Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

RISK MANAGEMENT POLICY

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1	May 2021	Senior Governance Manager	First Draft
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1.1	July	Governance Manager	Tidied up formatting.

Equality Statement

Equality, diversity and human rights are central to the work of the Hampshire, Southampton and Isle of Wight (HIS) CCG. This means ensuring local people have access to timely and high quality care that is provided in an environment which is free from unlawful discrimination. It also means that the CCG will tackle health inequalities and ensure there are no barriers to health and wellbeing.

To deliver this work CCG staff are encouraged to understand equality, diversity and human rights issues so they feel able to challenge prejudice and ensure equality is incorporated into their own work areas. CCG staff also have a right to work in an environment which is free from unlawful discrimination and a range of policies are in place to protect them from discrimination.

The CCGs' equality, diversity and human rights work is underpinned by the following:

- NHS Constitution 2015.
- Equality Act 2010 and the requirements of the Public Sector Equality Duty of the Equality Act 2010.
- Human Rights Act 1998.
- Health and Social Care Act 2012 duties placed on CCGs to reduce health inequalities, promote patient involvement and involve and consult the public.

Contents

1. Introduction

1.1 NHS Hampshire, Southampton and Isle of Wight CCG is responsible for commissioning Health services for a population of 1.6 million people. In doing so, the CCG acknowledges that we make decisions that can have a significant impact on the health and wellbeing of our local population. It is inevitable that many decisions we make are made with an element of uncertainty about the future and each decision has an inherent risk associated with it. In order to estimate the level of risk and the impact should this risk manifest itself, the CCG needs to be able record and understand the profile of risks that face it.

1.2 The CCG is committed to establishing an approach to the identification and management of risk throughout the organisation for all staff. This approach will ensure that all areas of risk are considered in the planning and delivery of services.

1.3 This policy will support the establishment of a proactive, honest, open and just environment where all types of risks can be identified and managed in a positive and timely way. Senior management will ensure that all staff are provided with training and support, appropriate to their role, to enable them to meet their responsibilities under the Risk Management Policy.

2. Purpose

2.1 This document aims to provide an overarching process for the management of internal and external risk by NHS Hampshire, Southampton and Isle of Wight Clinical Commissioning Group. This includes setting out the CCG's approach to risk management and the procedures that support the recording and assessment of risk.

2.2 Risk refers to uncertainty, the possibility of incurring misfortune or loss or missing opportunities. This is measured in terms of the likelihood of something happening and the impact of the possible consequences. A risk therefore is anything which has the potential to damage or threaten the achievement of organisational objectives, including keeping patients safe, ensuring the best value for money health services to our population and maintaining a reputation for delivering effective health services for our communities.

3. Scope

3.1 This policy applies to all CCG staff.

4. Definitions

Risk	A risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives of a programme area. It is measured in terms of impact and likelihood. It consists of a combination of the probability of a perceived *threat* or *opportunity* occurring, and the magnitude of its impact on the objectives, where: *threat* is an uncertain event that could have a negative impact on objectives; and *opportunity* is an uncertain event that could have a favourable impact on objectives.
Risk Management	Risk Management is the systematic application by individuals of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk.
Hazard	A hazard is anything with the potential to cause harm.
Risk Assessment	Risk assessment is the process used to evaluate the hazard/risk and to determine whether precautions are adequate or more should be done.
Impact	Impact is a measure of the effect that the predicted harm, loss or damage would have on the people, property or objectives affected.
Likelihood	Likelihood is a measure of the probability that the predicted harm, loss or damage will occur.
Strategic Risk	Strategic risk is a significant risk that will impact organisation wide and not just a team, project or Business Unit.
Operational Risk	Operational risk is a key risk, which impacts on an operational task/objective being achieved. Operational risks are managed on directorate risk registers.

5. Roles and responsibilities

5.1 **Accountable Officer** – has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to and ultimate responsibility for ensuring that the CCG has established an effective system for managing risk.

5.2 **CCG Governing Body** is responsible for ratifying all policies in use by the organisation.

5.3 **Executive Team** holds high level responsibility for the risks reported within their directorate, including escalating any high scoring risks to other members of the Executive Team and the Governing Body as appropriate. The Executive Team owns the CCG Governing Body Assurance Framework and are responsible for ensuring that this document remains live, accurate and is updated as required.

