Item Number: 8

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP **SHADOW GOVERNING BODY MEETING**	NHS Vale of York Clinical Commissioning Group

Meeting Date: 2 August 2012

Report Sponsor:	**Report Author:**
Rachel Potts Chief Operating Officer	Mark Alty, Strategy and Development Officer (seconded) Rachel Potts, Chief Operating Officer

1. Title of Paper: Risk Management Strategy

2. Strategic Objectives supported by this paper

Improve the quality and safety of commissioned services.

3. Executive Summary

The Clinical Commissioning Group (CCG) is required to have a Risk Management Strategy. This report asks the Shadow Governing Body to consider and approve the attached Risk Management Strategy.

4. Evidence Base

Not applicable

5. Risks relating to proposals in this paper

Failure to implement an effective strategy may result in the CCG failing to be authorised or carry out its role effectively.

6. Summary of any finance / resource implications

Delivery of the strategy will be managed through existing resources.

7. Any statutory / regulatory / legal / NHS Constitution implications

Adopting the strategy enables the CCG to meet requirements for authorisation.

8. Equality Impact Assessment

The strategy has no specific equality implications of itself, however the way equality implications are accounted for in relation to risk management is outlined in the strategy.

9. Any related work with stakeholders or communications plan

The strategy will be made available for comment to the Patient and Public Engagement Steering Group.

10. Recommendations / Action Required

The Shadow Governing Body is asked to agree the attached Risk Management Strategy.

11. Assurance

The strategy will be applicable from immediate effect.

NHS Vale of York Clinical Commissioning Group

Risk Management Strategy

Version:	1.0
Ratified by:	
Date ratified:	
Name of originator/author:	Rachel Potts, Chief Operating Officer
Name of responsible committee/individual:	Corporate Governance Manager
Name of executive lead:	Rachel Potts, Chief Operating Officer
Date issued:	25.07.2012
Review date:	25.07.2013
Target audience:	Internal Staff and Board Members

Please note that the intranet version is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Contents

1.0 Risk Management Statement

1.1 NHS Vale of York Clinical Commissioning Group (Vale of York CCG) is committed to a strategy, which minimises risks to all its stakeholders through a comprehensive system of internal controls, whilst maximising potential for flexibility, innovation and best practice in delivery of its strategic objectives to improve the health of all the residents within the CCG.

2.0 Introduction

2.1 Good risk management awareness and practice at **all** levels is a critical success factor for Vale of York CCG. Risk is inherent in everything that we do, from determining service priorities, taking decisions about future strategies, or even deciding not to take any action at all.

2.2 Although we manage risk continuously – sometimes consciously and sometimes without realising it, we do not always manage risk systematically and consistently.

2.3 In accordance with the guidance contained in Department of Health Building the Assurance Framework (2003) the Vale of York CCG proposes to implement a system of internal controls, which will encompass financial controls, organisational controls and clinical governance. The system of internal controls is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the CCG's policies, aims and objectives,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

3.0 Scope

3.1 This policy applies to all employees of the CCG in all locations including temporary employees, locums and contracted staff.

4.0 Definitions

4.1 <u>Risk</u>

Risk is the chance something will happen that will have an impact on the achievement of our objectives, programmes or service delivery. This may include damage to the reputation of the CCG, which could undermine the public's confidence in us. It is measured in the terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect

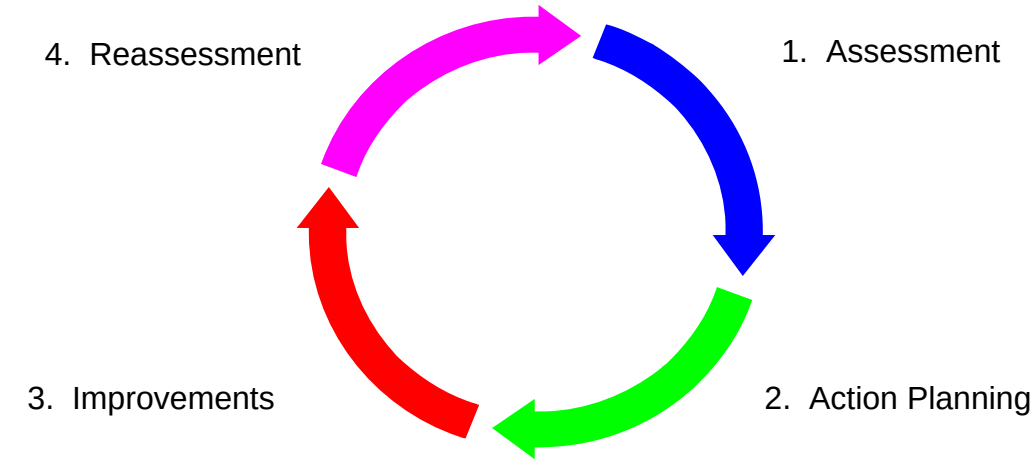
of the risk occurring). Risk may have a positive or negative effect. See Appendix A.

