NHS
Vale of York
Clinical Commissioning Group

Item 10.1

RISK MANAGEMENT POLICY AND STRATEGY

November 2014

Authorship:	**Rachel Potts, Chief Operating Officer**
Reviewing Committee:	**Senior Management Team** **Audit Committee**
Date:	**18/11/14** **10/12/14**
Approval Body	**Governing Body**
Approved date:	
Review Date:	**November 2017**
Equality Impact Assessment	**Yes**
Sustainability Impact Assessment	**Yes**
Related Policies	**Serious Incident Policy** **Health and Safety Policy** **Emergency Preparedness Plan** **Constitution,(includes Standing Orders)** **Information Risk Management Strategy** **IMT Security Policy and associated procedures** **Complaints Policy** **Induction Policy**
Target Audience:	**All employees, members, committee and sub-committee members of the group and members of the governing body and its committees.**
Policy Reference No:	**COR03**
Version Number:	**2.0**

The on-line 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.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by & Date	Date on Intranet
1.0	Chief Operating Officer	Initial Policy	Governing Body 25/07/14	
1.1	Policy and Assurance manager	Refresh of strategy to reflect change of title, implementation of Covalent, revisions in other corporate documentation, including Constitution and Five Year Plan.	SMT 18/11/14	
1.2 1.3 2.0	SMT Audit Committee 	Role of Caldicott Guardian included in Chief Nurse responsibilities. Final approved	Audit Committee 10/12/15 Governing Body	

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CONTENTS

1. INTRODUCTION

1.1. 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.

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

1.3. 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 on-going 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.

2. POLICY STATEMENT

2.1. The Vale of York Clinical Commissioning Group, (the 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.

3. IMPACT ANALYSES

Equality

3.1. As a result of performing the screening analysis, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. The results of the screening are attached.

Sustainability

3.2. A Sustainability Impact Assessment has been undertaken. xx positive or negative impacts were identified against the twelve sustainability themes. The results of the assessment are attached.

4. SCOPE OF POLICY

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

5. POLICY PURPOSE/AIMS & FAILURE TO COMPLY

5.1. The purpose of this document is to provide guidance to all staff within the CCG on the management of strategic, operational and project risks within the organisation and will describe the procedures to be used in identifying, analysing, evaluating and monitoring risks to the delivery of key objectives.

5.2. The objectives of this strategy and policy are to:

- Promote awareness of business risk and embed the approach of its management throughout the Group.
- Ensure that risk management is an integral part of the CCG's culture
- Seek to identify, measure, control and report on any risk that will undermine the achievement of the CCG's priorities, both strategically and operationally, through appropriate assessment criteria.
- Monitor and measure the overall performance of the Risk Management Policy and Assurance Framework and the way in which it contributes to the achievement of business activities

5.3. Failure to comply with policy may result in risks not being appropriate identified and effectively managed.

6. PRINCIPLE LEGISLATION AND COMPLIANCE WITH STANDARDS

6.1. The CCG needs to ensure that appropriate arrangements are in place to comply with the following Health & Safety legislation, including the legal requirements for fire safety:

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work regulations 1999
- The Workplace (Health and Safety and Welfare) Regulations 1992
- Information Governance Toolkit standards and requirements

The CCG Constitution

6.2. The CCG Constitution requires that the Audit Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk across the whole of the Clinical Commissioning Group's activities that supports the achievement of its objectives.

7. ROLES / RESPONSIBILITIES / DUTIES

Governing Body

7.1. 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 and Finance 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

7.2. The CCG Governing Body is responsible for approval of arrangements for risk sharing or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).

7.3. Where the CCG makes arrangements with NHS England (and another CCG if relevant) to co-commission services, the CCG shall develop and agree with NHS England how risk will be managed and apportioned between the parties.

The Audit Committee

7.4. The Audit Committee is responsible for providing assurance to the Governing Body that the CCG's Assurance Framework is valid and suitable for the significant risks to achieving its strategic objectives and that these controls are operating effectively.

7.5. The Chair of the Audit Committee is the Lay Member lead for risk management.

The Chief Nurse

7.6. The Chief Nurse 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; and
- Is the Caldicott Guardian for the organisation and oversees the Caldicott log.

