NHS Rotherham Clinical Commissioning Group

Operational Executive – 13th and 20th February 2017

Strategic Clinical Executive (for info) – 8th March 2017

GP Members Committee (GPMC) – Date

Clinical Commissioning Group Governing Body - 1st March 2017, 5th April 2017

Audit & Quality Assurance Committee – 17th March 2017

Risk Management System

Lead Executive:	Chris Edwards – Chief Officer
Lead Officer:	Ruth Nutbrown – Assistant Chief Officer
Lead GP:	Richard Cullen – SCE GP – Governance Lead

Purpose:

To update the new Risk Management System (RMS) for Governing Body.

Background:

Further to discussion at the January Confidential Governing Body meeting regarding the review of the CCG's Risk Management System, a new risk management system has now been developed and implemented.

The new risk management system includes a risk management framework incorporating the risk management policy and procedural documents, as well as a newly designed Governing Body Assurance Framework (GBAF), Risk Register (RR) and introduction of an Issues Log (IL).

The Risk Management system was initially approved by Governing Body on the 1st March 2017. It has since been updated following organisational change and presentation at AQuA for re-approval.

Analysis of key issues and of risks

The risk management framework has been radically updated, in line with the new GBAF, and RR, with the CCG's strategic objectives being included, as well as an updated risk matrix, risk appetite statement, and new templates for the GBAF, RR and IL.

For assurance the process followed transposed the entries on the original documents to the new documents, the risks were updated, re-written or retired. No risks were "lost" during the process. Appendix 1 Maps the migration from the old documents to the new.

The risk appetite linking to the strategic objectives was agreed during the governing body development session on the 1st March, this has now been updated within the policy presented today. Appendix 2 shows the minutes of the Governing Body development session.

Internal Audit are currently reviewing the RMS, and have (at the time of writing) suggested one amendment to the GBAF.

- With reference to internal and external assurances there are no implementation dates to act as a trigger for AQuA and GB to seek assurance when dates have passed to call officers to account

This will be discussed at OE, prior to being re-presented at GB in April.

Not having an updated Risk Management Framework, Policy and Procedural document updated as part of the review of the RMS may lead to a reduced internal audit assurance statement at year end.

As per the structure review the responsibilities for Risk Management moves from the Deputy Chief Officer to the Chief Officer so the policy has been altered due to the post April structure review to take this into account.

The new system is still in development, with discussions at OE around the number of AF risks per strategic objective, as some objectives contain more than one issue. As the system matures, and embeds this may change.

The suggested reporting on the new system is as follows:
Issues Log – bi monthly to OE
Risk Register – every 2 months to OE and to every other AQuA meeting
GBAF – to every other AQuA meeting and bi-annually to GB

Following representation to GB in April, the policy is expected to be formally adopted and communicated to staff, via email and the Senior Management team Meeting. A "spotlight" session at a forthcoming staff meeting will introduce the new documentation and raise awareness of the new system to all staff.

Patient, Public and Stakeholder Involvement:

OE members and Risk Owners have been consulted in the development of all the documents.

Equality Impact:

N/A

Financial Implications:

N/A

Human Resource Implications:

N/A

Procurement:

N/A

Approval history:

OE, GB, AQuA

Recommendations:

- Governing Body is asked to note the changes to the CCG's Risk Management System, following changes to the staffing structure.
- Governing Body is asked to ratify the Risk Management System.

Appendix 1

Migration of GBAF and RR to new format

Ref	Principle Risk	Lead person	Action	Reference (Risk Register / Issues Log / GBAF)
073	**Adverse impact on patient care due to challenges at TRFT evidenced by: leadership change, liquidity pressures and unresolved EPR implementation issues.**	**Ian Atkinson**	Meeting with Ian Atkinson 28.11.16 - Closed	N/A
033	**Failure to deliver planned efficiency savings in Planned Care**	**Ian Atkinson**	Meeting with Ian Atkinson 28.11.16 - Closed, new entry on issues log	IL3 & GBAF Objective 1
031	**Failure to deliver planned efficiency savings in unscheduled care**	**Keely Firth** Ian Atkinson Dominic Blaydon	Meeting with Keely Firth 05.01.17 - Reworded and included on issues log for (2016/17) & Risk Register thereafter	IL3 & RR7 & GBAF Objective 2
085	**Failure of YAS to achieve RED 1 8 minute Target 2014/15 at CCG level and Yorkshire & Humber wide.** **The position (Roth CCG) as at Oct is 65.73% against a target of 75%.**	**Claire Smith**	Meeting with Claire Smith 02.02.17 - Included on issues log	IL5 & GBAF Objectives1/3
066	**Subcontracted Commissioning services with CSU/LPF provider fail to deliver outcomes as a result on CSU not being on lead provider framework**	**Ian Atkinson**	Meeting with Ian Atkinson 28.11.16 - Closed	N/A
065	**Failure to meet A&E targets**	**Sarah Lever**	Reworded and included on Risk Register 2016/17, Issues Log thereafter	RR14 & IL4 & GBAF Objectives1/3
104	**Impact of changes to primary care support England from NHS to Capita contract**	**Jacqui Tufnell**	Meeting with Jacqui Tufnell 29.11.16 - Include on issues log	IL2 & GBAF Objective 1
102	**Inability to deliver CAMHS reconfiguration in a timely manner**	**Nigel Parkes**	Meeting with Nigel Parkes 14.02.17 - Closed	N/A
099	**Failure to deliver the National IAPT waiting times standards A. 75% of people seen within 6 weeks B. 95% of people seen within 18 weeks**	**Kate Tufnell**	Meeting with KateTufnell 14.02.17 - Included on issue log	IL7 & GBAF Objectives 1
079	**Impact of other commissioners efficiency plans on CCG core business.**	**Ian Atkinson**	Meeting with Ian Atkinson 28.11.16 - Closed	N/A
069	**Financial viability of key acute provider TRFT**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Reworded and included on risk register	RR8
037	**Delivery of corporate/running costs savings whilst taking on new services and hosting shared services has a negative impact on corporate performance**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Reworded and included on risk register	RR9
008	**Financial allocations reduced by Government. Review of Allocations by NHS England**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Closed	N/A
096	**Equipment provided by RCCG via IFR/CHC - failure to have a procurement service to ensure cost effectiveness and service that ensures that the**	**Alun Windle**	Meeting with Alun Windle 28.11.16 - Included on issues Log	IL1 & GBAF Objective 1

Ref	Principle Risk	Lead person	Action	Reference (Risk Register / Issues Log / GBAF)
	purchased equipment has a record of maintained and safety.			
097	**Failure to meet the National cut-off date of 1st March 2017 for Previously Unassessed Periods of Care (PUPoC) - previously known as CHC Retrospective Claims**	**Alun Windle**	Meeting with Alun Windle 28.11.16 - Reworded and included on risk register	RR1
093	**Collaborative commissioning of specialised services**	**Jacqui Tufnell**	Meeting with Jacqui Tufnell 29.11.16 - Reworded and included on risk register	RR2
071	**Impacts on quality and safety of the cost improvement plans of our key providers**	**Ian Atkinson** Sue Cassin	Meeting with Ian Atkinson 28.11.16 - Closed	N/A
105	**NHS RCCG reputation as responsible commissioner for Children in Care - not having initial health assessments within statutory framework**	**Sue Cassin** Catherine Hall	Reworded and included on risk register & Governing Body Assurance Framework	RR5 & GBAF objective 3
015	**Not maintaining accessible and responsive high quality primary care** **(current concerns are due to overall GP capacity)**	**Jacqui Tufnell**	Meeting with Jacqui Tufnell 29.11.16 - Reworded and included on risk register	RR3
080	**Reduction in resources through introduction of Better Care Fund**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Closed and replaced with a new risk	RR10
027	**Failure to improve Child and Adolescent Mental Health Services (CAMHS)**	**Nigel Parkes**	Meeting with Nigel Parkes 14.02.17 - Reworded and included on risk register	RR19
029	**Failure to deliver affordable prescribing trajectories**	**Ian Atkinson** Stuart Lakin	Meeting with Ian Atkinson 28.11.16 - Reworded and included on issues log	IL3 & GBAF Objective 2
005	**Insufficient funds to finance objectives on a recurrent basis**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Reworded and included on risk register	RR11
101	**Delivery of the CAMHS Local Transformation Plan (LTP)**	**Nigel Parkes**	Meeting with Nigel Parkes 14.02.17 - Closed	N/A
003	**Quality of Commissioned Services** **AF 09 now incorporates AF05**	**Sue Cassin** Sarah Lever Kate Tufnell J Tufnell Alun Windle Dawn Anderson	Included on risk register	RR23 & GBAF Objective 1
095	**CQC inspection of GP practices leading to less than 'good' rating**	**S Cassin** J Tufnell	Reworded and included on risk register	RR6 & GBAF Objective 1
053	**Reduced workforce capacity and capability to deliver projects and QIPP**	**Ian Atkinson**	Meeting with Ian Atkinson 28.11.16 - Closed	N/A
004	**Overspend due to high costs of individual patients of continuing care**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Reworded and included on risk register	RR12
083	**Child Sexual Exploitation (CSE) - RMBC may not be able to effectively work with NHSR CCG to deliver the partnership agenda as there resources will be targeted to dealing with CSE.**	**Chris Edwards**	Meeting with Chris Edwards 31.01.17 - Reworded and included on risk register	RR17
100	**Patient safety and financial implication of a**	**Ian Atkinson**	Meeting with Ian Atkinson 28.11.16 -	N/A