4.2 Risk Management

Risk Management is “the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.” Australian / New Zealand Risk Standards 4360:1999

4.3 The Risk Management Process

The risk management process is “the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.” Australian / New Zealand Risk Standards 4360:1999

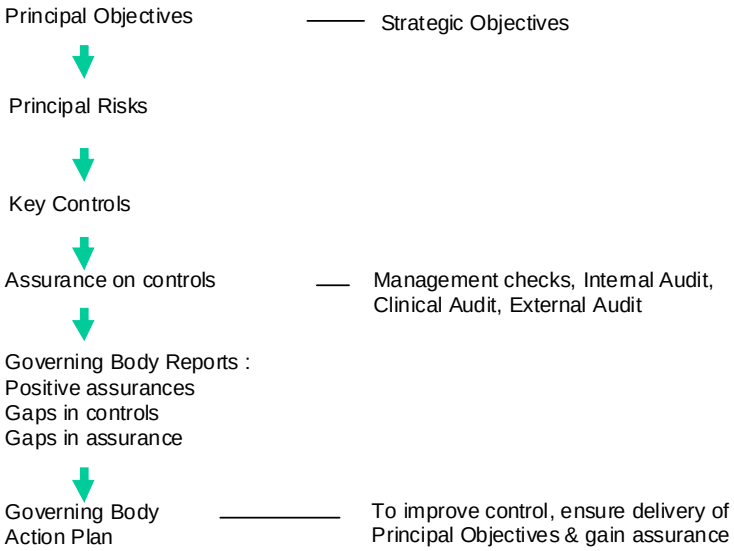


4.4 Significant Risks

Significant risks are those which, when measured according to the risk matrix at Appendix A are assessed to be high or extreme or threaten a corporative objective. The CCG Governing Body will take an active interest in the management of significant risks and will consider whether they need to be included on the Assurance Framework for ongoing assurance.

4.5 The Assurance Framework

The assurance framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Annual Governance Statement. This simplifies board reporting and the prioritisation of action plans, which, in turn allow for more effective performance management. (Reference B page 4).



4.6 Assurance

Assurance is a holistic concept based on best governance practice. It is a process designed to provide evidence that the CCG is doing its "reasonable best" to manage ourselves so as to meet our objectives, protect patients, staff, the public and other stakeholders against risks of all kinds. It is a fundamental process of governance that will assist us in identifying risks, determining unacceptable levels of risk and deciding where best to direct our limited resources to eliminate or reduce those risks. It exists to inform the CCG Governing Body about significant risks within the CCG for which they are responsible.

4.7 Encouraging Innovation and Experimentation

The CCG will seek to strike a balance between mitigating all risks and encouraging innovation and experimentation, within acceptable limits and where the potential benefits justify the element of risk.

5.0 Accountability and Responsibility

5.1 The Vale of York CCG Governing Body

The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces, and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:

- Identifies risks to the achievement of its strategic objectives
- Monitors these via the Assurance Framework
- Ensures that there is a structure in place for the effective management of risk throughout the CCG
- Approves and reviews strategies for risk management on an annual basis

- Receives regular reports from the Quality Committee and Audit Committee identifying significant clinical risks
- Receives regular updates and reports from the Management Team identifying significant risks and progress on mitigating actions
- Demonstrates leadership, active involvement and support for risk management

5.2 The Quality/Nursing Lead

The Quality/Nursing Lead promotes risk management processes with all Vale of York CCG member practices. This ensures that practices continuously improve quality of primary care and report risks to the CCG for assessment and mitigation. They are also responsible for:

- Ensuring risk management systems are in place throughout the CCG
- Ensuring the Assurance Framework is regularly reviewed and updated.
- Ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the Governing Body
- Overseeing the management of risks as determined by the Executive Group
- Ensuring risk action plans are put in place, regularly monitored and implemented

5.3 The Chief Operating Officer

The Chief Operating Officer has overall accountability for the management of risk and is responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support.
- Ensuring an appropriate committee structure is in place, with regular reports to the Governing Body.
- Ensuring that directors and senior managers are appointed with managerial responsibility for risk management.
- Ensuring appropriate Policies, Procedures and Guidelines are in place and operating throughout the CCG

5.4 Senior Managers

Senior Managers should incorporate risk management within all aspects of their work and are responsible for directing the implementation of the CCG Risk Management Policy by:

- Demonstrating personal involvement and support for the promotion of risk management
- Ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility.
- Setting personal objectives for risk management and monitoring their achievement
- Ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable.
- Ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis.
- Ensuring a risk register is established and maintained that relates to their area of responsibility and to involve staff in this process to promote ownership of the risks identified.
- Ensuring risks are escalated where they are of a strategic nature

5.5 Corporate Governance Manager

The Corporate Governance Manager has responsibility for:

- Ensuring that a risk register and Assurance Framework are developed and maintained and reviewed by the Management Team.
- Ensuring that Management Team have the opportunity to review risks jointly
- Providing advice on the risk management process
- Ensuring that the CCG Assurance framework and risk register is up to date for the Governing Body and all of its sub committees
- Working collaboratively with Internal Audit

