NHS
Wolverhampton
Clinical Commissioning Group

Risk Management Strategy

DOCUMENT STATUS:	**To be Approved /Approved**
DATE ISSUED:	**Draft Consultation February 2016**
DATE TO BE REVIEWED:	**June 2018**

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
1.0	**June 2012**	
2.0	**December 2013**	
3.0	**February 2016**	
3.1	**June 2016**	**In response to new guidance**

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Sarah Southall	Head of Quality and Risk/Author	February 2016	3 FD
Dawn Bowden	Quality Assurance Co-ordinator	June 2016	3.1

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Quality & Safety Committee	July	3.1 final

DISTRIBUTION

This document has been distributed to:

Distributed To:	Distributed by/When	Paper or Electronic	Document Location

DOCUMENT STATUS

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS

These documents will provide additional information:

REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION

RISK MANAGEMENT POLICY

STATEMENT OF INTENT

The overall aim of Wolverhampton Clinical Commissioning Group (CCG) is to be a first class commissioner of healthcare services putting customers and patient/service users at the centre of what they do. As part of this aim, it is vital that the services we commission are safe, effective and deliver positive experiences for patients

Integral to achieving this aim is the development and implementation of a robust and integrated system of managing all risks that could potentially impact on the CCG when it commissions services.

Wolverhampton CCG seeks to maintain a comprehensive system of internal controls that enables proactive identification and management of risks of a commissioning, operational, corporate and financial nature including fraud, whilst avoiding any loss of flexibility and innovation in service provision.

The management of risk is therefore a key organisational responsibility which all management and staff must accept as one of their fundamental duties, and every member of staff must have a real sense of ownership and commitment to identifying and minimising risks.

The Board endorses the **Risk Management Strategy**, which is a proactive approach to:

- **Identifying** the risks that exist
- **Analysing** those risks for potential frequency and severity
- **Eliminating** the risks that reasonably and practicably can be eliminated
- **Reducing** the effect of those risks that cannot be eliminated
- **Putting in place** mechanisms to absorb the financial consequences of those residual risks that remain.

The responsible committee – Quality & Safety Committee – will maintain close liaison with the Audit & Governance Committee to ensure risk management is actively reported and continuous improvement and learning associated with risk management is being actively managed & reviewed.

Signed

_____

Chief Officer
Date: June 2016

1.0 INTRODUCTION

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

Commissioning a healthcare service is in itself a fundamentally risky activity, so it can be said that we already manage some risks on a continual basis, e.g. making assessments of health economy need, ensuring that we work in relatively risk free environment etc. We will approach management of risk in a structured, systematic and consistent manner.

Wolverhampton CCG, recognizes that some risk is unavoidable and therefore control measures may need careful consideration and implementation to mitigate the risk(s) identified. It will have a risk management policy approved by the Quality and Safety Committee that describes its risk management philosophy and assigns the relevant responsibilities.

This Risk Management Strategy aims to provide Wolverhampton CCG with a framework for the development of a robust risk management strategy and related processes throughout the organization.

The strategic direction is focused on improvements in the local health system through the Quality Innovation, Productivity Prevention (QIPP) Programme with enhanced relationships with local authorities, patients and public groups, and the Health and Wellbeing Board. This strategic direction will:-

- foster an environment that promotes health and wellbeing and tackles inequalities
- ensure that everyone in Wolverhampton can access integrated services which are flexible and responsive to their needs
- commission services which deliver high quality, efficient and cost effective care but above all are safe.

QIPP will be heavily embedded within the CCGs undertaking and will be used as the vehicle to save money yet drive up standards to achieve higher quality services.

Furthermore, the CCG's operating plan is underpinned by care quality as a golden thread and through applying a risk based approach the CCG will strive for continuous improvement in care quality and efficiency.

2.0 Purpose & Scope

This strategy describes the procedures Wolverhampton CCG will use to minimise risk through a comprehensive system of internal control to commission the delivery of high standards of care and covers all patients, service users, staff, stakeholders and those working on or visiting CCG premises, but also covers clinical, organisational and financial risk at strategic and operational levels.

The key objectives of the approach are:-

- To identify, control and eliminate or reduce to an acceptable level all risks which may adversely affect;

- the quality of services commissioned by Wolverhampton CCG the health, safety and welfare of patients, service users, staff and visitors
- the ability of Wolverhampton CCG to provide services
- the ability of Wolverhampton CCG to meet its commitments to partner agencies and the public
- to actively manage it's organisational responsibilities including those afforded to their workforce and nominated representatives.

3.0 Roles & Responsibilities

The Governing Body

The Governing Body has a duty to assure itself that Wolverhampton CCG has properly identified the risks it faces, and that it has processes in place to mitigate those risk(s) and the impact they have on the organisation and its stakeholders.

Therefore, the Governing Body will seek to ensure that the following are achieved:

- Know the most significant risks facing the organisation
- Ensure appropriate levels of risk awareness throughout the organisation
- Know how the organisation will manage a crisis
- Understand the importance of external confidence in the organisation and how this affects risk
- Be assured that the risk management process is working in the organisation
- Have a clear risk management strategy that describes the risk management philosophy and responsibilities of the wider CCG

Senior Responsible Officer

The Senior Responsible Officer has overall accountability for the management of risk and the duties regarding quality of service. They will establish and maintain an effective strategy for risk management by:-

- Continually promoting risk management and demonstrating personal involvement and support
- Ensuring an appropriate committee structure is in place, with regular reports to the Board
- Ensuring that Executive Directors are appointed with managerial responsibility for progressing risk management

Directors

Directors are responsible for directing the implementation of the Risk Management Strategy and associated governance arrangements with staff & stakeholders pertinent to their area of responsibility by:-

- Identifying and carrying out risk profiling and assessment of risk across the functions for which they are accountable
- Treatment of risk(s) including identification, recording & reporting to demonstrate that all reasonable mitigating actions have been identified & put in place to effectively manage the risk
- Continually demonstrating personal involvement and support for the promotion of risk management & reporting on risks associated with their area of control via the central risk management system (Datix)
- Ensuring that managers and heads of department accountable to them understand and pursue risk management in their areas of responsibility

- Setting objectives for risk management and monitoring achievement
- Ensuring that staff employed are of an appropriate professional standing and adequately trained for the tasks they are required to undertake
- Ensuring the development and implementation of effective integrated governance which will promote safety, address risk and create an environment which pursues excellence

These reflect key operational, and day-to-day, responsibilities delegated to them.
Directors must ensure that the implementation of the policy is fully addressed within their respective areas, and that all their staff members are made aware of its overall content and implications

Chief Financial Officer is accountable for progressing financial risk management and for ensuring that effective risk management is in place.

Associate Director of Operations
At strategic level the Associate Director of Operations will be a firm advocate of the strategy and risk management processes, ensuring effective corporate governance practices duly reflect the principles therein. Operations will be a key enabler for full implementation of the strategy's governance arrangements and documentation.

