# Integrated Risk Management Framework

<table>
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<th>Author</th>
<th>Patient Safety Manager</th>
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## Document Control

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<th>Term</th>
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<tr>
<td>Assurance</td>
<td>Methods of reporting/information that gives some indication of the effectiveness of a control, both in design and in practice, in limiting risk exposure.</td>
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<td>Control</td>
<td>Elements that are currently in place and which limit (mitigate) the exposures to risk.</td>
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<tr>
<td>Gap in control</td>
<td>This is deemed to exist where adequate controls are not in place or where collectively they are not sufficiently effective.</td>
</tr>
<tr>
<td>Gap in assurance</td>
<td>This exists where there is a failure to gain evidence that the controls are effective.</td>
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<tr>
<td>Residual Risk</td>
<td>The level of risk exposure expected after all mitigating actions have been implemented.</td>
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<tr>
<td>Risk Appetite</td>
<td>The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.</td>
</tr>
<tr>
<td>Risk identification</td>
<td>This is the process of finding, recognising and recording risks. Once a risk is identified, the organization should identify any existing controls such as design features, people, processes and systems.</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>It is the overall process of risk identification, risk analysis and risk evaluation.</td>
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<tr>
<td>Risk analysis</td>
<td>This involves the consideration of the causes and sources of risks, their consequences, and the probability that those consequences can occur.</td>
</tr>
<tr>
<td>Risk Evaluation</td>
<td>This involves comparing estimated levels of risk with risk criteria defined when the context was established, in order to determine the significance of the level and type of risk. Risk evaluation uses the understanding of risk obtained during risk analysis to make decisions about future actions. Ethical, legal, financial and other considerations, including perceptions of risk, are also inputs to the decision.</td>
</tr>
<tr>
<td>Risk Management</td>
<td>This refers to the systems and processes in place within an Organisation such as the policies and procedures and other arrangements that will provide risk management throughout the organisation at all levels.</td>
</tr>
<tr>
<td>Framework</td>
<td>Risk Register</td>
</tr>
<tr>
<td></td>
<td>It is a central repository of all risks identified within an organisation and includes information such as source, nature, treatment option, existing counter-measures, and recommended counter-measures.</td>
</tr>
<tr>
<td>Risk Response</td>
<td>Actions identified in dealing with a risk and these may include, terminating, treating, transferring and tolerating.</td>
</tr>
<tr>
<td>Risk Treatment</td>
<td>This involves selecting or agreeing to one or more relevant options for changing the probability of occurrence, the effects of risk, or both and implementing these options. This is followed by a cyclical process of reassessing the new level of risk, with a view to determining its tolerability against the criteria previously set, in order to decide whether further treatment is required.</td>
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</table>
Statement of intent

NHS Greenwich CCG is committed to ensuring that all the services it commissions are of high quality and that any risks to service users, staff and other stakeholders are minimised through rigorous risk management processes. Greenwich CCG will therefore ensure that risks are identified, assessed, managed and where possible eliminated to create a safe and effective care for service users and staff as well as enable the achievement of corporate objectives. The assessment of risks will include all clinical, financial, corporate, operational and reputational risks.

Greenwich CCG recognises that some risks are inherent and not all risks can or should be avoided or eliminated, but these should be identified. The CCG does not therefore aim to create a risk-free environment, but rather one where risk is regularly assessed and considered as part of everyday management and appropriately identified and controlled. Every effort should be made to ensure that all risks are maintained at as low a risk grading as reasonably practicable.

Risk Management is not just the responsibility of one person within the organisation, it is everyone’s responsibility. To support the development of a proactive risk management approach across the organisation, the CCG commits to:

- Embed effective organisational governance arrangements that respond to strategic change, secure a safe and positive experience for patients and staff, and support high quality effective service delivery
- Accountability and responsibility (from leading and supporting staff)
- Performance management and compliance with NHS Regulator standards

Risk Appetite Statement

NHS Greenwich CCG is working toward a mature risk appetite. The CCG has no appetite for financial risk and zero tolerance for fraud and regulatory breaches e.g. safeguarding breaches, poor professional conduct of its staff and information governance (data protection) breaches.

NHS Greenwich CCG may take considered risks, where the long term benefits outweigh any short term losses. NHS Greenwich CCG supports well managed risk taking and will ensure that the skills, ability and knowledge are there to support innovation and maximise service improvement.

The Governing Body commits to review its risk appetite statement on an annual basis.