5.6 All Staff

All staff working for the CCG are responsible for

- Being aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by the CCG's business and to comply with appropriate CCG rules, regulations, instructions, policies, procedures and guidelines.
- Taking action to protect themselves and others from risks
- Identifying and reporting risks to their line manager using the CCG risk processes and documentation
- Ensuring incidents, claims and complaints are reported using the appropriate procedures and channels of communication
- Co-operating with others in the management of the CCG's risks
- Attending mandatory and statutory training as determined by the CCG or their Line Manager
- Being aware of emergency procedures relating to their particular department locations.
- Being aware of the CCG's Risk Management Policy and complying with the procedures.

5.7 Contractors, Agency and Locum Staff

Managers must ensure that where they are employing or contracting agency and locum staff they are made aware of and adhere to, all relevant policies, procedures and guidance of the CCG, including the Incident reporting Policy and Procedure and the Health and Safety Policy.

- Take action to protect themselves and others from risks
- Bring to the attention of others the nature of risks which they are facing in order to ensure that they are taking appropriate protective action

6.0 Principles of Risk Management

6.1 The CCG is committed to a risk management strategy that enables us to achieve our key tasks that are: -

- Assessing the health needs of the local population, drawing on the knowledge of other organisations
- Drawing up strategies for meeting those needs, in the form of the Operating Plan, Healthier Lives (Strategic Plan) and Joint Strategic Needs Assessments developed in partnership with all the local interests and ensuring delivery of the National Health Service (NHS) contribution to it

- Deciding on the range and location of health care services for the CCG's residents.
- Determining local targets and standards to drive quality and efficiency in the light of national priorities and guidance, and ensuring their delivery
- Supporting the development of NHS Trusts, GPs and other independent contractors, so that they can rapidly assume their new responsibilities
- Allocating resources to NHS Trusts and monitoring their activity, quality and compliance with targets through the Contract Monitoring Boards.

7.0 What is an Acceptable Risk?

7.1 The CCG recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health benefits for local residents. In order to establish a consistent framework for the assessment and management of risk, the CCG has adopted a risk assessment tool (Appendix A) and has determined the levels of authority at which risks should be addressed. Risks identified as being in the extreme or high categories are regarded as significant risks and should be reported to the Governance and Quality Committee.

7.2 However, as a general principle the CCG will seek to eliminate or reduce all identifiable risk to the lowest practicable level and control all risks which have the potential to: harm its staff, patients, visitors and other stakeholders; have a high potential for incidents to occur; would result in loss of public confidence in the CCG and/or its partner agencies; would have severe financial consequences which would prevent the CCG from carrying out its functions on behalf of its residents. The CCG is committed to achieving this through its holistic approach to risk management within the clinical and corporate governance agendas.

7.3 All identified risk should be brought to the attention of immediate line managers. They will have the responsibility for assessing the risk in accordance with the risk assessment tool (risk matrix) in Appendix A.

7.4 The CCG has determined that those risks identified as low or moderate in accordance with the risk matrix can be regarded as acceptable risks. Those risks both clinical and non-clinical identified as being in the high or extreme categories should be regarded as significant risk and where a manager cannot immediately introduce control measures to reduce the level of risk to an acceptable level, these should be managed through the risk register process as identified at Appendix B. These risks will also be entered onto the CCG's corporate risk register and consideration given to whether the risk impacts on an objective and this risk will also be reflected in the Assurance Framework.

8.0 Implementation of Risk Management Strategy (or Systems for Managing Risk)

8.1 Assurance Standards

The CCG will build upon and continue to use the Assurance Framework process as a means of identifying and systematically reviewing identified risks, this process will be reviewed annually. Individual directors are responsible for identification and grading of risks together with producing and monitoring action plans and formally reporting to the Governance and Quality Committee on a regular basis.

9.0 Risk awareness training for senior management (Executive Directors and Governing Body Members)

The Governing Body will receive ad hoc risk awareness training through Governing Body workshops etc. Minutes and notes will provide evidence of attendance. Any members that are not able to attend will receive a copy of the minutes and the presentation.

10.0 Consultation, Approval and Ratification Process

Involved in the consultation of the strategy are the Governance and Quality Committee and CCG Governing Body.

This Strategy will be approved and ratified by the CCG Governing Body.

11.0 Document Control including Archiving Arrangements

The previous version of this policy will be removed from the intranet and will be available if required by contacting the author.

12.0 Training and Awareness

12.1 This document will be made available to all employees via the CCG intranet. A programme of risk management training for all levels of staff will be developed to support the implementation of this policy.