When determining the effectiveness of corporate governance practices, risk management will be recognised as integral to the CCG so that risks are identified on a pro-active and re-active basis. In addition, the strategy will be fully implemented within all Operations portfolio's and is integral to the scrutiny of stakeholder activity that is encountered where risks may have an impact on the CCG.

Executive Lead Nurse (Quality) is responsible for all aspects of clinical quality for commissioned providers and is accountable for the risk management process across the CCG, regularly reviewing the effectiveness of strategy.

Head of Quality & Risk reporting to the Executive Lead Nurse, is the lead for risk management within the CCG ensuring that the day to day co-ordination of risk management is undertaken & duly reported to all responsible forums. They will take all reasonable steps to ensure recommendations for improving & responding to risk management information is effectively communicated.

Heads of Service are expected to be continually aware of risk management issues and will ensure the risk management system is used as an intrinsic component of their day to day work.

All Staff requires the full support of all staff in the assurance and risk management processes. It is the responsibility of all Wolverhampton CCG employees to:-

- Take account of and be actively aware of the potential for things to go wrong
- Report areas of concern including clinical, non-clinical and financial issues (including fraud) to line managers
- Recognise and report incidents, accidents & near misses in accordance with the incident reporting and investigation policy
- Participate in risk assessment processes as necessary

- Provide safe standards of clinical practice through compliance with the regulations of the appropriate professional bodies
- Be aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures etc. relating to their particular location
- Be aware that they have a statutory duty to take reasonable care for their own safety and the safety of all others that may be affected by their actions or inaction
- Be familiar and comply with all Wolverhampton CCG policies, procedures and instructions to protect the health, safety and welfare of anyone affected by services
- Be aware of Wolverhampton CCG Risk Management Strategy and Policy and their responsibilities
- Attend risk management training as required by the CCG
- Be aware of the Information Governance Policy

Program Delivery Boards will ensure that there are risks recorded for each project within their respective portfolio. The responsible Program Delivery Board will routinely consider the register of risks to ensure their portfolio has been duty assessed and a true representation of the risks and corresponding controls they have recognised.

Further guidance can be found in the Risk & Safety Management System.

4.0 Definitions & Terms Used

The Senior Responsible Officer has overall responsibility for ensuring robust systems in place to reduce risk to a minimal level. The risk management policy outlines processes and protocols staff are expected to follow to achieve effective risk management.

The following terms are used in this document:

Hazard	Hazards are the actual 'physical' situations that can cause the harm.
Risk	Risk is the chance that an event will occur and will impact upon the Trust's objectives. It is measured in terms of likelihood (frequencies probability of the risk occurring) and severity (consequence of effect of the risk occurring).
Risk Assessment	Risk Assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk.
Risk Management	Risk Management is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk
Control	The resources, systems, processes, culture, structure and tasks that support staff in the achievement of organisational objectives. Effective control provides a reasonable assurance that the organisation will achieve its objectives reliably, and enables it to respond to significant operational, financial and compliance risks
Clinical Risk	Clinical risk can be defined as direct risks relating to the care of the patient and the standards of care received on the patients' journey through the organisation. Issues that can have an impact on the standard of clinical care received include patient discharge arrangements, patient research studies, infection prevention & control, medicines management, clinical audit, ensuring that there are sufficient staffing levels and that these staff are appropriately trained
Organisational Risk	Organisational risk can be defined as risks relating to communication, provision of goods and services, data protection, information systems, human resources, and risks that threaten the achievement of the organisations objectives
Financial Risk	Financial risk can be defined as risks that will threaten the effective financial controls, including the systems to maintain proper accounting records and success of QIPP projects. It is important that the organisation is not exposed to avoidable financial risk and that financial information used within Wolverhampton CCG and for external publication is reliable
Information Risk	Information risks can be defined as risks that affect personal identifiable information. Information risk management seeks to identify and control information risks in relation to business processes and functions and is led by the Senior Information Risk Owner (SIRO).
Strategic Risk	Defined as risks which affect the achievement of the organisation's strategic objectives
Operational Risk	Is defined as risks which affect the achievement of local objectives
Environmental Risk	Is defined as risks associated with organisational actions which may have an impact upon the environment
Reputational Risk	Is defined as risks which affect public and stakeholder perception of the organisation

5.0 Delivery of the Risk Management Strategy

5.1 Through adopting a sensible approach to risk management practices steps can be taken to protect people from harm and suffering. The principles of risk management are:

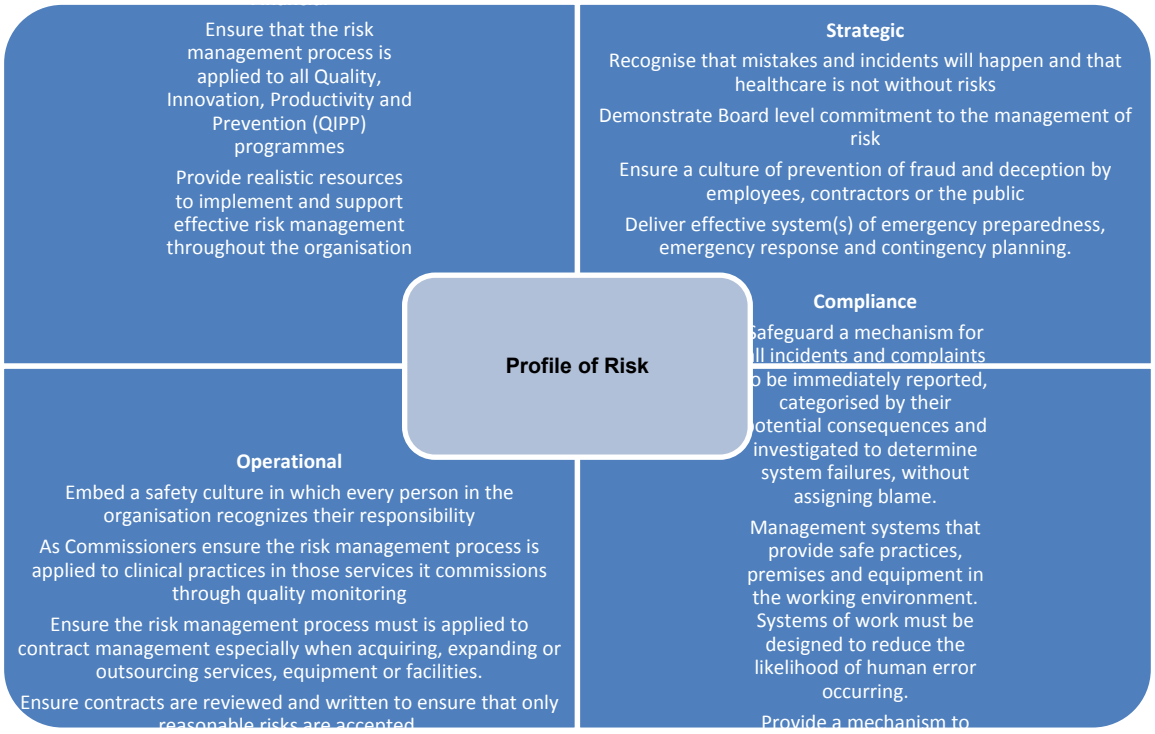
- ensure workers and the public are properly protected
- enable innovation and learning
- ensure that those who detect risks manage them responsibly
- provide overall benefit by balancing benefits and risks, with a focus on reducing significant risks
- enable individuals to understand that as well as the right protection, they also have to exercise responsibility

In healthcare clinical risk management enables us to recognise the events that may result in unfortunate or damaging consequences in the future, their severity and how they can be controlled. The definition of risk management has been defined as, the identification, analysis and economic control of those risks. Which can threaten the assets or earning capacity of an enterprise 9Dickson, G 1195).

