG Governing Body and, through testing these arrangements, providing 'independent' assurance to the Governing Body that these systems are robust and effective.

4.3. Responsibility of the Operational Leadership Team

4.3.1. The Operational Leadership Team is a sub-committee of the Governing Body and is responsible for putting in place arrangements for clinical and non-clinical risk management in the CCG and for monitoring these processes on behalf of the Governing Body and providing necessary assurances as required by the Governing Body. There are different chairing arrangements relating to each of the CCGs (WAMCCG – Head of Operations; BACCG – CCG Manager, Slough CCG – Head of Operations).

4.4. Joint Committees

4.4.1. The Governing Body of the CCG has delegated key functions - quality, strategy and planning, and policy approval to the respective joint committee. Each year the scope and responsibilities assigned to the various joint committees is reviewed and terms of reference updated. Sub-committee terms of reference are approved by the CCG's Governing Body.

4.4.2. The CCG will expect these committees to identify, manage and report on the risks within these areas through its own risk register. Bi-monthly these committees will provide the risks registers to the Head of Corporate Affairs who will review and include high and extreme risks for inclusion in the Governing Body Assurance Framework to ensure that CCG is sighted on risks and mitigation.

4.4.3. Each risk register / Assurance Framework will include the designated 'risk owner' who is responsible for updating the risk(s), producing the mitigating action plan and rating the risk. The Head of Corporate Affairs will contact the risk owner on a regular basis for the updated risk register.

4.5. Responsibility of the Chief Officer

4.5.1. The Chief Officer has overall responsibility for implementing and maintaining a sound system of internal control and management of risk within the CCG, including responsibility for signing the statutory annual governance statement on behalf of the Governing Body.

4.5.2. The Chief Officer has lead responsibility for implementing and monitoring the corporate governance and risk management process within the joint committees, including the management of the Governing Body Assurance Framework and Risk Registers and ensuring that the Governing Body is advised of all extreme and high risks. The Governing Body is responsible for obtaining specialist advice on the management of risk from the Head of Corporate Affairs; specific risks will are managed by the 'risk owner' who may be required to attend the Governing Body or a sub-committee of the Governing Body to provide assurance on any risk mitigation plan they have put in place.

4.5.3. The Chief Financial Officer has the lead for ensuring that CCGs able to manage their financial risks. This will include ensuring that the CCG has appropriate support from the Commissioning Support Unit functions including information support, contract management and financial management amongst other services.

4.5.4. Appendix A shows the reporting relationships between committees and working groups, which includes the reporting of risk.

4.6. Responsibility of Head of Operations / Head of Corporate Affairs

4.6.1. The Head of Operations has lead responsibility for implementing and monitoring the corporate governance and risk management processes within the local CCG and is assisted in this task by the Head of Corporate Affairs. This includes the management of the Governing Body Assurance Framework and Risk Registers and ensuring that the Chief Officer and Governing Body are advised of all extreme and high risks. They are responsible for obtaining specialist advice on the management of specific risk as required from CCG / CSU or other agreed advice providers. They are responsible for advising the CCG's partner stakeholders where risks to the CCG may impact on their own objectives and agreeing how these will be managed.

4.7. Responsibility of CCG Managers

4.7.1. Managers are responsible for maintaining those areas of the risk register relating to their work area and for ensuring that risks are identified, assessed and where necessary recorded on the register.

4.7.2. Managers should understand and implement this risk management framework, policies and procedures and all relevant legislation and ensure that they access appropriate expert advice when required.

4.7.3. Managers shall ensure that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility; and that staff are made aware of the risks within their work environment and of their personal responsibilities.

4.7.4. Managers will ensure any necessary risk assessments are carried out within their department in liaison with appropriate identified relevant advisors where necessary e.g. Health & Safety, Occupational Health, Infection Control etc.

4.7.5. Managers shall introduce the identification and mitigation of risk into all business plans, projects and all activities that are new to the organisation.