Electronic Signature
Chief Officer

Electronic Signature
Chief Finance Officer
1. Summary

The Integrated Risk Management Framework sets out the Clinical Commissioning Group’s (CCG) overarching approach to the management of risk in the organisation. The Governing Body will be aware of all significant risks and have sufficient information to enable it to make decisions on the implementation of appropriate controls and the allocation of appropriate resources.

The Governing Body is committed to ensuring the highest quality of services within the GCCG and from all providers to all patients where risk of injury, damage or loss to patients, staff, visitors or the organisation is either removed or, where this is not possible, managed so that the risk is minimised.

The Governing Body will use this strategy to ensure it meets its statutory requirements to comply with National Standards for Risk Management; guidance from regulators; compliance with UK and EU Health and Safety legislation in which risk assessment is required. The strategy details the approach necessary to demonstrate that sound risk management practices are embedded throughout the organisation and in accordance with the governance arrangements defined within NHS Greenwich CCG Constitution.

2. Introduction

Integrated Risk Management is an integral part of good general management practice consisting of steps that, when undertaken in sequence, enable continual improvement in decision-making. Properly understood and implemented, it provides NHS Greenwich CCG with an opportunity to re-orient itself around continuous performance improvement with a clear focus on quality of care and commissioned services.

NHS Greenwich CCG is required to have an approved framework for managing risk that clearly identifies the organisations objectives with regard to risk management, which details the accountability arrangements and outlines the main processes by which these objectives are to be achieved. This framework also offers guidance on what may be regarded as ‘acceptable risk’ by NHS Greenwich CCG and an agreed statement of zero tolerance risks through its Risk Appetite statement.

The NHS Greenwich CCG risk management system is designed to support the delivery of safe and effective health services for service users, staff and wider stakeholders. Risk Management is not about risk elimination; it is about encouraging appropriate risk-taking, i.e. those risks that have been evaluated and which are understood as well as is possible with currently available information.

It is also recognised that inadequately managed risks within commissioned services have the potential to prevent NHS Greenwich CCG from achieving its objectives and may directly or indirectly cause harm to those it cares for, employs or otherwise affects as well as incurring loss relating to assets, finance, reputation, goodwill, partnership working or public confidence.
3. Purpose and scope of the framework

The purpose of this framework is to define and document the CCG’s approach to risk and risk management and to:

- Enable the Governing Body to have an overview of the risks it faces, taking into account all aspects of its business
- Provide assurance to the Governing Body that action is being taken to mitigate risk to acceptable levels
- Assure the public, patients, practices, partner organisations and staff that the CCG is managing its risks effectively
- Enable the strategic deployment of resources to meet risk, beyond allocations made if necessary, including financial funding, human resources, capacity and knowledge
- Enable constant and consistent improvement of healthcare provision and patient experience

This framework relates to the management of risks faced by the CCG. Its scope therefore, primarily relates to the resources directly managed by or within the CCG. However, the CCG acknowledges that the activities of primary care practitioners and or partners in collaborative arrangements and the actions of organisations outside the CCG acting on its behalf through commissioning agreements, involve risk that can impact on whether the CCG achieves its objectives. To this extent, their activities and actions come within the scope of this framework.

3.1 Principles of the Framework

The following key principles are essential for the successful implementation of this framework:

- Governing Body and senior management are committed to, and provide risk management leadership
- The CCG recognises that while it will seek to eliminate or control risks, it is impossible to eliminate all risk from its activities and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources to achieve health benefits for our population
- The continuing development of the CCG’s clinical governance framework
- Clearly defined responsibility and ownership of risks and associated action plans
- Effective staff participation and consultation, where appropriate, in risk management processes
- The setting by Governing Body, or by its committee or senior management, of the risk appetite, i.e. the extent to which the CCG accepts levels of risk exposure in pursuits of its objectives
- The mechanism for all incidents and complaints to be immediately reported, categorised by their potential consequences and investigated to determine the extent of any system failure
• The risk management process will be applied to contract management especially when acquiring or outsourcing services, or facilities

4. Definitions

4.1 Risk
Risk is defined as “the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events” (HM Treasury Orange Book 2004) and may be associated with people, buildings and estate, equipment and consumables, systems and management. Risk is the chance of something happening that will have an impact on the achievement of the organisations objectives and the delivery of high quality patient care. It can be any type of risk spanning corporate, clinical, financial, operational or reputational.

For a public body such as the Clinical Commissioning Group, risk can be further defined as:

‘Anything that poses a threat to the achievement of our objectives, programmes and service delivery, as set out in the Governing Body’s Integrated Plan. This may include damage to the reputation of the Governing Body, which could undermine public confidence’.