The philosophy of risk management in the CCG is to actively identify risk(s), analyse them and ensure that all reasonable control measures have been considered, identified an applied to mitigate the risk.

5.2 Risk Assessment

In order to control the risks the CCG encounters, all teams are required to ensure they have undertaken risk profiling to determine the profile of risks within their portfolio.



These principles apply to all areas of Wolverhampton CCG.

A risk profiling template can be found within the appendices of this policy. When completed the responsible person should ensure a suitable and sufficient assessment of risk has been undertaken in line with Health and Safety Executive Guidance (5 Steps to Risk Assessment) http://www.hse.gov.uk/pubns/indg163.pdf

A risk assessment comprises of 5 steps:

- Identify the hazards
- Who might be harmed
- Evaluate the risks
- Record your significant findings
- Regularly review your risk assessment

Organisations with fewer than 5 employees do not have to write anything down but it is useful to do this so that you can review it at a later date.

The CCG Datix System is used to capture all 5 Steps to risk assessment and is reliant upon regular reviews being undertaken usually the following circumstances will apply:

- Have there been any significant changes?
- Are there improvements you still need to make?
- Have you learnt something new or has the situation changed?

In any event risk amendments should be reviewed in line with the following frequencies:

- Red Risk < 3 months
- Amber Risks 3-6 months
- Green Risks 6-12 months

5.3 Organisational Risk Management Structure & Governance Arrangements

Wolverhampton CCG has put in place a comprehensive structure of controls to co-ordinate and manage risk within the organisation. This consists of rigid lines of accountability through which issues of risk can be debated and the effectiveness of Wolverhampton CCG risk management arrangements assured.

Figure 1 below shows how the various elements of this structure and how they interrelate to ensure that the Board is kept fully informed and assured of the risk management processes.

The main committees and a summary of their remit are as follows:-

Quality & Safety Committee responsible for leading the risk management process, taking a strategic view of governance, to give directions to the other CCG committees and groups regarding management of risk and to receive assurance from these Groups where NHS Standards are being achieved/not achieved. Its remit includes Business Continuity, Financial Governance (including governance of the QIPP program, Quality and Clinical governance, Risk management (including health & safety), Security management and information governance.

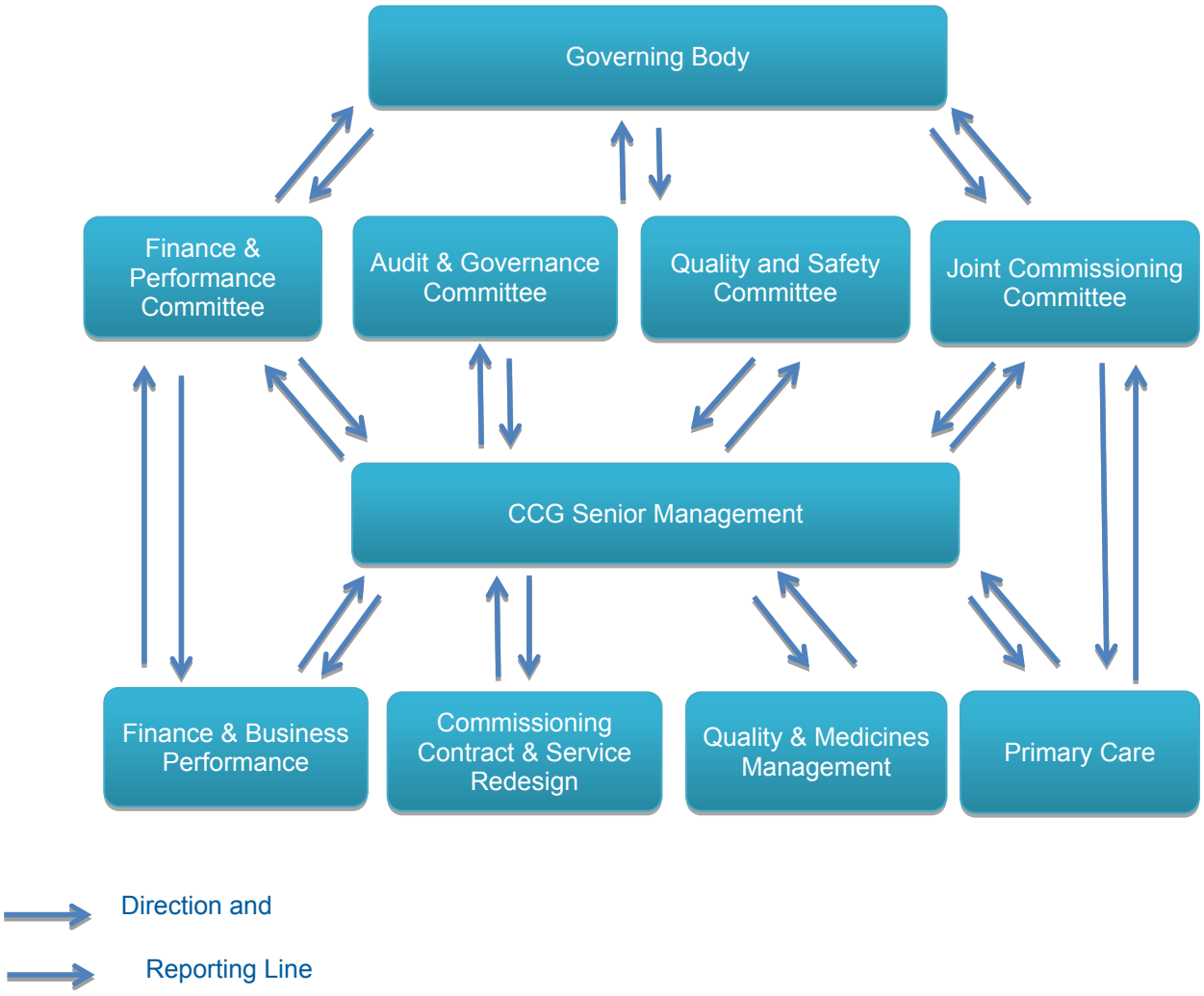
It keeps under active review the content of the corporate risk register, addressing corporate issues, and provides assurances to the Board that directorates and departments within the CCG are managing their risks effectively.