The Chief Operating Officer

7.7. 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
- The Chief Operating Officer is the organisation's Senior Information Risk Owner (SIRO). The SIRO is responsible for reviewing and approving information asset risk assessments and ensuring that information risks are managed appropriately.

Senior Managers

7.8. 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

The Policy and Assurance Manager

7.9. The Policy and Assurance 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

All Staff

7.10. 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.

Contractors, Agency and Locum Staff

7.11. 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

8. DEFINITIONS

Risk

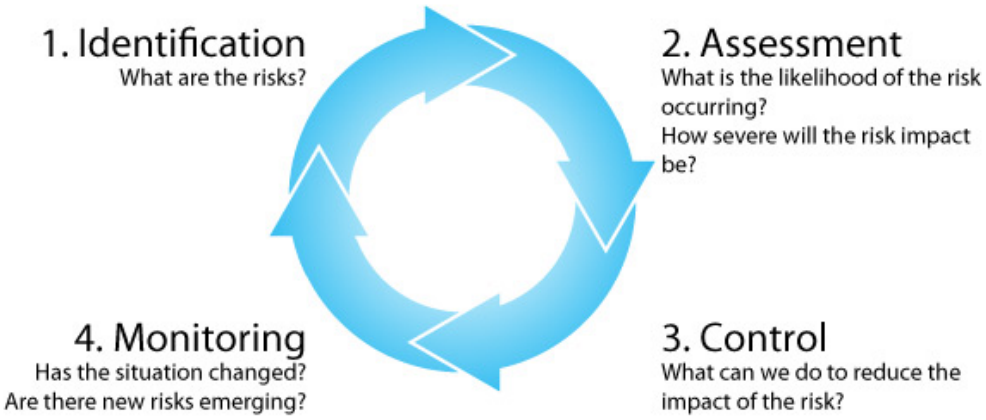
8.1. Risk is the chance something will happen that will have an impact on the achievement of our objectives, programmes or service delivery. This may include damage to the reputation of the CCG, which could undermine the public‟s confidence in us. It is measured in the terms of likelihood (frequency 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.

Risk Management

8.2. 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.

The Risk Management Process

8.3. 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



Significant Risks

8.4. 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 on-going assurance.

The Assurance Framework

8.5. The assurance framework provides the organisation with a simple but comprehensive method for the effective and focused management of the principal risks to meeting objectives. It also provides a structure for the evidence to support the Annual Governance Statement. This simplifies Governing Body reporting and the prioritisation of action plans, which, in turn allow for more effective performance management.

Assurance

8.6. 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.

Encouraging Innovation and Experimentation

8.7. 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.

9. PRINCIPLES OF RISK MANAGEMENT

9.1. The CCG is committed to a risk management strategy that enables the CCG to achieve our key objectives which are as follows: -

- People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life.
- People will have more opportunities to influence and choose the healthcare they receive and shape future services.
- People will continue to have good access to safe and high quality healthcare service.
- When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible.

- Where people have long term conditions they are supported to manage those conditions to give them the best possible quality of life.
- When people are terminally ill, the individual and their families and/or carers are supported to give them the best quality of life and choice in their end of life care.
- A move to 'Care Hubs' providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/blood tests), community services, mental health support and social care and community and voluntary services.
- High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area.
- A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York.
- Access to world class highly complex and specialist care provided through specialist centres across the country.
- Opportunities for accessing and leading research to improve healthcare systems for all.

10. WHAT IS AN ACCEPTABLE RISK?

10.1. 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.

10.2. 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.

10.3. 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 3.

10.4. 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.