4.7.6. Managers will implement and monitor any identified and appropriate risk management control measures within their scope of responsibility. Where extreme/high risks are found line managers are responsible for informing their line manager who must ensure that immediate steps are taken to mitigate the risk, that it is placed on the risk register if appropriate and reported to the appropriate committee and/or Governing Body.

4.7.7. Managers must ensure that all staff are given the necessary information and training together with the appropriate resources and that these are monitored, to enable them to: work safely, raise concerns, make risk assessments, take appropriate risk reduction measures, report risk to line managers when applicable and undertake directed statutory and mandatory training.

4.7.8. Manager shall ensure that the arrangements for the first aiders and first aid equipment required within the department are complied with. That the location of first aid facilities are known to employees; ensuring that proper care is taken of casualties and that employees know where to obtain appropriate assistance in the event of serious injury. Identify and release suitable staff to be trained as first-aiders.

4.7.9. Manager will make adequate provision to ensure that fire and other emergencies are appropriately dealt with and the correct action is taken.

4.7.10. Managers shall ensure that staff are aware of and encouraged in the use of the Adverse Event /Near Miss Policy and Procedure, understand their responsibilities and reports are made as required with appropriate risk reduction measures taken.

4.8. Responsibility of all CCG Staff

4.8.1. Be familiar with and comply with the Risk Management Framework and associated policies and procedures.

4.8.2. Report incidents/accidents and near misses using the procedures in the Adverse Event/Near Miss Policy and Procedure.

4.8.3. Be aware of the principles of risk management and undertake risk assessments for safe working within their department and working environment, eliminating risk where possible and managing and reporting risk to line managers.

4.8.4. Be aware of their duty under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the organisation's business and are responsible for ensuring that they undertake all available statutory health and safety training.

4.8.5. Comply with all policies, regulations and instructions to protect health, safety and welfare of anyone affected by the CCG's business.

4.8.6. Complete the organisation's statutory / mandatory training as required. .

4.8.7. Must not, either intentionally or recklessly, interfere with or misuse any equipment provided for the protection of safety and health.

4.8.8. Be aware of emergency procedures e.g. evacuation and fire precaution procedures relating to their particular work locations.

5. RISK IDENTIFICATION

5.1. The foundation of good risk management is a robust system of risk identification and assessment.

5.2. The table below sets out examples of situations where risks may be identified. This list is not exhaustive and risks may be identified from any number of other sources.

Source of risk identification	Person responsible for identification, analysis and assessment of the risk and action planning
Partnership risks	Head of Operations
Staff concerns	Line manager
CCG service development project	Head of Operations
Care Quality Commission reports	Director of Nursing (Quality Team)
Adverse events	Line Manager
Serious adverse events – federated quality committee	Deputy Director of Nursing (Quality Team)
Complaints	Head of Corporate Affairs (complaints service provided by the CSU)

Health and Safety audits	Line managers and safety representatives –
NICE guidance	Director of Nursing
Patient Satisfaction Surveys	Deputy Director of Nursing Quality Improvement
Audits and external assessments reports	Joint Federated Audit Committee Chief Financial Officer
Major Projects, business plans and new activities	Associate Director for QIPP & Business Planning
Major financial risks -QIPP	Chief Financial Officer
Strategic planning strategic and planning committee	Chief Officer Director of Strategy & Commissioning Chair of strategic planning and transition committee
New/ changing legislation	Head of Corporate Affairs
Clinical risk assessments (if required)	Competent clinicians
Safeguarding	Deputy Director of Nursing – Safeguarding

6. RISK ASSESSMENT

6.1. A risk assessment involves examining the level of risk posed by an event or issue, consideration of who and what may be affected by the risk and evaluating whether hazards are adequately controlled, taking into account any existing control measures.

6.2. Risk assessments should be carried out pro-actively to identify any significant risks arising out of all CCG activities.