5.4 **Risk Owners** ae the person responsible at a team level for ensuring that a risk is appropriately managed and regularly reviewed. For most risks, this will be lead manager of the relevant team.

5.5 **CCG Governance Team** is responsible for managing the risk management process at the CCG as outlined within this policy. They will support staff to understand the risk management process and ensure that risks are managed appropriately across the CCG. The team will also ensure that relevant risk reporting is carried out at the Governing Body and Committee level.

5.6 **Team Leads/Heads of Service** are responsible for their team risk registers and should ensure that all risks on these risk registers are reviewed and updated regularly and that any identified risks are evaluated and recorded in a timely manner.

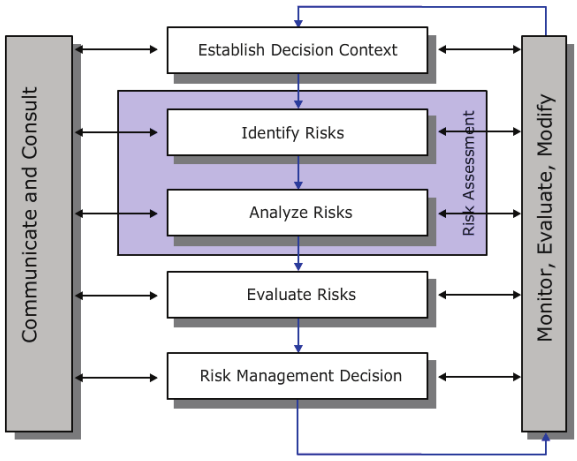
5.7 **All CCG staff** are responsible for ensuring that risks are appropriately managed and should ensure that work to minimise risk is undertaken by their teams as necessary. All staff should also raise any potential risks to their teams for assessment and adding to the CCG risk register as appropriate.

6. Risk Management

6.1 Risk Management Framework

The process for the management of risk within the CCG is summarised in the figure below and is identical to the process contained in AS/NZS 4360, which NHS organisations in England have been working with since the Department of Health issued the 1999 version of the AS/NZS 4360 Standard in 1999.

Whenever risks to the achievement of CCGs' strategic objectives have been identified, it is important to record, assess and report the risk using a standardised framework and in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk. The figure below outlines the CCG framework for risk management.



6.2 Identifying Risks

The first stage in the risk process is to identify what events might prevent or impact in a positive or negative way on the achievement of the organisation's objectives as set out in the CCG's Strategy and Operating Plans.
Any individual within the CCG can help to identify a risk and are actively encouraged to do so. Risks may be identified at any level of the delivery of the business of the CCG, including:

- project planning / management – risk workshops/risk prompts
- incident information within the CCG
- risk identification from internal sources e.g. external assessors, internal audit, minutes of meetings, word of mouth, informal conversations
- incident/ risk information from external sources e.g. impacts of national regulation, from meetings with providers
- Reviews/lessons learned.

Once identified, managers should assess and evaluate the risks in line with this policy. When identifying risks it is essential to link the risk to an objective or output in order to understand the impact and allow assignment of the risk to an owner. This linkage ensures that the risk management activity is focused on delivery of business objectives; a risk can only be assessed and prioritised in relation to objectives.

6.3 Risk Evaluation & Analysis

The identification of risk should be followed by an evaluation of the impact that the risk may have on the delivery of objectives. It is therefore important to use a process for this evaluation that can be consistently applied by managers across the organisation. Risk scoring involves the systematic use of all available information to determine how often specified events occur (the likelihood) and the magnitude of their consequences (the impact).

The tables below provide summary scoring guidance for the impact of the risk and likelihood of the occurrence.

What is the severity of the impact should the risk materialise?					
Impact Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Very Low**	**Low**	**Medium**	**High**	**Very High**
Impact should it happen	Unlikely to have any impact	May have an impact	Likely to have an impact	Highly probable that it will have a significant impact	Will have a catastrophic impact

Further detail on assessing impact has been set out by the National Patient Safety Agency and is included in Appendix 1.

What is the likelihood that harm, loss or damage from the identified hazard will occur?					
Impact Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
How often might it happen	May happen in exceptional circumstances	The event could occur	The event should occur at some time	The event will occur in most circumstances	The event is expected to occur in all circumstances

Risk Scoring

In order to grade the risks identified the CCG utilises the risk assessment tool and matrix shown below. The adoption of the matrix-scoring model set out in this document will enable the consistent evaluation of risk (for the purposes of the risk registers) across the CCG.

