NHS
Vale of York
Clinical Commissioning Group

# RISK MANAGEMENT POLICY AND STRATEGY
**April 2021**

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| **Target Audience:** | All employees, members, committee and sub-committee members of the group and members of the governing body and its committees |
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**APPROVAL RECORD**

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## 1. INTRODUCTION

1.1 Good risk management awareness and practice at all levels is a criticalsuccess factor for NHS Vale of York Clinical Commissioning Group (theCCG). Risk is inherent in everything that we do, from determining service priorities, taking decisions about future strategies, or even deciding not to takeany action at all.

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

1.3 In accordance with the guidance contained in The Health NHS Board 2013: Principles for Good Governance (The NHS Leadership Academy); and ISO31000; the CCG will undertake a systematic approach to the management of risk that builds public confidence. It is clear, however, that the future sustainability of the NHS and its founding values will require creative and innovative solutions to ensure that risk and innovation are not perceived to be mutually exclusive. The CCG proposes to implement a system of internal controls which will encompass financial controls, organisational control 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 priorities, 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 CCG is committed to a strategy, which minimises risk to all its stakeholders through a comprehensive system of internal controls, whilst maximising potential for flexibility, innovation and best practice in delivery ofits strategic objectives to improve the health of all the residents within the CCG.

## 3. IMPACT ALANYSIS

### 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. Positive and negative impacts are assessed against the twelve sustainability themes. The results of the assessment are attached.

## 4. SCOPE OF THE 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 AND 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; and
- 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 appropriately 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 CCG statutory duties, including:

- Health and Social Care Act 2012
- Data Protection Act 2018
- General Data Protection Regulations
- Mental Capacity Act 2005
- The Human Rights Act 1998
- Equality Act 2010
- Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
- United Nations Convention on the Rights of the Child
- Employment Rights Act 1996
- 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
- Freedom of Information Act 2000

- 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 that 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 CCG Board 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 Finance and Performance Committee; the Quality and Patient Experience Committee; the Executive Committee and the Primary Care Commissioning Committeeidentifying significant risks; and
- 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 commission groups or pooled budget arrangements under section 75 of the NHS Act 2006)

7.3 Where the CCG makes arrangement with another CCG to co-commission services, the CCG shall agree 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 Accountable Officer**

7.6 The Accountable Officer has overall accountability for the management of risk and with support from the Head of Legal and Governance 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 that appropriate Policies, Procedures and Guidelines are in place and operating throughout the CCG;
- Ensuring risk management systems are in place throughout the CCG;
- Ensuring the Board 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.

**The Executive Director of Quality and Nursing**

7.7 The Executive Director of Quality and Nursing supports and promotes risk management processes where they link with the Quality Strategy and those Regulatory Factors associated with the Quality and Nursing team, e.g. Serious Incidents and CQC Regulation.

7.8 The Executive Director of Quality and Nursing is the Caldicott Guardian for the organisation and oversees the Caldicott log. The Director may be supported by their Deputy in the discharge of this function provided that Deputy has been appropriately trained as a Caldicott Guardian.

**The Executive Director for Primary Care**

7.9 The Executive Director for Primary Care, support by the Assistant Director for Primary Care will be responsible for promoting risk management processes with all NHS 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.

**The Chief Finance Officer**

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

**Deputies Group**

7.11 The CCG Deputies group is a group of individuals reporting directly to a CCG Director. They do not hold any formal delegation other than that which is given to them through the Executive committee. One of the functions is the oversight of risk management. This means that the Deputies Group will monitor and maintain all of the risk registers for the CCG Committees and will work with their staff to ensure that the risk matrix is consistently and appropriately applied.

**Senior Managers**

7.12 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
- Ensureing risks are identified and managed and mitigating actions implemented in fuctions for which they are accountable
- Ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis
- Ensuring project/programme risk registers are established and maintained that relates to their area of responsibility and involve staff in this process to promote ownership of the risks identified.
- Ensuring risks are escalated where they are of a strategic nature.