6.3. All risks (clinical and non-clinical), adverse events and near misses, complaints and claims and estates and Health & Safety reviews will be identified, graded and analysed using the risk evaluation matrix, based on the Australian and New Zealand Risk Model set out in appendices B and C

6.4. See appendix D for guidance as to which risks go into a risk register once a risk assessment has been performed.

7. RISK QUANTIFICATION, ACCEPTABILITY AND REPORTING LEVELS

7.1. Risk Quantification

7.1.1. Risk is described as:

"The chance of something happening that will have an adverse impact on objectives".

7.1.2. It is measured in terms of impact and likelihood e.g.: Risk = Impact x Likelihood

7.1.3. To provide guidance and to ensure unanimity of scoring across the CCG, all staff will use the risk matrix and methodology in appendix C. When assessing the risk scores, the existing controls which are in place to manage and mitigate the risk should be taken into account. The risk score will therefore relate to the residual risk (see appendix C for guidance weighting of controls to determine the risk rating).

7.2. Acceptability

7.2.1. The organisation recognises that it is not possible and not always desirable or economic to eliminate all risks and that systems of control should not be so rigid that they prevent innovation and imaginative use of limited resources. When all reasonable control mechanisms have been put in place some residual risk will inevitably remain in many processes and this level of risk must be accepted. Different levels of acceptable risk may be applicable across the organisation.

7.3. Risk Management Reporting Levels

7.3.1. The Governing Body must be made aware of all significant risks. This is classified as all risks rated “high risk” and “extreme risk” on the Risk Matrix.

7.3.2. Extreme risks must be notified immediately to the Chief Officer/ Head of Corporate Affairs / Head of Operations responsible for ensuring mitigating action is taken. They are responsible for advising the CCG Governing Body and for ensuring that an entry is made on the CCG risk register and Governing Body Assurance Framework. The relevant senior manager is responsible for actioning, monitoring and reporting progress as appropriate.

8. THE GOVERNING BODY ASSURANCE FRAMEWORK

8.1. A key output from the Risk Management Framework is the Governing Body Assurance Framework. The assurance framework is driven by the organisation’s strategic objectives and provides the Governing Body with assurance that risks which threaten the achievement of those strategic objectives are being effectively managed.

8.2. The assurance framework for the CCG is the responsibility of the Governing Body and is led by the Head of Corporate Affairs and the Chief Officer

8.3. On an annual basis the Governing Body will identify the local risks which may threaten the CCG’s strategic objectives and the associated assurances and controls, and any gaps in those assurances and controls. In addition at the same period the joint committees will identify those risks that are pertinent to the those committees. Risks and actions to address gaps will be identified, owned and maintained by a named manager: joint risks will be owned and managed by the shared (federated) team: the local CCG risks will be managed by the CCG team. Each committee will review risk in an ongoing manner throughout the year.

8.4. Bi-monthly the CCG team and the joint committees will review the risk register and then send the updated position to each CCG Governing Body. These updated risk registers will combine with the local CCG risks to form the complete Assurance Framework for the CCG Governing Body.

8.5. The assurance framework will be regularly monitored by CCG Governing Body bi-monthly following discussion at the OLT meeting.

8.6. The Joint Federated Audit Committee is responsible for obtaining assurances from the Operational Leadership Team and directors / CCG managers that the processes to support the assurance frameworks are robust and that assurances and controls are in place.

9. RISK REVIEW PROCESS

9.1. All assurance framework risks and any other extreme or high graded risks will be reviewed and reported to the CCG Governing Body at every meeting held on public (in 2015 this will be on a quarterly basis).

9.2. The Joint Federated Audit Committee will assure themselves that the risk management process is robust by selecting high and extreme risks for further scrutiny, that controls and assurances are in place as described and that actions to mitigate risks are progressing satisfactorily. A 'deep dive' analysis of key risks will be undertaken by the Audit Committee at each meeting. Each CCG's Assurance Framework will also be submitted to the Audit Committee for review and scrutiny.