11. ASSURANCE STANDARDS

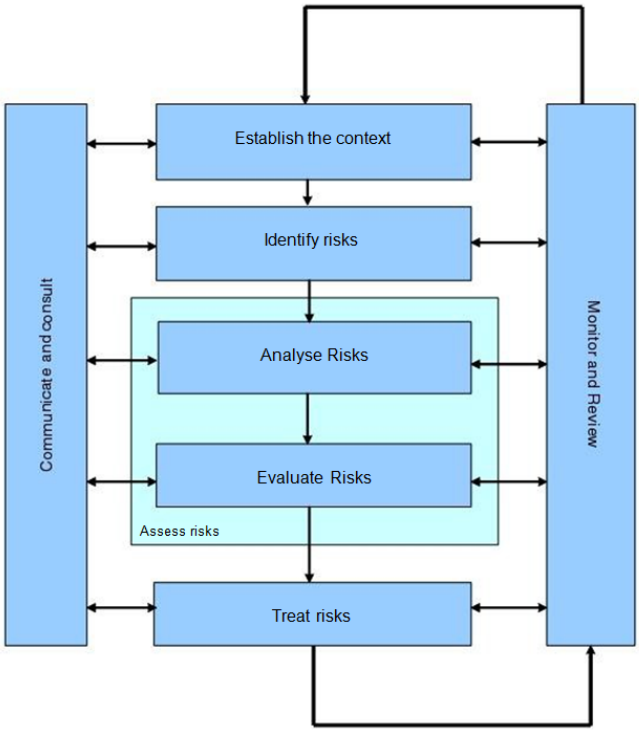
11.1. The CCG will build upon and continue to use the Assurance Framework process as a means of identifying and systematically reviewing identified risks, this process will be reviewed annually. Individual directors are responsible for identification and grading of risks together with producing and monitoring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

12. RISK AWARENESS TRAINING FOR SENIOR MANAGEMENT (EXECUTIVE DIRECTORS AND GOVERNING BODY MEMBERS)

12.1. 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.

13. RISK REGISTER PROCESS

13.1. 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

13.2. 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:

- 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 Whistleblowing (Raising Concerns) Policy
- Risks highlighted through business and local development plans.

External Methods of Identification

- Reports from assessments/inspections from external bodies i.e. 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.

13.3. 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

13.4. 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 e.g. in terms of consequence and likelihood
- Evaluating risk in order to set priorities.

13.5. 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, e.g. from the Health and Safety Executive or Local Authority.
- Cause damage to the environment.
- Cause property damage/loss.
- Result in operational delays (e.g. impacting on waiting lists).
- Result in the loss of reputation.

13.6. Risk assessments will be carried out locally by identified staff.

Risk Analysis and Evaluation

13.7. 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.

13.8. 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.

13.9. 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

13.10. 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.

13.11. 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.

13.12. 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)
- Transferred
- Shared

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 noncompliance 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.

Capturing Risk

13.13. The CCG has implemented Covalent software to provide an integrated assurance framework. Risk is captured and managed within the Covalent system and outputs used to:

- support alignment of risks to business objectives, track milestones and track control effectiveness;
- enable wider engagement of stakeholders in the identification, assessment of risks and management of risk;
- establish effective arrangements for the escalation of risk, ensuring that the audit committee has the appropriate up to date information on risks;
- provide evidence of key controls and effectiveness of risk management improvement plans to support the Business Assurance Framework
- enable linking of corporate/team risk management improvement plans to corporate risk strategies
- integrate project/programme risk management with corporate risk management objectives and systems; and
- support business continuity/emergency planning and operational insurance risk.

Monitoring and Review

13.14. 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.

13.15. 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

13.16. Body that the risk management arrangements are working effectively at all levels of the organisation.

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

13.18. 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.

The Process of Escalating Risks

13.19. 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

13.20. 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.

13.21. 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.

13.22. 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

13.23. the corporate risk register should be incorporated into the general management agenda.

14. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

14.1. 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.

15. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS

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

16. POLICY IMPLEMENTATION

16.1. This policy will be circulated to all teams to be cascaded to individual members of staff. The document will be made available for staff and users and other stakeholders through the CCG website.

16.2. The CCG has mechanisms in place in order to ensure that:

- staff can raise issues of concern with their manager(s);
- staff are consulted on proposed organisational or other significant changes;
- managers keep staff informed of progress on relevant issues;
- service users, their relatives, carers and advocates can identify points of concern or worry by using the complaints process or PALS service;
- the media are accurately advised of developments in the CCG.

16.3. The CCG principles of risk management are communicated to service providers and support service organisations through commissioning mechanisms and contract requirements.

17. TRAINING & AWARENESS

17.1. This policy will be published on the CCG's website and will be available to staff on the organisation's intranet.

17.2. The policy will be brought to the attention of all new employees as part of the induction process. Further advice and guidance is available from the Policy and Assurance Manager.

18. MONITORING & AUDIT

18.1. 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.