**The Head of Legal and Governance**

7.13 The Head of Legal and Governance has responsibility for:

- Ensuring that a risk register and Assurance Framework is developed and maintained;
- Ensuring that sub-committees of the Governing Body receive regular risk reports and have the opportunity to review risks jointly;
- Providing advice on the risk management process;
- Ensuring that the CCG Assurance framework and corporate risk register is up to date for the Governing Body and all of its sub committees;
- Working collaboratively with Internal Audit

**All Members of Staff**

7.14 All members of staff are responsible for:

- ensuring that the risk register and Assurance Framework are updated;
- ensuring that the relevant Executive Director is made aware of any risk associated with their area of business prior to the risk being added to the Register;
- 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 CCGs business and to comply with appropriate CCG rules, regulations, instructions, policies, procedures and guidelines;

- Take action to protect themselves and others from risks;
- Identify and report risks to their line manager;
- Ensure 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 the individuals 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**

7.15 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 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 aware of

## 8 DEFINITIONS

8.1 **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 itself so as to meet its 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 theCCG Governing Body about significant risks within the CCG for which theyare responsible.

8.2 **Risk -** risk is the "effect of uncertainty on objectives" and an effect is a positive or negative deviation from what is expected

8.3 **Risk Management -** Risk management refers to a coordinated set of activities and methods that is used to direct an organization and to control the many risks that
can affect its ability to achieve objectives.

The term risk management also refers to the programme that is used to manage risk. This programme includes risk management principles, a risk management framework, and a risk management process.

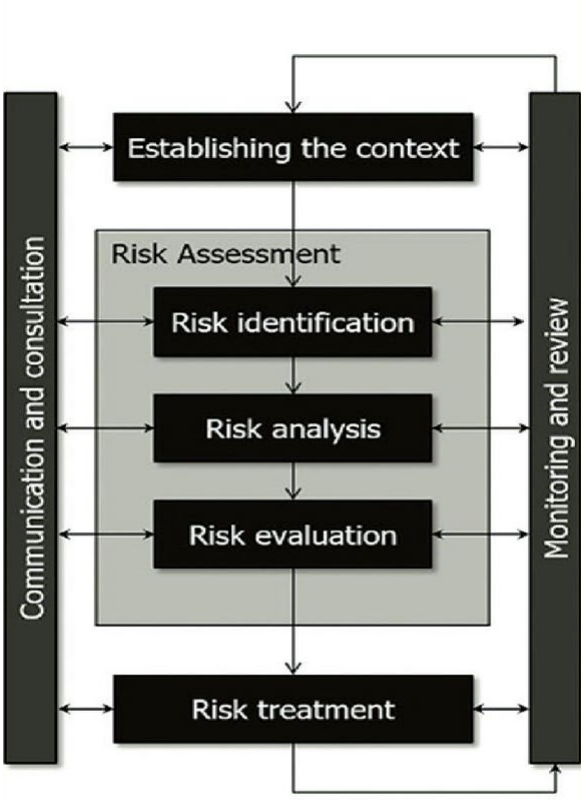
8.4 **Risk Management Plan -** An organization's risk management plan describes how it intends to manage risk. It describes the management components, the approach, and the resources that are used to manage risk. Typical management components include procedures, practices, responsibilities, and activities (including their sequence and timing). Risk management plans can be applied to products, processes, and projects, or to an entire organization or to any part of it.

8.5 **Risk Management Process -** According to ISO 31000, a risk management process systematically applies management policies, procedures, and practices to a set of activities intended to establish the context, communicate and consult with stakeholders, and identify, analyze, evaluate, treat, monitor, record, report, and review risk.

8.6 **Risk Owner -** A risk owner is a person or entity that has been given the authority to manage a particular risk and is accountable for doing so.

8.7 **Risk Treatment (also referred to as Mitigation) -** Risk treatment is a risk modification process. It involves selecting and implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls.

You have many treatment options. You can avoid the risk, you can reduce the risk, you can remove the source of the risk, you can modify the consequences, you can change the probabilities, you can share the risk with others, you can simply retain the risk, or you can even increase the risk in order to pursue an opportunity.




PROCESS

8.8 **Significant Risks –** Significant risks are those which, when measured according to the risk matrix at Appendix 3 are assessed to be high or extreme or threaten an 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.

8.9 **The Assurance Framework –** 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.