9.3. Risks will be regularly assessed as to acceptability (as set out in section 8.2), remedial action and progress and will in due course, when the level of risk has reduced, be removed from the relevant register.

9.5. The CCG Governing Body Assurance Framework will be reported to the Governing Body on a quarterly basis and will be available as part of the papers for that meeting on the CCG's website.

10. OPEN AND FAIR CULTURE

10.1. The CCG supports an 'open and fair' culture for its staff. However, where, following investigation, there is clear evidence of wilful or gross neglect contravening the organisation's policies and procedures and/or professional codes of conduct, or repeated evidence of poor performance despite intervention and support, these cases will be dealt with under the Disciplinary Policy. Available on the CCG's intranet http://nww.eastberksccgscollaborative.nhs.uk/wp-admin

11. WHISTLE BLOWING

11.1. The organisation believes that this strategy provides a robust structure for appropriate and pro-active risk management. If staff are concerned that risks are not being dealt with appropriately in their work areas, they are advised to raise this with their line manager, where this is inappropriate or unsuccessful, staff should refer to the process for raising concerns contained in the Whistle Blowing Policy available on the CCG intranet http://nww.eastberksccgscollaborative.nhs.uk/wp-admin

12. STAKEHOLDER INVOLVEMENT

12.1. The organisation will make this framework available to its stakeholders. Due to the complex organisational nature of the health landscape it will be important to identify accountability for risks shared across organisational boundaries and agree how these are best managed. This will be the responsibility of the Chief Officer. The Governing Body will at all times be mindful of ensuring that there is sufficient accountability in place to ensure risks do not fall between organisations because they are unidentified or unmanaged.

13. TRAINING

13.1. All CCG staff will be expected to undertake induction, statutory and mandatory and role-based training as directed and will be supported to do so by their line manager. The full list of statutory / mandatory training is available on the CCG intranet. http://nww.eastberksccgscollaborative.nhs.uk/wp-admin

14. MONITORING COMPLIANCE AND REVIEWING EFFECTIVENESS

14.1. Internal Monitoring of Effectiveness

14.1.1. The Joint Federated Audit Committee will arrange for periodically test the controls and assurances in place with particular risks (known as the 'deep dive' analysis) to provide assurances to the Governing Body that the risk management system conforms to internal and external audit requirements.