Ref	Principle Risk	Lead person	Action	Reference (Risk Register / Issues Log / GBAF)
	complex patient transferred from NHS England Commissioning responsibility in November 2015	Kate Tufnell	Closed	
091	**Financial risk to the CCG arising from it's duties under developing case law regarding potential Deprivation of Liberties (DoLS)**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Included on issues Log	IL6 & GBAF Objectives 3
072	**Impact of NHS 111 on the local health community. Specifically potential for increase in number of patients being referred to A&E / 999** ***note that the elements of the risk scored through are now mitigated***	**Claire Smith**	Meeting with Claire Smith 02.02.17 - Included on Risk register	RR18
089	**Failure to deliver against the Public Health Memorandum of Understanding**	**Ruth Nutbrown**	Closed	N/A
078	**NHS England unable to locate CAMHS Tier 4 Bed. As a result RDaSH are placing under 18's with Rotherham's Adult beds - Risk Children in adult beds. Adult beds occupied (currently CCG not charging) could result in CCG having to fund out of area bed for Adult. (Emergency Issue)**	**Kate Tufnell** Nigel Parkes	Meeting with KateTufnell 14.02.17 - Included on issues log	IL8 & GBAF Objectives1
076	**Financial pressure due to rebasing of ambulance costs across Y&H**	**Keely Firth**	Meeting with Keely Firth 05.01.17 - Reworded and included on risk register	RR13
075	**Payment approaches for Mental Health for Older People & Adults (Potential increase in costs for services to the CCG due to transfer from block contract to a PbR type mechanism)**	**Ian Atkinson** Nigel Parkes	Meeting with Ian Atkinson 28.11.16 - Closed	N/A
092	**Impact of PMS/MPIG changes on the stability of practices**	**Jacqui Tufnell**	Meeting with Jacqui Tufnell 29.11.16 - Reworded and included on risk register	RR4
106	**Failure to effectively adhere to the revised statutory Conflict of Interest Guidance for CCG's ` which could lead to confidence in the probity of commissioning decisions and the integrity of officers and others to be seriously undermined.**	**Ruth Nutbrown** John Barber	Closed	N/A
054	**Failure of CCG IT Systems**	**Ian Atkinson** Andrew Clayton	Meeting with Ian Atkinson 28.11.16 - Closed	N/A

Appendix 2

GP Development Session

Risk Appetite

1st March 2017

Introduction by Ruth Nutbrown, including a definition of Risk Appetite. The Risk Matrix currently describes RCCGs Risk Appetite at 11 i.e. Medium = **Minimal** Preference for ultra-safe options that are low risk and only have potential for limited reward. The members were asked to consider if this overall score is correct. Each of the CCG's objectives were introduced as follows:

Objective 1
Quality – improving safety, patient experience and outcomes and reducing variations…was introduced to the floor with examples taken from the current Risk Register. Discussion ensued which was followed by a Chief Officer proposal to change the current 11 to 12, this was agreed by members.

A score of 12 = **HIGH** **Cautious -** Preference for safe options that have a low degree of risk and may only have limited potential for reward.

Objective 2
Delivery – leading system wide efficiency programmes that consistently achieve measureable improvements whilst meeting our financial targets...was introduced to the floor with examples taken from the current Risk Register and issues log. Discussion took place. It was proposed and agreed that this objective be raised to 15.

A score of 15 = **HIGH** **Cautious** - Preference for safe options that have a low degree of risk and may only have limited potential for reward

Objective 3
Assurance – having robust internal constitutional and governance arrangements, ensuring that provider services are safe and ensuring vulnerable people have effective safeguarding… was introduced with explanation that this was in essence three separate objectives which in the future would perhaps be separated. It was further explained that the third element of this objective also appears as a standalone in objective 4. Discussion took place and it was agreed that the risk appetite of 11 should remain.

A score of 11 = **MEDIUM** = **Minimal -** Preference for ultra-safe options that are low risk and only have potential for limited reward.

Objective 4
Safeguarding – ensuring all children and vulnerable adults are protected from harm, including implementing all actions on Child Sexual Exploitation from the Jay and Casey report…Discussion ensued and it was decided that this objective be rescored as 10.

A score of 10 = **MEDIUM** - **Minimal** Preference for ultra-safe options that are low risk and only have potential for limited reward.

The Chief Officer suggested that the current position be reviewed in 6 months' time and that we should compare ourselves with other CCGs.

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NHS
Rotherham
Clinical Commissioning Group

Title:	**Rotherham CCG – Integrated Risk Management Framework – Policy & Procedure**
Reference No:	007/Corporate
Owner:	Operational Executive
Author:	Ruth Nutbrown, Assistant Chief Officer
First Issued On:	June 2012 v1.0 (as a CCG Policy)
Latest Issue Date:	June 2012 v1.0
Operational Date:	1 July 2012 v1.0
Date Reviewed:	September 2013 v1.1
Date Reviewed:	January 2015 v2.1
Date Reviewed:	February 2017 V2
Review Date	January 2020
Consultation Process:	
Ratified and Approved by:	
Distribution:	All staff and GP members of the CCG. All other staff working at Oak House for the CCG (CSU staff).
Compliance:	Mandatory for all permanent & temporary employees of Rotherham CCG.
Equality & Diversity Statement:	An Equality Impact Assessment has been completed and the policy has been assessed as having no negative impact

C o n t e n t s

Definitions

Assurance: Confidence, based on sufficient robust evidence, that internal controls are in place, operating effectively and objectives are being achieved e.g. internal and external audits and reviews.

Clinical Risk: Identified and managed in accordance with HSC1999/065 'Clinical Governance in the new NHS'. Clinical risk can be defined as direct risks relating to the care of the patient and the standards of care received on the patients' journey. Issues that can have an impact on the standard of clinical care received include patient safety, safeguarding, consent issues, patient research studies, infection prevention & control, medicines management, clinical audit, and ensuring that there are sufficient staffing levels and that these staff are appropriately trained.

Control: The measures and systems which are in place to control a risk and reduce its likelihood of occurring. Controls can be preventative, detective or directive. Effective control provides a reasonable assurance that the organisation will achieve its objectives reliably, and enables it to respond to significant operational, financial and compliance risks.

Environmental Risk is defined as risks associated with organisational actions which may have an impact upon the environment.

Financial Risk is managed in accordance with the codes of Resource Accounting and Budgeting, supported by Standing Orders, Standing Financial Instructions and appropriate risk management plans. Financial risk can be defined as risks that will threaten the effective financial controls, including the systems to maintain proper accounting records. It is important that the organisation is not exposed to avoidable financial risk and that financial information used within NHS Rotherham CCG and for external publication is reliable.

Governing Body Assurance Framework: A structure/document within which the Governing Body identify the risks to the organisation meeting its strategic objectives and map out both the key controls in place to manage them, how they have gained sufficient assurance about their effectiveness and identify any gaps in controls or assurances.

Hazard: A potential source of risk e.g. damage or harm

Information Risk is inherent in all activities and an information risk assurance process is set out as a requirement of the Information Governance Toolkit. Information risk management seeks to identify and control information risks in relation to business processes and functions and is led by the Senior Information Risk Owner (SIRO).

Integrated risk management: A process through which organisations identify, assess, analyse and manage all risks and incidents for every level of the organisation and aggregate the results at a corporate level e.g. patient safety, health and safety, complaints, litigation and other risks

Issue: is a present problem or concern affecting the organisation. A risk can become an issue, but an issue is not risk – it is already happening. There is a separate Issues Log which the CCG uses to manage issues.

Operational Risk is defined as risks which affect the achievement of local objectives. Operational risks are captured on the organisation's Risk Register.

Organisational / Corporate Risk is defined as risks relating to the business of the organisation such as communication, provision of goods and services, data protection, information systems, human resources, and risks that threaten the achievement of the organisation's objectives. It also includes risks relating to the delivery of the organisation's delivery plans and efficiency programme.

Reputational Risk is defined as risks which affect public and stakeholder perception of the organisation.

Risk: The combination of likelihood and consequence of hazards being realised, resulting in some form of loss or damage. The possibility that objectives will not be achieved.

Risk Analysis: The systematic use of information to identify hazards and to estimate risk

Risk Appetite: The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives.

Risk assessment: A process of identifying the hazards in a workplace or system so as to effectively eliminate or adequately control the risks.

Risk Management: A process that enables organisations to identify, analyse, control and monitor risks. By doing this we can protect our patients, visitors, contractors and employees.

Risk Matrix (Risk evaluation/scoring system): Tool used to help estimate Likelihood x Consequence resulting in an overall risk score.

Strategic Objective: An overall goal of the organisation

System of Internal Control: A system, maintained by the Governing Body, that supports the achievement of the organisation's objectives. This should be based on an on-going risk management process that is designed to identify the risks to the organisation's strategic objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically

Strategic Risk is defined as risks which affect the achievement of the organisation's strategic objectives. Strategic risks are captured on the organisation's Assurance Framework.

1 Introduction

1.1 NHS Rotherham Clinical Commissioning Group (CCG) has a responsibility to ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance. Every activity that the CCG undertakes or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the organisation achieving its objectives.

1.2 This Integrated Risk Management Framework (policy and procedure) provides the framework that enables the organisation to have a clear view of the risks affecting each area of its activity; that may prevent it from achieving its objectives, and how those risks are being managed. This document sets out the framework for the identification and management of risk within the CCG.

1.3 This policy is intended for use by all directly employed and agency staff and contractors engaged on CCG business in respect of any aspect of that work, including clinicians and others paid by the CCG, whether employed or otherwise funded, directly employed staff, and staff managed by the Commissioning Support Unit.

2 Policy Statement, Aims & Objectives

2.1 The CCG Governing Body recognises that robust risk management and assurance is an integral part of its governance responsibilities and is committed to the management of risk throughout all its activities.

2.2 The Governing Body is committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate programme, and that responsibility for implementation is accepted at all levels of the organisation.

2.3 The purpose of this Integrated Risk Management Framework is:

- To encourage a culture where risk management is viewed by the CCG and staff, including the Strategic Clinical Executive, as an essential process of the CCG's activity.
- To ensure structures and processes are in place to support the assessment and management of risks throughout the CCG.
- To assure the public, patients and their carers and representatives, staff and partner organisations that the CCG is committed to managing risk appropriately.

2.4 The Governing Body aims to take all reasonable steps in the management of risk with the overall objective of protecting patients, staff, and publically funded resources and assets by recognising, preparing for or avoiding events or inactions, which could have a negative impact; making the organisation more effective and meeting national objectives and the local corporate, clinical and financial governance core objectives.

2.5 The aim of this policy is to ensure that all significant risks associated with the business of NHS Rotherham CCG are identified, assessed, evaluated, recorded, reviewed, managed appropriately and effectively and reduced to the minimum practicable level. In order to achieve this, it is necessary to:

- Define a coordinated approach for the management of risk across all its activities.
- Satisfy all statutory and mandatory duties.
- Promote safe working practices aimed at the reduction or elimination of risk, as far as is reasonably practicable.
- Raise awareness of risk and its management through a programme of communication, education and training.

2.6 The Governing Body's objectives for managing information risk are to:

- Protect the CCG, its staff and its patients from information risks where the likelihood of occurrence and the consequences are significant. See appendix A.
- Provide a consistent risk management framework in which information risks will be identified, considered and addressed in key approval, review and control processes
- Encourage pro-active rather than re-active risk management
- Provide assistance to and improve the quality of decision making throughout the CCG
- Meet legal or statutory requirements
- Assist in safeguarding the CCG's information assets.