13.0 Equality and Diversity

13.1 The CCG recognises the diversity of the local community and those in its employ. Our aim is therefore to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need, regardless of age, disability, race, nationality, ethnic or national origin, gender, religion, beliefs, sexual orientation, gender reassignment or employment status. The CCG recognises that equality impacts on all aspects of its day to day operations and has produced an Equality and Human Rights Strategy and Equal Opportunities Policy to reflect this. All policies and procedures are assessed in accordance with the Equality & Diversity Assessment Toolkit, the results for which are monitored centrally.

14.0 Review

14.1 This strategy will be reviewed annually. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

15.0 Monitoring

15.1 The CCG monitors and reviews its performance in relation to the management of risk, and the continuing suitability and effectiveness of the systems and processes in place to manage risk through a programme of internal and external audit work, and through the oversight of the CCG Governing Body, Management Team and Governance and Quality Committee.

16.0 References

DOH 1999 – HSC 1999/123 Controls Assurance Statement 1999/2000: Risk Management & Organisational Control, DoH London

DOH 2003 – Building the Assurance Framework, DOH, London

Australian/New Zealand Standard: Risk Management 4360:1999

Mayatt (Ed) (2004) Tolley's Managing Risk in Healthcare (UK) 2nd Edition 2004 Lexis Nexis

NPSA (2008) A Risk Matrix for Risk Managers, NPSA

Controls Assurance Support Unit (2002), Making It Happen, A Guide for Risk Managers on how to populate a risk register, Controls Assurance Support Unit

17.0 Associated Documentation

- Serious Incident Policy
- Health and Safety Policy
- Fire Safety Policy
- Emergency Plan
- Adverse Incident Reporting Policy.
- Corporate Governance Framework Manual
  - Includes Standing Orders, Standing Financial Instructions etc.
- Security Policy and associated procedures
- Relevant Human Resources Policies
- Training Needs Analysis
- Induction Policy

Appendix A

RISK ASSESSMENT TOOL (RISK MATRIX)

The CCG has adopted a risk assessment tool, which is based upon a 5 x 5 matrix. *(Used by Risk Management AS/NZS 4360:1999)* The Risk Matrix shown below is taken from the National Patient Safety Agency '*A Risk Matrix for Risk Managers'* guidance published in January 2008. Risk assessment involves assessing the possible consequences of a risk should it be realised, against the likelihood of the realisation (i.e. the possibility of an adverse event, incident or other element having the potential to damage or threaten the achievement of objectives or service delivery, occurring). Risks are measured according to the following formula:

Probability (Likelihood) x Severity (Consequences) = Risk

All risks need to be rated on 2 scales, probability and severity using the scales below.

Probability

Risks are first judged on the *probability* of events occurring so that the risk is realised.

Enter a number (1-5) indicating the probability of the risk occurring. Please refer to the definition scale below.

		Broad descriptors of frequency	**Time framed descriptors of frequency**
1	Rare	This will probably never happen/recur	Not expected to occur for years
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so	Expected to occur at least annually
3	Possible	Might happen or recur occasionally	Expected to occur at least monthly
4	Likely	Will probably happen/recur but it is not a persisting issue	Expected to occur at least weekly
5	Almost certain	Will undoubtedly happen/recur,possibly frequently	Expected to occur at least daily

Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5
Probability / **Severity**	**Negligible**	**Minor**	**Moderate**	**Serious**	**Catastrophic**

Severity

Enter a number (1-5) indicating the impact of the risk occurring. Please refer to the matrix below.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Serious**	**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 unresolved	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 findings are not acted on	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
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 / media interest Damage to an individual's reputation.	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Damage to a team's reputation	Local media coverage – long-term reduction in public confidence Damage to a services reputation	National media coverage with <3 days service well below reasonable public expectation Damage to an organisation's reputation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence (NHS reputation)
Business objectives/ 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 Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
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 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / 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
Data Loss / Breach of Confidentiality	Potentially serious breach. Less than 5 people affected or risk assessed as low eg files were encrypted	Serious potential breach and risk assessed high eg unencrypted clinical records. Up to 20 people affected	Serious breach of confidentiality eg up to 100 people affected	Serious breach with either particular sensitivity eg sexual health details or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

Risk

Based on the above judgments a risk assessment can be made of the potential future risk to stakeholders and the organisation as follows:

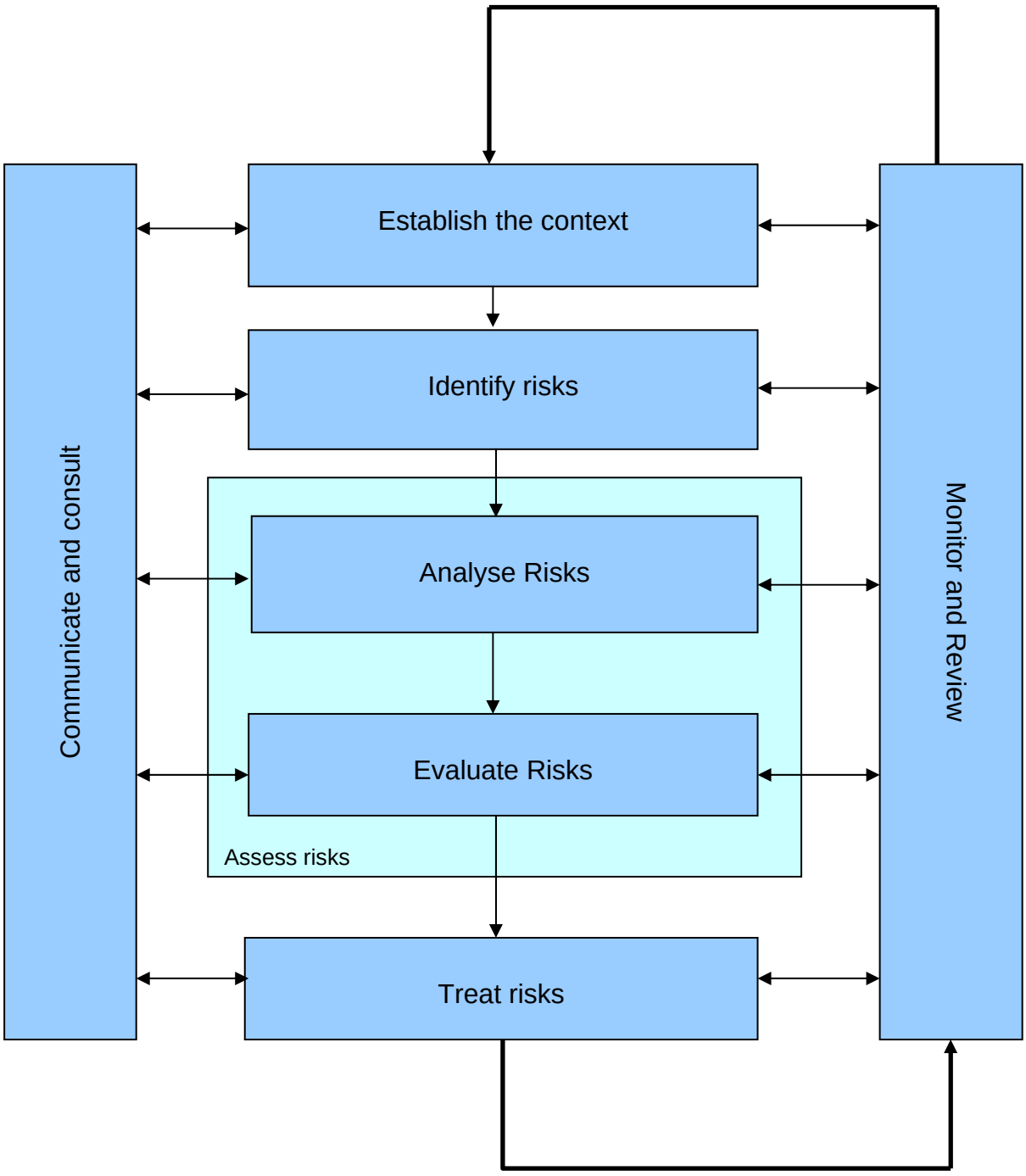
- Green – low risk
- Yellow – moderate risk
- Amber – high risk
- Red – extreme risk

Appendix B

Risk Register Process

The process for the management of risk within the CCG mirrors the requirements as set out in Australian/New Zealand Standard: Risk Management 4360:1999 (see Figure 1).

Figure 1 – Risk Management Process



All risks, clinical, strategic, organisational and financial, will need to be assessed rigorously, thus creating a continuum of risk assessments across the length and breadth of the organisation. Risks will need to be systematically identified, assessed and analysed on a continual basis. The effort and resources that are spent on managing risk should be proportionate to the risk itself. The CCG should therefore have in place an efficient assessment processes covering all areas of risk. It is also a legal requirement that all NHS staff actively manage risk.

Risk identification

Risk identification involves examining all sources of risk, from the perspective of all stakeholders, both internal and external (see Appendix H for list of external stakeholders). Within the CCG, risks are identified using a number of sources.

Internal Methods of Identification (see Figure 2)

- Adverse Incidents, Serious Incidents (SIs), complaints, patient advisory liaison service (PALS) enquiries and claims reporting.
- Internal audit recommendations, identifying the CCG's gaps in control.
- Self assessment workshops.
- Strategic level risks highlighted by CCG Governing Body, Senior Clinicians and Directors.
- Risks highlighted via sub-committees of the Governing Body.
- Patient satisfaction surveys.
- Staff surveys.
- Clinical audits, infection control audits, PEAT inspections etc.
- Risks highlighted by the Unions.
- Risks highlighted by new activities and projects.
- Risks highlighted via the Whisteblowing (Raising Concerns) Policy.
- Risks highlighted through business and local development plans.

External Methods of Identification (see Figure 2)

- Reports from assessments/inspections from external bodies ie Audit Commission, Care Quality Commission, NHSLA Risk Management Assessors, Health and Safety Executive (HSE) etc.
- National reports and guidance.
- Coroner's reports.
- Media and public perception.
- National Patient Safety Agency (NPSA) alerts.
- Central Alerting System (CAS) alerts.
- Health Ombudsman reports.