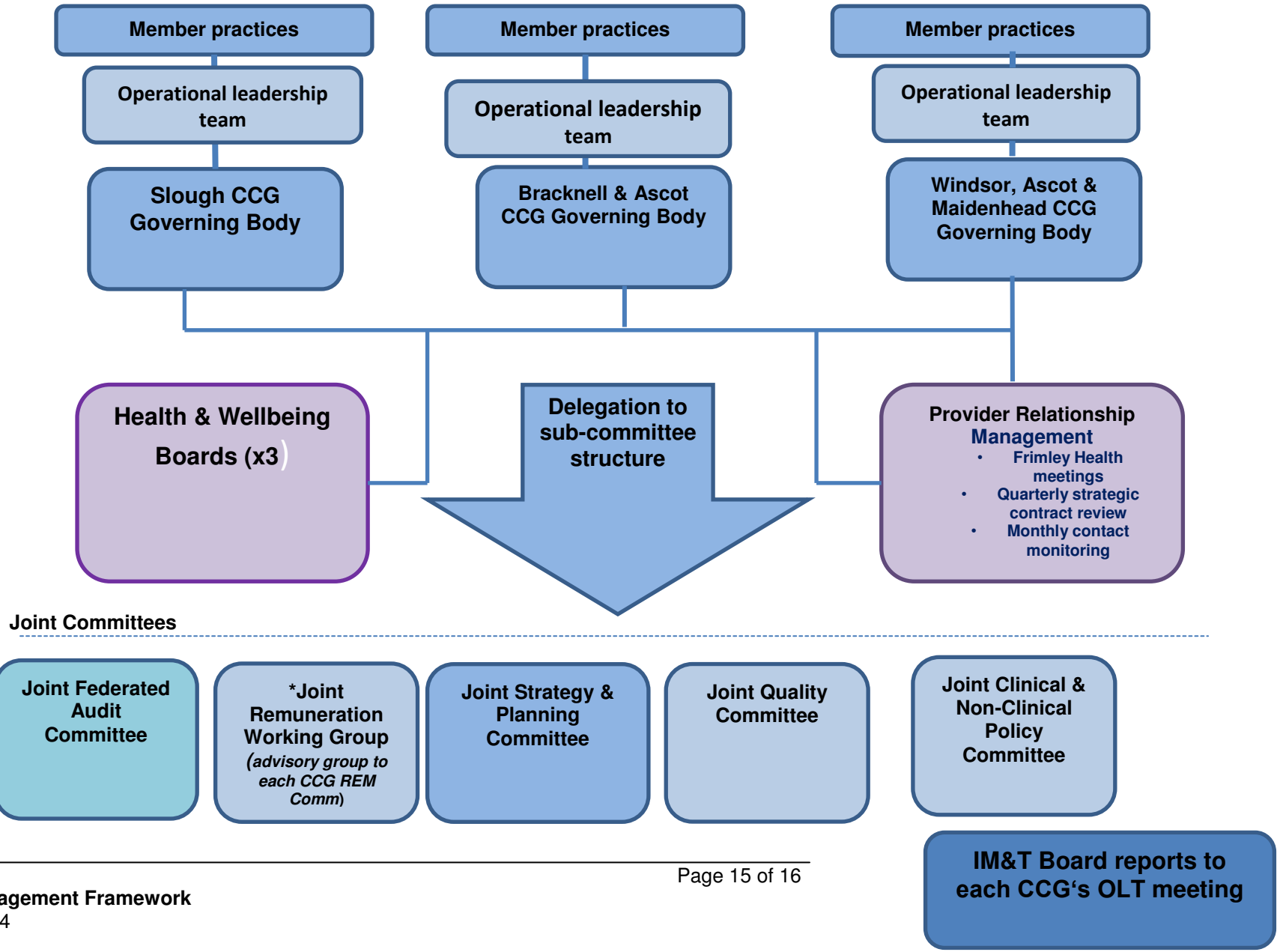
14.1.2. The uptake of training will be monitored via the workforce report reported to OLT and the Joint Policy Committee. Where issues in uptake are identified, or changes to the content of risk related training, frequency or staff group are proposed, these will be dealt with by the relevant Committee.

14.2. External Monitoring

14.2.1. The CCG's internal auditors will undertake an audit of the risk management system on a yearly basis which contributes to the internal auditor's opinion on the system of internal control. The results of this audit will be reported to the Joint Federated Audit Committee and any actions monitored on a six monthly basis.

14.2.2. External reports received from organisations such as the Care Quality Commission, External Auditors etc, will also be used as assurance over the effectiveness of the risk management controls in place and reported to the Joint Federated Audit Committee.

Governance structure / Governing Body / sub-committees



Appendix B - Australian and New Zealand Risk Model

Risk Management Process
(AS/NZS 4360:1999 – Risk Management)

Establish the context	-	Define the activity
	-	What are the goals and objectives
Risk identification	-	What can happen
	-	How can it happen
Risk assessment	-	How could risks occur
	-	What would be the effect if they did
	-	How could they be reduced
Evaluation and Ranking	-	Evaluate options for reducing risks
	-	Quantify costs of actions to reduce risks
	-	Identify actions, which reduce total, cost of risk and give best value for money
	-	Compare costs against benefits
Risk Treatment	-	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
Communication internal/external	-	Who needs to know,
Consult	-	Who is affected

Risk Assessment Forms

A generic risk assessment form is used for assessing risks within the organisation and can be applied to clinical or organisational risks (The form can be found on the intranet). The form ensures the principles of risk assessment are followed:

- Identify the hazard
- Identify those at risk
- Evaluate the risk
- Identify a risk treatment plan

Where there are specialist risk assessment tools in place, these are specified within the relevant policy. Please refer to the Policies section on the intranet

Appendix C – Calculating Risk Rating

Impact

To establish the Impact score go to the impact definition scale. For the risk issue you have identified consider what would happen if this risk were to be realised and choose the most appropriate row. The Impact score is the number at the left hand end of the selected row.