## 9. PRINCIPLES OF RISK MANAGEMENT

9.1 The CCG is committed to a risk management strategy that enables the CCG to achieve its key priorities which are as follows:

| |
|---|
| **Support General Practice and wider primary care system to maintain a level of resilience to deliver safe and sustainable services.** |
| **Support innovation and transformation in the development of sustainable mental healthand complex care services** |
| **Working with partners to deliver the recovery of acute care across elective, diagnostic,cancer and emergency care** |
| **Achieving and supporting system financial sustainability** |
| **Work with system partners to ensure provision of high quality, safe services.**<br>**Work as partners to safeguard the vulnerable in our communities to prevent harm** |
| **Support the wellbeing of our staff and manage and develop the talent of those staff** |
| **Work with partners to tackle health inequalities and improve population health in theVale of York** |

9.2 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.

## 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 frameworkfor the assessment and management of risk, the CCG has adopted a risk assessment tool and has determined the levels of authority at which risks should be addressed. Risks identified as being in the extreme of high categories are regarded as significant risks and should be reported to the appropriate Committee.

10.2 The CCG will, however, as a general principle, 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 the relevant member of the CCG Deputies group highlighted in the structure at Appendix 5. They will have the responsibility of assessing the risk in accordance with the risk assessment tool.

## 11. RISK APPETITE

11.1 The adoption of a risk appetite statement is considered a fundamental aspect of risk management and is set out in a number of authoritative sources:

- Treasury guidance: it is essential that both private and public organisations set out the Boards attitude to risk and that this is used to inform decision making
- British Standard (BS31100) states “the organisation should prepare a risk appetite statement which may provider direction and boundaries on the risk that can be accepted at various levels of the organisation, how the risk and any associated reward are to be balanced and the likely response”
- The UK Corporate Code of Governance sets out that “The board is responsible for determining the nature and extent of the principal risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management and internal control systems.”

11.2 The CCG recognises the importance of having a documented statement that reflects its approach to risk appetite/tolerance in line with British Standard BS31100 which provides direction and boundaries on the risk that can be accepted at various levels of the organisation and how the organisation responds to risk to ensure that the level of risk and any associated reward are to be balanced.

11.3 The CCG is not risk averse and recognises that decisions with the potential to improve services or performance can also carry risks. This should not deter from making the decision, but is considered when making the decision so that the decision is informed based on the risk assessment and a decision on the level of tolerance of any risks.

11.4 The CCG’s approach to risk is that:

- The lower the appetite for risk the less the CCG is willing to tolerate the consequence and there is a requirement for higher levels of controls and assurance to manage the risk.
- The higher the CCG appetite for risk, the more the CCG is willing to accept potential consequences in order to achieve objectives. The CCG will accept business as usual activity for established systems of internal control, and will not necessarily seek to strengthen those

controls above all else.

11.5 The CCG shall prepare a risk appetite statement that shall be reviewed annually in line with the refresh of the CCG's Board Assurance Framework.

## 12. THE CCG RISK APPETITE STATEMENT

12.1 The CCG's Risk Appetite Statement establishes risk tolerance in the following four categories:-

i. Safety risk – The risk that the CCG will not be able to deliver services which are safe for patients.
ii. Compliance risk – The risk that the CCG will not comply with the requirements of legislation and regulation including the NHS Constitution
iii. Financial risk – The risk that the CCG fails to operate within its allocation and therefore operate in deficit
iv. Service Delivery risk – The risk that the CCG is unable to deliver services to patients and is linked to the risks above

12.2 The CCG considered a number of factors to determine risk appetite. With due regard to the risk appetite, when a risk is recorded in the register, it will be categorised as high risk (red), medium risk (amber) or low risk (green) and will be based on an assessment of risk by staff in possession of this statement of risk appetite.

12.3 The risk appetite of the CCG was established by the CCGs Governing Body in October 2019 using the criteria below.

| | Finance | Compliance | Safety | Service delivery |
|---|---|---|---|---|
| Adverse | Minor loss < £1000 | Trivial, very short term single non-compliance | Insignificant injury (no intervention) | Negligible impact/unnoticed by service users |
| Cautious | Small loss £1,001-£10,000 | Small, single short-term non compliance | Minor injury (local intervention) | Small impact/small inconvenience |
| Moderate | Moderate loss £10,001 - £100,000 | Sustained single or a few short-term non-compliances | Moderate injury (professional intervention) | Medium level impact/moderate inconvenience |
| Open | Significant loss £100,001 - £1,000,000 | Multiple sustained non-compliances | Major injury (hospital stay) | Significant impact/serious inconvenience |
| Hungry | Substantial loss > £1,000,000 | Multiple, long-term, significant non-compliances | Fatal injury | Substantial/complete service failure |