3 Accountabilities & Responsibilities for Risk Management

3.1 NHS Rotherham CCG Governing Body

3.1.1 The Governing Body is accountable for the performance management of NHS Rotherham CCG's Integrated Risk Management Framework Policy & Procedure and systems of clinical, financial and organisational control, and oversees the overall system of risk management and assurance to satisfy itself that NHS Rotherham CCG is fulfilling its organisational responsibilities and public accountability.

3.1.2 The Governing Body uses the risk management processes outlined in this policy as a means to help it achieve its goals and provides a clear commitment and direction for Risk Management within NHS Rotherham CCG.

3.1.3 The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces, and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:

- Identifies risks to the achievement of its strategic objectives
- Monitors these on an ongoing basis via the Governing Body Assurance Framework
- Ensures that there is a structure in place for the effective management of risk throughout the CCG
- Receives assurance regarding risk management within organisations providing services commissioned by the CCG
- Approves and reviews strategies for risk management on a biannual basis
- Receives the minutes of the Audit and Quality Assurance Committee, and any items that have been identified for escalation to the Governing Body
- Receives the Risk Register and Assurance Framework twice a year, assures itself of progress on mitigating actions and assurance regarding the significant risks identified in relation to commissioned services
- Demonstrates leadership, active involvement and support for risk management.

3.1.4 Risks are also considered at other Committees of the Governing Body relevant to their areas of delegated responsibility.

3.2 Audit & Quality Assurance Committee

3.2.1 The Audit and Quality Assurance Committee is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical including information and financial risk) to support the achievement of the organisation's objectives and to escalate significant strategic risks as appropriate, to the CCG Governing Body.

3.2.2 Responsible for agreeing and monitoring the Internal Audit work plan and seeking assurance to ensure development of the Annual Governance Statement.

3.2.3 In particular the group will review the adequacy of:

- All risk and control-related disclosure statements, including the Annual Governance statement, together with any accompanying head of internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Governing Body.
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and self-certification
- the policies and procedures for all work related to fraud and corruption as required by NHS Protect.

3.3 The Strategic Clinical Executive and GP Members Committee

3.3.1 The eight GP members of the Strategic Clinical Executive and members of the GP members Committee promote risk management processes, as part of clinical governance, with all Rotherham CCG member practices. This ensures that practices continuously improve and report risks relating to commissioned services to the CCG, and risks relating to primary care to NHS England to ensure that risks are identified and managed.

3.4 The Chief Officer

3.4.1 The Chief Officer is the Accountable Officer and has overall accountability for the management of risk and is accountable/responsible for:

- Establishing and maintaining an effective risk management system within NHS Rotherham CCG, for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance.
- Ensuring a sound system of internal control is maintained that supports the achievements of the organisation's aims and objectives,
- Continually promoting risk management and demonstrating leadership, involvement and support
- Ensuring an appropriate committee structure is in place, with regular reports to the CCG Governing Body
- Ensuring that the operational executive, strategic clinical executive and senior managers are appointed with managerial responsibility for risk management
- Ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG
- Ensuring complaints, claims and health and safety management are managed appropriately.

These responsibilities are delegated to the following individuals:

3.5 Deputy Chief Officer

3.5.1 The Deputy Chief Officer is the executive lead for risk management and has delegated this responsibility to the Assistant Chief Officer – these responsibilities include:

- Ensuring risk management systems are in place throughout the CCG
- Ensuring the Assurance Framework is regularly reviewed and updated and reported to the Audit and Quality Assurance Committee and the CCG Governing Body
- Ensuring that an organisational risk register is established, maintained and reported to the Audit and Quality Assurance Committee

- Ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the CCG Governing Body
- Overseeing the management of risks as determined by the Executive Team
- Ensuring that identified risk mitigation and actions are put in place, regularly monitored and implemented.

3.5.2 The Deputy Chief Officer is the Senior Information Risk Owner (SIRO) for NHS Rotherham CCG with responsibility for information risk management. The SIRO is the focus for the management of information risk at Governing Body level.

3.5.2.1 The role of SIRO requires the nominated lead to:

- Lead and foster a culture that values, protects and uses information for the public good.
- Own the overall information risk policy and risk assessment process, test its outcome, and ensure it is used.
- Advise the Accountable Officer on the information risk aspects of the Annual Governance Statement.
- Understand how the strategic business goals of NHS Rotherham CCG may be impacted by information risks.
- Act as an advocate for information risk, providing a focal point for the resolution and / or discussion of information risks.
- Ensure that information security threats are followed up and incidents managed through appropriate action plans.
- Provide up-to-date information to the Accountable Officer and Governing Body on information risks.

3.6 Chief Finance Officer

3.6.1 The Chief Finance Officer has delegated responsibility for financial risk management and financial governance including those relating to efficiency programmes and the maintenance of key financial controls.

3.7 Chief Nurse

3.7.1 The Chief Nurse has delegated responsibility for managing the development and implementation of clinical risk management, clinical governance and patient safety including:

- The executive lead responsible for safeguarding adults, safeguarding children and Infection, Prevention and Control
- Managing and overseeing the performance management of serious incidents reported by the Rotherham NHS Foundation Trust and Rotherham, Doncater and South Humber NHS Trust as per delegated responsibility by NHS England.
- Ensuring that processes are in place to provide assurance with regard to clinical risk management within commissioned services, this includes (but not exclusively), patient safety regarding commissioned services in line with local and national legislation and guidance
- Collating intelligence from the Strategic Clinical Executive GPs with responsibility for quality of primary care, secondary care and mental health services.

3.7.2 The Chief Nurse is also the Caldicott Guardian. The Caldicott Guardian is an advisory role, and is the conscience of the organisation, providing a focal point for patient confidentiality & information sharing issues and is concerned with the management of patient information.

3.8 Head of Health Informatics

3.8.1 The Head of Health Informatics has delegated responsibility for the development and implementation of Information Technology risk management.

3.9 Assistant Chief Officer

3.9.1 Responsibilities include:

- Ensuring that systems are maintained to manage health, safety & security risk effectively.
- Being the Nominated Competent Person for all Health, Safety & Security issues.
- Providing expert advice and training on risk, health and safety and security.
- Ensuring health and safety, fire and security incidents are investigated appropriately and trends identified.
- Liaising with the Health and Safety Executive and other external organisations e.g. South Yorkshire Fire & Rescue Service.
- Ensuring that notification to external agencies regarding serious incidents takes place (e.g. RIDDOR).
- Providing update reports on health & safety, fire safety and security risk.

3.10 Clinical Chair of CCG Governing Body, Vice Chair of CCG Governing Body, GPs with lead responsibility for Primary Care Quality, Secondary Care, Mental Health Quality, Children's and Adult Safeguarding

3.10.1 The individuals identified above have responsibility for identifying risks in their specific areas and discussing these with the Chief Nurse to ensure that assessment and mitigation is carried out providing assurance to the CCG Governing Body via the Audit and Quality Assurance Committee.

3.11 Project Support Officer

3.11.1 The Project Support Officer has responsibility for:

- Ensuring that an organisational Risk Register and a Governing Body Assurance Framework are developed and maintained and reviewed by the Executive Team
- Ensuring that risks are reviewed on a quarterly basis by the senior managers designated as risk holders
- Ensuring that the Operational Executive have the opportunity to review risks regularly
- Providing advice on the risk management process
- Ensuring that the CCG Assurance Framework and Risk Register are up to date for the CCG Governing Body and Audit and Quality Assurance Committee
- Working collaboratively with Internal Audit
- Ensuring that the Integrated Risk Management Policy is updated on a three yearly basis and approved by the CCG Governing Body.

3.12 All Senior and Line Managers

3.12.1 Senior and Line Managers are responsible for incorporating risk management within all aspects of their work and for directing the implementation of the CCG Integrated Risk Management Policy by:

- Demonstrating personal involvement and support for the promotion of risk management
- Ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility and are included in the organisational risk register as appropriate
- Setting personal objectives for risk management and monitoring their achievement
- Identifying and monitoring risks associated with their working practices and their areas of responsibility.

- Ensuring that risk assessments are undertaken throughout their area of responsibility on a proactive basis.
- Implementing and monitoring appropriate risk control measures within their designated areas. Where implementation or risk control measures is beyond the authority or resources available to the manager this should be brought to the attention of their line manager or the Corporate Governance Manager or Assistant Chief Officer.
- Ensuring risks are escalated where they are of a strategic nature
- Implementing the framework in relation to Health & Safety and other employment legislation by:
  a) Ensuring that they have adequate knowledge and/or access to all legislation relevant to their area and as advised by appropriate specialist officers ensure that compliance to such legislation is maintained
  b) Ensuring that adequate resources are made available to provide safe systems of work
  c) Ensuring that all employees attend appropriate mandatory training, as relevant to the role, e.g. Health & Safety, Fire, Moving and Handling and risk management training
  d) Ensuring that all staff are aware of the system for the reporting of accidents and near misses
  e) Monitoring of health and safety standards, including risk assessments, and ensuring that these are reviewed and updated regularly
  f) Ensuring the identification of all employees who require Health Surveillance according to risk assessments; ensuring that where Health surveillance is required no individual carries out those specific duties until they have attended the Occupational Health Department and have been passed fit
  g) Ensuring that the arrangements for the first-aiders and first aid equipment required within the organisation are complied with. That the location of first aid facilities are known to employees; ensuring that proper care is taken of casualties and that employees know where to obtain appropriate assistance in the event of serious injury
  h) Making adequate provision to ensure that fire and other emergencies are appropriately dealt with.

3.13 All Staff

3.13.1 All staff working for the CCG are responsible for:

- Being aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by the CCG's business and to comply with appropriate CCG rules, regulations, instructions, policies, procedures and guidelines
- Taking action to protect themselves and others from risks
- Identifying and reporting risks to their line manager
- Ensuring incidents, claims and complaints are reported using the appropriate procedures and channels of communication
- Co-operating with others in the management of the CCG's risks
- Attending mandatory and statutory training as determined by the CCG or their Line Manager
- Being aware of emergency procedures relating to their particular locations
- Being aware of the CCG's Integrated Risk Management Policy and complying with the procedures.