	1	2	3	4	5
Descriptor	**Negligible/Insignificant**	**Low**	**Moderate**	**Major**	**Extreme**
Objectives/Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage or minor reduction in quality / scope	5 -10% over budget / schedule slippage or reduction in scope or quality.	10 - 25% over budget / schedule slippage or failure to meet secondary objectives	> 25% over budget / schedule slippage or doesn't meet primary objectives
Injury (Physical/Psychological)	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, first aid treatment needed	RIDDOR / Agency reportable	Major injuries, or long term incapacity / disability (loss of limb	Death or major permanent incapacity
Patient Experience /Outcome	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience - readily resolvable	Mismanagement of patient care, short term effects (less than a week	Serious mismanagement of patient care, long term effects (more than a week	Totally unsatisfactory patient outcome or experience
Complaints/Claims	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaint	Multiple claims or single major claim
Service Business/Interruption	Loss / interruption > 1 hour	Loss / interruption > 8 Hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
HR /Organisational development **Staffing and Competence**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff. Minor error due to ineffective training. Ongoing unsafe staffing level	Uncertain delivery of key objective / service due to lack of staff. Serious error due to ineffective training	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training
Financial	Small loss	Loss > 0.1% of budget	Loss > 0.25% of budget	Loss > 0.5% of budget	Loss > 1% of budget
Inspection/Audit	Minor recommendations. Minor noncompliance with standards	Recommendations given. Noncompliance With standards	Reduced rating. Challenging recommendations. Noncompliance with core standards	Enforcement Action. Low rating. Critical report. Major non compliance With core standards	Prosecution. Zero Rating. Severely critical report
Adverse Publicity/Reputation	Rumours	Local Media - short term. Minor effect on staff morale.	Local Media - long term. Significant effect on staff morale	.national Media < 3 Days	National Media > 3 Days. MP Concern (Questions in House)

Likelihood

To establish the Likelihood score go to the Likelihood definition scale. Choose the most appropriate likelihood of the event occurring again from the five rows. The Likelihood score is the number at the left hand end of the row.

Level	Detail Description examples
1	**Rare:** May occur only in exceptional circumstances
2	**Unlikely:** Could occur at some time
3	**Possible:** Might occur at some time
4	**Likely:** Will probably occur in most circumstances
5	**Almost certain:** Is expected to occur in most circumstances

Risk Rating

To calculate the risk rating go to Risk Rating Matrix. Select the appropriate column for Impact and the appropriate row for Likelihood. The square where the rows intersect is the risk rating, and the colour coding categorises the risk as Low (green), Medium (yellow), High (orange), Extreme (red).

This table may not be applicable for all situations. If this is the case the table sets out a scale of parameters which can be used as comparable measures

The rating should take into account the controls and assurances in place to manage the risk – it is therefore the residual risk score.

Risk Rating Matrix

		Impact				
Likelihood		1	2	3	4	5
	1	L	L	M	H	H
	2	L	L	M	H	E
	3	L	M	H	E	E
	4	M	M	H	E	E
	5	M	H	E	E	E

The 'Impact' and 'Likelihood' scores are multiplied together to calculate the overall risk score

Appendix D – Example of Governing Body Risk Assurance Framework

For risks assessed as medium risk, managers are empowered to manage them within their services. Risks scoring higher than this must be brought to the attention of the Accountable officer/Operational Director.