4.2 Risk Assessment
For an organisation’s Assurance Framework to be robust there must be a robust system in place for the identification, assessment and prioritisation of risk. Risk assessment is the overall process of risk identification, risk analysis and risk evaluation. Risks can be assessed at an organisational level, departmental level, for projects, individual activities or specific risks. Risk assessments provide an understanding of risks, their causes, consequences and their probabilities. This provides input decisions about:
• Whether an activity should be undertaken
• How to maximise opportunities
• Whether risks should be treated
• Choosing between options with different risks
• Prioritizing risk treatment options
• The most appropriate selection of risk treatment strategies that will bring adverse risks to a tolerable level

The output of a risk assessment is an input to the decision making processes of the CCG

BS EN 31010

4.3 Risk Management
Risk management involves the application of logical and systematic methods for:
• Communicating risks and consulting throughout the organisation
• Establishing the context for identifying, analysing, evaluating, treating risk associated with CCG activity, processes and functions
- Monitoring and reviewing risks
- Recording and reporting results appropriately

Effective risk management will enable NHS Greenwich CCG to set priorities and improve decision making to reach an optimal balance of risk, benefit and cost. Robust risk management will reduce the CCG’s vulnerability in all its business objectives.

4.4 Risk Management Cycle

The Risk Management process is an integral part of management processes, embedded in culture and practices; and tailored to the business processes of the organisation. Practically, this means that risk identification, assessment and management will form part of delivery and planning within Greenwich CCG.

Fig 1: Risk Management Cycle

The key to effective risk management is being aware of which risks are likely to occur so that they can be proactively managed. An effective mechanism to capture and report risks is therefore essential. Initially, Greenwich CCG will establish the contexts of risks, including identifying stakeholders who may be affected by the risks. Thereafter, the risks are assessed and suitable responses are sought.

The CCG’s four possible responses to risks will be:
• **Terminate** - avoid the risk by making the likelihood of its occurrence totally impossible (break the “cause-risk-effect” links at either point)
• **Tolerate** - accept that the effects of the risk are, or have been following treatment, reduced to a reasonably practicable level and continue monitoring to ensure controls remain effective
• **Transfer** – involve some third party to share some degree of risk via contracts terms or insurance
• **Treat** – Take action to reduce the overall risk score (weaken the link between the “cause-risk” to reduce likelihood, weaken the link between the “risk- effect” to reduce impact, resulting in removal of risk or tolerate the risk at the lowest possible score.

5. Risk Management Process

5.1 Risk Identification

Identification of risk is the first part of an effective risk management strategy. A strong organisational commitment to risk management will ensure that risks identified at all levels in the organisation are properly managed. Risks can be escalated to the Governing Body through the Governance structures with the Corporate Risk Register being the consistent factor throughout the whole organisation.

The CCG has established and maintains via the Quality and Audit Committee, continual reporting, auditing and monitoring to ensure that standards are being implemented and therefore risk is being controlled to the lowest reasonably practicable levels.

5.2 Identifying and Managing risks

Methods of identifying and managing risks will include:

**Internal methods** such as:

• Incidents
• Complaints
• Claims
• Serious Incident Reporting and identification of trends
• Quality Issues Log
• Audits
• QIPP related risks
• Projects risks based on the achievement of project objectives
• Patient satisfaction surveys
• Risk assessments
• Staff surveys
• Contract quality and monitoring of commissioned services
• Whistle blowing
External methods such as:

- Media
- New Legislation
- National reports
- NPSA surveys
- Reports from assessments or inspection by external bodies
- Reviews of partnership working

All Directors and managers are required to identify risks specific to their own activities and circumstances. Risks may be identified from a number of sources, both internal and external (Appendix 1). No valid risk will be excluded from the register due to its identification source. All staff are encouraged to be risk aware.

Closed risks will be reviewed twice a year (January and July) with Directors to check if mitigating actions continue to be performed and assess if the risk needs to be re-opened.

The Director of Integrated Governance maintains a strategic overview of risk.

6. Risk Analysis Tools
Greenwich CCG will evaluate each risk using the risk assessment tools available on the CCG intranet (Risk Management page). Risks will be analysed using estimates of severity and likelihood. By ensuring all risk assessments follow the same process of evaluation and calculation the Governing Body can be assured that a continual, systematic approach to all risk assessments is followed throughout the organisation.

6.1 Risk Assessment Matrix

The Risk Assessment Matrix below represents the possible combined risk scores based on a measurement of both the likelihood (probability) and consequence/severity (impact) of risk issues. A combination of likelihood and severity/Consequence score provides the combine risk score.