This Quality & Safety Committee is accountable to the CCG Governing Body and will give monthly integrated assurance reports to this forum.

Audit and Governance Committee fulfills the role of scrutiny and verification of the entire process of governance in accordance with the requirements of standing financial guidance and the requirements of the annual Statement on Internal Control.

Figure 1

Organisational Monitoring and Reporting Structure

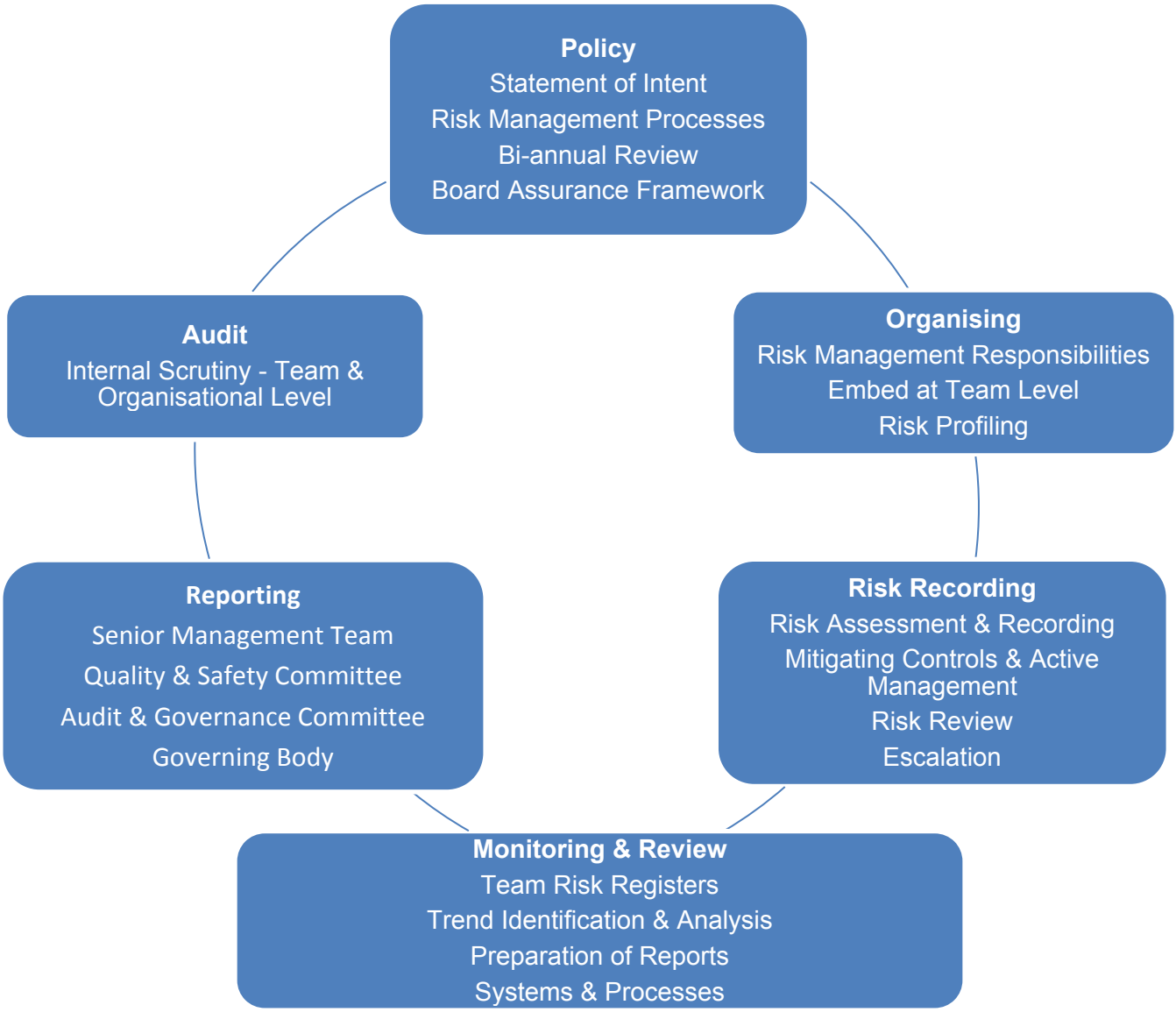


Integrated Governance - Integrated governance provides the umbrella for all NHS governance approaches, it is a co-coordinating principle. It does not seek to replace or supersede clinical, financial or any other governance domain. It highlights their vital importance and their inter-dependence and interconnectivity hence the relationship between both the Quality & Safety Committee & Audit & Governance Committee, in addition to onward reporting to the CCG Governing Body.

Wolverhampton CCG uses an integrated governance approach to examine the risks to its strategic and operational objectives, using the same methodology no matter the nature and context of the risk. This approach enables Wolverhampton CCG to manage risk in an identical way across services and provides a uniform method of assurance for the Board via the Audit & Governance Committee.

Figure 2

Risk Management Framework



Policy – The policy is owned by the Quality & Risk Team and is overseen by the Head of Quality & Risk. The systems & processes contained within it are actively managed on a day to day basis via the Quality & Risk Team.

Organising - The CCG cannot manage its risks effectively unless it knows what the risks are. All directors & heads of service are responsible for ensuring their teams are briefed on the policy and that the processes contained within it are actively implemented and embedded. Therefore, all teams will hold a risk profile and ensure this is accurately recorded on the risk register to encompass ALL risks the service faces. Key personnel from within teams may be tasked with maintaining such records in support of their team.

Risk Recording – All risks whether controlled or not should be recorded on the Datix Risk Management System. Using the five steps to risk assessment found in appendix 2 all risk handlers will adopt these principles to record risks and arrange for approval by the responsible manager. Risk assessment is a continuous process and will therefore require all assessments to be regularly reviewed. The CCG recognises that it is impossible to eliminate all risks, but that a robust risk assessment process is essential. Where risks are increasing or not progressing satisfactorily they should be escalated initially to the responsible Head of Service, Director followed by discussion at Senior Management Team.

Managers and heads of service are responsible for profiling risks within their areas of responsibility. The risk profiling will cover a breadth of types of risks including employer risks i.e. health and safety and statutory risks and Commissioning risks i.e. achievement of QIPP projects.

Risks will be identified, assessed and analysed and added to the risk register. Managers are responsible for ensuring that risk assessments are carried out within their respective areas and that a rolling program of risk assessments is determined.

The risk identification and assessment will be undertaken by multidisciplinary teams comprised of suitably competent persons who have detailed working knowledge of the working processes, procedures and systems. In the process of carrying out risk assessments, staff will identify hazards and areas of risk in their workplace or in aspects of their work duties. The results of risk assessments should be reported and communicated to the managers responsible.

Monitoring & Review – All teams will have access to the Datix System, depending upon the level of access will determine the types of report team members have access to. Risk registers can be generated at manager & team level. The Quality & Risk Team introduce such reports to teams for their ongoing monitoring and review at team level.
The Quality & Risk Team will routinely review all entries on the system to ensure timely review, scoring, assurance & identify trends for consideration by teams and where necessary shared routinely at Senior Management Team. The Risk Management Process is defined in figure 3 below.

In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, will need to be brought to the attention of the Quality and Safety Committee, if local resolution has not been satisfactorily achieved.

Managers should treat risks locally if the risk has scores in low (green) or medium (amber) categories. This will include reviewing and analysing formal assessment reports, establishing risk treatment plans and ensuring the appropriate information is entered onto the Risk Register. Risks identified as extreme (red) will be brought to the immediate attention of the Responsible Officer(s) for their approval/authorisation.

Reporting – A range of groups will receive reports within the CCG, at strategic level the responsible committees and Senior Management Team will receive regular reports for consideration and approval. Following approval assurance reports are prepared at quarterly intervals for the Governing Body.

Confidential Risks – There will be occasions when information is deemed confidential and when risks should not be evident in public facing reports all risk owners will have the opportunity to confirm if a risk entry is confidential.

Audit – There are two core methods that will be used to scrutinise the risk management system, these are:-

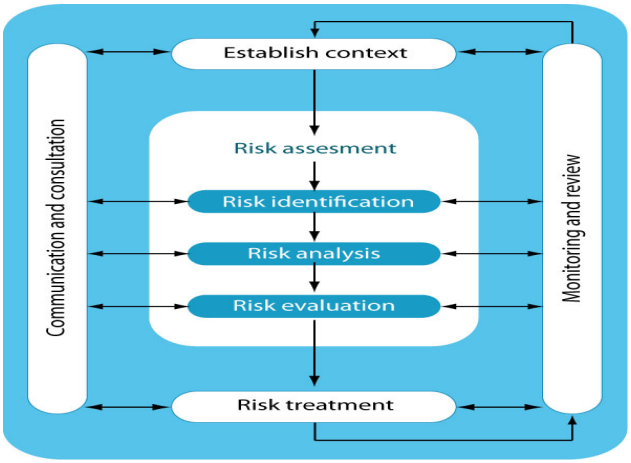
Scorecard/Self-Assessment: Internal scrutiny will be completed by adopting the scorecard system that will determine levels of compliance across the organization. The scorecard will be at six month intervals and used to demonstrate compliance across the organization with risk management processes and standards.

Internal Audit: Internal audit will assess the CCG's assurance framework to ensure that

- It covers all of its key business areas and provides a proper balance of all principal objectives and the risks that threaten their achievement
- It identifies the controls used to manage those risks and the potential sources of assurance about their effectiveness
- The Board will be informed, via the Audit Committee, how well the PCT's internal control arrangements (including governance and risk management) help it to achieve its objectives.

Where weaknesses are identified in the control environment or any systems and procedures, a timetable for remedial action with the relevant managers will be agreed.

Risk management process based on ISO 3100 should be actively applied by all teams and staff within the CCG as follows:-



Statutory Responsibilities
The Health & Safety at Work Act 1974 sets out the legal framework for the management of risks, requiring all risks to be reduced until they are as low as is 'reasonably practicable'.
In practice, this means that Wolverhampton CCG will balance possible risk reduction activities with the cost and difficulty of implementation to determine what level of risk is 'acceptable'. Wolverhampton CCG will regard those risks that have been reduced until they are as low as is reasonably practicable as being 'acceptable risks'. In effect this means that steps have been taken to reduce the severity of the risk and likelihood of it occurring, and that the resources required for further reduction significantly exceed the potential financial, operational and reputational impact.

As a general principle Wolverhampton CCG will seek to eliminate and control all risks which have the potential to:
• harm its staff, service users, visitors and other stakeholders;
• have a high potential for incidents to occur;
• result in loss of public confidence in Wolverhampton CCG and/or its partner agencies;
• have severe financial consequences which would prevent Wolverhampton CCG from carrying out its functions on behalf of its residents.

Wolverhampton CCG recognises that it is impossible, and not always desirable, to eliminate all risks and that systems of controls should not be so rigid that they stifle innovation and imaginative use of limited resources.

All risks that are identified as red that cannot be reduced to an acceptable level will have a supporting contingency plan in place that has been agreed with the responsible director and shared with the Quality and Safety Committee.

As a general principle Wolverhampton CCG has determined the following levels of risk:

Acceptable Risks
Risks in the low (green) category will be considered to be an "Acceptable risk".
Existing controls should be monitored and adjusted. No further action or additional controls are required. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden.
Review 6-12 months intervals.

Unacceptable Risks
Risks in the medium (amber) categories will be considered to be "Unacceptable risks." Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and weighed against the impact of an event. There is also a need to establish more precisely the likelihood of harm as a basis for determining the need for improved control measures. Such risks may be temporarily "acceptable" if new controls are in the process of being implemented.
Review 3-6 months intervals.

Significant Unacceptable Risks
Risks in the extreme (red) category will be considered to be "Significant risks".
Immediate action must be taken be taken to manage the risk. Control measures should be put into place, which will have the effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required. Significant resources

may have to be allocated to reduce the risk. Where the risk involves work in progress urgent action should be taken.
Review at no longer than 3 month intervals.

5.4 Risk Registers

Managers are responsible for adding risks identified through risk profiling exercises and continual assessment of risk to the organisations risk register. Risks will be recorded and quantified in the CCG's Risk Register, for which the Senior Management Team and Quality and Safety Committee will routinely monitor. The Register will be populated by reference to incidents, complaints and contract non-compliances as well as management assessments of inherent risk. Action plans to address such risks will be clearly defined, as required by the risk management policy, will be endorsed by responsible Director for the risk(s) contained so that the necessary actions can be approved in line with the CCG's Risk Management System.

Datix will be used to record all risks and comprises of all risks identified from the following sources:

- Department Risk Registers / Risk Assessments
- Information Governance Risks/Assessments
- Internal Inspections/Audits
- Complaints
- Queries
- Serious untoward incidents/incident trends
- Staff, stakeholders and patient consultation exercises
- Benchmarking
- Mandatory targets
- National reports/inquiries
- Care Homes (high risk)
- Notices from NHSE i.e. high alert investigations
- Care Quality Commission, Health and Safety Executive, NHSLA, PHSO, WMQRS and risk management assessment reports.

5.5 The risk register template will comprise of the following context:

Board Assurance Framework

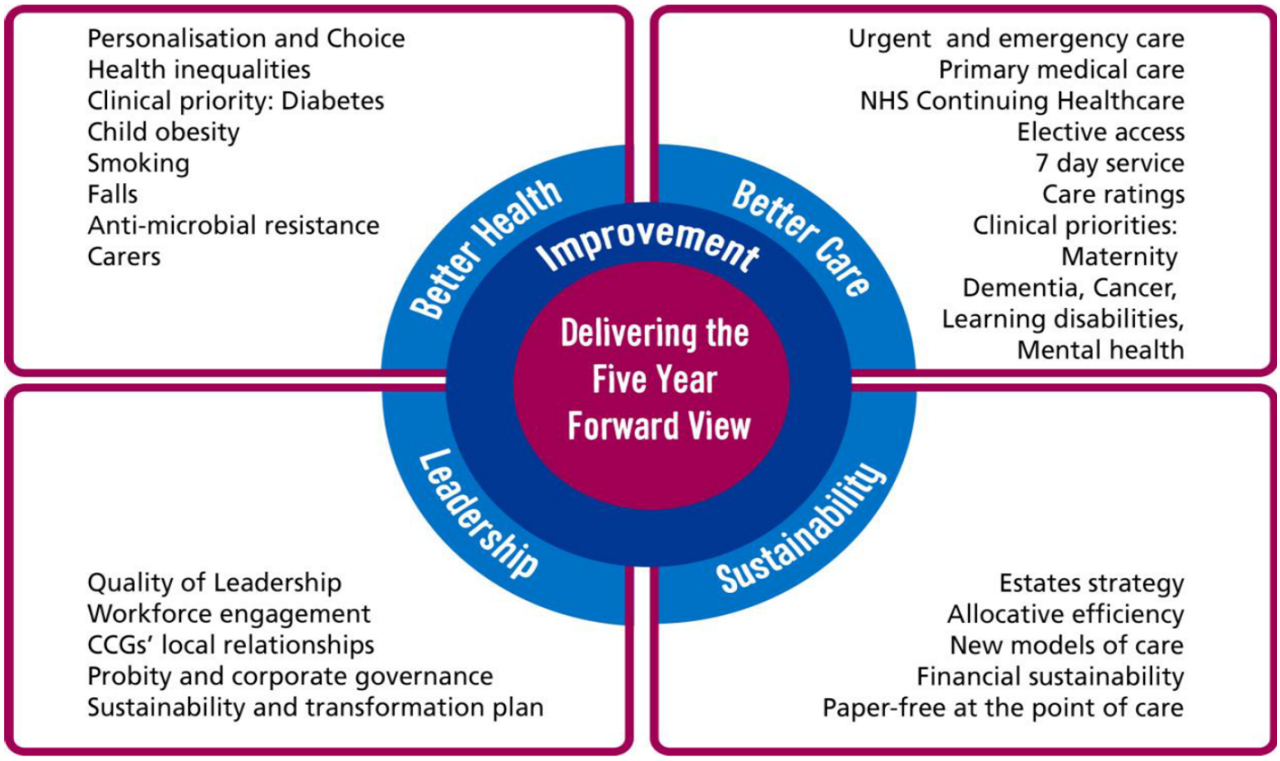
NHS England has introduced a new Improvement and Assessment Framework for CCGs (CCG IAF) from 2016/17 onwards to replace both the existing CCG Assurance Framework and separate CCG performance dashboard. The new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS. The CCG IAF brings clarity, simplicity and balance to the conversation between NHS England and CCGs about what matters to both sides. It draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals and transformational changes. In combination, these provide a more accurate account of the real job description of CCGs.

The new framework covers indicators located in four domains:

1) Better Health – this section looks at how the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve;

2) Better Care - this principally focuses on care redesign, performance of constitutional standards and outcomes, including in important clinical areas;
3) Sustainability – this section looks at how the CCG is remaining in financial balance and is securing good value for patients and the public from the money it spends;
4) Leadership – this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

The diagram below summarises the framework:



The Board Assurance Framework sets out:

- Strategic objectives of the CCG
- Rationale for satisfying the objectives
- Board Lead Director
- Initial Risk Score (based upon likelihood of achievement within the financial year)
- Quarterly Risk Score (reviewed at quarterly intervals)

The individual domains are updated at quarterly intervals and are considered at Quality and Safety for approval

Domain Number	Description	Rationale	Board Lead	Q4 2014/15	Risk Review Status 2015/16			
					Q1	Q2	Q3	Q4
Domain								
	Mitigating Controls Documents : Forums :							
Red Risks Associated with Domain								

Wolverhampton CCG will review their strategic objectives and principal risks on an annual basis in line with national guidance and where deemed appropriate the CCG will identify at local level any further domains they will work towards.

The CCG Governing Body will approve the Board Assurance Framework at the commencement of each financial year and at quarterly intervals thereafter.

6.0 Communication, Monitoring and Review

Communication

Communication and transparency for risk management arrangements is crucial to the effectiveness of the processes defined within the strategy. The strategy will be consulted on among responsible heads of service & directors (Senior Management Team) and shared with stakeholders via distribution at responsible committees, newsletter and by posting on both the Internet and Intranet.

Monitoring & Review

The effectiveness of the implementation of Wolverhampton CCG Risk Management Strategy will be measured using the following indicators as the basis for the regular assurance to the Quality and Safety Committee and Audit and Governance Committee:-

Indicator Description	***What this will tell us***
Meet suggested NHSLA Risk Management and ISO 31000 standards as defined within the strategy.	The CCG does/does not have a suitably embedded risk management framework in line with ISO 3100.
Implement Wolverhampton CCG strategy (ie Risk Management Structure, Framework & Process) as per ISO 3100	The CCG has a robust procedure in place for identification and management of risk that is included in the implementation plan.
Completed risk assessments/datix risk entries are fully completed including the provision of assurance information.	Risks are being recorded correctly & the information in reports is timely & accurate for the audience(s).
Risk Registers utilising Datix software are fully in place including a range of types of risk in each department and at corporate level.	There is evidence of effective management of risk within the CCG.
Applicable staff attend a Team Briefing using the strategy training presentation as a form of information and instruction on Risk Management training.	That heads of department and their staff have been well-informed of their role and responsibility for risk management. Specifically each are/function that are being maintained to the expected standard.
A Board Assurance Framework exists in line with the requirements of the strategy and is approved by the Governing Body at the beginning of each financial year and they received regular updates on performance & advocate action required to address gaps in assurance.	The Board Assurance Framework is in place and endorsed by the Governing Body who are clear on where the gaps in assurance are for the organization & the actions being taken to address them.
Risk register reporting to responsible forums and persons	Risk register is challenged at SMT by a deep dive into specific risks to ensure risk entries are scored and accurately reflect the latest position.

This scorecard will be used as the basis for assurance reporting to the responsible committees who will receive assurance at no longer than quarterly intervals.

7.0 Training

The Strategy comprises if a breadth of responsibilities for all staff and will therefore be reliant on a series of supportive measures lead by the Quality and Risk Team. Staff will need to be fully aware of the requirements of this strategy if it is to be effectively implemented. It is the responsibility of all managers to ensure their staff groups receive appropriate information instructions for training and supervision in risk management.

Implementation training to support this strategy for each aspect of Risk Management will comprise of the following:

Area	Staff Group	Method	Contact	Frequency
Strategy Implementation Training Presentation	GPs All CCG staff and Board Members	Strategy Implementation Presentation slides, Team meetings, staff briefings, presentation on internet.	Head of Service, Quality and Risk Team	Annual
Risk Profiling	Heads of Service Directors and PDB Chairs	1:1 or Group Exercise	Quality Assurance Officer (DB)	Annual
Use of Datix System	Nominated Team Members Heads of Service Directors	Group Demonstration	Quality Assurance Officer (DB)	Annual Refresher (as required)
Risk Assessment		Documented Guidance (via intranet)		
Risk Registers		1:1/Group Demonstration for Heads of Service/Directors		
Board Assurance Framework	Senior Management Team Quality & Safety Committee Audit & Governance Committee Board Members	Report or Presentation	Head of Quality & Risk	Annual

The above program of training will be overseen by the Quality & Risk Team commencing March 2016 onwards and will feature in reports on risk management to the Quality and Safety Committee and Governing Body.

8.0 Linked Policies & Procedures

Information Governance Policy
Finance Strategy
Serious Incident Reporting Policy
NICE Assurance Policy
Health and Safety Management Plan
Operating Plan 2015-2017
Commissioning Strategy

Appendix 1

Quick Guide to Risk Management

Step by Step Guide to Risk Management	The following section provides a step-by-step approach to be used to manage risk across any organisation and is used when carrying out tasks such as risk assessment and the setting up of corporate and department/program risk registers. The process can also be used for projects, independent contractors and where relevant for specific projects or service developments. Risk management does not occur in a vacuum but within the context of the organisation itself taking into account its financial resources, corporate objectives and strategic aims, legal requirements, nature of its business and the needs of the population that it serves.	
Step 1: Defining the Context	Risk management should be a continuous process that supports the development and implementation of the strategy of an organisation. Defining the context is on-going rather than one off process at both organisational and operational levels. It should methodically address all the risks associated with all of the activities of the organisation. Examples of key documents that can help define context within the CCG as a whole include: • Business Plan • Heath improvement and modernisation plan • Organisational Strategy documents There must be good communication and consultation with staff, service users, the public and other stakeholders in order to ensure that the context within which you are assessing the risk is up to date, relevant and accurate. Establishing the context also means defining the goals, objectives, strategies, scope and parameters of the activity or part of the organisation to which the risk management process is being applied. This can include: • Defining the project or activity and establishing its goals and objectives. • Defining timescales and responsibilities. • Identifying any further information needed. Establishing and defining the context is a vital stage in the risk management process whether you are looking at strategic or operational risk. By narrowing the parameters of the context you can divide the management of the risk into more easily manageable pieces which can enable more focus on relevant risks.	*Examples of establishing a context for risk management might be looking at risk in a specific project such as QIPP projects, refurbishment of a building, along a care pathway, during a specific intervention or within a specific area, site or environment*
Step 2: Hazard Identification	Hazard identification establishes the exposure of the organisation to risk and uncertainty. Comprehensive identification using a well-structured systematic approach is critical, because a potential risk not identified at this stage is excluded from further analysis. All risks relevant to the context, whether under control of the organisation or not, should be included at this stage. The aim is to generate a comprehensive list of events that might happen during/within the process/activity/project/ environment etc under review should be captured during risk profiling. This needs to be an inclusive process. Sources might include brainstorming, checklists, incidents and complaints, claims, audit data, external inquiry reports, morbidity mortality data, trend analysis, care pathway analysis, experience – here or elsewhere. The key questions are: • What could happen and at what point? • How could it happen and why? Risks identified need to be captured during risk profiling then documented on the Risk Register.	*An example of identifying risks might be considering the sort of harm that could happen to a frail patient during rehabilitation to mobilise. This would include the patient breaking a bone due to an inadequate assessment of their mobility or inappropriate handling by health professional. The health professional might sustain a back injury due to poor manual handling. Equipment used might be faulty or worn causing injury to either. Risks to a corporate project such as the delivery of a new service might include, financial loss, loss of service etc*

Step 3: Risk Analysis	Identify the controls (currently in place) that deal with the identified hazards and assess their effectiveness. Based on this assessment, analyse the risks in terms of likelihood and consequence. Refer to the Risk Matrix to assist you in determining the level of likelihood and consequence, and the current risk level (a combination of likelihood and consequence). The objectives of risk analysis are to separate the minor more acceptable risks from the major risks and to provide data to assist in the evaluation and treatment of risks. The first stage is to determine existing controls for each of the hazards identified – existing management, safe systems of work, procedures etc to control the risk. The next step is to look at the severity of the risk materialising and the likelihood of it happening given controls that may already be in place. There are a variety of ways of analysing consequences and likelihood. Wolverhampton CCG has adopted a quantitative analysis. **Likelihood** The likelihood level should be assessed using the quantification matrix and be documented on the risk assessment and risk register. See matrix **Consequence** The severity level should be assessed using the quantification matrix and be documented on the risk assessment and risk register. See matrix **Controllability** The ability of the CCG to control the risks identified should be ascertained using the controllability matrix on the quantification matrix, this should also be documented on the risk assessment and register. Once the likelihood and consequence have been ascertained, the combined risk rating can be found by multiplying the corresponding numbers to achieve a risk score/rating. Once the risk rating has been ascertained, action can then be taken to eliminate the risk, or reduce it to an acceptable level. The above colour ratings signify the level of risk and therefore the level of attention that is required to manage them, which are as follows: • Green – Low Risk: These are risks that can be managed by routine procedures usually by line managers, review the risk at 6-12 month intervals. • Amber – Medium Risk: These are risks that require the attention of line management at a bare minimum and/or senior management as deemed appropriate in order to be eliminated or reduced to an acceptable level as soon as is reasonably practicable, review at 3-6 month intervals. • Significant Amber – High Risk: These risks require the attention of line management and the appropriate Senior Manager as soon as is reasonably practicable. • Red – Extreme Risk: These are risks that require **immediate** attention and responsibility from senior management up to Director Level in order to quickly and effectively eliminate, reduce or manage them. Any risk graded at this level **must** be flagged immediately for the attention of the appropriate Director (who will inform the Senior Responsible Officer) and approved by them. Reviewers of red risks must be at no more than 3 month intervals and approved by the relevant Director.	*Risks can be analysed and quantified in this way from both a pro-active and reactive perspective. Pro-Actively, this process can be carried out as part of the Risk Assessments process. Reactively, any incident that occurs must be rated in this way and the risks managed. In both cases this process would take into consideration both the severity and likelihood of risks that have been identified. For example, a member of staff performs a risk assessment exercise on their work environment and identifies one hazard as sharps injuries. Analysing the risk of this occurring would involve considering many factors; what is the number of task involving needles, competence of staff, equipment, time constraints etc. Looking at the severity/likelihood charts, they would make judgment call possibly along the lines of:* *• Severity of a frail patient falling during mobilizing on a hard floor is:* ***Moderate (3)*** *• The likelihood of this occurring, using correct mobility aids, under supervision of competent staff:* ***Possible (2)*** *• The overall risk rating would therefore be* ***6 (likelihood x severity),*** *falling into the green low risk level. This risk would require the attention of the line manager in order to monitor practice and ensure that any additional controls are implemented.*

Step 4: Risk Prioritisation	Risk prioritisation involves agreeing the order in which risks need to be addressed. The starting point for this will be the rating itself and in the main the priorities will reflect high and moderate risks. However, some minor risks may be easy to address and tackled for that reason sooner rather than later. Some high risks may be part of the nature of care given itself and therefore difficult, impractical and even inappropriate to reduce. Reducing a risk may have an adverse impact on another aspect of PCT business or prevent the taking up of an important opportunity. The risk prioritisation must take the broader context of the service and PCT into account. Local and corporate objectives as well as the extent of the opportunity, which could result from taking the risk, should be considered here. Where the priority is agreed is different to the numerical rating given, the rationale for the prioritisation must be documented. As this is in part a subjective process the need for good communication, consultation and transparency is crucial. The end result is a prioritised list of risks for further action.	*An example of risk evaluation would be where a service completed its identification and analysis of risks and found that patient falls and the risk of hospital acquired infection were the two highest rated risks they faced – both being amber risks. As such the service agreed to deal with these two issues as their highest priorities*
Step 5: Risk Treatment	Risk treatment involves identifying the range of options for dealing with the risk. The options include: **Prevention** Terminate the risk by doing things differently and thus removing the risk, where it is feasible to do so. Often this is not an option in the provision of health care. In any event avoiding activity likely to generate risk is often the result of an inappropriate understanding and attitude to risk management. Risk aversion can lead to missed opportunities and increase in other risk areas by failure to engage with appropriate decision making around risk management. **Reduction -** Treat the risk, take action to control it in some way where the actions either reduce the likelihood of the risk developing or limit the impact/consequence of the risk. **Transference -** This involves another party bearing or sharing the risk – for example service level agreements, jointly managed services etc. Where risks are transferred in whole or in part the organisation acquires a new risk in that the organisation to which the risk has been transferred may not manage the risk or their share in it appropriately. **Acceptance -** After risks have been reduced or transferred there may be residual risks, which are retained. Risks may be tolerated because nothing can be done at a reasonable cost to mitigate it or the likelihood and consequence of the risk are at an acceptable level. **Contingency -** Plans should be put in place to manage the consequence of these risks if they should occur, including identifying means of financing the risk. The various options for treating the risk need to be assessed on the basis of a costs and benefit derived. Options can be taken in combination or separately. In general the cost of managing risks needs to be commensurate with the benefits obtained. However, decisions should take account of the need to carefully consider rare but severe risks, which may warrant risk reduction measures that are not justifiable on strictly economic grounds. Once the options have been considered and the most appropriate way forward identified, a risk action plan needs to be drawn up and implemented.	*For example, the service decided that the most appropriate way of dealing with the risk of harm during mobilising of patients required following action:* *• Mandatory manual handling training and refresher courses for all staff engaged in manual handling.* *• Clinical supervision sessions for staff to look at best practice around assessing patient frailty, mobility assessment and issues around documentation.* *The ward manager took responsibility for organising the training and the lead nurse took responsibility for facilitating the supervision session. It was agreed that a small clinical audit group would undertake a review of records and report back after 6 months to the team meeting.*

Step 6: Monitoring & Review	It is necessary to monitor risks, the effectiveness of risk action plans, strategies and the management system set up to control the implementation. Risk and the effectiveness of control measures need to be monitored to ensure that changing circumstances do not alter risk priorities. Few risks remain static. It is necessary to regularly repeat the risk management cycle.	*After 6 months, the number of falls in the ward had decreased; this led to further review of the risk assessment.*
Step 7: Communication & Consultation	These are important considerations in each step of the risk management process – to both internal and external stakeholders. This ensures that those who are responsible for implementing risk management and those with a vested interest understand the basis upon which decisions are made and why particular actions are required.	*For example a number of issues has been raised regarding suitability of manual handling/mobility equipment. This information was fed into the next team meeting where the risk register was considered. As all staff had had an opportunity to take part in identifying risks and had been able to comment on the risk register at team meetings, there was considerable support for continuing to use the risk register as structured way of looking at risks*

CCG BOARD ASSURANCE FRAMEWORK
Principle Objectives & Risks (BAF)

Appendix 2

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 1	**Better Health** Personalisation and choice Health Inequalities Clinical priority – Diabetes Child obesity Smoking Falls Anti-microbial resistance Carers		Manjeet Garcha				
	Mitigating Controls e.g. documents/plans						

Red Risks Associated with Domain 1	

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 2	**Better Care** Urgent and Emergency Care Primary Medical Care NHS Continuing Healthcare Elective Access 7 day service Care ratings Clinical priorities Maternity Dementia Cancer Learning Disabilities Mental Health		Steven Marshall				

	Mitigating Controls e.g. documents/plans
Red Risks Assocated with Domain 2	

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 3	**Sustainability** Estates Strategy Allocative Efficiency New models of care Financial sustainability Paper free at the point of care		Claire Skidmore				
	Mitigating Controls e.g. documents/plans						

Red Risks Associated with Domain 3	

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 4	**Leadership** Quality of Leadership Workforce engagement CCG's local relationships Probity and corporate governance Sustainability and transformational plan		Dr Helen Hibbs				
	Mitigating Controls e.g. documents and plans						

Red Risks Associated with Domain 4	

Appendix B

Policy & Protocol Pro-forma

This Pro-forma should be completed by any CCG staff member to:

- Request the production of a new CCG Approved Document
- Request an update to a CCG Approved Document. ✓

The completed pro-forma must be sent to the COM for review. See Appendix A – Policy Development Process

Name of Person Making the Application	Sarah Southall	Date: 8.2.16
Job Title/Contact Email	Head of Quality & Risk sarah.southall@nhs.net	
Signature of Line Manager Supporting the Application		
For Policy: Name of Proposed Document	Risk Management Strategy	
Area(s) Impacted by the Document E.g.: (HR/Finance/ Governance/ Health & Safety/ IM&T/ etc.)	Risk, governance	
Is this a New Document or an Amendment to an Existing Document?	Revision to existing	
Reason for the Request: (please provide brief details – if the change relates to a change in legislation please indicate if a wholesale review if required)	Periodic review of content as expected by Quality & Safety Comm	
Ex: DoH Guidelines/directives	✓	
NHSCB Guidelines		
Legislative Change		
Local Management issue	✓	
Risk Management	✓	
Audit Recommendation		
Other		
For Protocol: Which Policy does the Protocol Support?		
Is this a CCG wide or local protocol?		
Is this a New Protocol or an Amendment to an Existing Protocol?		
Reason for the Request: (please provide brief details)		