Clear communication lines have to be established to enable all the systems above to report all risks and allow for the population of both the corporate and directorate and sub committee risk registers.

Risk Assessment

The methodology for the assessment of risk can be complex. Risk assessment involves examining the level of risk posed by a hazard, consideration of those in danger and evaluating whether risks are adequately controlled, taking into account any measures already in place. Risk assessment involves two distinct stages:

- Analysing risk eg in terms of consequence and likelihood.
- Evaluating risk in order to set priorities.

Risk assessment should identify the significant risks arising out of the tasks or activities undertaken within the organisation and assess their potential to:

- Cause injury or ill health to individuals.
- Result in civil claims or litigation.
- Result in enforcement action eg from the Health & Safety Executive or Local Authority.
- Cause damage to the environment.
- Cause property damage/loss.
- Result in operational delays (eg impacting on waiting lists).
- Result in the loss of reputation.

Risk assessments will be carried out locally by identified staff.

Risk Analysis and Evaluation

Risk analysis involves systematically using available information to determine how often specified events occur and the magnitude of their consequences. In order to grade the risks identified the CCG utilises the risk assessment tool (Appendix A).

All risks highlighted to the CCG need to be graded using this risk matrix. If other quantitative methods are used then risk analysis will be inconsistent, and the population of the risk register will be unreliable.

Risk identification and risk assessment is a continuous process and should not be considered as a one off exercise. In order to ensure a well structured systematic approach to the management of risk an action plan or work programme has been produced as follows:

- Adverse incidents (including Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) incidents), PALS, complaints and claims will be analysed on a six monthly basis.
- A report will be produced annually on Risk Management issues, including clinical and non-clinical risk for the Governing Body.

Significant project risk registers

After the process of risk identification and risk assessment has been completed, those responsible will be expected to add risks to the corporate risk register.

All the risks highlighted will need to be co-ordinated, rated according to the risk they pose, and then prioritised. Responsibility for identified risks will then need to be allocated to individuals.

Decisions will have to be made as to whether the risk should be:

Eliminated Eliminate the risk entirely

Reduced Reduce the likelihood or the consequence of the risk (there is a trade off between the level of risk and the cost of reducing it to an acceptable level)

Tolerated The decision could be to tolerate acceptable risk until reasonable action can be taken. Action should always be taken to treat unacceptable or principal risks.

Corporate Risk Register

The corporate risk register will assimilate all risks and will then feed the CCGs' Assurance Framework. The Governing Body will be made aware on a regular basis of all principal risks which the organisation faces, and which risks may lead to the non-compliance of the corporate objectives. The risk register will form the basis of the risk treatment plan and will be a living document, always changing to reflect the dynamic nature of risk and the organisations management of it.

Example of a risk register (headings and description)

Number	CCG reference
Source of Risk	How / by which process the risk was identified eg incident reports, risk assessment, internal audit report
Project/forum	Project/forum in which the risk occurs and the date that the risk was added to the risk register
Summary Description of Risk	The summary description of risk should be about the risk and not about the actions (e.g. risk of injury due to broken bed which cannot be repaired, not, we need a new bed)
Summary of Risk Treatment Plan	Description of how the risk will be managed (removed, mitigated, or otherwise managed).
Corporate Objective	number of corporate objective the risk links to - refer to corporate objectives
Likelihood	Refer to the risk grading matrix for guidance.
Impact	Refer to the risk grading matrix for guidance.
Risk Rating	Likelihood x impact
Anticipated Resource Implication (£)	Expected costs

Responsibility for implementing plan	Director/ Dept Head with responsibility for managing risk
Expected date of completion	Date by which the risk is expected to be treated
Source of review	Which external review body will be reviewing this risk in the financial year. If not external the CCG / dept will implement an internal review.
Date of review	The date when the risk will be re-evaluated
Is this rating acceptable?	CCG/dept identifies whether the treatment has been successful and whether it now considers the risk acceptable

As risk is managed within the CCG, and risks are eliminated, reduced or tolerated the risk treatment will be recorded on a risk treatment plan. The treatment plan will allow the CCG to ensure that risks are being effectively managed.

Example of a risk treatment plan

No	Risk Area	Principal Risk	Action Taken	Risk Rating before treatment	Eliminate/ Reduce/ Tolerate	Risk Rating after treatment	Decision made by	Date decision made	Respon-sibility	Date completed
1				25	Reduce	9				

The risk treatment plan will therefore enable the initial risk rating before treatment to be altered to reflect the results of risk management. The purpose of this is to demonstrate that risk treatments are reducing risk and therefore an excellent way of demonstrating that risk management systems are indeed effective.

Monitoring and Review

It is necessary to monitor risks, the effectiveness of the treatment plan and the adequacies of controls that have been implemented. It is essential for the CCG to be aware of and monitor all risks as even risks deemed acceptable or tolerable may become unacceptable due to external forces such as adverse publicity or political agenda.