Using the risk "RAG" rating, risks can be ranked so that the most severe are addressed first. Decisions can then be made as to what mitigating action can be taken to alleviate the risk.

Impact	Very High	5	10	15	20	25
	High	4	8	12	16	20
	Medium	3	6	9	12	15
	Low	2	4	6	8	10
	Very low	1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost Certain
		Likelihood				

6.4 Recording Risks

All identified risks will be primarily recorded on the CCG's risk registers. Risk registers are intended as 'living' documents that will outline the risk profile for each directorate, business unit, service, project or programme of work at any given time. Having identified and evaluated risks it is the responsibility of the accountable Executive to ensure that the risks are being managed appropriately in line with the risk management strategy.

Senior management within each directorate is expected to own the risks within their risk registers. The risk registers should be reviewed and updated bi-monthly at a minimum.

All operational risk registers will be maintained on Datix and will include the components below:

Risk Description	A description of the risk to the organisation including the potential consequences should the risk materialise, articulated in an 'If…then…leading to…' format.
Risk Owner	This person is responsible for ensuring that the risk is managed appropriately and should ensure that
Initial Risk Score	The impact and likelihood of the risk when it was initially identified.
Current Risk Score	The current impact and likelihood of the risk, given any controls and mitigations in place and any other changes that may have an effect on the impact or likelihood of the risk.
Target Risk Score	The risk level at which the risk will be considered well managed or tolerated.
Controls	Systems and processes *already in place* that mitigate the risk.
Mitigating Actions	What we are doing to manage the risk and how this is evidenced – including who owns the actions and how and when progress is made.

Corporate Risk Register

The Corporate Risk Register is comprised of all risks across directorate risk registers with scores of 15 or higher. The Executive Team is expected to review and challenge the Corporate Risk Register at regular intervals. The Corporate Governance and Assurance Group will assure the Executive Team that risk is being appropriately managed by regular review of the Corporate Risk Register. The Corporate Governance Team will support the co-ordination and collation of the Corporate Risk Register for all risks scoring 15 and above.

6.5 Risk Treatment

The selection of the most appropriate option for treating and managing controls to mitigate risks involves balancing the cost of implementing each option against the benefits derived from it. The accountable Executive will be responsible for overseeing and prioritising risk treatment options. The risk register will summarise the control measures and the actions to deliver those controls.

CCG staff who are accountable for the delivery of a project or programme will operate robust risk management practice and place risks on the appropriate registers. Risks will be escalated accordingly.

There are four recognised types of response to identified risks, as outlined below.

Avoidance (or Terminate)	Some risks will only be treatable, or containable to an acceptable level by terminating the activity.
Reduction (or Treat)	The purpose of treatment is not necessarily to remove the risk, but to reduce it to an acceptable level.
Transfer	For some risks the best response will be to transfer them. This might be done through insurance (where appropriate) or by paying a third party to take the risk in another way.
Retention (or Tolerate)	The ability to take action to mitigate some risks may be limited, or the cost of action may outweigh the potential benefit gained. In these cases the response may be toleration

The appropriate response to managing a risk will depend on a number of factors, however, the chosen method should be supported by the controls and mitigating actions for each risk.

6.6 Monitoring and Reviewing Risks

Evaluating identified risk to establish a risk rating will not automatically identify the areas that require the greatest levels of attention or escalation within the organisation, but can act as a suggested guide for the level of action that should be taken and at what organisational level. The chart below outlines the appropriate levels of management and escalation for risks scoring within each category.

Risk Action Guideline				
Descriptor	**Low Risk**	**Medium Risk**	**High Risk**	**Very High Risk**
Risk Rating	**1-3**	**4-6**	**8-12**	**15-25**
Action guide	Acceptable level of risk. manage by routine controls	Acceptable level of risk, manage by monitoring and controls including risk register at division level	Unacceptable level of risk exposure which requires action and active monitoring including risk register at division level	Unacceptable level of risk exposure which requires immediate corrective action to be taken risks to be added to corporate risk register
Ownership / Authority	Individuals and managers of teams	Managers	Senior Managers	Directors

Green risks scoring between 1-3 are defined as Low Risk. Individuals should manage low risks by maintaining routine procedures and taking proportionate action to implement any additional new control measures to reduce risk where possible. Individuals must escalate higher levels of risk.