3.14 Contractors, Agency and Locum Staff

3.14.1 Managers must ensure that where they are employing or contracting agency and locum staff they are made aware of and adhere to, all relevant policies, procedures and guidance of the CCG, including the CCG Incident reporting policy and procedure and the Health and Safety Policy they must also:

- Take action to protect themselves and others from risks

- Bring to the attention of others the nature of risks which they are facing in order to ensure that they are taking appropriate protective action.

4 Risk Management Framework

4.1 The CCG will put in place a framework to support the management of risk. This policy outlines this framework which includes:

4.2 Governing Body Assurance Framework

4.2.1 The CCG will establish, populate and maintain an Assurance Framework that identifies the strategic objectives of the CCG and the risks that could threaten their achievement, and is reported on a regular basis to the executive team, Audit and Quality Assurance Committee and CCG Governing Body via the Corporate Assurance Report.

4.2.2 NHS Rotherham Strategic Objectives are:

Quality *- improving safety, patient experience and outcomes and reducing variations*

Delivery *– leading system wide efficiency programmes that consistently achieve measurable Improvements whilst meeting our financial targets*

Assurance *- having robust internal constitutional and governance arrangements, ensuring that providers' services are safe and ensuring vulnerable people have effective safeguarding*

Safeguarding *– ensuring all children and vulnerable adults are protected from harm, including implementing all actions on Child Sexual Exploitation from the Jay and Casey reports.*

4.3 Risk Register

4.3.1 The CCG will establish, populate and maintain an organisation Risk Register that profiles all operational risks relating to the business planning and delivery of services and is reported on a regular basis to the executive team, Audit and Quality Assurance Committee and CCG Governing Body via the Corporate Assurance Report.

4.4 Issues Log

4.4.1 The CCG will establish, populate and maintain an organisation Issues Log that profiles all the current issues relating to the CCG and is reported on a regular basis to the executive team, Audit and Quality Assurance Committee and CCG Governing Body via the Corporate Assurance Report.

4.5 Corporate Assurance Report

4.4.1 The Corporate Assurance Report provides a framework which incorporate reports from individual areas within the organisation providing assurance and information on risks and possible escalation.

- A copy of the format of the organisational Risk Register is attached at appendix A
- A copy of the format of the Governing Body Assurance Framework is attached at appendix B
- A copy of the structure for risk management is attached at appendix C.

5 Open and Fair Culture

5.1 The CCG supports an open, fair and a positive learning culture. A culture of openness is central to improving patient safety and the quality of healthcare systems. Encouraging openness and honesty about how and why things have gone wrong will help improve the safety of NHS services.

5.2 However, disciplinary action may be appropriate to be considered in the following circumstances:

- Repeat occurrences of incidents involving the same individual
- Deliberate failure to report an incident
- Failure to co-operate fully in subsequent investigation.

5.3 All employees should be familiar with Rotherham CCG's whistle-blowing and bullying and harassment policies and procedures. These procedures support staff to raise concerns in accordance with the Public Interest Disclosure Act 1998.

6 Training and Support

6.1 To ensure the successful implementation and maintenance of this Integrated Risk Management Policy, Governing Body members and staff will have access to appropriate advice, guidance, information and training in order to carry out their respective responsibilities for risk control and risk assessment.

6.2 All staff will receive mandatory training annually in Health, Fire & Safety, including risk assessment and management and Information Governance, via the CCG's mandatory learning and development programme.

6.3 General awareness raising for staff is also undertaken through staff briefings, staff newsletters, induction programmes and inclusion of relevant documents on the Intranet. The Integrated Risk Management Policy is accessible to staff via Rotherham CCG's Intranet and on the public internet.

7 Consultation and Communication with Stakeholders

7.1 It is good practice to involve stakeholders, as appropriate, in all areas of Rotherham CCG's activities, and this includes informing and consulting on the management of any significant risks. Interested parties would include:

- Staff, NHS England, Patients and the Public within Rotherham CCG's area
- Local politicians and the Secretary of State for Health
- Rotherham Partnership
- Statutory and Voluntary agencies
- Local Authority Health Scrutiny Committee
- Primary Care Practices
- Patient and Public Involvement Forum/HealthWatch
- Health and Wellbeing Board.

7.2 A wide range of communication and consultation mechanisms already exist with relevant stakeholders, both internal and external. General public awareness raising of Rotherham CCG's Integrated Risk Management Policy will be achieved through its presentation at CCG Governing Body meetings, which are all open to the public, in the Annual Report, posting on Rotherham CCG's Website and through HealthWatch.

8 Monitoring the Effectiveness of this Policy

8.1 The CCG monitors and reviews its performance in relation to the management of risk, and the continuing suitability and effectiveness of the systems and processes in place to manage risk through a programme of internal and external audit work, and through the oversight of the CCG Governing Body, Executive Team and Audit and Quality Assurance Committee.

9 Review and Revision of the Policy

9.1 This Integrated Risk Management Policy is a working document and will be reviewed on a biannual basis, and in accordance with the following on an as and when required basis:

- Legislatives changes
- Good practice guidelines
- Case Law
- Significant incidents reported
- New vulnerabilities identified
- Changes to organisational infrastructure
- Changes in practice

10 Dissemination and Implementation

10.1 This document will be made available to all employees via the CCG intranet.

11 Equality and Diversity

11.1 The CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. All policies and procedures should be developed in line with the CCG's Equality and Diversity policies and need to take into account the diverse needs of the community that is served.

12 Associated CCG documentation

- Policy for the reporting and management of incidents and near misses including SIs and Never Events
- Complaints Policy
- Procedure for the Management of Claims
- Health and Safety Policy.

Integrated Risk Management Procedure

13 The Risk Management Process

13.1 Risk Management is a continuous process, ensuring NHS Rotherham CCG works within the legal and regulatory framework, identifying and assessing possible risks facing the organisation, and planning to prevent and respond to these. The process of risk management covers the following 5 steps to risk assessment:

14 Risk Identification

14.1.1 Step 1 in the "Five steps to Risk Assessment" (http://www.hse.gov.uk/risk/controlling-risks.htm) is to identify the risk. We cannot manage our risks effectively until we know what the risks are. Risk identification is therefore vital to the organisational success of the risk management process.

14.1.2 All staff within NHS Rotherham CCG may identify risks through the course of their work and their interaction with patients, the public, partner organisations and other key stakeholders.

14.1.3 Risk identification should take place on a continual basis but particularly where new activities are planned, new legislation or NHS policy requirements are identified, at the initiation of projects or where incidents or near misses have taken place. Committees of the Governing Body should consider any risks emerging from discussions within the meeting.

14.2 Methods for identifying and managing levels of risk would include:

14.2.1 Internal methods, such as; Incidents, complaints, claims and audits, project risks based on the achievement of project objectives, patient satisfaction surveys, risk assessments, surveys including staff surveys, whistle-blowing. Contract quality monitoring of commissioned services.

14.2.2 External methods, such as**;** Media, national reports, new legislation, NPSA surveys, reports from assessments/inspections by external bodies, reviews of partnership working.

14.2.3 All identified risks will be recorded and managed through the organisational Risk Register and risks identified which could impact on the achievement of the CCG's strategic objectives are recorded and managed through the Assurance Framework.

14.2.4 Risk identification is also obtained from member practices through practice visits, locality meetings, GP Members Committee meetings, patient engagement forums, practice feedback forums and practice managers meetings.

15 Assess the Risk

15.1 Step two in the Five steps to Risk Assessment is identifying the people who are at risk from each of the identified risks. The main categories of people who are affected by risks are:

- Employees

- Patients
- Visitors to the premises
- Contractors working on the premises
- "Others" which covers particularly vulnerable groups who may be more at risk than others, such as pregnant women or inexperienced staff.
- The corporate body e.g. through reputational risks.

16 Evaluation of Risk

16.1 Step 3 in the Five Steps to Risk Assessment is evaluating the risk. Employees are required to make suitable and sufficient assessments of significant risks that arise out of work activity so as to implement preventative and protective measures. All new activities/programmes/projects must have a formal risk assessment undertaken as part of the implementation of the activity/programme/project. Risk analysis is also required on the coversheet of all formal papers to the Governing Body and Committees.

16.2 In order to score risks systematically so that they can be classified and remedial action can be prioritised, it is necessary for all risks to be quantified using a standard methodology. The full risk assessment scoring methodology (risk matrix) for the CCG is shown in Appendix D and should be used for all risk assessments within the organisation. To use the tool it is necessary to identify the consequences and the likelihood of occurrence of harm from the risk. From this, the level of risk can be calculated as a score.

Consequence x Likelihood = Risk Score

16.3 The consequence score is derived from the most probable consequence of a particular risk occurring, and not from the worst imaginable and extremely improbable consequence of a particular risk occurring. Once set, it is unusual for the consequence score to change over time.

16.4 The likelihood score is derived from the likelihood of the risk occurring following the implementation of controls. Controls are measures which are in place to control the risk and reduce its likelihood of occurring. Controls can be:

- Preventative (controls which stop the risk occurring e.g. access controls, financial authorisation levels).
- Detective (controls which identify if the risk is threatening to occur e.g. performance monitoring reports).
- Directive (controls such as instructions or guidance which aim to reduce the likelihood of the risk occurring e.g. policies, training).

16.5 When scoring risks, an "uncontrolled risk score" is the score if there were no controls in place. This helps the CCG to prioritise risks. The "actual risk score" is the risk score with the current controls in place.

16.6 This allows construction of a risk matrix which can be used as the basis of identifying acceptable and unacceptable risk as discussed below.

17 Risk Appetite and unacceptable risk

17.1 The UK Corporate Governance Code states that "*the board is responsible for determining the nature and extent of the significant risk it is willing to take in achieving its strategic objectives*"

17.2 Risk Appetite is defined as: "*The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives*". The lower the risk appetite the more the CCG is willing to accept in terms of risk and tolerate in its efforts to achieve its strategic objectives.

17.3 The CCG understands there is a balance to be struck between risk and reward and recognises that as a Commissioner there are sometimes constraints that limit the control measures that can be established to manage risks, particularly when CCG risks relate to third parties (i.e. provider organisations)

17.4 The CCG Risk appetite and levels of unacceptable risk will be developed by the Governing Body and reviewed in line with the review of the GBAF.