18.2. The Quality and Finance Committee is responsible for monitoring the effectiveness of this policy/strategy and for providing assurance to the Governing Body. The Quality and Finance Committee receives monthly risk reports that detail headline risks rated 15 and over.

18.3. Monitoring of this policy/strategy may form part of the Internal Audit review of governance compliance.

19. POLICY REVIEW

19.1. 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.

20. 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
- Taking it on Trust – Audit Commission, 2009

21. ASSOCIATED POLICIES

- Serious Incident Policy
- Health and Safety Policy
- Emergency Preparedness Plan
- Constitution,(includes Standing Orders)
- Information Risk Management Strategy
- IMT Security Policy and associated procedures
- Complaints Policy
- Induction Policy

22. CONTACT DETAILS

Job Title
Manager Name: Policy and Assurance Manager
Telephone: 01904 555778
Email: valeofyork.contactus@nhs.net

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23. LIST OF APPENDICES

Appendix 1: Equality Assessment
Appendix 2: Sustainability Assessment
Appendix 3: Risk Assessment Tool

24. APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM

1.	**Title of policy/ programme/ service being analysed**
	Risk Management Strategy and Policy
2.	**Please state the aims and objectives of this work.**
	To define and document the CCG's approach to risk and risk management to ensure: • risks within the organisation are identified, assessed, treated and monitored as part of the corporate governance of the CCG. • robust risk assessment and monitoring mechanisms are in place for all elements of the commissioning process, including needs assessment, tendering, contract management and evaluation.
3.	**Who is likely to be affected? (e.g. staff, patients, service users)**
	CCG staff, partner organisations (where applicable), public, patients and member practices. CCG managers and staff (and other providers and partners where applicable). If Risk management arrangements are not effective patients and service providers may be impacted.
4.	**What sources of equality information have you used to inform your piece of work?**
	NHS England
5.	**What steps have been taken ensure that the organisation has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics**
	The analysis of equalities is embedded within the CCG's Committee Terms of Reference and project management framework.

6.	**Who have you involved in the development of this piece of work?**
	Internal involvement: Senior Management team **Stakeholder involvement**: Consultation with Senior Managers **Patient / carer / public involvement**: This is an Internal policy aimed at staff employed by the CCG and contractors working for the CCG. The focus is on compliance with statutory duties and NHS mandated principles and practice. There are no particular equality implications.
7.	**What evidence do you have of any potential adverse or positive impact on groups with protected characteristics?** **Do you have any gaps in information?** **Include any supporting evidence e.g. research, data or feedback from engagement activities** **(Refer to** Table 1 - Embedding Equality into the Commissioning Cycle if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)

Disability People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)	Consider building access, communication requirements, making reasonable adjustments for individuals etc
N/a	
Sex Men and Women	Consider gender preference in key worker, single sex accommodation etc
N/a	

Race or nationality People of different ethnic backgrounds, including Roma Gypsies and Travelers	Consider cultural traditions, food requirements, communication styles, language needs etc.
N/a	
Age This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc.
N/a	
Trans People who have undergone gender reassignment (sex change) and those who identify as trans	Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.
N/a	
Sexual orientation This will include lesbian, gay and bi-sexual people as well as heterosexual people.	Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.
N/a	
Religion or belief Includes religions, beliefs or no religion or belief	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.
N/a	
Marriage and Civil Partnership Refers to legally recognised partnerships (employment policies only)	Consider whether civil partners are included in benefit and leave policies etc.
N/a	

Pregnancy and maternity Refers to the pregnancy period and the first year after birth	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
N/a	
Carers This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
N/a	
Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc
N/a	
8.	**Action planning for improvement** Please outline what mitigating actions have been considered to eliminate any adverse impact? Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people? An Equality Action Plan template is appended to assist in meeting the requirements of the general duty

Sign off
Name and signature of person / team who carried out this analysis *Helen Sikora, Policy and Strategy Manager* *Audit Committee*
Date analysis completed *December 2014*
Name and signature of responsible Director
Date analysis was approved by responsible Director

26. APPENDIX 2: SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document	Risk Management policy and Strategy
What is the main purpose of the document	To effective identify, manage and monitor risk within the organisation.
Date completed	November 2014
Completed by	Governance Team