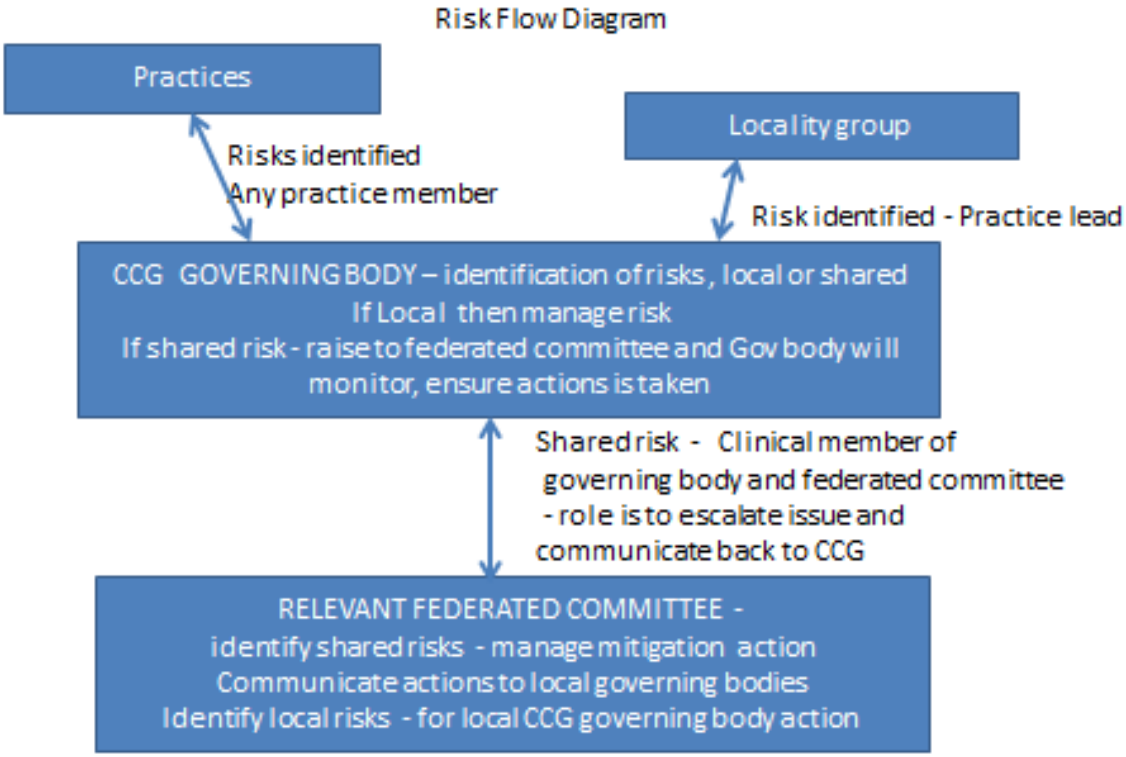
Controls, Action and Residual Risk

The controls already in place must be taken into account when assessing the risk rating (unless the risk treatment is to avoid the risk) and this would then be the residual risk rating. The register must state the actions that can be taken to improve the control of the risk.

Significant Risks and Acceptable Risks

The CCG accepts that no system can be totally risk-free and that there are occasions when the CCG will have to accept a degree of risk in the course of its undertakings. An acceptable level of risk is where all reasonable controls have been put in place to eliminate or reduce the risks to the lowest reasonably practicable level. This should be determined at a level in the organization as set out in Section 8.2.

Appendix E


Risk Flow Diagram
Practices
Locality group
Risks identified
Any practice member
Risk identified - Practice lead
CCG GOVERNING BODY – identification of risks, local or shared
If Local then manage risk
If shared risk - raise to federated committee and Gov body will monitor, ensure actions is taken
Shared risk - Clinical member of governing body and federated committee - role is to escalate issue and communicate back to CCG
RELEVANT FEDERATED COMMITTEE -
identify shared risks - manage mitigation action
Communicate actions to local governing bodies
Identify local risks - for local CCG governing body action