Likelihood x Severity/Consequence = Risk Score

An example risk score calculation has been provided below, where:

Likelihood = Possible (3);
Severity/Consequence = Major (4); therefore:

(Likelihood) 3 x 4 (Severity/Consequence) = 12

The risk score can then be compared to the risk matrix below and a ‘colour’ or ‘grade’ can be determined. In the example above, a risk score of 12 would be graded as ‘amber’ (moderate). The Trust can then prioritise mitigation actions based on an understanding of the nature of the risk presented.
6.2 International Risk Management Standard (ISO31000)

NHS Greenwich CCG has adopted a standard methodology consistent with the International Risk Management Standard (ISO31000), also advocated by the National Patient Safety Agency, for identifying and measuring risks. The methodology is also in line with the standard in HM Treasury Orange Book 2004. This standard methodology will be applied across all organisation-wide assessments of risk including, for example, purchase of new equipment, the allocation of funding and organisational changes.

The document “Guidance for Completing a Risk Assessment”, available on the NHS Greenwich CCG intranet, describes the agreed risk assessment process and should be used for the assessment of all risks.

All Risk Assessments must be reviewed by the relevant governance meeting for agreement or adaptation. Following this review and agreement of the Action Plan, the risk can be added to the Risk Register on Datix and the correct level of responsibility allocated as part of the record.

If the risk is graded 15 or above and this is agreed as correct, the Risk Assessment must be escalated to the relevant Director lead (risk owner) for review. The Integrated Governance Directorate will advise on the level at which the risk should be managed. Following this decision the risk can be added to the register.

Risks should not be added to the Risk Register without the oversight of the relevant Director Lead who is the risk owner. The Director Lead must consider whether the risk needs to be reported to the Governing Body for immediate management.

All risks identified should be aligned to the Governing Body’s corporate objectives and should have the following identified and monitored:

- Existing sources/evidence of assurance that support the identified control measures
Any gaps in assurance

6.3 Organisational Risks

Table 1: Types of Organisational Risks

<table>
<thead>
<tr>
<th>Type of risk</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>Legal, regulatory control and professional risks</td>
</tr>
<tr>
<td>Reporting</td>
<td>Information and reporting risks</td>
</tr>
<tr>
<td>Operational</td>
<td>Environmental, financial, business continuity, Innovation, human resources, health and safety and reputational risks</td>
</tr>
<tr>
<td>Strategic</td>
<td>Economic, social, technological, political and organisational risks</td>
</tr>
</tbody>
</table>

Apart from organisational risks identified above, risk in healthcare falls into three categories. The boundaries between these categories are not always clear, and some risks may fall into more than one category.

Clinical/Quality Risk is associated with the assessment, care and treatment of all patients including safeguarding arrangements. Clinical risk is inherent within the delivery of healthcare; users of the provider services are ill and interventions are often invasive and potentially dangerous. The systems used within clinical risk management ensure that clinical risks are identified, analysed and, where possible, reduced to a minimum through the implementation of appropriate controls. Although the retrospective review of adverse events provides important information on how systems and processes can be improved, there must also be on-going examination of services to predict where latent risk exists. This risk must be actively managed in order to protect patient and staff safety and to ensure the best possible clinical outcome.

Corporate Risk is associated with income, expenditure, fulfilment of contracts and the correct application of Standing Financial Instructions and Orders whilst operating the Governing Body as a significant business, and risks threatening the fulfilment of corporate objectives. Corporate risk also includes threats to the Governing Body’s authorisation and governance, finance including QIPP delivery. Agreeing the corporate risk appetite is important to enable safe risk taking and that opportunities are taken within a risk aware environment as well as corporate understanding of zero tolerance risks.

Business Continuity and Emergency Planning and Resilience (EPRR) Risk is associated with the CCG’s ability to continue delivering services at acceptable predefined levels following a disruptive incident. In an effort to prepare Greenwich CCG to deal with disruptive incidents that may otherwise prevent it from achieving its objectives, GCCG has a Business Continuity Management System in place which is in line with the International Standard for Business Continuity (ISO 22301). This has been developed in conjunction with the Emergency Preparedness Resilience and...
Response (EPRR) plan. The CCG is required, as Category 2 responder, under the Civil Contingencies Act (2004); to support Category 1 responders in the event of emergencies. The CCG works closely with NHS England to ensure that it fulfils all EPRR required aspects as identified in the EPRR Framework for Category 2 responders. The CCG will participate in the Local Resilience Forums and the London Health Resilience Partnership as part of multi-agency and partnership working in managing EPRR and Business Continuity risks. The Executive Manager has operational responsibility for Business Continuity and Emergency Planning in the CCG.