17.5 The current CCG risk appetite linked to the risk matrix is shown in the table below

Table 1 – NHS Rotherham CCG Risk Appetite

Ref	Strategic Objective	Risk Appetite
1	***Quality*** *- improving safety, patient experience and outcomes and reducing variations*	Currently 11 Will be developed during the GB development session March 2017
2	***Delivery*** *– leading system wide efficiency programmes that consistently achieve measurable Improvements whilst meeting our financial targets*	Currently 11 Will be developed during the GB development session March 2017
3	***Assurance*** *- having robust internal constitutional and governance arrangements, ensuring that providers' services are safe and ensuring vulnerable people have effective safeguarding*	Currently 11 Will be developed during the GB development session March 2017
4	***Safeguarding*** *– ensuring all children and vulnerable adults are protected from harm, including implementing all actions on Child Sexual Exploitation from the Jay and Casey reports.*	Currently 11 Will be developed during the GB development session March 2017

Table 2 – NHS Rotherham CCG Risk Matrix

Risk Matrix		Likelihood				
		(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost certain
Consequence	(1) Negligible	1	2	3	4	5
	(2) Minor	2	4	6	8	10
	(3) Moderate	3	6	9	12	15
	(4) Major	4	8	12	16	20
	(5) Extreme	5	10	15	20	25

Table 3 – Risk Appetite

Risk Score	Risk Descriptor	Risk Appetite Statement
1-5	Low	**Averse** Avoidance of risk and uncertainty is a key organization objective.
6-11	Medium	**Minimal** Preference for ultra-safe options that are low risk and only have a potential for limited reward.
12-15	High	**Cautious** Preference for safe options that have a low degree of risk and may only have limited potential for reward.
16-20	Very High	**Open** Willing to consider all potential options and choose the one

		most likely to result in successful delivery, while also providing an acceptable level of reward and value for money.
25	**Extreme**	**Hungry** Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.

17.6 NHS Rotherham CCG regards any risk with a score of 11 or below to be an acceptable level of risk for toleration by the organisation. This does not preclude actions being taken to further mitigate risks to the lowest practicable level.

18 Risk Assurance/Control

18.1 In risk management terms, "assurances" are those measures which are in place to check that the key controls for the risk are operating effectively e.g. reports, audits. Assurances can be broken down into:

- Internal assurances such as internal reports.
- External assurances such as the independent External and Internal Audit Reports.
- Positive assurances: validated proof that the assurances are working and the risk is controlled.

18.2 Gaps in control or assurance are those that, if addressed, would reduce the risk score. Once scored and gaps identified, risks can be:

- **Treated** (via an action plan). In many cases action can be taken to change the way in which activities are carried out in order to reduce the risk identified. All risks scored as 12 or over must be treated. See also the risk hierarchy below.
- **Tolerated**: Low and medium risks can be accepted as requiring no further action. On reviewing this type of risk, it may however be decided that some further cost effective action would reduce the risk score still further. Action on this level of risk is a lower priority.
- **Transferred** (e.g. to another organisation). NHS Rotherham CCG is a member of the Liabilities to Third Parties (LTPS), Property Expenses Scheme (PES) and Clinical Negligence Scheme for Trusts (CNST) risk pooling schemes run by the NHS Litigation Authority (NHSLA). This membership transfers some financial risk to these risk pooling schemes. Not all risks are suitable for risk transfer.
- **Terminated.** It may be decided that a particular risk should be avoided altogether. This may involve ceasing the activity giving rise to the risk.

18.3 Risk treatment generally follows the following sequence (called the "Hierarchy of Controls"), starting at the top and working down the hierarchy.

- Can the risk be **eliminated** entirely? E.g. remove and condemn a piece of equipment that keeps shorting out and poses the risk of electric shock.
- Can we make a **substitution**, substituting one item for another that is less harmful? E.g. for example substituting a detergent for a corrosive cream cleaner.
- Can we put in place **physical or mechanical engineering controls** such as guards, barriers and isolation.
- Can we put in place **administrative controls** such as supervision or training, information and induction, policies, protocols and safe systems of work to ensure that people working with risks are suitable informed and trained and know what to do if something goes wrong.
- Finally, can we use **personal protective equipment** (PPE) such as gloves, aprons and masks.

18.4 Where risk treatment plans require significant additional funding above that available within individual budgets or within NHS Rotherham CCG contingencies under the delegated

authority of the Chief Finance Officer, or changes to the working patterns of NHS Rotherham CCG, these decisions will be made by the Governing Body.

18.5 Risk assessments are carried out for a variety of activities, however, additional risk assessments must be carried out by Line Managers or other corporate persons in accordance with the following:

- Health and Safety
- Control of Substances Hazardous to Health (COSHH)
- Display Screen Equipment
- Moving & Handling
- Work Equipment
- Personal Safety
- Fire Safety
- Pregnancy & Maternity

18.6 Line Managers are responsible for implementing and monitoring any identified appropriate risk control measures within their designated areas. Where implementation or risk control measures are beyond the authority or resources available to the line manager, this should be brought to the attention of the Health & Safety Lead or Corporate Governance Manager as appropriate. Clinical risks including patient safety and safeguarding risks must be notified to the Chief Nurse (or equivalent).

19 Record the risk

All risk assessments must be recorded on NHS Rotherham CCG's approved risk assessment templates as detailed below.

Assurance Framework	The Assurance Framework is used for recording strategic risks (i.e. risks affecting achievement of the CCG's strategic objectives). The Assurance Framework is coordinated by the Project Support Officer, to whom risks should be reported. The Assurance Framework will be regularly reviewed and updated (at least quarterly) by the Assistant Chief Officer/Project Support Officer in liaison with Leads identified on the Framework and updates reported quarterly to the Governing Body. The Framework will also be regularly reported to and reviewed by the Audit and Quality Assurance Committee. The Assurance Framework template is shown at Appendix B.
Risk Register	The Risk Register is used for recording operational directorate-level risks (risks which underpin strategic Assurance Framework risks). The Risk Register is coordinated by the Project Support Officer, to whom risks should be reported. The Risk Register will be regularly reviewed and updated (at least quarterly) by the Project Support Officer/Assistant Chief Officer in liaison with Leads identified on the Register and updates reported quarterly via the Corporate Assurance Report to the Governing Body. The Register will also be reported to and reviewed by the Audit and Quality Assurance Committee on an annual basis. The Risk Register template is shown at Appendix A.

Generic risk assessments	Generic risk assessments can be undertaken for areas where none of the other risk templates apply e.g. specific public engagement events. Risks arising out of generic risk assessments should be reported appropriately to the Assistant Chief Officer, Corporate Services Manager, Project Lead or Health & Safety Lead dependant on the nature and severity of the risk. The generic risk assessment template is shown at Appendix E.
Specific risk assessments	There are a range of specific risks assessments which may be required. This is not an exclusive list – see individual procedural documents for further details and reporting arrangements. • Health and Safety • Control of Substances Hazardous to Health (COSHH) • Display Screen Equipment • Moving & Handling • Work Equipment • Personal Safety • Fire Safety • Pregnancy & Maternity

20 Review the risk

20.1 All risk assessments should be reviewed on a regular basis or when activities change.

20.2 The nominated lead as detailed in Step 4 is responsible for updating any changes to the risk assessment (whether on the Assurance Framework or Risk Register) and ensuring that actions are implemented. Identified risks will be reviewed on the following basis:

Score	Category	Review frequency
1-5	**Low**	Annually
6-11	**Medium**	6-monthly
12-15	**High**	Quarterly
16-20	**Very High**	Monthly
25	**Extreme**	Monthly

20.3 The assurance process is the process which NHS Rotherham CCG is required to undertake to ensure a sound system of internal control is maintained which supports the achievement of the organisation's policies and objectives. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

20.4 NHS Rotherham CCG is committed to establishing and maintaining assurance processes to ensure an adequate level of assurance is provided which will enable the Accountable Officer (Chief Officer) to sign the Annual Governance Statement. NHS Rotherham CCG will ensure there is Governing Body approved Assurance Framework which:

- Covers all of NHS Rotherham CCG's main activities.
- Identifies which objectives NHS Rotherham CCG is aiming to achieve.
- Identifies the risks to the achievement of those objectives.
- Evaluates and assesses those risks and records them appropriately.
- Identifies and examines the system of internal control in place to manage the risks.
- Identifies and examines the review and assurance mechanisms which relate to the effectiveness of the system of internal control.
- Records the actions taken by NHS Rotherham CCG to address gaps in control and assurance.

21. Information Risk Management

21.1 The principles of information security require that all reasonable care is taken to prevent inappropriate access, modification or manipulation of data from taking place. In the case of the NHS, the most sensitive of our data is patient record information. In practice, this is applied through three cornerstones - confidentiality, integrity and availability.

- Information must be secured against unauthorised access – confidentiality.
- Information must be safeguarded against unauthorised modification – integrity.
- Information must be accessible to authorised users at times when they require it – availability.

21.2 Information security risk is inherent in all administrative and business activities and everyone working for or on behalf of the organisation continuously manages information security risk. The aim of information security risk management is not to eliminate risk, but rather to provide the structural means to identify, prioritise and manage the risks involved in organisational activities. It requires a balance between the cost of managing and treating information security risks with the anticipated benefits that will be derived.

21.3 The Trust Information Risk Owner (SIRO) is responsible for coordinating the development and maintenance of information risk management policies, procedures and standards for the CCG.

21.4 CCG Information Asset Owners (IAOs) ensure that information risk assessments are performed regularly on all information assets where they have been assigned 'ownership', following guidance from the SIRO on assessment method, format, content, and frequency.

21.5 Information risk assessments should be performed on a regular basis for key information systems and critical information assets. Information Risk assessments must also be undertaken at the following times:

- At the inception of new systems, applications and facilities that may impact the assurance of NHS Rotherham CCG Information or Information Systems.
- Before enhancements, upgrades, and conversions associated with critical systems or applications.
- When NHS policy or legislation requires risk determination.
- When the NHS Rotherham CCG Management team / Governing Body requires it.

21.6 Information incident reporting will be in line with the organisation's Incident Management Policy. All very high and extreme information risks should be reported to and discussed with the Senior Information Risk Owner (SIRO) as soon as they are identified. The Senior Information Risk Owner (SIRO) will coordinate and monitor implementation of an annual Information Security Management and Assurance Plan.

22. Embedding Risk Management

22.1 The effective implementation of this Integrated Risk Management Framework, Policy & Procedure will facilitate the delivery of quality commissioning and, alongside staff training and support, will provide an improved awareness of the measures needed to prevent, control and contain risk.