| | Approach to Achieving aim/objectives | Potential reward/benefit from risk taking | Organisational culture |
|---|---|---|---|
| Adverse | Safe; exposure to only the very lowest levels of risk | Very low | Little or no empowerment beyond most senior team considerable control over all activities |
| Cautious | Guarded; as little risk as reasonably possible | Low | Empowerment to senior and key middle managers; strong control over most activities |
| Moderate | Balanced; exposure to middle-ground risks | Medium | Empowerment to front-line managers; control over some activities, more latitude for others |
| Open | Creative; elevated levels of risk exposure | High | Empowerment to all managers, supervisors and selected staff; control over small core of activities, considerable latitude for others |
| Hungry | Pioneering; substantial levels of risk exposure | Extremely High | Widespread empowerment to all managers and staff; very few controls, individual initiative strongly encourage and supported |

**Overall Risk Appetite Statement**

12.4 The CCG has an overall open/moderate risk appetite. The CCG will act in accordance with this risk appetite statement to support its strategic objectives.

12.5 The Governing Body has determined current risk appetite for the CCG as follows:

| | Finance | Compliance | Safety | Service delivery |
|---|---|---|---|---|
| Adverse | Minor loss < £1000 | Trivial, very short term single non-compliance | Insignificant injury (no intervention) | Negligible impact/unnoticed by service users |
| Cautious | Small loss £1,001-£10,000 | Small, single short-term non compliance | Minor injury (local intervention) | Small impact/small inconvenience |
| Moderate | Moderate loss £10,001 - £100,000 | Sustained single or a few short term non-compliances | Moderate injury (professional intervention) | Medium level impact/moderate inconvenience |
| | Significant loss £100,001 - £1,000,000 | Multiple sustained non-compliances | | |
| Hungry | Substantial loss > £1,000,000 | Multiple, long-term, significant non- compliances | Fatal injury | Substantial/complet eservice failure |

12.6 This statement must be kept under review as the CCGs mission, objectives and values develop over time and positions change.

12.7 **Safety Risks**

The CCG has a moderate appetite for risk relating to safety. This will cut across a number of areas including where constitutional targets not being met puts patient safety at risk as well as the commissioning of safe services. The CCG must understand the impact of decisions on patients and the safe delivery of services must be the paramount consideration of the organisation.

12.8 **Compliance Risks**

The CCG has an open appetite for compliance risks except where these risk the safety of patients. The CCG understands that it is required to comply with its duties and obligations under legislation and the NHS constitution however the CCG is content that necessary plans are in place to address these as far as this is within the CCGs control. For this reason the CCG is content to accept a level of risk which is associated with a failure to comply with these requirements as steps are taken to address these.

Whilst this is the case the CCG is keen to ensure that where a failure to comply with a requirement directly impacts on patient safety, the CCG has a low appetite for these risks.

Information Governance Risks also fall under this heading.

12.8 **Finance Risks**

Based on the last known pre-Covid-19 allocation the CCG would still be in a recurrent deficit position. The CCG therefore has an open risk appetite for financial risks. Broadlyspeaking this means that the CCG will tolerate a risk of financial loss of between £100,001 and £1,000,000 however this is dependent upon the circumstances. For example where this is unplanned expenditure that ought to have been anticipated had proper horizon scanning or risk management been undertaken this is less tolerable than a change in system position etc.

The Governing Body also views loss as a situation where a projected saving is not going to be delivered and this should be assessed in the same way.

12.9 **Service Delivery Risks**

The CCG is moderate to risk to service delivery. This is the case whether service delivery is put at risk as a result of financial challenges, recruitment

challenges or planned staffing changes. The impact of the failure to deliver a service should also be described.

12.10 Whilst the CCG has a moderate to open tolerance of risk generally where there are risks which cut across a number of categories and may fall into a more tolerant category (for example compliance risks); where these are also related to patient safety they should be reported through the relevant committee; a safety risk will take priority over a compliance risk.