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Travel	Will it provide / improve / promote alternatives to car based transport?	0		
	Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?	0		
	Will it reduce 'care miles' (telecare, care closer) to home?	0		
	Will it promote active travel (cycling, walking)?	0		
	Will it improve access to opportunities and facilities for all groups?	0		
	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery?	0		
Procurement	Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	0		
	Will it promote ethical purchasing of goods or services?	0		
Procurement	Will it promote greater efficiency of resource use?	0		
	Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	0		
	Will it support local or regional supply chains?	0		
	Will it promote access to local services (care closer to home)?	0		
	Will it make current activities more efficient or alter service delivery models	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	0		
Workforce	Will it provide employment opportunities for local people?	0		
	Will it promote or support equal employment opportunities?	0		
	Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)?	0		
	Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development?	0		
	Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	N/a		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	0		
	Will it increase safety and security in new buildings and developments?	0		
	Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?	0		
	Will it provide sympathetic and appropriate landscaping around new development?	0		
	Will it improve access to the built environment?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	0		
	Will it promote prevention and self-management?	0		
	Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?	0		
	Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		

27. APPENDIX 3 RISK ASSESSMENT TOOL (RISK MATRIX)

27.1. 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

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

27.3. 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.

27.4. Based on the judgments in the matrices 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

Vale of York CCG Risk Matrix

Impact	Probability 1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

PROBABILITY DEFINITIONS

Rating	Classification	Broad descriptors of frequency	Time framed descriptors of frequency
1	Rare	This will probably never happen/recur	Not expected 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 happen 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

IMPACT										
Rating	**Classification**	**Patient Safety**	**Quality/Complaints/ Audit**	**HR/Staffing**	**Statutory Duty/ Inspections**	**Adverse Publicity/Reputation**	**Business Objectives/ Projects**	**Finance Including Claims**	**Service/Business Interruption Environmental impact**	**Data Loss / Breach of Confidentiality**
1	Negligible	Minimal injury requiring no/minimal intervention or treatment. No time off work	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Short-term low staffing level that temporarily reduces service quality (< 1 day)	No or minimal impact or breech of guidance/ statutory duty	Rumours Potential for public concern / media interest Damage to an individual's reputation.	Insignificant cost increase/ schedule slip	Small loss Risk of claim remote	Loss/interruption of >1 hour Minimal or no impact on the environment	Potentially serious breach. Less than 5 people affected or risk assessed as low e.g. files were encrypted
2	Minor	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	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	Low staffing level that reduces the service quality	Breech of statutory legislation Reduced performance rating if unresolved	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Damage to a team's reputation	<5 per cent over project budget Schedule slippage	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss/ interruption of >8 hours Minor impact on environment	Serious potential breach and risk assessed high e.g. unencrypted clinical records. Up to 20 people affected

IMPACT										
Rating	**Classification**	**Patient Safety**	**Quality/Complaints/ Audit**	**HR/Staffing**	**Statutory Duty/ Inspections**	**Adverse Publicity/Reputation**	**Business Objectives/ Projects**	**Finance Including Claims**	**Service/Business Interruption Environmental impact**	**Data Loss / Breach of Confidentiality**
3	Moderate	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	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	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	Single breech in statutory duty Challenging external recommendations/ improvement notice	Local media coverage – long-term reduction in public confidence Damage to a services reputation	5–10 per cent over project budget Schedule slippage	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss/interruption of >1 day Moderate impact on environment	Serious breach of confidentiality e.g. up to 100 people affected

IMPACT										
Rating	**Classification**	**Patient Safety**	**Quality/Complaints/ Audit**	**HR/Staffing**	**Statutory Duty/ Inspections**	**Adverse Publicity/Reputation**	**Business Objectives/ Projects**	**Finance Including Claims**	**Service/Business Interruption Environmental impact**	**Data Loss / Breach of Confidentiality**
4	Serious	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	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	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	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	National media coverage with <3 days service well below reasonable public expectation Damage to an organisation's reputation	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	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	Loss/interruption of >1 week Major impact on environment	Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected
5	Catastrophic	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients	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	Non-delivery of key objective/ service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report	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)	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met	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	Permanent loss of service or facility Catastrophic impact on environment	Serious breach with potential for ID theft or over 1000 people affected