22.2 NHS Rotherham CCG ensures stakeholders are involved in managing risks which impact on them by the following mechanisms:

- Communication, Engagement and Experience Strategy.
- Commissioning arrangements involving a wide range of partner NHS organisations.
- Joint commissioning arrangements with the local authority.
- Governing Body meetings held in public.
- Patient Experience data.
- Publication of the Integrated Risk Management Framework Strategy, Policy & Procedure with its key partners and the public through the NHS Rotherham CCG website.
- Meeting the public sector Equality Duties.

Appendix A: Risk Register Template

Ref	Entry date	Lead Person	Risk Description	Risk Cause	Risk Consequence	Risk rating			Assurance & Actions	Date reviewed
						L	C	T		

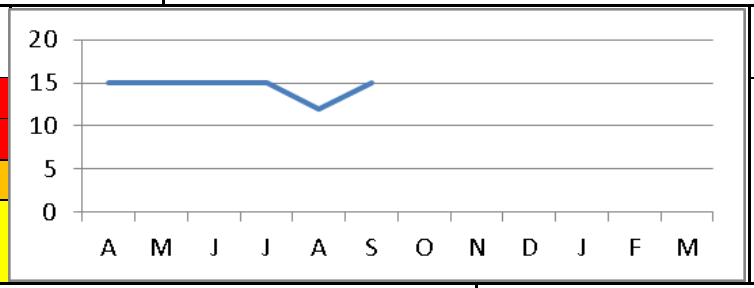
Appendix B:

Governing Body Assurance Framework (EXAMPLE)

Objective:	***NHSE Domains:***	*Committee providing assurance*
	Better Health	
	Better Care	*Executive lead(s)*
	Sustainability	
	Leadership	*Clinical / Lay Lead*

What are the key enablers / deliverables to support this objective?	**Principal threat(s) to delivery of the objective**

Risk rating	Likelihood	Consequence	**Total**
Initial			
Current			
Appetite			
Approach	**Treat**		



Date reviewed	
Rationale:	

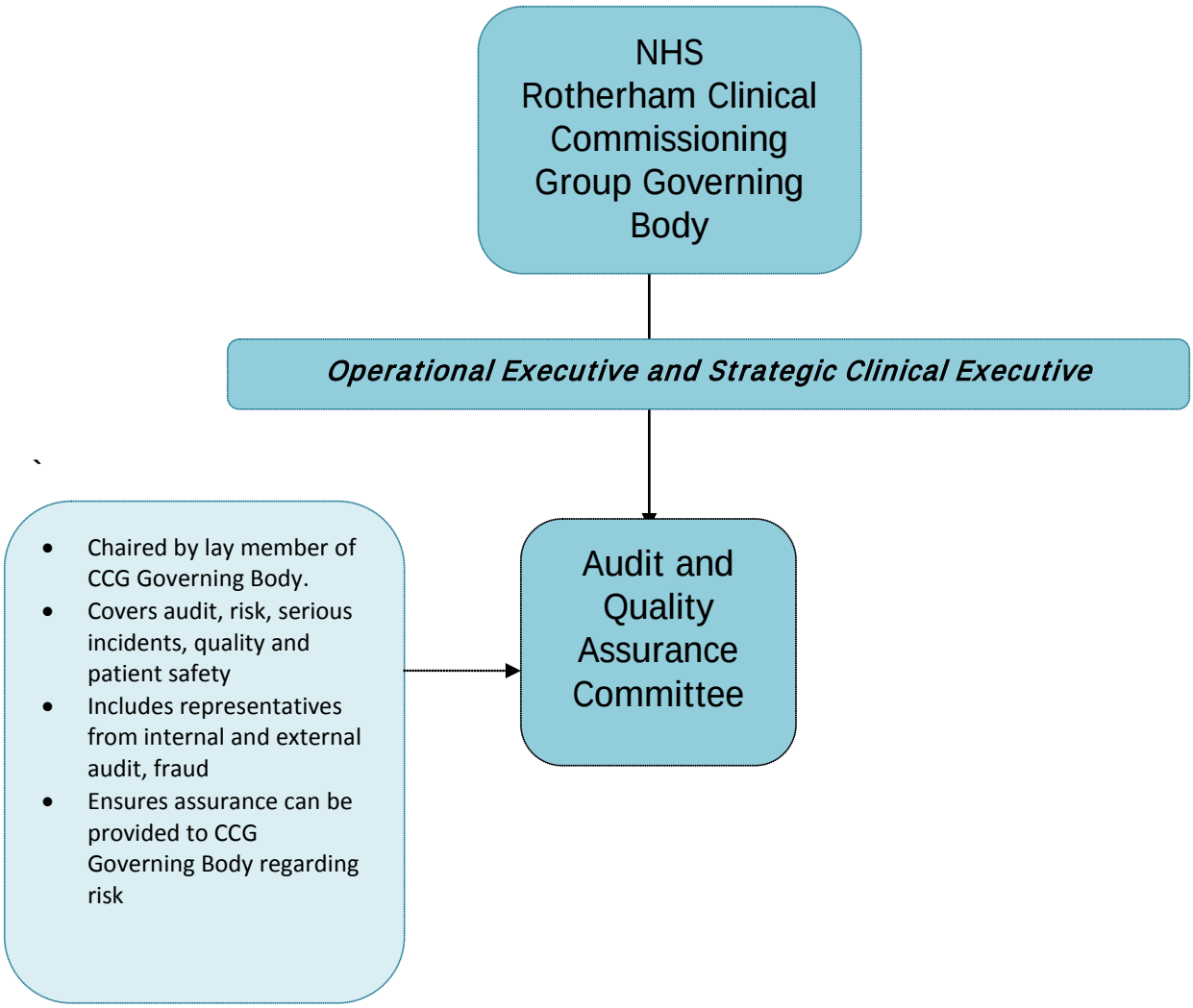
Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**

Gaps in control	**Positive assurances received**

Gaps in assurance	**Actions being taken to address gaps in control / assurance**

SCORE:	A	M	J	J	A	S	O	N	D	J	F	M
Likelihood												
Consequence												
Risk rating												
Tolerance												

Appendix C: Structure for Risk Management



Risk Scoring Matrix

Table 1 Consequence score (C)

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**
Patient and staff safety	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	Moderate injury requiring professional intervention Requiring time off work for 4-14 days. RIDDOR 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 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	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint 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 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	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	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	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	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

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**
			training	No staff attending mandatory/ key training	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	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	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 **Impact on environment**	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 Extreme impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

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.

	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
Probability **Percentage likelihood of occurrence**	**0-5%**	**6-20%**	**21-50%**	**51-80%**	**81-100%**

Table 3 Risk scoring = consequence x likelihood (C x L)

Calculate the risk score by multiplying the consequence score by the likelihood score.

Risk Matrix		**Likelihood**				
		(1) Rare	**(2) Unlikely**	**(3) Possible**	**(4) Likely**	**(5) Almost certain**
Consequence	**(1) Negligible**	**1**	**2**	**3**	**4**	**5**
	(2) Minor	**2**	**4**	**6**	**8**	**10**
	(3) Moderate	**3**	**6**	**9**	**12**	**15**
	(4) Major	**4**	**8**	**12**	**16**	**20**
	(5) Extreme	**5**	**10**	**15**	**20**	**25**

1-5	**Low**
6-11	**Medium**
12-15	**High**
16-20	**Very High**
25	**Extreme**

The CCG risk tolerance/appetite under which risks can be tolerated is a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances.

Appendix E Generic Risk Assessment Template

Risk Assessment

Area/Task: **Date:**

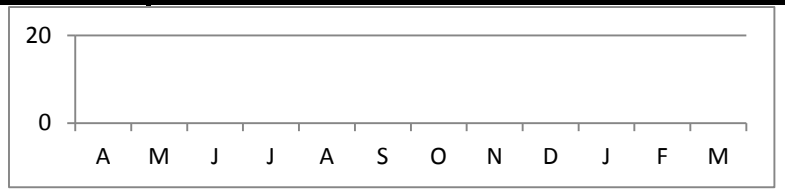
Persons Assessing the Risks: **Overall Score**

Ref No:	Activity/Task/Area	Hazard Identified	Likelihood 1 – 5	Consequence 1 – 5	Risk Rating	Controls in place (including PPE as a last resort)	Recommended Additional Controls	Post Risk Rating
Note: You should rate the risks on the basis of the current controls in place								
1.								
2.								
3.								
4								
5.								
6.								
7.								
8.								
9.								
10.								

Objective 1: Quality - improving safety, patient experience and outcomes and reducing variations	***NHSE Domains:***		*Committee providing assurance*	AQUA
	Better Health	✓		
	Better Care	✓	*Executive lead(s)*	SC/IA
	Sustainability			
	Leadership	✓	*Gp Lead / Lay Lead*	JK - JB

What are the key enablers / deliverables to support this objective?	**Principal threat(s) to delivery of the objective**
Improved outcomes for patients Improved performance by providers in delivery of all key performance measures	Activity growth in A&E Failure to deliver system wide efficiency programme for unscheduled care. Suboptimal care for patients resulting in poor outcomes

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current			
Appetite			
Approach	**Treat**		



Date reviewed	**15.02.17**
Rationale: Historic poor performance by TRFT, RDaSH and YAS against some key quality measures means failure is possible	

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
A&E Delivery Board	Meeting minutes and actions	Ongoing
Monthly Contract Quality meetings - Quality lead, GP lead and Contract lead	Monthly Governing Body report	Ongoing
INA Framework Quality Premium		
CQC inspection of all providers		
Delegated responsibility for Commissioning Primary Care Services	Primary Care Commissioning Minutes	

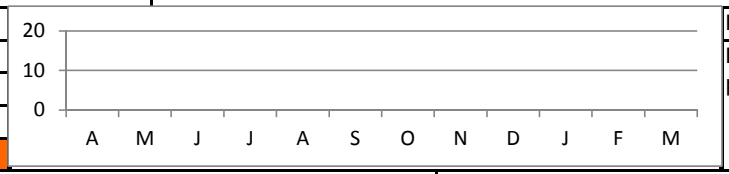
Gaps in control	**Positive assurances received**
No assurance regarding YAS performance	Commissioning Plan Performance report
Gaps in assurance	**Actions being taken to address gaps in control / assurance**
No assurance regarding YAS performance	

SCORE:	F	M	A	M	J	J	A	S	O	N	D	J
Likelihood	3											
Consequence	4											
Risk rating	12											
Tolerance	12											

Objective 2: Delivery – leading system wide efficiency programmes that consistently achieve measurable improvements whilst meeting our financial targets	***NHSE Domains:***		*Committee providing assurance*	**AQUA**
	Better Health	✓		
	Better Care		*Executive lead(s)*	IA
	Sustainability	✓		
	Leadership	✓	*GP Lead / Lay Lead*	RC/JK - JB

What are the key enablers / deliverables to support this objective?	**Principal threat(s) to delivery of the objective**
Primary Care Quality Contract	
Completion of capital build for the Urgent & Emergency Care Centre	Delivery of new model in pressured environment
Clinical thresholds	
Implementation of locality village	Lack of skill and capacity to roll out
Delivery of medicines waste agenda	
MH IAPT / dementia transformation	

Risk rating	Likelihood	Consequence	**Total**
Initial	4	4	16
Current			
Appetite			
Approach	**Treat**		



Date reviewed	**15.02.17**
Rationale: Deliver CCG Commissioning plan identified key priorities and progress against those priorities within 15 priority areas.	