12.11 ***Examples***

*(i) The CCG has become aware that the local provider of Acute Services has had a significant rise in the number of 12 hour trolley waits. The information which the CCG holds is that this is not uncommon regionally and that the provider is not an outlier on the basis of the figures provided. 12 hour trolley waits is a target that is recorded and provided to regulators and breaches should be reported accordingly. As this matter is a single incident and is not one which the CCG is concerned about, Managers would be in a position to deal with this without escalation to a committee.*

*The CCG have however become aware that two of the 12 hour trolley waits resulted in significant harm to patients and the Provider did not report these incidents to the CCG in accordance with the escalation requirements. For that reason patient safety becomes a greater concern than compliance with the target and the risk should be recorded as such and escalated to Quality and Patient Experience Committee.*

*(ii) The CCG has become aware of a service which was commissioned by NHSE from Primary Care has moved to be commissioned by the Trust however there is no specific envelope of money being provided to the Trust to commission the service. There appears to have been a breakdown in communication and the Trust have not accounted for the need to provide this service and are unable to do so.*

*The CCG are approached to offer a LES to practices to cover this service in the meantime. The CCG are not the commissioners of this service however NHSE are leaving this to be resolved with the Trust and if the CCG want to offer a LES to cover the gap that is a matter for the CCG. This additional cost is not in the CCG financial plan and would come at a cost of approximately £150,000. Patients who do not receive this service may be at risk of harm as a result.*

*This risk may be reported to Finance and Performance Committee as a variance from plan however should be managed by Quality and Patient Experience Committee.*

## 13. ASSURANCE STANDARDS

13.1 The CCG will maintain a Board Assurance Framework which is based upon the strategic priorities of the organisation and risk. 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 Committees on a regular basis.

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

14.1 The Governing Body will receive ad hoc risk awareness training through Governing Body workshops. 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.

## 15. RISK REGISTER PROCESS

15.1 All risks, clinical, strategic, organisation 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 a risk should be proportionate to the risk itself. The CCG should therefore have in place efficient assessment processes covering all areas of risk. It is also a legal requirement that all NHS staff actively manage risk.

### 15.2 Risk Identification

Risk identification involves examining all sources of risk, from the perspective of all stakeholders, both internal and external. 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

15.3 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.

15.4 **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. Riskassessment involves two distinct stages:

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

15.5 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 the Local Authority
- Cause damage to the environment
- Cause property damage/loss
- Result in operational delays
- Result in the loss of reputation

15.6 Risk assessments will be carried out locally by identified staff

15.7 **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.

15.8 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.

15.9 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-structure 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.

15.10 **Project Risk Registers**

All projects should develop a risk log which captures risks relating to the work stream. The process of risk identification should capture principal threats and opportunities associated with the project. A risk assessment should be completed for each risk identified and documented in the risk log for the project.

15.11 Responsibility for identified risks will then need to be allocated to individuals

15.12 Decisions will have to be made as to whether the risk should be:
- Terminated (Eliminate the risk entirely);
- Treated (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

## 16. MONITORING AND REVIEW

16.1 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.

16.2 The monitoring and review of risk management systems is embedded within the CCG. The Governance Structure at Appendix4 provides assurance to the CCG Governing Body that the risk management arrangements are working effectively at all levels of the organisation.

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

16.4 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**

16.5 The process that should be followed to escalate a risk to the corporate risk register is detailed below. The Head of Legal and Governance will:

- Work with the Executive Team to complete the Board Assurance Framework
- Once the risk register has been completed, the Executive Team will decide which risks they feel should be escalated to the Governing Body with the Board Assurance Framework. Risks to consider for escalation are those where the risk:
    - Has an overall risk rating of over 20
    - Impacts on a corporate objective or;
    - Is not within their remit to rectify (for example, fire safety)

**Finance and Performance Committee**

16.6 The Finance and Performance Committee is responsible for reviewing the risk register and updating the Governing Body on key risks relating to Performance, Finance, Information Governance and Business Continuity/Emergency Planning Risks.

16.7 The Finance and Performance Committee has responsibility for oversight of the development of an annual financial plan for income and expenditure withinan understood and accepted level of risk.

**Quality and Patient Experience Committee**

16.8 The Quality and Patient Experience Committee is responsible for reviewingthe risk register and updating the Governing Body on key risks relating to Quality Assurance, patient safety, patient outcomes and safeguarding issues. Quality and Patient Experience Committee is responsible for reviewing the risks relating to ALL commissioned services including but not limited tooacute, mental health and primary care.

16.9 The Quality and Patient Experience Committee has responsible for oversight of the development of a Quality Assurance Strategy within an understood and accepted level of risk.

**Executive Committee**

16.10 The Executive Committee is responsible for reviewing the risk register and updating Governing Body on key risks relating to Corporate functions and HR. This will include estates issues, staffing issues and other HR matters.

16.11 The Executive Committee is responsible for monitoring risk sharing agreements between Commissioners or Commissioners and Providers where such agreements exist.

**Primary Care Commissioning Committee**

16.12 The Primary Care Commissioning Committee is responsible for reviewing the

risk register and updating Governing Body on key risks relating to primary care functions including workforce and resilience concerns. Care will need to be taken to link any risks escalated in this committee with the risks raised in Quality and Patient Experience Committee and should be transferred by the Chair if they are raising patient safety or service quality concerns.

16.13 The Primary Care Commissioning Committee is responsible for development of a Primary Care Strategy including Primary Care Estates and Technology, within an understood and accepted level of risk.

**Audit Committee**

16.14 The duties of the Committee are driven by the priorities by the CCG and the associated risks.

16.15 The Audit Committee is responsible for establishing and maintaining and effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

16.16 The Audit Committee is responsible for evaluating fitness for purpose of the CCG Board Assurance Framework

16.17 In particular the Committee will review underlying assurance processes; the adequacy and effectiveness of all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the CCG Governing Body.

16.18 The CCG Board Assurance Framework will be presented to the Audit Committee twice a year to be reviewed and monitored and a summary of all strategic risks will be presented at each meeting.

**Governing Body**

16.19 The Governing Body will be routinely briefed regarding all principal risks which the organisation faces, and which risks may lead to the noncompliance of the corporate objectives or failure to deliver statutory duties. 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.

## 17. MONITORING AND REVIEW PROCEDURES

17.1 The corporate risk register should be incorporated into the general management agenda. A Standard Operating Procedure will be maintained to ensure that the approach to managing and maintaining risk registers is consistent.

17.2 Identification – Identified risks should be specific in detail e.g. "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.

17.3 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 management is a continuous process and should not beconsidered as a one off exercise. Evaluating the risks will assist the Governing Body in setting priorities.

17.4 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.

17.5 Both the risk register and the risk treatment plans need to be regularly reviewed, evaluated and monitored. It is good practice to review the corporaterisk register quarterly and this will be undertaken by the Head of Legal and Governance with a paper prepared for Governing Body.

## 18. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

18.1 The Committees reporting to the Governing Body will be involved in the development and maintenance of the strategy. The framework will be approved and ratified by the CCG Governing Body, in line with the CCGs Policy on Policies.

## 19. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS

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

## 20. IMPLEMENTATION

20.1 This policy/strategy 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.

20.2 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;
- Services users, their relatives, carers and advocates can identify pointes of concern or worry by using the complaints process or PALS service;
- The media are accurately advised of developments in the CCG through the CCG Communications Team or one of the Directors.

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

## 21. TRAINING AND AWARENESS

21.1 This policy/strategy will be published on the CCG's website and will be available to staff on the organisations' intranet.

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

## 22. MONITORING AND AUDIT

22.1 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.

22.2 The Audit Committee is responsible for monitoring the effectiveness of this policy/strategy and for providing assurance to the Governing Body.

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

## 23. REVIEW

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

## 24. 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
- 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
- ISO31000


## 25. ASSOCIATED POLICIES

- Serious Incident Policy
- Health and Safety Policy
- Emergency Preparedness Plan
- CCG Constitution (includes Standing Orders)

- Information Risk Management Strategy
- IMT Security Policy and associated procedures
- Complaints Policy
- Induction Policy

## 26. CONTACT DETAILS

Manager Name: Head of Legal and Governance
Telephone: 01904 555870
Email: voyccg.governance@nhs.net
Address: NHS Vale of York Clinical Commissioning Group, West Officers, Station Rise, York, YO1 6GA

