Bradford City Clinical Commissioning Group
Bradford Districts Clinical Commissioning Group

NHS Bradford City Clinical Commissioning Group & NHS Bradford Districts Clinical Commissioning Group

Risk Management Strategy & Risk Register Policy

Status	**APPROVED**
Approved by	**NHS Bradford City CCG governing Body** **NHS Bradford Districts CCG governing Body**
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1. Introduction

Bradford City Clinical Commissioning Group and Bradford Districts Clinical Commissioning Group (hereafter known as the CCGs) recognise that risk management is an integral part of good management practice. There is a legal requirement for all employers to ensure that assessments of risks to employees, those affected by its undertakings and the organisation are carried out, which should be reviewed at regular intervals to ensure that they remain accurate and valid.

The Management of Health and Safety at Work Regulations (1999) require that employers should carry out assessments of the risks created by their activities, which may affect their employees, or anyone else who might be affected. At its simplest, risk management is good management practice.

Furthermore, the Corporate Manslaughter and Corporate Homicide Act 2007 highlights the commitment required of senior management to take reasonable steps to protect employees, or anyone else who might be affected where risks are created by their operations; the implementation of robust risk management systems is of paramount importance.

This strategy takes into account legislative framework and appropriate national guidance that the organisation is bound by, the recent failures in the public and private sector and also recognises the collaborative working that is essential within health and care systems.

The CCGs have the responsibility for monitoring key information in risk related areas, from all areas of service delivery. The CCGs Governing Bodies will ensure that systems are in place to inform them, via the governing body assurance framework (GBAF) and risk register, of current and emerging risks. The GBAF contains strategic risks which will impact upon the whole organisation and the achievement of the CCG's objectives, rather than having an impact only on one department. The risk register contains operational risks which will impact upon the organisation's ability to carry out its functions on a daily basis in a safe and efficient manner.

2. Aims

The aim of this Strategy and policy is to:

- Define and document the organisations' commitment to risk management, and to outline the commissioning process for monitoring and managing risk. All actions contain inherent risks.

- Support the development and implementation of integrated governance, integrating risk management within corporate objectives, strategic intents and organisational culture.

- Ensure robust mechanisms for learning and sharing at all levels, ie national/local to encourage employee involvement in the risk process, to identify and acknowledge good practice.

- Improve processes as a consequence of learning lessons from identified risks, adverse events and near misses with a focus on service user care and their experience.

This strategy identifies the management structure, accountabilities and responsibilities in relation to risk management. It also details the processes involved and specifies the maintenance of the governing body assurance frameworks, risk registers and associated action plans.

3. Scope

This strategy and policy applies to all staff, clinical leaders and governing body members within the CCGs.

4. Risk management objectives

Five key objectives have been developed to ensure that the CCGs achieve their risk management aims. These key objectives are set out below.

Objective 1	Objective 1 will be achieved by:
To develop a risk aware culture throughout the CCGs, ensuring that the concepts and ideas of risk assessment and risk management are embedded into the day to day working practices.	• Continuously improving risk management training and continuous professional education. • Ensuring mandatory risk management training is available for all staff and identified through the Joint Performance Development Review (JPDR). • Ensuring that managers are informed and appropriate action is taken when staff fail to attend mandatory training. • Reinforcing the need for staff to consider and assess risk in all daily activities. • Making risk management a regular agenda item at the Clinical Commissioning Group Governing Body meeting and senior management team meetings • Ensuring all strategic and business plans consider risk management.
Objective 2	Objective 2 will be achieved by:

To ensure that appropriate systems are in place for identifying, assessing and controlling key risks.	• Implementing the incident management system and organisational corporate risk registers across all areas of the CCGs. • Via mandatory training and communication resources to: ~ Ensure all staff are aware of and understand the risk management procedures. ~ Ensure that all staff are aware of their responsibility for identifying, assessing and managing risk. • Ensuring that lessons learned from incidents, complaints and claims are shared across the organisations and with the wider health economy to prevent recurrence. • Annual review of key risk systems (e.g. risk registers, incident reporting and central alert system) to ensure that they are meeting the changing needs of the organisation.
Objective 3	Objective 3 will be achieved by:
To maintain effective organisational structures for risk management so that a consistent approach is taken across the CCGs that reflects best practice.	• Ensuring that the structures and responsibilities set out in the policy are effective in practice. • Ensuring that the CCGs Governing Bodies review the effectiveness of the structures and responsibilities to identify any useful improvements. • Implementing findings from review of risk management systems. • Ensuring that the risk management strategy is reviewed to take into account national guidance and best practice. • Ensuring that up to date policies are available to staff and key stakeholders on the intranet, internet and in paper at each base
Objective 4	Objective 4 will be achieved by:
To ensure that the CCGs' Chief Officer is provided with evidence that risks are being appropriately identified, assessed, addressed and monitored by the appropriate committee.	• Ensuring the risk registers and action plans are kept up to date through regular reviews by each department/programme maintaining effective risk recording and analysis and suitable evidence files. • Annual monitoring of the risk systems. • An annual audit of the risk register and governing body assurance framework, presented to the Joint Audit and Governance Committee to review the risk management progress on behalf of the CCGs Governing Bodies. The audit findings will be taken into account when undertaken and when signing the annual governance statements. • Ensuring that amber & red risks are reviewed by the Joint Audit and Governance Committee and presented to the Clinical Commissioning Group's clinical boards.
Objective 5	Objective 5 will be achieved by:
To ensure good and steady progress in the implementation of effective risk management across the CCGs.	• Establishing and monitoring performance indicators covering the risk management process. • Taking corrective actions in light of audit and review processes. • Taking part in the national benchmarking studies to identify not only how well the CCGs are doing but also what steps it can take to improve further.

5 The Risk Management Process

Risk management is a proactive systematic process of risk identification, analysis, treatment and evaluation of potential and actual risks. The primary purpose of risk management is to enable individuals and the organisation to competently deal with all key risks, clinical or non-clinical.

The risk management process therefore is:

1. Identification of risks
2. Assessment of the identified risks for potential likelihood and impact
3. Elimination of identified risks, or mitigation and management of the identified risks that cannot be eliminated
4. Implementation of controls, leading to a reduction in the exposure to risk to individuals and/or the organisations

Through the implementation of this strategy and appropriate training, it is anticipated that staff will develop a deeper understanding of the breadth of their statutory duties of care and the benefits of the appropriate management of risks. This should lead to staff feeling confident in identifying potential risks and in reporting incidents and near misses, freely participating in audits and peer reviews and having ownership of policies, procedures and guidelines. Managers in particular should appreciate the value of their contribution to risk management through implementing the risk assessment process within their area.

6 Definition of Risk Registers

A Risk Register can be described as:

'*a log of risks of all kinds that threaten an organisation's success in achieving its declared aims and objectives. It is a dynamic living document, which is populated through the organisation's risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated*'. (Source: CASU Risk Register Working Group 2002)

7 Approach to Risk Management and Assessment

7.1 Risk Definitions

7.1.1 This strategy is based on the following definitions, as follows;

- Risk is the chance that something will happen that will have an impact on the achievement of the CCGs objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

- Risk Management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

- Risk Assessment is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk.

7.2 Categories of Risk

7.2.1 Risk management is about improving quality and reducing harm. It embraces risks that are encountered by the CCGs in the commissioning of services and as a corporate body and includes clinical, financial and reputational risks.

7.2.2 Examples of the types of risk that the CCGs might encounter and need to protect against include;

- Corporate risks – operating within powers, fulfilling responsibilities, ensuring accountability to the public

- Clinical risks – associated with service standards, competencies, complications, equipment, medicines, staffing, patient information

- Reputational risks – associated with quality of services, communication with public and staff, patient experience

- Financial – associated with achievement of financial targets, commissioning decisions, compliance issues

- Environmental including health and safety – ensuring the well-being of patients and staff whilst using the services we commission.

7.2.3 All risks identified are categorised on the CCGs risk registers in one of the following categories:

- Clinical
- Financial
- Organisational

7.3 Assessment of Risk

7.3.1 Whenever risks have been identified it is important to assess each one to ensure appropriate controls (actions) are put in place to eliminate the risk or mitigate its effect. To do this a standard matrix must be used, details of which are provided in Appendix A of this document. The matrix has been adopted from current national guidance from the National Patient Safety Agency.

7.3.2 In using this standardised tool, it will ensure risk assessments are undertaken in a consistent manner with 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.

7.3.3 The approach taken to risk assessment is set out in detail in Appendix A. Risks are assessed in terms of the likelihood of occurrence/re-occurrence and the consequences of impact. In order to arrive at an overall risk rating of the residual risk, the risk is rated to take account of the effectiveness of the controls (actions) by identifying whether the controls are considered to be satisfactory, have some weaknesses or weak. This then provides the overall residual risk rating. Once the residual risk rating has been determined, an action plan should be developed to identify what further controls need to be put in place to eliminate or mitigate the risk.

7.3.4 The four risk ratings are:

- Extreme – the consequence of these risks could seriously impact upon the achievement of the organisations objectives, it's financial stability and its reputation. Examples of these may include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability. These risks will be entered into the CCGs' Risk Registers.

- High – these are significant risks that require prompt action. With a concerted effort and a challenging action plan, the risks could be realistically reduced within a realistic timescale. These risks will be entered into the CCGs Risk Registers.

- Moderate – these risks can be realistically reduced within a timescale through reasonably practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements.

- Low – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department.

7.3.5 Any risk that is identified through the risk assessment process (as well as the incident reporting system) and which the CCGs are required legally to report, will be reported externally to the appropriate statutory bodies, e.g. Health and Safety Executive for health and safety risks and the Information Commissioner for more serious information governance breaches.

7.4 Risk Appetite

7.4.1 The CCGs endeavour to reduce risks to the lowest possible level where reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However there is the recognition that by understanding the organisations 'risk appetite', will

ensure the CCGs support a varied and diverse approach to commissioning, particularly for practices to work proactively to improve efficiency and value.

7.4.2 Risk appetite is the amount of risk that the organisations are prepared to accept, tolerate or be exposed to at any point in time. It can be influenced by personal experience, political factors and external events. Risks need to be considered in terms of both opportunities and threats and should not be confined to money. They will also invariably impact on the capability of the CCGs, their performance and their reputation.

7.4.3 The Governing Bodies will set boundaries to guide staff on the limits of risk they are able to tolerate in the pursuit of achieving their strategic objectives. The Governing Bodies will set these limits annually and review them as appropriate.

7.4.4 The Governing Bodies will set these limits based on whether the risk is:

- A threat: the level of exposure which is considered acceptable;
- An opportunity: what the Governing Bodies are prepared to put 'at risk' to encourage innovation in creating changes.

8. Risk Management structure

8.1 Governing Body Assurance Framework (GBAF)

8.1.1 The CCGs have an overarching GBAF and produce two further registers to support this, namely team/work stream risk risks and corporate risks. This approach ensures that once identified risks are identified, they are filtered upwards through different levels of management to Joint Audit and Governance Committee and CCGs' Governing Bodies as appropriate. (See Appendix B)

8.1.2 The GBAF is a record of those risks that threaten the organisations achieving its stated aims and objectives. It is usually populated by those risks rated 15 or more (extreme risks) but can also contains risks with a rating of 8 or above (high risks) depending on the nature of the risk. The GBAF is compiled by the CCG Governance Manager with appropriate support from the Senior Management Team. The register will be reviewed quarterly by the Joint Audit and Governance Committee, and on an annual basis by the CCGs' Governing Bodies.

8.2 Risk Registers

8.2.1 The risk registers provide a local record of all potential or actual risks for the CCGs. Actions to mitigate these risks will be managed by the respective director in conjunction with the appropriate senior lead. However, where necessary risks can be a signal of a failure in assurance at which point it becomes a GBAF issue it can be reported onto the GBAF for further

scrutiny by the Joint Audit and Governance Committee and CCGs' Governing Bodies as appropriate.

8.2.2 Using the process outlined above and detailed in Appendix A, will ensure current and potential risks are captured in the organisations' risk register. However, experience suggests that the risk register should not be completed as a desktop exercise and are best done as part of a team/group discussion.

8.2.3 Appendix C shows how risks are identified, whether proactively or reactively, and fed into the risk register structure described above.

8.3 Risk Ratings

8.3.1 Risk rating scores 6 or less – these risks are to be managed by the individual teams and programmes via the team/work stream risk registers. A lead should be nominated within each team/programme for completion of the risk register, although ultimate responsibility for managing these risks lies with the appropriate director/senior lead (see roles and responsibilities in section 5 below).

8.3.2 Risk rating scores of between 8 and 14 – these risks are to be managed via the individual team/programmes via team/work stream risk registers but will be monitored by the Clinical Boards. It remains the responsibility of the appropriate director/senior lead for managing the these risks, however where necessary, individual risks can be escalated to the GBAF for further scrutiny by the Joint Audit and Governance Committee and CCGs' Governing Bodies as appropriate.

8.3.3 Risk rating scores of 15 and above – these risks are monitored by the Joint Audit and Governance Committee via the GBAF on behalf of the CCGs' Governing Bodies. It is still the responsibility of the individual directors/senior leads to manage the risks within their respective teams/work streams and provide feedback on progress to the Committee. Risks identified at local level and escalated to the GBAF must also remain on the team/work stream risk register.

9. Roles and responsibilities

9.1 Chief Officer

9.1.1 The Chief Officer is ultimately responsible for the management of risk within the organisations. It is their responsibility to ensure that there is a clear and appropriate management structure that enables risks to be identified and decisions taken at an appropriate level. However, every individual within the CCGs has some responsibility and involvement in risk management (see Appendix C).

9.1.2 Risk registers and their accompanying action plans should be widely 'owned' and understood. Risk management priorities should reflect national priorities and the risk registers aim to utilise organisational "intelligence', by engaging staff at all levels in identifying and assessing risk.

9.2 Lay Member with responsibility for Governance

9.2.1 The Lay Member with the responsibility for governance is the lead for risk management and is supported by the Chief Finance Officer. They are responsible for:

- ensuring risk registers are in place for the CCGs and comply with the CCGs Risk Management Framework;
- ensuring the GBAF is regularly reviewed and updated;
- highlighting to the Joint Audit and Governance Committee where there are inadequate controls in place to manage extreme or high risks.
- oversee the management of risks as identified by the Audit and Governance Committee;
- liaising with the CCG Governance Manager to ensure the appropriate support is provided by to ensure the management of risk registers

9.3 Joint Audit and Governance Committee

9.3.1 The Joint Audit and Governance Committee has delegated responsibility from the CCGs' Governing Bodies to monitor the risk management function within the organisations. Its responsibilities are to:

- ensure there is a clear and appropriate risk management structure that enables risks to be identified and decisions taken at an appropriate level;
- monitor progress or risk action plans for all extreme and appropriate high risks recorded on the GBAF;
- inform the CCGs' Governing Bodies of extreme and appropriate high risks as appropriate;
- review the GBAF on a quarterly basis;
- agree corporate priorities for funding risk reduction strategies identified during the risk assessment procedure;

9.4 CCG Governance Manager

9.4.1 The roles and responsibilities of the CCG Governance Manager are to:

- Provide assistance and support to those undertaking risk assessments and direct them to sources of specialist help and advice where necessary;

- Coordinate and prepare updates to risk register and bi-monthly updates to the GBAF by liaising with the appropriate CCG senior lead(s);

- Ensure all risk registers are completed correctly, including the completion of exception reports identifying changes to existing risks;

- Maintain an up to date list of all extreme and appropriate high risks on the GBAF as identified on the risk register;

- Prepare the risk registers and accompanying reports on behalf of the CCGs for review by the Clinical Boards on a monthly basis;

- Prepare the GBAF and accompanying report on behalf of the CCGs for review by the Governing Bodies on a bi-monthly basis.

9.5 Governing Body members

9.5.1 The roles and responsibilities of the Governing Body members are to:

- ensure risks are reviewed, progress monitored against risk action plans and target dates and action is taken to eliminate/reduce the risks identified;

9.6 Directors

9.6.1 The roles and responsibilities of the directors are to:

- ensure that ‘suitable and sufficient’ risk assessments are carried out to identify actual and/or potential risks within their area of responsibility;
- ensure an up to date record is maintained of all risks for their respective team/work stream;
- update the risk register and GBAF monthly within the required timescales for reporting.
- inform the lay members with the responsibility for Governance/Chief Finance Officer of all extreme risks and appropriate high risks that challenge the controls and assurances in place.

10.7 All Staff

10.7.1 The roles and responsibilities of all staff are to:

- be aware of the results of risk assessments in their area;

- be aware of what actions they need to take to contribute to the control measures (actions) put in place to mitigate identified risks (such as following appropriate procedures and protocols).
- support the relevant manager/senior lead during the risk assessment process;
- inform the appropriate manger/senior lead of any hazards identified through their work, which may require a risk assessment to be carried out;
- inform the appropriate manager/senior lead when control measures (actions) are not working, or when circumstances dictate that they cannot be followed.

Staff with line manager/team responsibilities are also required to:

- inform the CCG Governance Manager of all risks for their area of responsibility to ensure these risks are included on the risk register;
- ensure that all risks relevant to their area of responsibility are reviewed and progress monitored against risk action plans and target dates;
- inform the appropriate director and the CCG Governance Manager of any extreme and appropriate high risks within their area of responsibility to ensure these risks are escalated to the GBAF;

Appendix D refers to the integration of risk within the management processes described above.

10. Equality and Diversity

10.1 Equality and diversity statement

10.1.1 The CCGs are committed to promoting human rights and providing equality of opportunity; not only in employment practices, but also in the way services are commissioned. The CCGs also value and respect the diversity of thier employees and local communities. In applying this Policy, the CCGs will have due regard for the need to:

- Promote human rights
- Eliminate unlawful discrimination
- Promote equality of opportunity
- Provide for good relations between people of diverse groups

10.1.2 This Policy aims to be accessible to everyone regardless of age, disability (physical, mental or learning), gender (including transgender), race, sexual orientation, religion/belief or any other factor which may result in unfair treatment or inequalities in health or employment.

10.1.3 Throughout the development of this Policy the CCGs have sought to promote equality, human rights and tackling health inequalities by

considering the impacts and implications when writing and reviewing the Policy. The impact of this Policy is subject to an on-going process of review which is completed by the formal Equality Impact Assessment when the Policy is reviewed.

10.2 Equality impact assessment

10.2.1 In accordance with appropriate equality duties an Equality Impact Assessment has been carried out on this Policy. There is no evidence to suggest that this Policy would have an adverse impact in relation to race, disability, gender, age, sexual orientation, religion and belief or infringe individuals' human rights.

10.3 Dissemination and implementation

10.3.1 This Policy will be available through the relevant intranet site to which the all staff have access and from line managers on request. Policies will be cross referenced with the CCG's policy framework. Policies will be signposted to new staff on induction and to current staff during the statutory/mandatory training.

10.3.2 Directors, senior leads/clinicians and managers will be responsible for ensuring the policy is implemented in their areas and compliance with this Policy may be monitored through a process of auditing which will be co-ordinated through the CCG Governance Manager.

Appendix A

THE CCGS' RISK MANAGEMENT SYSTEM

1. Introduction

The CCGs use the guidance provided by ISO 31000:2009 (formerly AZ/NZ Standard 4360:2004) and the National Patient Safety Agency in developing its approach to risk management and particularly in carrying out risk assessments.

2. Risk Matrix: Carrying out a Risk Assessment

2.1 Step 1: Determine the Impact Score

Choose the most appropriate domain for the identified risk from the left hand side of table 1 below. Work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the impact score, which is the number given at the top of the column. The impact will be negligible, minor, moderate, major or catastrophic. This guidance should be used when completing a risk assessment for an incident that has occurred or if the impact of potential risk(s) is being considered.

Table 1: Impact scores (I)

	Impact 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
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	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry

		unresolved Reduced performance rating if unresolved	meet internal standards Major patient safety implications if findings are not acted on	Critical report	Gross failure to meet national standards
Human resources/ organisational development / staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	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	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage

				million Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption/ Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

2.2 Step 2: Determine the likelihood

Now determine what the likelihood of the impact occurring is using table 2 below. The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. The frequency-based score will be rare, unlikely, possible, likely or almost certain.

Table 2: Likelihood score (L)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency: How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

2.3 Step 3: Assigning a Risk Rating

Now apply the impact and likelihood ratings to give you a risk rating for each of the risks you have identified. Calculate the risk rating score by multiplying the impact by the likelihood: Risk rating = I (impact) x L (likelihood)

Table 3: Risk rating scores

	Impact score				
Likelihood	1	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

2.3 Step 4: Assessing the effectiveness of the control(s)

For each of the risks (and especially extreme and high risks) identify the controls that are in place. For example, in an operational setting and where an incident may have occurred the controls may take the form of a policy, guideline, procedure or process, etc. For risks that have been identified as preventing achievement of organisational objectives then the control is likely to be a management action plan.

Review the control(s) for each of the risks and apply the following criteria;

Satisfactory:	Controls are strong and operating properly, providing a reasonable level of assurance that objectives are being delivered.
Some Weaknesses:	Some control weaknesses/inefficiencies have been identified. Although these are not considered to present a serious risk exposure, improvements are required to provide reasonable assurance that objectives will be delivered.
Weak:	Controls do not meet any acceptable standard, as many weaknesses/inefficiencies exist. Controls do not provide reasonable assurance that objectives will be achieved.

2.4 Step 5: Determining the residual risk

Taking the risk rating and the assessment of the effectiveness of the control together, you can now assess the residual risk that needs to be managed, as follows;

	Residual Risk Rating			
Control Effectiveness	Low	Moderate	High	Extreme
Satisfactory	Low	Low	Moderate	High
Some Weaknesses	Low	Moderate	High	Extreme
Weak	Moderate	High	Extreme	Extreme

2.5 Step 6: Developing an action plan

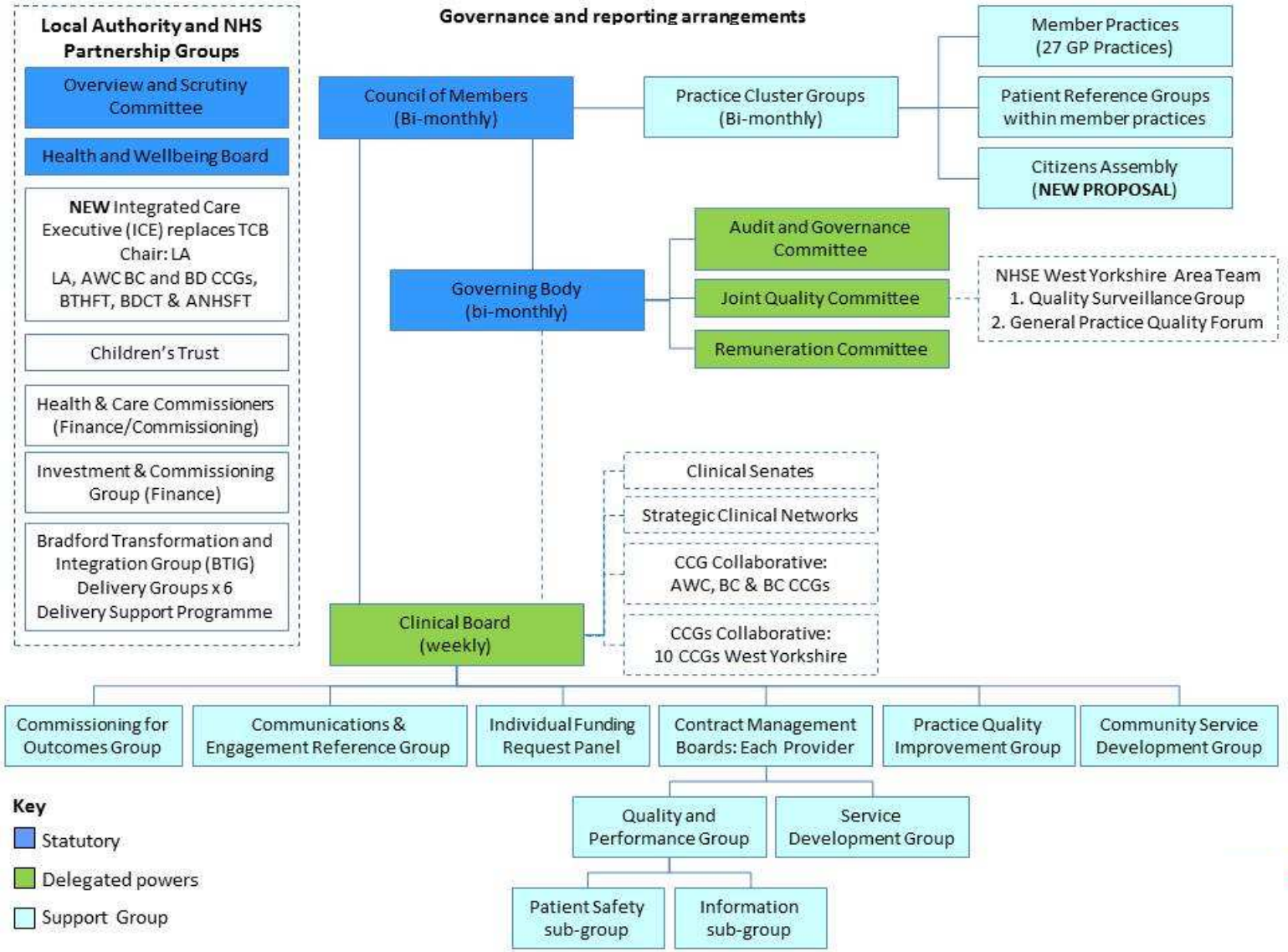
Once the residual risk is known then a detailed action plan of improved controls should be developed.

2.6 Step 7: Risk Prioritisation and Action

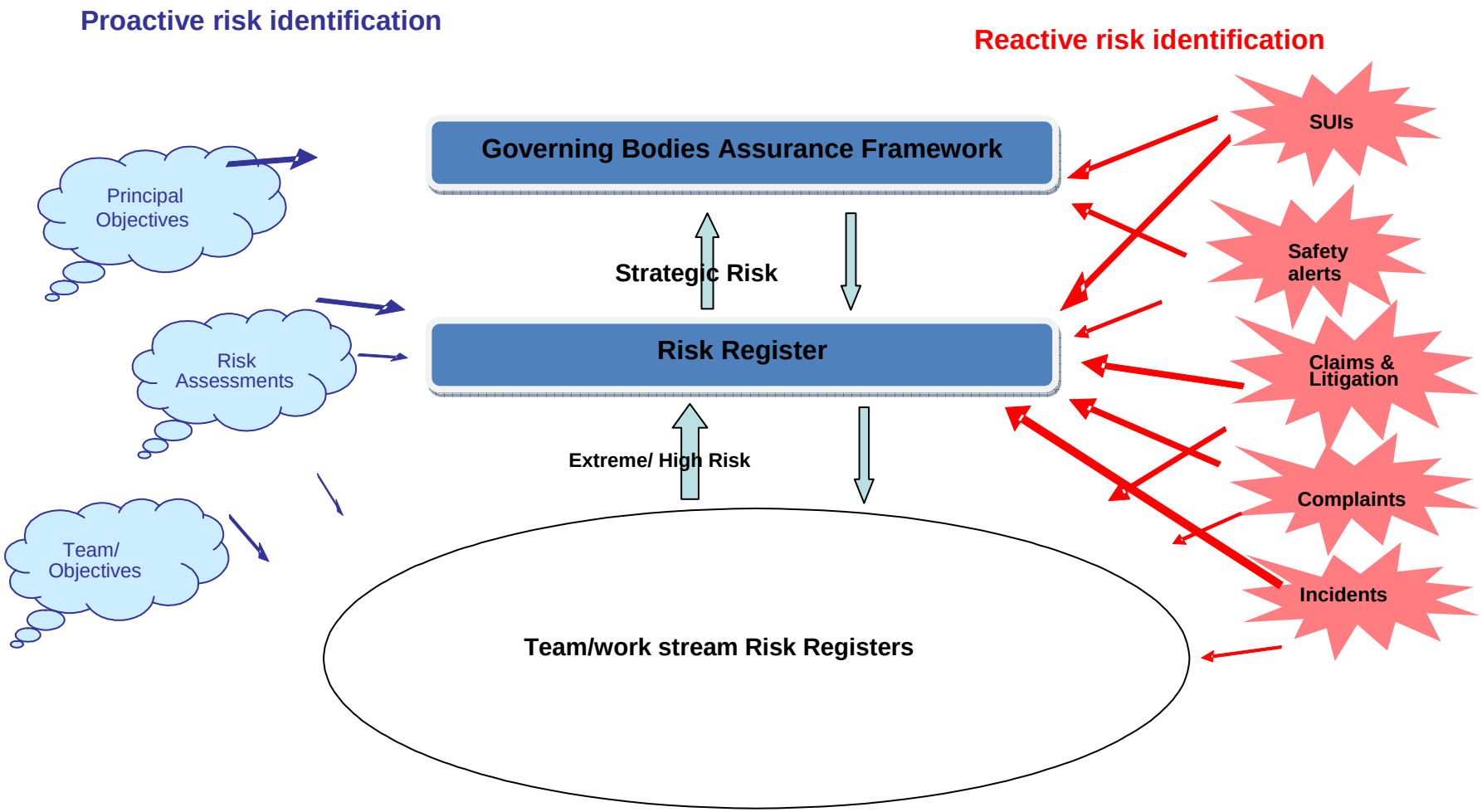
Where risks have been identified and scored, more likely as a consequence of an incident, then the following escalation arrangements should be used:

Risk Score	Risk Category	Action	Level of Authority
25	Unacceptable	Halt activities **IMMEDIATELY** and review status	Warrants Chief Officer and Director attention
15,16,20	Extreme Risk	Significant probability that major harm will occur if control measures are not implemented **URGENT ACTION REQUIRED**. Director may consider limiting or halting activity.	
8-12	High Risk	Moderate probability of moderate harm if control measures are not implemented. Action in THE mediate term.	Warrants Senior Lead attention
1-6	Low and Moderate Risk	The majority of control measures are in place. Harm severity is low. Action may be long term.	Warrants Manager attention

Appendix B


Governance and reporting arrangements
Local Authority and NHS Partnership Groups
Overview and Scrutiny Committee
Health and Wellbeing Board
NEW Integrated Care Executive (ICE) replaces TCB
Chair: LA
LA, AWC BC and BD CCGs, BTHFT, BDCT & ANHSFT
Children's Trust
Health & Care Commissioners (Finance/Commissioning)
Investment & Commissioning Group (Finance)
Bradford Transformation and Integration Group (BTIG)
Delivery Groups x 6
Delivery Support Programme
Council of Members (Bi-monthly)
Practice Cluster Groups (Bi-monthly)
Member Practices (27 GP Practices)
Patient Reference Groups within member practices
Citizens Assembly (NEW PROPOSAL)
Governing Body (bi-monthly)
Audit and Governance Committee
Joint Quality Committee
Remuneration Committee
NHSE West Yorkshire Area Team
1. Quality Surveillance Group
2. General Practice Quality Forum
Clinical Senates
Strategic Clinical Networks
CCG Collaborative: AWC, BC & BC CCGs
CCGs Collaborative: 10 CCGs West Yorkshire
Clinical Board (weekly)
Commissioning for Outcomes Group
Communications & Engagement Reference Group
Individual Funding Request Panel
Contract Management Boards: Each Provider
Practice Quality Improvement Group
Community Service Development Group
Quality and Performance Group
Service Development Group
Patient Safety sub-group
Information sub-group
Key
Statutory
Delegated powers
Support Group

Appendix C


Proactive risk identification
Reactive risk identification
Governing Bodies Assurance Framework
Strategic Risk
Risk Register
Extreme/ High Risk
Team/work stream Risk Registers
Principal Objectives
Risk Assessments
Team/ Objectives
SUIs
Safety alerts
Claims & Litigation
Complaints
Incidents

Appendix D

Integrating risk assessments and risk registers into management Processes

All staff	Ensure that all incidents/hazards/risks/complaints are reported in line with CCGs policies and procedures	**PROCESS MONITORED BY THE AUDIT COMMITTEE**
Senior leads	Undertake and document risk assessments and develop action plans as necessary Forward copies of all extreme and high rated risk assessments and appropriate action plans, where identified, to their Director for inclusion in the GBAF Ensure all medium and low rated risk assessments and are included in the Team/Work Stream Risk Register, developing actions plans as necessary Action all medium and low rated risk assessments and monitor progress of action plans against specified deadlines Forward copies of all medium and low rated risk assessments and appropriate action plans which cannot be funded or managed within their area of responsibility to their Director.	
Directors	Ensure that risk assessments are undertaken in their area of responsibility, with accompanying actions plans if necessary, and documented in line with the risk assessment procedure Ensure that copies of all extreme and high rated risk assessments and relevant action plans are forwarded to the CCG Governance Manager for inclusion in the GBAF Receive and review all extreme and high rated risk assessments and action plans identified by the senior leads Action all extreme and high rated risk assessments and monitor progress of risk action plans against specified deadlines Review Team/Work Stream Risk Registers with appropriate senior leads and managers Receive and review all medium and low rated risks that cannot be funded or managed by senior leads and managers within their area of responsibility Monitor progress of all medium and low rated risk assessments and action plans against specified deadlines	
CCGs Governance Manager	Coordinate the process to ensure the Risk Register is updated appropriately with associated risk assessments and action plans Advise directors and senior leads on the assessment and management of risks Populate and update the GBAF with extreme and any appropriate high rated risk assessments and action plans Provide updated copies of the Risk Register and GBAF to the Audit and Governance Committee within the specified timescales	
Joint Audit and Governance Committee	Review the Risk Register and GBAF Review specific risk issues and action plans as appropriate Receive and review any team/program risks that cannot be funded or managed by the directors Monitor progress of all extreme and high rated risk assessments and action plans against specified deadlines	
Governing Bodies	Review the GBAF Review the assurance system of risk posed against achieving strategic objectives and implement changes as appropriate	