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Emergency Centre Sponsoring Group - Contract Group	Minutes and action log	Ongoing
Community Transformation Group	Minutes and action log	Ongoing
Clinical Referrals Management Committee	Minutes and action log	Ongoing
Unscheduled Care QUIPP Group	Minutes and action log	Ongoing

Gaps in control	**Positive assurances received**
IAPT and CAMHS transformation	Commissioning Plan Performance Report
	Finance & Contracting Report

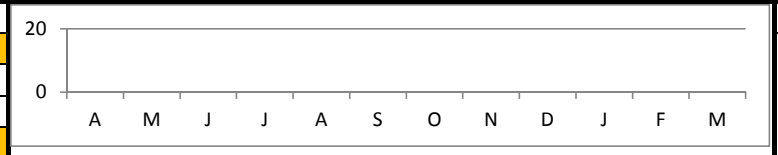
Gaps in assurance	**Actions being taken to address gaps in control / assurance**
Lack of data for some KPI's in the Commissioning Plan Performance Report	

SCORE:	F	M	A	M	J	J	A	S	O	N	D	J
Likelihood	4											
Consequence	4											
Risk rating	16											
Tolerance	16											

Objective 3: Assurance - having robust internal constitutional and governance arrangements, ensuring that providers' services are safe and ensuring vulnerable people have effective safeguarding	***NHSE Domains:***		*Committee providing assurance*	**AQUA**
	Better Health	✓		
	Better Care	✓	*Executive lead(s)*	CE/SC
	Sustainability			
	Leadership	✓	*GP Lead / Lay Lead*	RC - JB

What are the key enablers / deliverables to support this objective?	**Principal threat(s) to delivery of the objective**
Services commissioned safeguard vulnerable clients including safeguarding in all commissioned services Annual Internal Audit opinion Delivery of annual internal audit plan Contract quality processes e.g. well defined leads for all major contracts Performance management key indicators	Services commissioned do not appropriately deliver to vulnerable people

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current			
Appetite			
Approach	**Treat**		



Date reviewed	**15.02.17**
Rationale: Concerns regarding care homes in Rotherham have been raised in the Patient Safety & Quality Assurance report.	

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Safeguarding team, including designated nurse and Dr, named GP & safeguarding adults lead		
CCG and Providers Membership of Rotherham wide safeguarding boards, and all sub groups	Minutes of meetings and sub groups and annual report	
Serious incident reports reported onto STEIS	Reports received as appropriate	
Safeguarding Standards included in provider contracts		
Serious Case Reviews		
Monthly report on contract quality to GB	Reports	

Gaps in control	**Positive assurances received**
Low achievement of intitial health assessments for LAC	Patient Safety & Quality Assurance report Safeguarding Adults Review

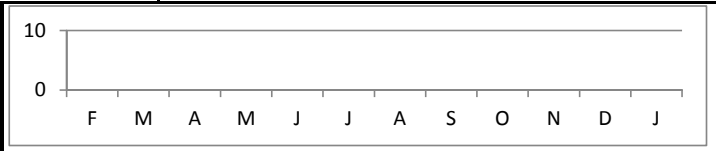
Gaps in assurance	**Actions being taken to address gaps in control / assurance**
Low attendance at TRFT contract quality meetings	Escalation to contract performance executive members
	Raised at exec to exec meeting
	Multi agency work to improve process for IHA for LAC plus peer review from Sheffield CCG Designated

SCORE:	F	M	A	M	J	J	A	S	O	N	D	J
Likelihood	3											
Consequence	4											
Risk rating	12											
Tolerance	12											

Objective 4: Safeguarding – ensuring all children and vulnerable adults are protected from harm, including implementing all actions on Child Sexual Exploitation from the Jay and Casey reports.	***NHSE Domains:***		*Committee providing assurance*	**AQUA**
	Better Health			
	Better Care	✓	*Executive lead(s)*	SC
	Sustainability			
	Leadership	✓	*Gp Lead / Lay Lead*	JK - JB

What are the key enablers / deliverables to support this objective?	**Principal threat(s) to delivery of the objective**
Multi Agency Safeguarding Hub	Partnership working with RMBC and other agencies
Membership of borough wide safeguarding group	
Levels of safeguarding training in Primary Care and other commissioned services	
Named GP and adult safeguarding lead	
Designated Doctor and Designated Nurse for Safeguarding children	

Risk rating	Likelihood	Consequence	**Total**
Initial	3	3	9
Current			
Appetite			
Approach	**Tolerate**		



Date reviewed	**15.02.17**
Rationale: In response to the Jay and Casey reports	

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Rotherham Safeguarding Adults Board	Minutes	Ongoing
Rotherham Local Safeguarding Children's Board	Minutes	Ongoing
All staff training and awareness including GP staff	Training figures for CCG staff and CQC reports	
CCG safeguaring annual report to GB and monthly updates	annual report	
CQUIN to reward additional reporting of safeguarding training	Report	

Gaps in control	**Positive assurances received**
Unaware of unmet need for post abuse support for historic cases or pre trial support for current cases	Patient Safety & Quality Assurance Report monthly to GB CQC reports Winterbourne submission
Gaps in assurance	**Actions being taken to address gaps in control / assurance**
Evidence base for post abuse and pre trial support	working with NHSE, RDaSH and RMBC to identify unmet need and develop appropriate processes

SCORE:	F	M	A	M	J	J	A	S	O	N	D	J
Likelihood	3											
Consequence	3											
Risk rating	9											
Tolerance	9											

NHS Rotherham Clinical Commissioning Group – Risk Register

Ref	Entry date	Lead Person	Risk Description	Risk Cause	Risk Consequence	Risk rating			Assurance & Actions	Date reviewed	Links to Governing Body Assurance Framework /Issues Log
						L	C	T			
1	28.11.2016	Alun Windle	CCG not hitting March 2017 deadline imposed by NHSE for the PUPoC claims process to complete	NHSE deadlines and extensive review process of NHS RCCG	Possible maladministration notice (unknown financial impact) for NHS RCCG			5	Action completed by end of January 2017. Closure requested.	Feb-17	N/A
2	29.11.2016	Jacqui Tuffnell	Collaborative commissioning of specialised services	Insufficient funding transferred for provision of services	Inability to procure required services and/or additional financial impact for RCCG	3	4	12			N/A
3	29.11.2016	Jacqui Tuffnell	Not maintaining accessible and high quality primary care as a consequence of recruitment issues	High numbers of GPs and practice nurses in Rotherham aged 55-59 and insufficient new trainees coming in to replace and insufficient providers using new workforce models	Inability for providers to continue delivering all requirements and ultimately may have to cease all provision causing more pressure on other providers.	3	4	12			N/A
4	29.11.2016	Jacqui Tuffnell	Impact of PMS changes on the stability of practices	Changes in the funding arrangements for practices	Inability for providers to continue delivering all requirements and ultimately may have to cease all provision causing more pressure on other providers	3	3	9			N/A
5	13.12.2016	Sue Cassin	Reputational risk to NHS RCCG and individual risk to one or more Looked After Children	Low achievement of undertaking initial health assessments with statutory framework	Not identifying health needs of children entering the care system and putting necessary care plans in place may result in harm.	3	4	12	Working closely with RMBC and TRFT to refresh processes and joint working to ensure children attend clinics. Peer review by Sheffield CCG	Feb-17	Objective 3 GBAF
6	13.12.2016	Sue Cassin	Reputational risk to NHS RCCG and possible instability to Strategic Clinical Executive from CQC inspection of GP practices	CQC inspection of GP practice and resultant ratings	Need to support practices to take remedial action through the contract	2	4	8	PM forum, nurses forum, facilitation of information sharing, support via development of templates for collation of evidence. Support with areas of underachievement identified	Feb-17	Objective 1 GBAF
7	05.01.2017	Keely Firth	Failure to deliver QIPP programme for 2017/18	Added costs in prescribing, planned care, unscheduled care	Higher levels of expenditure	3	4	12	Focus on waste by MM team; Protocols agreed for clinical thresholds; Block contract for non electives	Feb-17	Objective 1 GBAF
8	05.01.2017	Keely Firth	TRFT operate within control total agreed with NHS Improvements for 2016/17 which is a deficit plan. If the trust cannot sustain the provision of services within its financial envelope the services may be withdrawn by the trust	Lack of capacity	Cost of buying capacity at premium and tariff payments	4	4	16	There is a national cap on locum and agency payments for FTs; FTs working together vanguard looking at vulnerable specialites; FT held to account by NHSI re quality and financial performance and and HEE re clinical staffing	Feb-17	N/A