The monitoring and review of risk management systems is embedded within the CCG. The Governance Structure at Appendix F provides assurance to the CCG Governing Body that the risk management arrangements are working effectively at all levels of the organisation.

The Audit Committee provides independent assurance(s) that a risk management system is in place to the CCG Governing Body.

Reviews by independent bodies, both external and internal will assist the CCG in demonstrating performance and will highlight any areas that need to be addressed. Examples of external audit include NHSLA Risk Management Standards, Care Quality Commission and HSE (Figure 2).

Figure 2 is adapted from ‘Making it Happen, A guide for risk managers on how to populate a risk register (Controls Assurance Support Unit, 2002).

The process escalating risks

The process that should be followed to escalate a risk to the corporate risk register is:

- The Corporate Governance Manager works with the Management Team to complete their risk register.
- Once the risk register has been completed, the Management Team decides which risks they feel should be escalated to the Quality and Governance Committee. Risks to consider for escalation are those where the risk:
    - Has an overall risk rating of over 15,
    - impacts on a corporate objective or ;
    - is not within their remit to rectify (for example, fire safety).
- **Audit Committee**
  One of the roles of the Audit Committee is to identify and manage key risks facing the organisation. The assurance framework and risk register are brought to the Audit Committee twice a year to be reviewed and monitored.

Appendix E illustrates the level at which risk is managed, recorded and monitored.

Guidance on the risk register process:

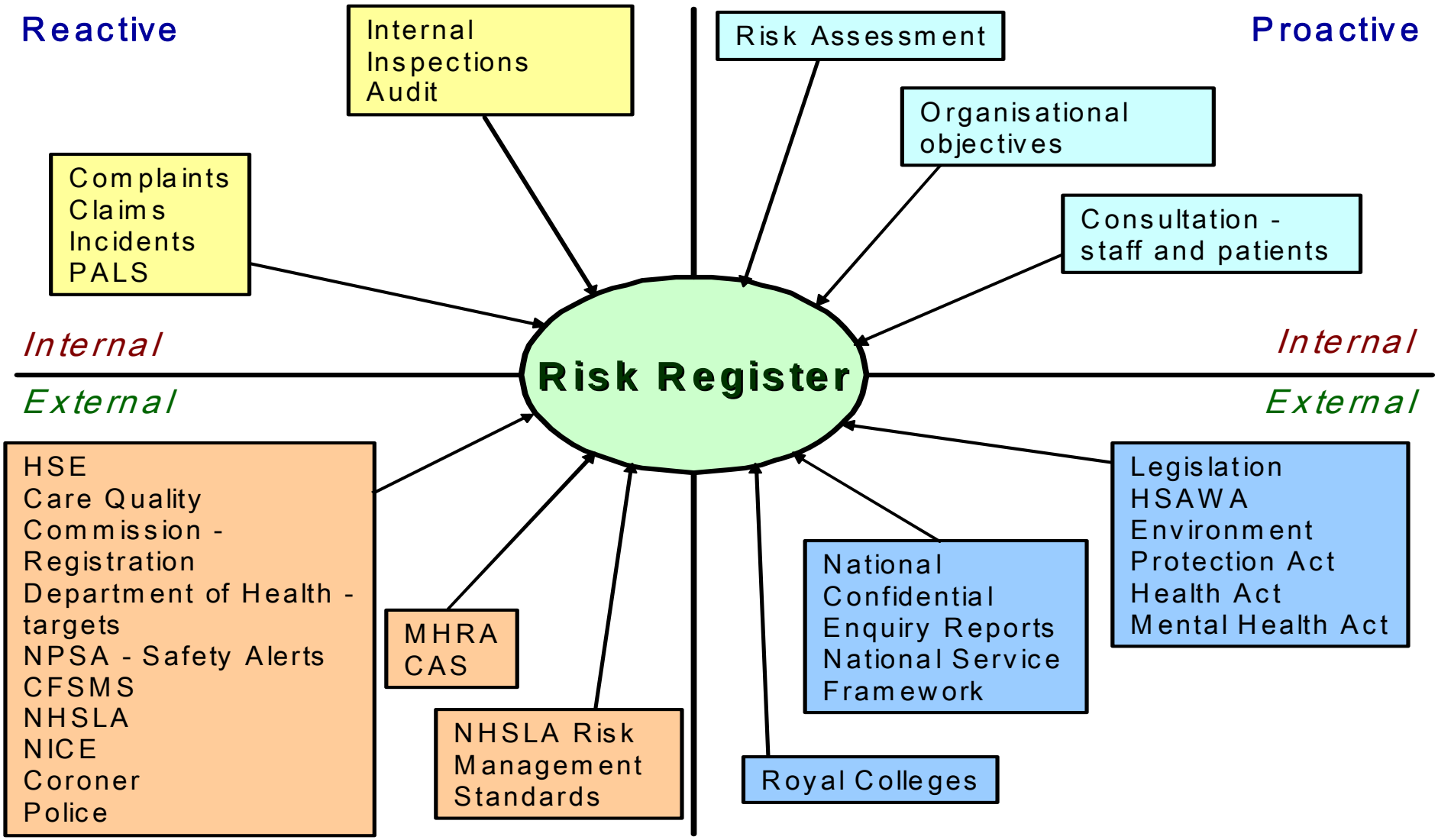
The CCG may wish to form a risk forum or use an existing relevant meeting to facilitate communication between all the individuals identified with risk responsibilities ie IOSH Manager, Patient public involvement lead and the Clinical Governance lead etc.