## 27. LIST OF APPENDICES

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

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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:<br>• Risks within the organisation are identified, assessed, treated and monitored as part of the corporate governance of the CCG.<br>• 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:**<br>Senior Management team<br>**Stakeholder involvement**:<br>Consultation with Senior Managers<br><br>**Patient / carer / public involvement**:<br>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**<br><br>**(Refer to** Error! Reference source not found. if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle) |
|---|---|

| | |
|---|---|
| **Disability**<br>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**<br>Men and Women | Consider gender preference in key worker, single sex accommodation etc. |
| N/A | |
| **Race or nationality**<br>People of different ethnic backgrounds, including Roma Gypsies and Travellers | Consider cultural traditions, food requirements, communication styles, language needs etc. |
| N/A | |
| **Age**<br>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**<br>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**<br>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**<br>Includes religions, beliefs or no religion or belief. | Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc. |

| | |
|---|---|
| N/A | |
| **Marriage and Civil Partnership**<br>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**<br>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**<br>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**<br>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**<br>Please outline what mitigating actions have been considered to eliminate any adverse impact?<br><br>Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people?<br><br>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<br>*Abigail Combes, Head of Legal and Governance* |
| Date analysis completed<br>*December 2019* |
| Name and signature of responsible Director |
| Date analysis was approved by responsible Director |

1. 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 | December 2019 (reviewed 29 March 2021) |
| 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 | | |

| Domain | Objectives | Impact of activity<br>Negative = -1<br>Neutral = 0<br>Positive = 1<br>Unknown = ?<br>Not applicable = n/a | Brief description of impact | If negative, how can it be mitigated?<br>If positive, how can it be enhanced? |
|---|---|---|---|---|
| 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 | | |
| Facilities Management | Will it reduce the amount of waste produced or increase the amount of waste recycled?<br>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 | | |

| Domain | Objectives | Impact of activity<br>Negative = -1<br>Neutral = 0<br>Positive = 1<br>Unknown = ?<br>Not applicable = n/a | Brief description of impact | If negative, how can it be mitigated?<br>If positive, how can it be enhanced? |
|---|---|---|---|---|
| | 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 | | |
| 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 | | |

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## 2. APPENDIX 3 : RISK ASSESSMENT TOOL (RISK MATRIX)

2.1. 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

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

2.3. 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.

2.4. 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 DEFINITIONS | | | | | |
|---|---|---|---|---|---|
| **Rating** | **Classification** | **Finance** | **Compliance** | **Safety** | **Service Delivery** |
| 1 | Adverse | Minor loss < £1000 | Trivial, very short term single non-compliance | Insignificant injury (no intervention) | Negligible impact/unnoticed by service users |
| 2 | Cautious | Small loss £1,001-£10,000 | Small, single short-term non compliance | Minor injury (local intervention) | Small impact/small inconvenience |
| 3 | Moderate | Moderate loss £10,001 - £100,000 | Sustained single or a few short-term non-compliances | Moderate injury (professional intervention) | Medium level impact/moderate inconvenience |
| 4 | Open | Significant loss £100,001 - £1,000,000 | Multiple sustained non-compliances | Major injury (hospital stay) | Significant impact/serious inconvenience |
| 5 | Hungry | Substantial loss > £1,000,000 | Multiple, long-term, significant non-compliances | Fatal injury | Substantial/complete service failure |