Yellow risks scoring between 4-6 are defined as Moderate Risk. Managers must ensure that actions are identified and delivered to reduce risk or remove the risk. The risk must be entered on a risk register and managed at Division level. Managers must escalate higher levels of risk.

Amber risks scoring between 8-12 are defined as High Risk. Senior Managers must prepare actions are identified and delivered to mitigate for high risks. Appropriate management assurance must evidence and control the risk assessment, and oversee the actions to reduce the risk. The risk may be a low score as it is in its early stages. Senior Managers must consider developing implications of the risk and report to Directors if appropriate. The risk must be reported on a risk register at Division level.

Red risks scoring between 15-25 are defined as Very High Risk. Management action is required to ensure immediate risk treatment, in line with the context of the risk. Actions must be overseen by an Executive lead, who will ensure that the risk is reported on the Corporate Risk Register and reviewed at Executive level.

All risks recorded on the CCG risk register should be reviewed and revised as controls and mitigations are applied and actions are completed (or as the risk changes). The risk should be managed down to a tolerable level consistent with demonstrating best value relative to the resources applied.

The Risk Owner should review progress of the controls and mitigating actions relating to the risk. From this review the Risk Owner should satisfy a number of questions so that appropriate changes can be made to the plan if necessary:

- Has the risk changed/does it remain relevant to the CCG?
- Are all the tasks, associated with each action, being carried out and if not what are the constraints?
- Can the constraints (where appropriate) be removed?
- Are the tasks completed so far having the desired effect in reducing the probability or impact?
- If the mitigating actions are not having the desired effect, what other risk responses can be used?
- Have any secondary risks been identified as a result of the actions carried out so far?

6.7 Governing Body Assurance Framework

The Governing Body Assurance Framework (GBAF) maps the CCG's key strategic risks against the organisational objectives agreed by the CCG's governing body.

The GBAF will be regularly reviewed by the Governing Body and the CCG Audit Committee, in order to provide assurance that the most significant risks to the CCG are being monitored and managed appropriately.

7. Statutory requirements

7.1 Equality

This policy has been assessed as having a low impact on people with characteristics protected by the Equality Act. As such a full equality impact assessment is not required.

7.2 Other requirements

"Bribery Act 2010 – the CCG has a responsibility to ensure that all staff are made aware of their duties and responsibilities arising from The Bribery Act 2010. The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed. The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed and an individual convicted of an offence can face a prison sentence of up to 10 years.

For further information see http://www.justice.gov.uk/guidance/docs/bribery-act2010-quick-start-guide.pdf.

Due consideration has been given to the Bribery Act 2010 in the review of this policy and no specific risks were identified/the following risks were identified.

Data protection legislation – (as defined in the Data Protection Act 2018) – Due consideration has been given to Data Protection Legislation in the review of this policy and no specific risks were identified/the following risks were identified.

8. NHS Constitution

8.1 The CCG is committed to:

Designing and implementing services, policies and measures that meet the diverse needs of its population and workforce, ensuring that no individual or group is disadvantaged.

8.2 This Policy supports the NHS Constitution as follows:

"The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population".

9. Training considerations

9.1 A robust training programme is a key component of effective risk management. A training programme will be developed following a training needs analysis and will include all aspects of this policy as well use of the CCG's risk management system.

9.2 Attendance at any training session carried out as a consequence of the policy implementation must be formally recorded and documented.

10. Dissemination/Publication

10.1 This policy will be published on the CCG website and / or intranet (as appropriate) and promoted to staff through internal staff communications such as the intranet / staff App / newsletters / staff briefings.

11. Monitoring

11.1 The CCG auditors are responsible for agreeing (with the Audit Committee) a programme of audits which assess the adequacy of the risk management process of the CCG. As there are already established audit / review processes in place, a separate audit standard in relation to this policy is not required.

12. Review and revision

12.1 This policy will be reviewed on a yearly basis by the Governance Team to ensure continued validity and relevance and in accordance with the following as and when required:

- Legislative changes
- Good practice guidance
- Case law
- Significant incidents reported
- New vulnerabilities and
- Changes to organisational structure.

13. References and links relating to this policy

- Good Governance Institute
- NHS Resolution
- Department of Health and Social Care
- Institute of Risk Management
- National Patient Safety Agency (NPSA)

Appendix 1: Risk Impact Scoring Guidance
Source: National Patient Safety Agency, A risk matrix for managers v9

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
				Purchasers failing to pay on time	Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment