NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

RISK MANAGEMENT POLICY

VERSION 5

Approval Process

Lead Author:	Director of Governance / CCG Secretary
Reviewed by	Audit Committee – 20 July 2021 Risk Co-ordinators – July 2021
Approved by: Date	Integrated Performance and Assurance Committee 24 August 2021
Ratified by Date	Governing Body 7 September 2021
Version:	5
Review date:	Two years from ratification date or earlier if required by local or national changes.

Document Control Sheet

Development and Consultation:	This Policy has been developed by members of the Corporate Governance and Quality Directorates.
Dissemination	This policy will be disseminated to all services within the CCG via the CCG website/Extranet
Implementation	Policy implementation involves all staff, managers and will be monitored by the Governance Team. The communication requirements are set out in section 10
Training	Refer to Section 9
Audit	The Policy will be audited as part of the annual review of Integrated Governance and Assurance Framework conducted by Internal Audit
Review	The document will be reviewed in ahead of the transition to the Integrated Care System from 1 April 2022.
Links with other policies and procedures and documentation	The Policy should be read in conjunction with: • Health and Safety Policy • Fire Safety Policy • CCG Claims and Complaints policies • Risk assessment guide • Disciplinary Policy • IG Forensic Readiness Policy • Service Level Agreement for Risk Services with CPFT • Incident Reporting Page on Staff Extranet • STP/ICS Board Assurance Framework
Equality Impact Assessment	An Equality Impact Assessment has been completed by the Corporate Governance Team.

Version Control

Version	Description of change	Date approved
1	Development of new Integrated Risk Management Policy Note: changes made to reflect LCG responsibilities as per GB 5.11.2013	
2 (Draft)	Reviewed by CCG Secretary Incorporated Risk Statement approved by Governing Body Added Risk Co-ordinators Group and Terms of Reference Revised Flow Diagram	September 2015
3	Reviewed by CCG Secretary. New CCG Logo. Updated to reflect the new organisational structure agreed by Governing Body and confirmed by NHSE approval of variance to Constitution – January 2017 Updated to demonstrate linkages to the STP Risk Management processes.	Approved March 2017
4	Refresh of roles and responsibilities to align with the Chief Officer Team and Interim Governance Framework	Reviewed April 2019 for approval by IPAC

	to align with the Chief Officer Team and Interim Governance Framework Removal of the Risk Co-ordinator Group, and transfer of responsibilities to the Senior Leadership Team Introduction of Three Lines of Defence Assurance Mapping Updated Risk Cycle Framework – Appendix 4	30.04.2019 then to GB 14.05.2019
5	Minor Amendments throughout document - New paragraph on reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR 2013) (section 7.5) - Appendix 5 amended and Appendix 6 (Assessment checklist for near miss incidents) removed. • **References to Director of Governance to be reviewed post October 2021*	Reviewed during July 2021 by Audit Committee, Risk Co-ordinators Group members & Richard Sharman, CPFT Health & Safety Manager To be presented to IPAC for approval August 2021 ahead of formal ratification by GB on 7 September 2021.

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1. STATEMENT OF INTENT

In NHS Cambridgeshire and Peterborough CCG (CCG) risk management is not seen as the responsibility of one role or one individual, it is seen as the responsibility of everyone. The CCG is committed to ensuring that integrated risk management is key part of the CCG's role of improving the health of the local population and ensuring an outstanding level of patient safety through commissioning high quality services that meet the needs of local people. To this end:

- Risks within the organisation are identified, assessed, treated and monitored as part of the corporate governance of the CCG
- All elements of the commissioning process, including needs assessment, tendering, contract management and evaluation, include robust risk assessment and monitoring mechanisms

Risk management is a continuously evolving process and the engagement of all staff and partners is essential for its successful implementation. Therefore, the CCG will work with its partners to promote robust risk management systems across the whole health and social care economy, working towards improving patient safety and learning from all incidents.

It is not the intention of the CCG to use risk management to stifle risk taking and innovation. Risk is inherent in all activity. The risk management systems ensure that risk is identified. In many cases the level of risk will be deemed acceptable as part of the overall impact of the project or process.

All managers and staff need to acknowledge that the overall level of risk within the CCG will be reduced if everyone adopts an attitude of openness and honesty. The overall approach within the CCG will be one of help and support to each other, rather than recrimination and blame. The CCG Governing Body is committed to this approach.

2. INTRODUCTION

Effective management of potential risks enables organisations to focus effort on high quality commissioning and working towards health improvement. The benefits of proactively and robustly managing risk include:

- Improved decision making, planning and prioritisation
- Support for efficient resource allocation and delivery of business plan
- Anticipation and management of possible areas of financial, corporate and clinical concern
- Identification and action planning for project development

To manage risk effectively, the commitment and participation of all staff and the support of the CCG Governing Body is required. The CCG's policy therefore involves creating an awareness and responsibility for the principles of risk management both as an organisation and as part of the commissioning process. The policy is supported at Governing Body level and aims to complement and support the corporate strategy.

In the same way, the CCG require the organisations it commissions to use effective risk management within their organisations. The CCG's approach to risk management will be developed in line with the following legislative and regulatory requirements,

NHS Resolution administers the CNST Clinical Negligence Scheme for Trusts.

NHS England co-ordinates the reporting and learning of adverse events occurring in the NHS. The CCG reports all notifiable Patient Safety incidents to NHS England via the National Reporting and Learning System.

The Care Quality Commission (CQC) assesses the quality of health and social care organisations through the requirements for registration. Compliance with the Commissions registration requirements will be one of the means by which the CCG assures itself and the NHS providers from which it commissions services, that high quality care is being provided.

The Health and Safety Executive's role is to protect people against health and safety risks arising out of work activities.

All incidents and weaknesses should be reviewed to determine the threat (potential or actual) so that they can be recorded and managed in accordance with correct procedure. The NHS Digital Data Security and Protection Toolkit (DSPT) requires all organisations that are processing NHS and social care data to use the DSPT Incident Reporting Tool to report IG Serious Incidents that meet the criteria for requiring investigation (SIRI) to the Department of Health and Social Care (DHSC), NHS England and Information Commissioner's Office.

Risk and Serious Incidents Requiring Investigation will be reported in the Annual Report.

3. PURPOSE AND SCOPE

3.1 The purpose of this Policy is to define and document the CCG's approach to risk and risk management and to

- Enable the Governing Body to have an overview of the risks it faces, taking into account all aspects of its business, developing a risk-aware culture throughout the organisation and across the wider Cambridgeshire and Peterborough system by linking risks to the ~~STP~~ the Integrated Care System Board Assurance Framework.
- Provide assurance to the Governing Body that actions are being taken to mitigate risks to acceptable levels.
- Embed consideration and assessment of risk in all aspects of planning, commissioning and delivery.
- Ensure a consistent approach to risk management across the organisation.

- Assure the public, patients, member practices, staff and our partner organisations that the CCG is managing its risks effectively and appropriately.

- Enable resources to be deployed effectively to manage risk.

- Enable constant and consistent improvement of healthcare provision and patient experience.

3.2 The Policy relates to the management of CCG risks. Its scope therefore relates to resources directly managed within or by the CCG. Where activities of other providers and partners in collaborative arrangements and the actions of other organisations outside of the CCG acting on its behalf through commissioning agreements involve risk that can have an impact on whether the CCG achieves its objectives, these activities and actions come within the scope of this policy.

4. ACCOUNTABILITY

4.1 The **Chief Officer** has overall accountability for having an effective Risk Management system in place within the CCG and for meeting all the statutory requirements and adhering to the guidance issued by the Department of Health in respect of Governance.

4.2 The **Chief Finance Officer** is the executive director for risk management and has delegated responsibility for leading the organisation in responding to Risk and Health and Safety, ensuring systems are in place to manage Health & Safety and that the CCG complies with Health & Safety legislation, including the legal requirements for fire safety. He will be supported by the *Director of Governance who will report through the Integrated Performance and Assurance Committee/Audit Committee on all non-clinical risk management activities.

4.3 The **Chief Finance Officer** is responsible for all finance risks, control of assets and provisions for liabilities.

4.4 The **Chief Nurse** is the Caldicott Guardian and the Governing Body member with delegated responsibility for aspects of clinical risk management, ensuring quality and governance systems are in place and inclusion of risk management processes in commissioning mechanisms. The Caldicott Guardian will review confidentiality breach and data loss incident assessments for the purposes of ensuring appropriate use of NHS Digital's DSPT Incident Reporting Tool. The **Deputy Chief Nurse** is the deputy Caldicott Guardian.

4.5 The **Chief Finance Officer** is the Senior Information Risk Owner (SIRO). The SIRO will review confidentiality information security incident assessments for the purposes of ensuring appropriate use of NHS Digital's DSPT Incident Reporting Tool. The *Director of Governance (CCG Secretary to the Governing Body) is the Deputy SIRO.

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

4.6 The **Information Governance Lead or Manager** will review all data security and protection incidents notified to the IG Team via the CCG's Datix Incident Reporting System for the purpose of ensuring appropriate use of NHS Digital's DSPT Incident Reporting Tool..

4.7 **GP Governing Body Members and Chief Officers/Executive Directors** are responsible for the day to day management of risks within their respective areas of responsibility, including assurance that appropriate controls are in place, and that action plans are owned, being progressed and monitored. They must ensure that all staff are aware of the CCG's Risk Management Policy and guidance, and their individual responsibilities for management risk. They also take responsibility for their Directorate Risk Registers.

4.8 **Managers and staff** should be familiar with the Risk Management Policy including Risk Registers and methodologies for risk assessment and risk ratings.

4.9 **Contractors and other external staff** must be made aware of their responsibilities under health & safety and CCG risk management procedures by the CCG manager responsible for their contract.

4.10 **Units** that are hosted by the CCG must comply with Health and Safety and CCG Risk Management requirements. There must be a named lead with responsibility for these areas. The CCG and its hosted units will work collaboratively to ensure robust Health and Safety and Risk Management systems are in place and there is evidence of compliance.

4.11 **The Chief Officer Team** is responsible for ensuring implementation of the CCG's Risk Management Framework and Risk Management Policy.

4.12 **Specialist Support** is currently provided by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) who in relation to risk management provide support for clinical negligence claims, security management and risk management training. The CCG also has access to a named approved competent person to provide risk management advice for general risk issues, health and safety and security and fraud management. This will be monitored quarterly by the Corporate Services ~~and Governance~~ Team within the Governance Directorate.

5. GOVERNANCE FRAMEWORK

5.1 CCG Governing Body

The CCG Governing Body is responsible for:

- Ensuring that a robust strategy is in place for identifying, reviewing and managing all types of significant and high level risk as set out in the CCG Assurance Framework and Risk Register;

- Reviewing any significant resource allocations requested for the execution of the policy, either within the business plan or in ad hoc proposals;
- Ensuring that management spreads understanding of the policy throughout the CCG's staff and among partners, and itself demonstrates commitment to the policy and its dissemination.

5.2 Audit Committee

The Audit Committee reports directly to the CCG Governing Body and is responsible for:

- Maintaining direct oversight of all risks, including generic risks, specific risks arising from CCG strategic plans, and risks to financial processes and control.
- Reviewing the effectiveness of risk management arrangements through the deployment of audit time and the review of resulting reports.

5.3 Committees of the Governing Body

Each responsible Committee will review the CCG Assurance Framework and Risk Register (CAF) at each meeting to ensure action plans are progressing and the CAF are kept up-to-date so that it can inform decision making within the CCG. Any high or significant level risks from the Directorate Risk Registers are escalated to the CAF.

The Committees will ensure that robust systems are in place and operating effectively for the identification, assessment and prioritisation of potential clinical risk and non-clinical risks including financial and performance risks, both within the organisation and in commissioned services and independent contractors.

5.4 Chief Officer Team

The Chief Officer Team will ensure implementation of the CCG's Risk Management Framework and Risk Management Policy and to ensure that this is fully embedded across the organisation.

5.5 Directorate and Team Meetings

Each Directorate and Team will be responsible for developing and maintaining a Directorate / Team Risk Register which will be part of the overall Corporate Risk Register. Risk Registers should be regularly managed and updated through the Directorate and Team meetings. Notes of risk management discussions should be recorded for governance and assurance purposes.

5.6 Risk Co-ordinators

Each Directorate/Team should appoint a Risk Co-coordinator who is responsible for keeping the details of their risks up-to-date in the risk register,

with current action plans and risk scores. A role description is set out at Appendix 1. The Risk Co-ordinators will meet three/four times a year to ensure alignment of risks where appropriate and to ensure consistency of risk assessment, risk registers and risk management development.

6. RISK MANAGEMENT

6.1 Overview

Risk is defined as the possibility of loss or injury and is measured using the likelihood that harm or damage may occur and the consequence / severity of the outcome. Risk Management is a systematic process to identify and control risks in the activities of the CCG to the benefit of service users, staff and the public'.

Risk Management is about improving quality and reducing harm. It is not confined to clinical practice and encompasses health and safety for clients, patients, visitors and staff, as well as environmental issues. It is not limited to physical injury but includes financial damage and psychological harm.

Strategic Risks the CCG will encounter will include such areas as:

- The CCG's vision, its objectives and the risks attached to them
- Serious clinical failure in service redesign and commissioning intentions
- Finance – failure to achieve financial balance, serious failure of probity
- Failure to deliver major targets
- Population growth
- Failure to comply with Data Protection Act and NHS Code of Confidentiality

The CCG will need to protect against the following corporate risks:

- Corporate - operating within powers, fulfilling responsibilities, accountability to public
- Financial - risks to achieving our statutory breakeven duties
- Reputation - associated with quality of services, communication with the public and staff, patient experience and breach of confidentiality
- External - political, environmental, social, environmental, meteorological
- Clinical - associated with service standards, competencies, complications, equipment, medicines, staffing, patient information
- Health and safety - ensuring the well-being of staff and patients whilst providing or using our services
- Commissioning - associated with decisions whether to purchase services or - to the individual, to financial stability, to opportunities to improve health
- Business - associated with managing the affairs of the CCG, financial and investment decisions, human resources, information and IT management, fraud, internal management, achieving objectives.
- Assets - security, protection, optimum use, maintenance, replacement

- Business - on-going business model of the CCG including the loss of corporate memory, changes in organisational structures or non-compliance with standards and legislation.
- Operational - day-to-day management of the CCG necessary for the on-going service delivery.

6.2 Identification, Assessment, Treatment and Monitoring of Risk

Any new projects or services need to identify and assess potential risks to ensure effective management is in place, decisions are made taking account of these risks, and organisations maintain an optimal balance of risk, benefit and cost. Services should also carry out risk assessment when major changes are made or incidents occur. For these assessments only the areas where change is being made need to be assessed. It is a legal requirement to carry out certain risk assessments on a regular basis. Further details are given in the Fire and Health & Safety policies.

The objective of risk assessment is to identify and manage risk. It is not used to prevent a project or service taking place. Risk is inherent in all activity. Organisations should not be risk adverse, but risk aware. In many cases the level of risk identified will be deemed acceptable as part of the overall impact of the project or service.

Risk assessments should also be carried out when an issue has been raised, either as an incident or near miss, and there is concern that the incident may re-occur. A risk assessment may also be used to support decision making by analysing risks and benefits of differing courses of action.

Risk assessment should be carried out at all levels within the CCG, from the CCG Governing Body to each Directorate and in some instances each Team. Each risk assessment will feed into the next level to provide a hierarchy of risks. Risk assessment is the first stage in risk management, and identifies and assesses actual and potential risks which can then be treated and monitored. All risk assessments should be fully documented and entered onto the risk register.

Any proposed changes to the organisation's processes and/or information assets must be assessed using the CCG Data Protection Impact Assessment to ensure that the confidentiality, integrity and accessibility of personal information are maintained. Identified risks should be incorporated and managed through the project risk assessment.

The process of risk assessment should involve all directorate or team members. Training and facilitation to support risk assessment is available from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). The flow chart at Appendix 2 sets out the way in which risks should be identified, assessed, treated and monitored.

6.3 Risk Rating

The CCG uses The NHS England adopted Model Risk Matrix to evaluate and score its organisational risks. In short this involves identifying and

scoring the potential consequence(s) of a risk and assessing and scoring the likelihood of that risk occurring. These two figures are then multiplied to provide an overall risk score. A top-level summary is set out in the table below:-

Likelihood	X	Consequence				
		Insignificant = 1	Minor = 2	Moderate = 3	Major = 4	Catastrophic = 5
Rare – 1		1	2	3	4	5
Unlikely – 2		2	4	6	8	10
Possible – 3		3	6	9	12	15
Likely – 4		4	8	12	16	20
Almost Certain – 5		5	10	15	20	25

Low risk	**Score (1 – 3)**	Normal risks which can be managed by routine procedures
Moderate risk	**Score (4 – 6)**	Risks requiring assessment and action planning allocated to Directorates
Significant risk	**Score (8 - 12**	Risks requiring urgent executive management team action linked with Action Plan
High Risk	**Score (15 – 25)**	Risks requiring immediate action by Director/Executive Management Team/Governing Body

For reference the guidance that is used to calculate these scores is set out in the Matrix set out at Appendix 3.

6.4 Risk Statement

6.4.1 Introduction

This Risk Statement provides guidance as to the level of risk that the CCG is willing to tolerate or expose itself to when managing risks as they arise during day to day business or when embarking on new projects. The Statement provides detail on how the Governing Body will manage and monitor risks in relation to different programmes of work or projects. It also describes the accountability arrangements.

The CCG will ensure that risks are considered in terms of both opportunities and threats and are not confined to the financial consequences of a risk materialising. Risks also impact on the capability of the organisation, its performance and its reputation. This will be influenced by our Strategic Aims and Strategic Priorities, and the Cambridgeshire and Peterborough health economy through the Cambridgeshire and Peterborough Long Term Plan.

The CCG acknowledges that risk is a component of every day business and improvement programmes and therefore does not expect or consider the absence of risk as necessarily achievable. The organisation will, where necessary, tolerate overall levels of risk where action is not cost effective or reasonably practicable. There will be issues where the benefits deriving from achieving objectives are sufficient to mean that exposure to the risk is seen as necessary. In such cases the risks identified need to be evaluated in terms of likelihood and severity and the decision taken to tolerate the risk in accordance with the CCG's Scheme of Delegation.

6.4.2 Process

As set out above, all risks identified are evaluated and given a risk level rating based on the NHS England's adopted model Risk Rating. The higher the risk level, the greater the likelihood an opportunity or threat will occur and the greater its impact. All risks that are risk rated extreme (red) between 15 and 25 will be esclated to the CCG's CAF. The Governing Body will ensure that plans are put into place to lower the level of risk whenever an extreme risk has been identified. A target risk will be identified to support reducing the risk through the appropriate mitigating actions.

The CCG requires that risk management is seen as everybody's business. Identifying and reporting a risk does not end the responsibility and a major part of risk treatment is control and the control to mitigate the risk may be easily put in place, for example by cleaning up a spillage. The CCG expects that all reported and registered risks will be considered for risk treatment options. Risk treatment includes implementing controls, removing the risk completely, reducing the risk, transferring the uncertainty of the risk (for example by insurance) or making a decision to tolerate the risk in line with the appropriate level of delegation.

6.4.3 Controls

The CCG acknowledges that the majority of risks will need to have controls implemented to reduce the likelihood or severity of the risk. The cost-benefit of the control needs to be considered to ensure that the risk reduction benefits outweigh the cost of the control and achieves the desired outcome. Existing control mechanisms/activities and the level of confidence in these existing controls will be considered when identifying options for additional control measures.

6.4.4 Assurances

Understanding where assurance comes from will help provide a clearer picture of where the organisation receives assurance and whether it has too much, is duplicated, or has none at all, and whether the coverage of assurances is set at the right level to provide confidence to the Governing Body.

The CCG's Governing Body will ensure that it receives three lines of assurance on the risks which are escalated to the CAF. These assurances can be described as follows:-

First Line Assurance – Directorate / Team – the first level of assurance comes from the Directorate / Team that performs the day to day activity
Second Line Assurance – Organisational Oversight - Other functions in the organisation such as quality, finance, governance and HR.

Third Line Assurance – Independent assurance from outside the organisation such as NHSE/I, Care Quality Commission, Internal and External Assurance.

These assurances will be set out on the CAF, and an assurance mapping tool will be utilised to provide an Assurance Map which captures the levels of assurance on a quarterly basis.

6.4.5 Accountability

The CCG Governing Body has determined its accountability and treatment of risk as follows:-

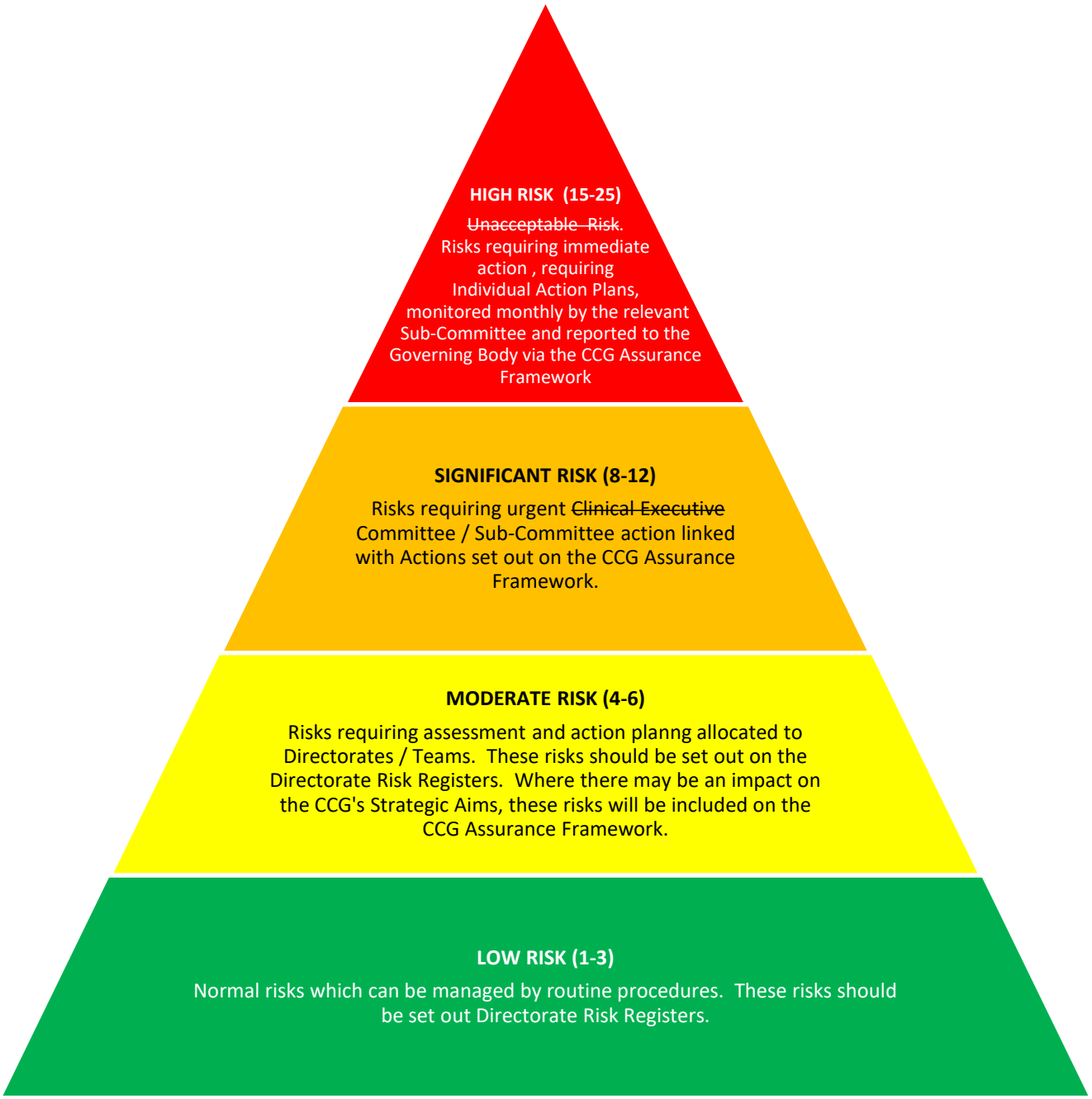
RED - HIGH RISK (15-25). Risks which will require immediate action, with clear actions developed by a Senior Risk Owner who will be held to account for progress to manage, mitigate and reduce the risk. Timescales for delivery will be set by the Senior Risk Owner and agreed by the appropriate Sub-Committee. The Action will be monitored by the relevant Sub-Committee and progress will be reported to the Governing Body via the CCG Assurance Framework.

AMBER - SIGNIFICANT RISK (8-12). These risks will require urgent Committee / Sub-Committee action linked with Actions set out on the CCG Assurance Framework. These will also have a Senior Risk Owner who will be held to account for the actions and timescales set out on the CCG Assurance Framework. The actions will be monitored by the relevant Sub-Committee and will be reported to the Governing Body via the CCG Assurance Framework.

YELLOW - MODERATE RISK (4-6). These risks will require assessment and action planning allocated to Directorates / Teams. These risks should be set out on Directorate Risk Registers. Where there may be an impact on the CCG's Strategic Aims, these risks will be included on the CCG Assurance Framework. A Risk Owner will be held to account for the actions linked to the risk.

GREEN - LOW RISK (1-3). These are normal risks which can be managed by routine procedures. These risks should be set out on Directorate/Team Risk Registers. A Risk Owner will be held to account for the actions linked to the risk.

The narrative above is also depicted in the Risk Triangle set out below.


HIGH RISK (15-25)
~~Unacceptable Risk~~.
Risks requiring immediate action , requiring Individual Action Plans, monitored monthly by the relevant Sub-Committee and reported to the Governing Body via the CCG Assurance Framework
SIGNIFICANT RISK (8-12)
Risks requiring urgent ~~Clinical Executive~~ Committee / Sub-Committee action linked with Actions set out on the CCG Assurance Framework.
MODERATE RISK (4-6)
Risks requiring assessment and action planng allocated to Directorates / Teams. These risks should be set out on the Directorate Risk Registers. Where there may be an impact on the CCG's Strategic Aims, these risks will be included on the CCG Assurance Framework.
LOW RISK (1-3)
Normal risks which can be managed by routine procedures. These risks should be set out Directorate Risk Registers.

6.4 CCG Assurance Framework and Risk Registers

The CCG will use the CCG Assurance Framework and Risk Register (CAF), and Directorate Risk Registers to prioritise and manage risks. The risk registers enable risks to be assessed against each other and provides a basis to facilitate decision-making regarding risk control and resource allocation. The CCG will also link, where appropriate, the Sustainability and Transformation Plan Risk Register where risks are shared across the system.

The risk register requires each risk to be analysed in order to assess what is the likelihood of it recurring and what the likely impact would be, resulting in a score for that risk. The process is then repeated taking into an account any action taken to manage the risk.

The CAF and other risk registers are structured in such a way as to ensure that legal requirements are met.

The Directorate Risk Co-ordinators are responsible for keeping the details of their risks up-to-date in the risk register, with current action plans and risk scores, and in presenting any high or extreme risks to the responsible Committee.

Significant and high level corporate risks from the risk register are reported to and monitored by the CCG Governing Body via the CAF.

Appendix 4 shows the links between CAF and risk registers and the structure for development and management of these registers.

7. INCIDENTS AND NEAR MISSES – REPORTING, INVESTIGATION AND LEARNING

An incident is any unplanned occurrence or event where there is loss of life, injury, loss or damage to persons or property. It can include any event that may give rise to physical, emotional or psychological harm. The CCG encourages a culture of openness within the organisation through continuous support and feedback to staff involved in incidents. The CCG realises that it is important that staff understand that the purpose of reporting incidents is not to apportion blame to any individual or group of people, but to identify problems and to remedy them. Without an open culture, the reporting of incidents will not take place and it will be difficult to learn lessons thus preventing similar situations. The CCG will seek to reduce risk from the effective management of incidents.

7.1 Initial Action

- Establish a safe environment
- Notify line manager
- Complete the incident form on Datix (The Datix Icon is available to all staff on their desktops) - link below https://cambridgeshireandpeterboroughccg.datix.thirdparty.nhs.uk/live/index.php

7.2 **Reporting**

Further guidance on reporting incidents and review arrangements is included in Appendix 4. The Risk Matrix should be used to identify the incident risk severity level.

7.3 **Investigation**

Management of the investigation will be dependent on the risk severity level (see Risk Matrix). The CCG requires investigations to be carried out in a timely and thorough way at a level appropriate to the severity level. Initial reviews should aim to identify if further action is required to reduce the risk of reoccurrence. Analysis of the information will be required to determine the cause of the incident. Managers and those involved in the investigation process must remember that confidentiality should be maintained. Information given to them in order to carry out the investigation is on a need to know basis. Identified actions should have appropriate timescales for completion and should be monitored by the investigating manager. All IG related incidents will be assessed by the IG Lead or Manager.to decide whether it is necessary to report using NHS Digital's DSPT Incident Reporting Tool. NHS Digital Incident Reporting Guidance: https://www.dsptoolkit.nhs.uk/Help/29

7.4 **Learning**

Lessons learnt should be listed in the investigation report and disseminated with appropriate timescales.

7.5 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR 2013)

The CCG has a legal requirement to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR 2013) regarding the reporting of certain categories/types of incidents / accidents within the workplace. RIDDOR reports are required when the accident is work related, or it results in a type of reportable injury. Further guidance and support is available from the CPFT Health & Safety Team and the Health & Safety Executive (HSE) **https://www.hse.gov.uk/riddor/**
and http://www.hse.gov.uk/healthservices/riddor.htm

8. SERIOUS INCIDENTS

The NHS Constitution outlines a responsibility to protect patients from harm. In order to do this, lessons need to be learned and shared when incidents do occur. The CCG has produced Serious Incident (SI) guidance which gives local detail in the context of the national requirements for maintaining and improving quality. The CCG guidance should be followed by CCG staff and Provider organisations commissioned by the CCG in the event of a SI.

Definition of a Serious Incident
The definition of a serious incident requiring investigation is given as an incident that occurred in relation to NHS-funded services and care resulting in:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public

- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy, or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- A scenario that prevents or threatens to prevent a Provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/ organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of abuse
- Potential or adverse media coverage or public concern for the organisation or the wider NHS
- One of the core set of 'Never Events' as updated on an annual basis.

9. TRAINING

All employees will have access to risk management and health & safety information, instruction and training. The level and nature of the training will vary according to the local need. Risk management and incident reporting are introduced in the corporate induction training.

All risk co-ordinators will receive training in basic risk management.

10. LINKS TO OTHER POLICIES AND PROCEDURES

This Policy should be read in conjunction with the following CCG's Policies and Procedures,

- Health and Safety Policy
- Fire Safety Policy
- CCG Claims and Complaints policies
- Risk Assessment guide
- CCG Reporting and investigation guideline for serious incidents
- Disciplinary Policy
- IG Forensic Readiness Policy
- CCG Incident Response Plan
- CCG Business Continuity Plan
- Service Level Agreement for Risk Services with CPFT; and also
- NHS Digital's Incident Reporting Guidance

11. COMMUNICATION OF THE RISK MANAGEMENT POLICY

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

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

- staff can raise issues of concern with their manager(s)
- staff are consulted on proposed organisational or other significant changes
- managers keep staff informed of progress on relevant issues
- service users, their relatives, carers and advocates can identify points of concern or worry by using the complaints process or Patient Experience Team

- the media are accurately advised of developments in the CCG

The CCG principles of risk management are communicated to commissioned organisation through commissioning mechanisms and contract requirements.

12. EVALUATION

The effectiveness of the Risk Management Policy will be reviewed on an annual basis as part of the Internal Audit Review of Integrated Governance Systems. This will form the basis of the Head of Internal Audit Opinion on the effectiveness of the organisations systems of internal control.

13. REVIEW

The Policy will be reviewed every two-years, or earlier if required to address local changes or National guidance.

APPENDIX 1

Directorate Risk Co-ordinator
Role Description

1. Summary

Each Directorate will nominate a Risk Co-ordinator to oversee and co-ordinate the Directorate's Risk Register which supports the overall CCG Risk Management Framework.

2. Key Objectives

The key objectives for the Risk Co-ordinator are set out below:

- To be responsible for co-ordinating the development / oversight of Directorate Risk Registers – working with the Corporate Governance Team.

- To be responsible for keeping the details of their risks up-to-date in the risk register, with current action plans and risk scores, and in presenting any high or extreme risks to the Integrated Performance and Assurance Committee via the Senior Risk Owner.

- To ensure discussions regarding risks are embedded within Team and Directorate meetings and accurate records of risk management are maintained.

- To be responsible for communicating the CCG's Risk Management Framework within the Team / Directorate meetings.

- To attend regular meetings of the Risk Co-ordinators Group.

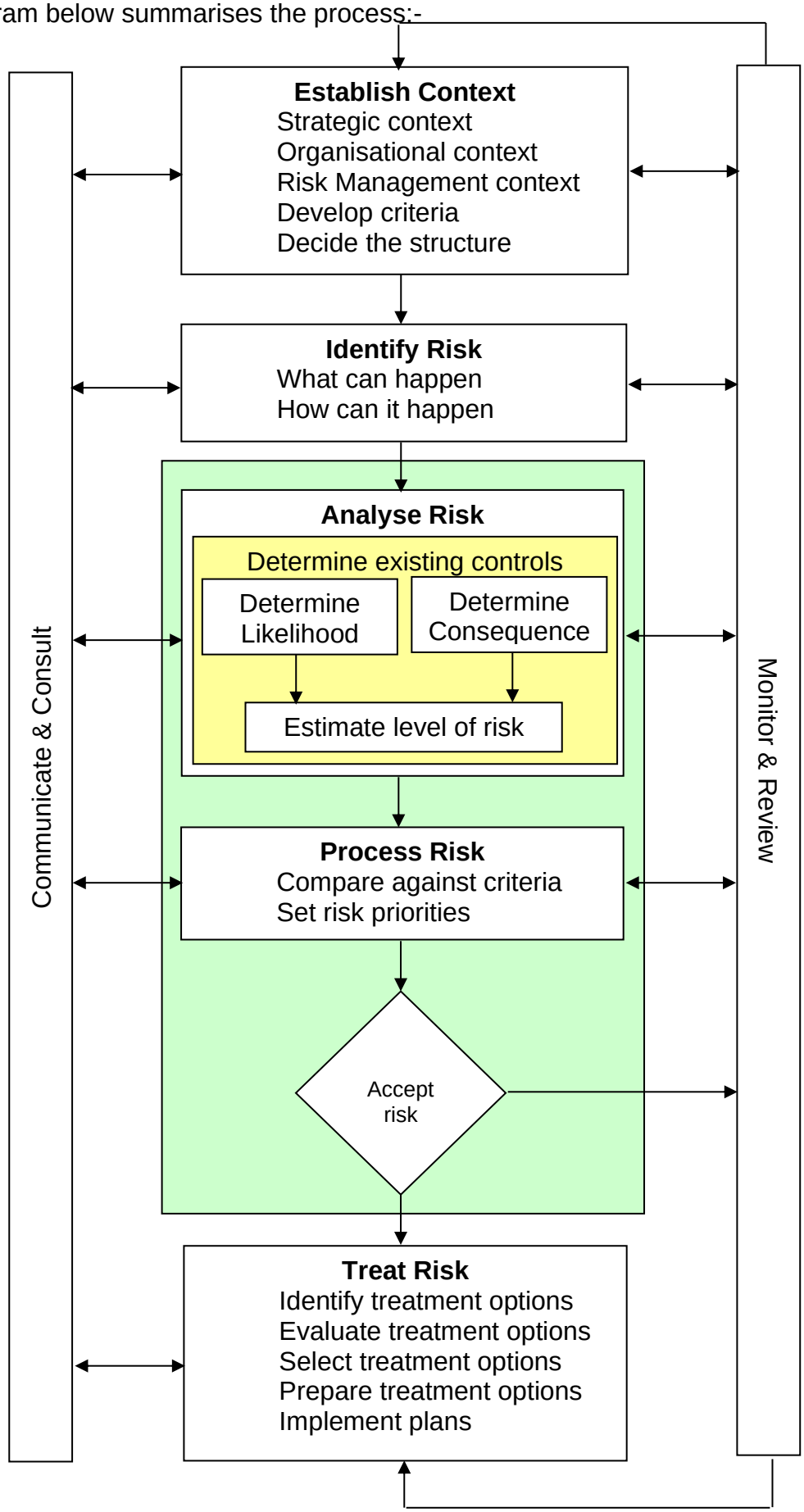
Sharon Fox
Director of Governance
Revised July 2021

APPENDIX 2

ELEMENTS OF RISK MANAGEMENT

Identification, assessment, Treatment & Monitoring of Risk

The following sections describe the stages of risk management within the CCG. The diagram below summarises the process:-



APPENDIX 3

RISK MATRIX

CALCULATING RISK SCORES FOR THE CCG ASSURANCE FRAMEWORK AND RISK REGISTERS

The CCG uses NHS England's adopted Risk Matrix to evaluate and score its organisational risks. In short this involves identifying and scoring the potential consequence(s) of a risk and assessing and scoring the likelihood of that risk occurring. These two figures are then multiplied to provide an overall risk score. For reference the guidance that is used to calculate these scores is set out below.