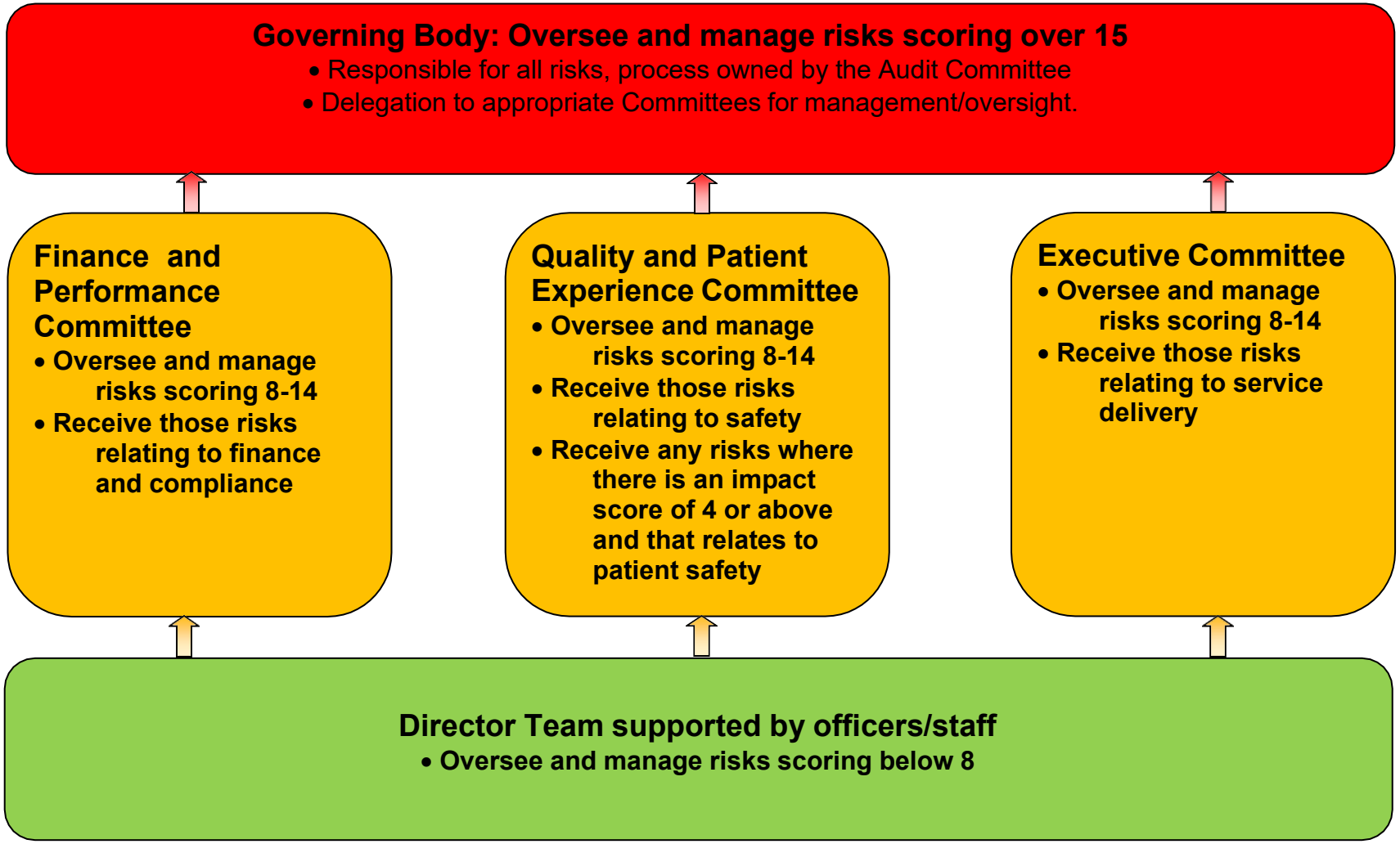
Appendix 3 cont…

| 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 |

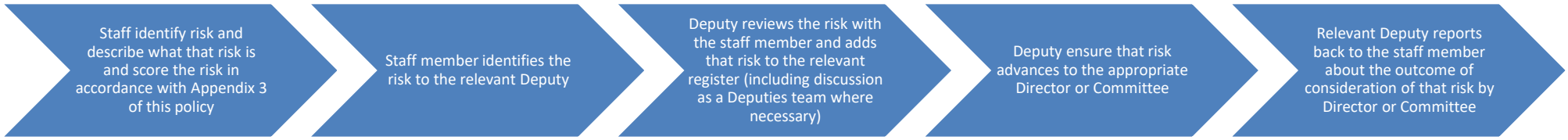
| IMPACT | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Rating** | **Classification** | **Patient Safety** | **Quality/Complaints/ Audit** | **HR/Staffing** | **Statutory Duty/ Inspections** | **Adverse Publicity/Reputation** | **Business Objectives/ Projects** | **Finance Including 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 |
| **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 |

| 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** |
| **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 |

## APPENDIX 4: RISK MANAGEMENT THROUGH THE COMMITTEE STRUCTURE



## APPENDIX 5: RISK IDENTIFICATION AND NOTIFICATION PROCESS




Relevant Deputy for each Committee as at 20 May 2021 (this is subject for change. If in doubt speak to the Head of Legal and Governance for clarity

| **Governing Body** | **Quality and Patient Experience Committee** | **Finance and Performance Committee** | **Primary Care Commissioning Committee** | **Executive Committee** |
|---|---|---|---|---|
| Abigail Combes<br><br>Abigail.combes@nhs.net | Paula Middlebrook<br><br>Paula.middlebrook@nhs.net | Michael Ash-McMahon<br><br>(M.ash-mcmahon@nhs.net) | Stephanie Porter<br><br>Stephanie.porter@nhs.net | Abigail Combes |