- **Identification** - Identified risks should be specific in detail eg, “Lifts are not level,” is not adequate, but must reflect the real risk, for example expanded to advise of the risks such as, “Risk of manual handling injury to staff and slip/trip injury to staff, patients and visitors due to lifts not levelling.” The *Summary Description of Risk* will put the risk into context and adds detail to the issue and its impact in the CCG.
- **Assessment/Evaluation** - Any risks identified should be added to the corporate risk register and graded using the CCG’s risk matrix. Responsibility for action and timescales should also be included. Only those risks which cannot be managed locally will be considered for escalation. Risk identification and risk assessment is a continuous process and should not be considered as a one off exercise. Evaluating the risks will assist the Governing Body in setting priorities.
- **Treatment** - Once a decision has been made as to the treatment of a risk (eliminate, reduce or tolerate), the action taken must be documented appropriately on a risk treatment plan. This ensures an audit trail is kept of all risks and their treatment.

Both the risk register and the risk treatment plans need to be regularly reviewed, evaluated and monitored. It is good practice to review the corporate risk register quarterly.

- **Monitoring/Review** – the corporate risk register should be incorporated into the general management agenda.

Figure 2


Reactive
Proactive
Internal
Inspections
Audit
Risk Assessment
Organisational objectives
Complaints
Claims
Incidents
PALS
Consultation - staff and patients
Internal
External
Risk Register
Internal
External
HSE
Care Quality Commission - Registration
Department of Health - targets
NPSA - Safety Alerts
CFSMS
NHSLA
NICE
Coroner
Police
MHRA
CAS
NHSLA Risk Management Standards
National Confidential Enquiry Reports
National Service Framework
Royal Colleges
Legislation
HSAWA
Environment Protection Act
Health Act
Mental Health Act

It is the responsibility of the Governance and Quality Committee to manage the development of the risk register process and co-ordinate the risks identified by the organisation. The risk register has to incorporate **strategic level risks** – or risks which have the ability to affect the development, implementation and control of corporate objectives.

In order for the Governing Body to be fully aware of and understand the organisations risk profile, the Governing Body via the Governance and Quality Committee will regularly review the corporate risk register and minutes will evidence that the register has been received, considered and reviewed. Action plans and business cases will also be used as examples of verification.

Risk Treatment and Funding

Annual Process

The Management Team are required to undertake an annual scoping exercise, in order to determine their risk resource requirements. This in turn will be linked to the Operating Plan. It is expected that the corporate risk register plays an important part in this process.

Risk Treatment Option

Any risks identified with a risk rating over 15, or which threatens a corporate objective, or is not within their remit to rectify should be considered for escalation.

Risk treatment options will then need to be reviewed and any residual risk monitored, by the relevant committee.

Shared Risks

It would be impossible for the CCG to manage risk in isolation, and clear lines of communication are crucial. In a complex environment such as healthcare organisations, the crossing of boundaries is inevitable. It is therefore imperative that the management of risks, the identification, assessment and analysis is shared and communicated. The CCG have to consider all our external as well as internal stakeholders, ie York Teaching Hospital NHS Foundation Trust.

In order to achieve this effective communication, the following arrangements are in place:

- Sharing of minutes of the Governance and Quality Committee and its sub committees
- Representative memberships from both organisations on relevant committees.
- Serious Incidents investigations include staff from all the relevant organisations.
- Pro-active approach to the sharing of adverse incident and claims information.
- Awareness of risks on risk registers.

Assurance Framework

The corporate risk register will feed, on a continual basis the CCG's Assurance Framework. The Audit Committee reviews the Assurance Framework regularly. It is the responsibility of the Governance and Quality Committee to identify mitigating controls and allocate responsibility for the principal risks identified. The framework is a comprehensive method for the effective and focused management of the principal risks to meeting CCG objectives, it also provides a structure for the evidence to support the Annual Governance Statement. The Assurance Framework will therefore simplify Governing Body reporting and the prioritisation of action plans, which, in turn, allow for more effective performance management (Department of Health, 2003).

The above risk management process will ensure that all risks, whether financial, organisational, strategic or clinical, are captured in a systematic way, thus creating a continuum of risk assessments across the length and breadth of the organisation. These risks can then be continuously monitored and reviewed by the CCG Governing Body and will enable the CCG to learn and make improvements.

Risk Process Flowchart