TABLE 1 – IDENTIFYING THE CONSEQUENCE SCORE

The most appropriate domain that an identified risk may fall under is chosen from the first column on the left-hand side of the table. Then by working along the columns in the relevant row the severity of the risk is assessed on a scale of 1 to 5 to determine the consequence score. This is the number at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
Domains Please note: These are examples used in the national model and can be tailored to individual organizations')	**1**	**2**	**3**	**4**	**5**
	Insignificant	**Minor - GREEN**	**Moderate - YELLOW**	**Major - AMBER**	**Catastrophic - RED**
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 unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

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 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
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

TABLE 2 – IDENTIFYING THE LIKELIHOOD SCORE

The table used to determine the likelihood score(s) (L) for those adverse outcomes to a risk is shown below. If possible, the likelihood is scored by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, a probability to the adverse outcome occurring within a given time frame is assigned, such as the lifetime of a project. If it is not possible to determine a numerical probability the probability descriptions set out in the table can be used to determine the most appropriate score.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely - GREEN**	**Possible - YELLOW**	**Likely - AMBER**	**Almost certain - RED**
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

TABLE 3 – CALCULATING THE OVERALL RISK SCORE

The overall risk score is calculated by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

Likelihood	**X**	**Consequence**				
		Insignificant = 1	**Minor = 2**	**Moderate = 3**	**Major = 4**	**Catastrophic = 5**
Rare – 1		**1**	**2**	**3**	**4**	**5**
Unlikely – 2		**2**	**4**	**6**	**8**	**10**
Possible – 3		**3**	**6**	**9**	**12**	**15**
Likely – 4		**4**	**8**	**12**	**16**	**20**
Almost Certain – 5		**5**	**10**	**15**	**20**	**25**

Low risk	**Score (1 – 3)**	Normal risks which can be managed by routine procedures
Moderate risk	**Score (4 – 6)**	Risks requiring assessment and action planning allocated to Directorates
Significant risk	**Score (8 - 12**	Risks requiring urgent executive management team action linked with Action Plan
High Risk	**Score (15 – 25)**	Risks requiring immediate action by Director/Executive Management Team/Governing Body

MONITORING PROGRESS

Revised Risk

If controls are inadequate or uncertain, the revised risk stays the same as the original risk rating.

If they are perceived as adequate, then the revised risk drops

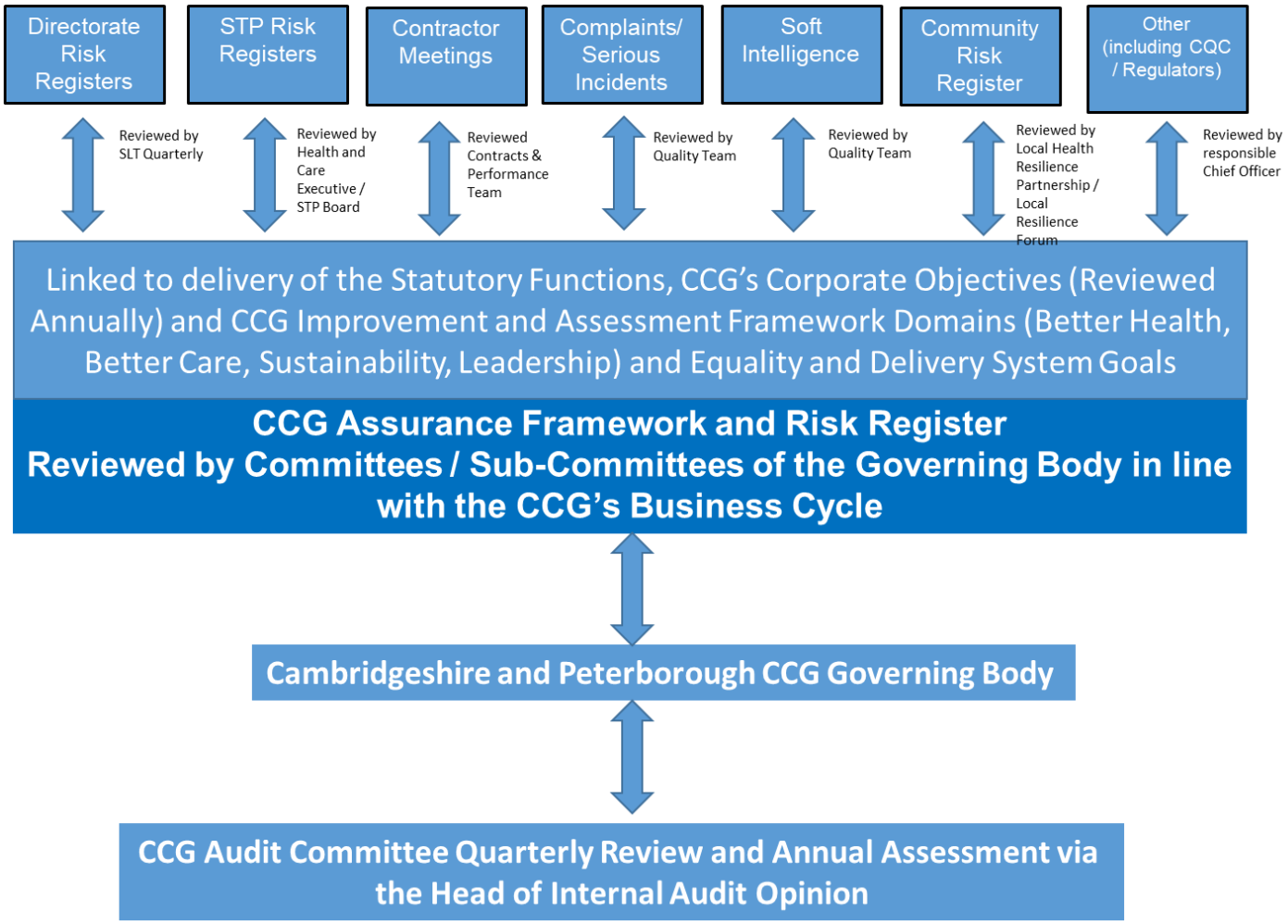
Risk Status

Status of risk remains the same

Status of risk increases

Status of risk decreases

CCG Assurance Framework and Risk Register Reporting Diagram



Appendix 5

Examples of Incidents and Near Misses

Information Governance	Security Issues	Health and Safety
• Lost or stolen IT equipment • Disclosure of confidential information (data breach) • Evidence of shared Passwords Document misfiling Data Loss • Malware or Phishing attack aimed at gaining access to personal data	• Theft of personal property • Unauthorised person gaining access to premises • Cyber Attack against systems or data resulting in loss of access to, corruption or destruction of the systems or data • Cyber-attack or physical attack against equipment or buildings resulting in loss of systems, equipment, services or data.	• Spillage • Burn due to hot water / radiator • Slip or trip on CCG premises • Injury when moving equipment
Organisational	**Abuse Issues**	**Other organisations**
• Failure of power supply	• Physically abuse of colleague or member of public • Verbally abuse of colleague or member of public • Persistent callers	• Breach of confidentiality from another organisation • Concern about care raised between organisations

Once the incident risk severity level has been assessed the following table should be used to decide on the investigation and management arrangements required.

Incident risk grading	Incident and investigation and management arrangements
1-3 Low	Complete DATIX incident form. Manager and staff to monitor and review at local level and report follow up actions on DATIX when agreed.
4-6 Moderate	Complete DATIX incident form. Manager and staff to monitor and review at local level and report initial follow up actions on DATIX within 1 working day.
8-12 High	Inform the Manager on duty immediately, who will take action as soon as possible. Complete DATIX incident form. Urgent review & investigation to be completed within Directorate, remedial action plans to be formalised and put in place within 5 days.
15 – 25 Extreme	Inform the Manager on duty immediately, who will take action as soon as possible. Complete DATIX incident form. Urgent review & investigation to be completed within Directorate, remedial action plans to be formalised and put in place within 2 days.

APPENDIX 6

Cambridgeshire and Peterborough Clinical Commissioning Group

Equality Impact Assessment - Form

Name of Proposal (policy/strategy/function/service being assessed)	Risk Management Policy
Those involved in assessment:	CCG Secretary, Corporate Governance Team
Is this a new proposal?	Updated Policy
Date of Initial Screening:	19 September 2013 Reviewed February 2017 Reviewed April 2019 Reviewed July 2021

What are the aims, objectives?	To define and document the CCG's approach to risk and risk management to ensure: • risks within the organisation are identified, assessed, treated and monitored as part of the corporate governance of the CCG. • robust risk assessment and monitoring mechanisms are in place for all elements of the commissioning process, including needs assessment, tendering, contract management and evaluation.
Who will benefit?	CCG staff, partner organisations (where applicable), public, patients and member practices.
Who are the main stakeholders?	CCG managers and staff (and other providers and partners where applicable).
What are the desired outcomes?	A consistent approach to risk management across the organisation is successfully implemented. Consideration and assessment of risk in all aspects of planning, commissioning and delivery is embedded within the organisation. The Governing Body regularly receives an overview of the risks it faces and is assured that actions are being taken to mitigate risks to an acceptable level.

	Assurance is given to the public, patients, member practices, staff and our partner organisations that the CCG is managing its risk effectively and appropriately.
What factors could detract from the desired outcomes?	Lack of awareness and/or non-enforcement of the policy.
What factors could contribute to the desired outcomes?	Increased awareness of the requirements set out in the policy throughout the CCG. Targeted risk management training for individuals/teams as and when required. Full adherence by staff in the processes in the Risk management and reporting processes detailed.
Who is responsible?	Chief Officer Team
Have you consulted on the proposal? If so with whom? If not why not?	Policy originally developed/discussed with the Policies Review Task and Finish Group which included representatives from different Departments/sections of the CCG. Policy reviewed by relevant Teams/individuals July & August 21

Which protected characteristics could be affected and be disadvantaged by this proposal (Please tick)		Yes	No
Age	Consider: Elderly, or young people		✓
Disability	Consider: Physical, visual, aural impairment Mental or learning difficulties		✓
Gender Reassignment	Consider: Transsexual people who propose to, are doing or have undergone a process of having their sex reassigned		✓
Marriage and Civil Partnership	Consider: Impact relevant to employment and /or training		✓
Pregnancy and maternity	Consider: Pregnancy related matter/illness or maternity leave related mater		✓
Race	Consider: Language and cultural factors, include Gypsy and Travellers group		✓
Religion and Belief	Consider: Practices of worship, religious or cultural observance, include non-belief		✓
Sex /Gender	Consider: Male and Female		✓
Sexual Orientation	Consider: Know or perceived orientation		✓

What information and evidence do you have about the groups that you have selected above?

N/a

Consider: Demographic data, performance information, recommendations of internal and external inspections and audits, complaints information, JNSA, ethnicity data, audits, service user data, GP registrations, CHD, Diabetes registers and public engagement/consultation results etc.

How might your proposal impact on the groups identified? For example you may wish to consider what impact it may have on our stated goals: Improving Access, Promoting Healthy Lifestyles, Reducing Health Inequalities, Supporting Vulnerable People

Examples of impact re given below:

a) Moving a GP practice, which may have an impact on people with limited mobility/access to transport etc.

b) Planning to extend access to contraceptive services in primary care without considering how there services may be accessed by lesbian, gay, bi-sexual and transgender people.

c) Closure or redesign of a service that is used by people who may not have English as a first language, and may be excluded from normal communication routes.

Please list the positive and negative impacts you have identified in the summary table on the following page.

1 Summary	
Positive impacts (note the groups affected) N/a	Negative impacts (note the groups affected) N/a

Summarise the negative impacts for each group:

N/a

What consultation has taken place or is planned with each of the identified groups?

N/a

What was the outcome of the consultation undertaken?

N/a

What changes or actions do you propose to make or take as a result of research and/or consultation?

Briefly describe the actions then please insert actions to be taken on to the given Improvement Plan template provided.
N/a

Will the planned changes to the proposal: **Please state Yes or No**

Lower the negative impact?	N/a
Ensure that the negative impact is legal under anti-discriminatory law?	N/a
Provide an opportunity to promote equality, equal opportunity and improve relations i.e. a positive impact?	N/a

Taking into account the views of the groups consulted and the available evidence, please clearly state the risks associated with the proposal, weighed against the benefits.

N/a

What monitoring/evaluation/review systems have been put in place?

The effectiveness of the Risk Management Policy will be reviewed on an annual basis as part of the Internal Audit Review of Integrated Governance Systems.

When will it be reviewed?

March 2022 or earlier if required by changes in local or national requirements.

Date completed:	19 September 2013 Reviewed February 2017 Reviewed April 2019 Reviewed 17 August 2021
Signature:	Simon Barlow, Corporate Governance Manager
Approved by:	OD & HR Advisor, Equality & Advisor
Date approved:	24 August 2021