Ref	Entry date	Lead Person	Risk Description	Risk Cause	Risk Consequence	Risk rating			Assurance & Actions	Date reviewed	Links to Governing Body Assurance Framework /Issues Log
						L	C	T			
9	05.01.2017	Keely Firth	Adverse impact on staffing capacity by additional community responsibilities and national policy changes	Refocusing of corporate capacity	Lack of corporate performance	4	3	12	Review of structure now comnpleted with comments from staff now received; New structure to be introduced wef 1st April 2017	Feb-17	N/A
10	05.01.2017	Keely Firth	Financial pressures in non-health organisations may result in reduction in investments upon which healthcare services are reliant	Lack of capacity in wider services leading to reduced support for specific patient groups.	CCG's objectives to reduce admissions and safely support patients in alternative setting may be compromised.	4	4	16	The Rotherham place plan commits all partners to the delivery of joint objectives and organisations will be held to account by each other.	Feb-17	N/A
11	05.01.2017	Keely Firth	Insufficient funds to finance CCG planned objectives on a recurrent basis	Reductions in allocation growth levels and increases in national pricing tariffs	Increased efficiency requirements	3	4	12	The CCG plan invests in areas where growth in demand is anticipated and where there is limited opportunity to intervene to minimse it.	Feb-17	N/A
12	05.01.2017	Keely Firth	Increasing costs of individual patients of continuing care	Growth in new patients requiring CHC	Overspends on CHC budget	3	4	12	Robust application of the legal framework by the CHC team.	Feb-17	N/A
13	05.01.2017	Keely Firth	Adverse financial pressure from YAS contract	Rebasing exercise undertaken by YAS regarding the costs of services to CCG's	Significant increase in the contract value for YAS with RCCG.	3	3	9	This will not occur in 2017/18.	Feb-17	N/A
14	09.01.2017	Sarah Lever	Failure to deliver A&E standards (constitutional requirement)	Increased ambulance arrivals, and shortage of medical staffing at TRFT	Low performance against the A&E standard for which the CCG are held to account by NHSE	3	4	16	CCG chair the A&E delivery Board and there are detailed action plans to ensure that all enablers to the performance are optimised.	Feb-17	N/A
15	13.2.2017	Ian Atkinson	Failure to deliver 6ww diagnostic standards (constitutional requirement)	Staffing Challenges within TRFT impacting on the number of available diagnostic clinics	Low performance against the 6ww standard for which the CCG are held to account by NHSE, could impact on other Waiting Time targets if not resolved.	3	4	12	CCG Chair TRFT contractual meetings, agreement with TRFT to outsource diagnostics capacity to meet demand. Agreed recovery trajectory in place to improve performance	Feb-17	N/A
16	13.2.2017	Ian Atkinson	Failure to IAPT 6ww Access Target get (constitutional requirement)	Staffing Challenges within TRFT impacting on the number of available diagnostic clinics	Low performance against the 6ww standard for which the CCG are held to account by NHSE, could impact on other Waiting Time targets if not resolved.	3	4	12	CCG Chair RDASH contractual meetings, IAPT National Intensive Support team visited Rotherham and actions being taken to improve position, e.g. further training of Workforce, Self Referral. Agreed recovery trajectory in place to improve performance	Feb-17	N/A

Ref	Entry date	Lead Person	Risk Description	Risk Cause	Risk Consequence	Risk rating			Assurance & Actions	Date reviewed	Links to Governing Body Assurance Framework /Issues Log
						L	C	T			
17	13.2.2017	Ian Atkinson	Delivery of CAMHS Transformation, Waiting Times and lack of improvement in the quality of service	Mobilisation of the new CAMHS Model, increase refferals impacting on the ability to deliver access times	Transformation Plan is being delivered with significant recruitment into the CAMHS service. Waiting times for access remain challenging. Continued dissatisfaction in the serviceby GP's families and young children	3	4	**12**	CCG Chair CAMHS Strategy and Partnership Group and fortnightly CAMHS performance meeting. Recently agreed to develop a Section 75 agreement with RMBC for CAMHS.	Feb-17	N/A
18	11.11.2011	Sue Cassin	Quality of Commissioned Services	Inability of providers to deliver quality safe services.	Sub optimal care for patients resulting in poor outcomes. Loss of reputation for both provider and commissioner	4	3	12	Three officers are responsible for quality of each major contract area. For TRFT as largest contract we maintain quality assurance by monitoring the national quality standards within the NHS standard contract along with national and locally agreed Local Incentive Schemes. Participating in providers assurance meetings. Ad hoc and planned visits to provider units, including a programme of clinically led visits. Managing the assurance of responses to Serious Incidents on behalf of the NHSE. A wide range of benchmarking data is monitored including data on HSMRs and condition specific HSMRs peer, CQC risk ratings. Similar processes are in place for RDASH. A wide range of hard and soft intelligence is used through contract for assurance of GP quality.	Feb-17	GBAF 1
19	24.01.2017	Emma Royle	Failure to implement SEND reforms (part 3) of the Children and Families Act 2014/SEND Code of Practice.	Complexity of the new SEND reforms. Lack of assurance for the CCG due to non-attendance at the Education Health & Care Panel CCGs failure to identify correct attendee at EHC panel	EHC plans agreed at panel become statutory documents and the CCG must provide health provisions stated in the plan. If the CCG does not have oversight of these plans it may result in the CCG having to provide non universal services.	3	4	**16**	CCG completed a diagnostics self-assessment (provided by the council for disabled children). A second assessment is due to take place by the end of January 2017. This covers all aspects of the SEND reforms. 23.01.17 OE requested ER obtain information regarding how CCGs across the country are dealing with this.	Feb-17	N/A

Ref	Entry date	Lead Person	Risk Description	Risk Cause	Risk Consequence	Risk rating			Assurance & Actions	Date reviewed	Links to Governing Body Assurance Framework /Issues Log
						L	C	T			
20	31.01.2017	Chris Edwards	Services are currently commissioned on South Yorkshire & Bassetlaw footprint and sustainability of hospital services is being reviewed.	Some services may no longer be provided by our local acute provider.	Risk around sustainability of services on a local footprint	3	4	12	STP plan commissioned a review by Sept 2017 to asses hospital sustainability	Feb-17	N/A
21	31.01.2017	Chris Edwards	Risk of possible lack of support to victims of CSE due to the scale of criminal proceedings and political issues as commissioners still running Children's services at the council.	Ongoing CSE criminal proceedings	Requiring additional mental health support for victims. Reputational damage to CCG for Adult Mental Health/CAMHS	3	4	12	Children's Board CCG Commissioning strategy CAMHS transformation plan Investment in IAPT services (Adult mental health)	Feb-17	N/A
22	02.02.2017	Claire Smith	Demand flux in the 111 service	Number of referrals and patient contacts. Capacity of the service.	Patients currently in inappropriate destinations e.g. A&E. Impact on demand management.	4	5	20	Capacity versus Demand is monitored through the contract. Although useage has increased this is not above the contracted capacity at present	Feb-17	N/A

Risk Matrix		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Consequence	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Major	4	8	12	16	20
	5 Extreme	5	10	15	20	25

Risk Score	Risk Descriptor	Risk Appetite Statement
1-5	Low	**Averse** Avoidance of risk and uncertainty is a key
6-11	Medium	**Minimal** Preference for ultra-safe options that are
12-15	High	**Cautious** Preference for safe options that have a
16-20	Very High	**Open** Willing to consider all potential options and
25	Extreme	**Hungry** Eager to be innovative and to choose

NHS Rotherham Clinical Commissioning Group - Issues Log

Description of selected headings:

Status is used to establish the current phase of the issue. Status can be: New, Emerging, Open, Pending Update, Requesting Closure, and Closed. It is important to keep a record of closed issues until the project is over, they can often be used to establish lessons learned and occasionally provide useful reference points. If Excel is used for the Issue log then it is much easier to filter the Issues on open or closed status.

Issue Author is the individual who has recorded the issue. The **Issue Owner** is the individual who has taken the responsibility for resolving the issue.

Latest update needs to include the date, the initials of the person updating, the update including progress on any actions and any new actions.

The **Priority Rating** column is populated by a rating to indicate the priority of the issue. For example:
1 – Negligible
2 – Minor
3 – Moderate
4 – Major
5 – Extreme

ID	Status	Date identified	Issue Author	Issue description	Latest Update	Issue Owner	Priority rating	Links to Governing Body Assurance Framwork /Issues Log
1	Open	28.11.2016	Alun Windle	Litigation and patient safety issues. Caused by a lack of management system for equipment in the community commissioned by NHS Rotherham CCG. Resulting in possible patient harm, faulty equipment, staff working above competencies and litigation.2 cases where families have purchased equipment and the NHS are now providing consumables therefore condoning the purchase of this equipment.	This issue remains the same – because the issue was/is unquantifiable due to the CCG having not held a list of equipment previously it's difficult to assess what service is needed to be procured in the future. Over the past 9 months CHC have commenced collating a list of equipment – using CHC data the CCG maybe able to go back to procurement with a level of service required – The service is also scoping other CCGs on how they monitor such equipment	S Cassin	5	GBAF 1
2	Open	29.11.2016	Jacqui Tufnell	Ineffective patient care. Caused by lack of delivery of the Capita contract. Resulting in possible impact on patient care, CCG costs and reputation.		J Tufnell	5	GBAF 1
3	Open	05.01.2017	Keely Firth	Failure to deliver QIPP programme for 2016/17	Added costs in prescribing, planned care, unscheduled care is resulting in higher levels of expenditure.	K Firth	5	GBAF 2
4	Open	09.01.2017	Sarah Lever	Failure to deliver the A&E standards for 2016/17 (constitutional requirement).	Increased ambulance arrivals, and shortage of medical staffing at TRFT resulting in low performance against the A&E standard for which the CCG are held to account by NHSE.	S Lever	5	GBAF 1/3
5	Open	02.02.2017	Claire Smith	Failure of YAS to achieve RED 18 minute Target 2016/17 at CCG level and Yorkshire & Humber wide.	The target is not being achieved in 2016/17 - this is comparable to other emergency ambulance providers across the country.	C Smith	5	GBAF 1/3
6	Open	06.02.2017	K Leahy	Financial risk to the CCG arising from its duties under developing case law regarding potential Deprivation of Liberty for health commissioned care packages in the community (CHC clients)	Ongoing meeting arranged for mid-February between Head of Quality, Safeguarding Adult/ Clinical Quality Lead and Operational Lead for CHC team regarding managing the risk and moving forward	S Cassin	4	GBAF 3

ID	Status	Date identified	Issue Author	Issue description	Latest Update	Issue Owner	Priority rating	Links to Governing Body Assurance Framwork /Issues Log
7	Open	06.02.2017	K Tufnell	Failure to deliver the National IAPT waiting times standards 75% of people seen within 6 weeks 95% of people seen within 18 weeks	95% of people seen within 18 weeks - achieved 75% of people seen within 6 weeks - not yet achieved. Remedial action plan under-development	K Tufnell	4	GBAF 1
8	Open	06.02.2017	K Tufnell	NHS England unable to locate CAMHS Tier 4 Bed. As a result RDaSH are placing under 18's with Rotherham's Adult beds - Risk Children in adult beds. Adult beds occupied (currently CCG not charging) could result in CCG having to fund out of area bed for Adult. (Emergency Issue)	No such admissions in this period	K Tufnell	4	GBAF 1