**Significant Risks** are those risks which, when measured according to NHS Greenwich CCG risk grading tool are assessed to be high (red). The NHS Greenwich CCG, supported by its Committees and Governance structure will take an active interest in the management of significant risks.

**Acceptable Risks** are those risks which have been identified and measured according to the risk-grading tool and for which risk mitigation action plans have been developed. Such risks are deemed to be acceptable according to the risk appetite of NHS Greenwich CCG, a delegated committee or Directorate, depending on the nature and grade of the risk. Acceptable risks should be monitored, reviewed and entered onto the appropriate risk register. By this definition an unacceptable risk/zero tolerance risk is one where such a risk is rated above the risk appetite of NHS Greenwich CCG

**Risk Appetite** is the level, amount or degree of risk that NHS Greenwich CCG or a particular delegated authority is willing to accept. Risk Appetite is measured through the Risk Maturity Matrix (Appendix 2).

**Quality Issues Log** is an internal log that captures quality issues raised or received by the organisation. The purpose for this log is to ensure that quality issues that are not monitored formally elsewhere (i.e. complaints, quality alerts, serious incidents, corporate risk register, clinical quality review groups [CQRGs] etc) are monitored at every Quality Committee meeting and escalated as necessary to appropriate committees or groups for further action. If the quality issue is deemed a risk by the Quality Committee, it will be transferred to the corporate risk register and will be monitored accordingly. Issues on the log will be closed once actions have been approved as closed by the Quality Committee.

7. **Risks across Boundaries**

NHS Greenwich CCG works closely and collaboratively with a wide range of partner organisations and recognises that risks exist in such arrangements. Responsibilities and accountabilities for risks in such relationships can be difficult to ascertain. With this in view, NHS Greenwich CCG will endeavour to involve partner organisations in all aspects of risks management as appropriate.

Such organisations will include those that deliver services jointly or share joint appointments with, e.g. safeguarding adults and continuing care. Partner organisations which NHS Greenwich CCG works closely with, include, other NHS
Organisations, Social Services, the Police, statutory and voluntary bodies and patient representative groups.

8. Corporate Risk Register

The Governing Body uses Datix, an electronic risk management system for the management of all risks, claims, complaints, and incident reporting data. This database is accessible corporately for appropriate population, interrogation and reporting so that risk issues and themes can be identified and reviewed. The elements of the risk register include:

- All identified risks will be recorded and managed on the CCG Risk Register
- The Risk Register sets out the controls on each risk which the responsible CCG Director will put in place to effectively mitigate the risk, together with sources of assurance which will inform the Quality committee, FPQ committee, the GEG and the Governing Body as to the effectiveness of such controls.
- The Risk Register will identify any reasons in the controls or sources of assurances requiring improvement in order to be as effective as possible and sets out the actions necessary to secure improvement.
- The corporate Risk Register will also identify the member of the CCG staff tasked with delivery of the identified action to be taken in response to the risk together with relevant timescales
- The Risk Register will be reviewed at every Greenwich Executive Group (GEG) meeting and updated as necessary.

Risks can be entered onto the database by key staff within the Integrated Governance Directorate and will be extended as part of the responsibility of Associate Directors/Assistant Directors.

9. Risk Management Levels and Responsibilities

The responsibility for the management of risk will be clearly indicated on the entry to the Risk Register. Each Directorate can run reports separately to identify the risks that are their responsibility. Significant risks scoring 12 or above, or high level risks requiring involvement higher up the organisation, are escalated to the Governing Body. This may also include risks that have been on the Corporate Risk Register for more than 12 months without mitigation or improvement.

All individual content of the Risk Register is based upon individual risk scores that assign a risk level of risk (low, moderate, high, significant), which determines the timescale for their management and minimisation. However, the Governing Body does have the discretion to prioritise risk based on the level assessed where there is a mandatory, legal or Zero Tolerance requirement or prohibition. In these cases these risks automatically assume high priority, regardless of score.

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1 Zero Tolerance Risks: Adult Safeguarding; Significant Reputation; Significant Staffing; Child Safeguarding; Reputational risk; Information Governance (Data Protection)
Low scoring risks should also be considered as if they are not given due attention, they could escalate and then become a priority for action.
Fig. 3. Risk Level and Management Responsibility

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Risk Description</th>
<th>Action Required to Reduce Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>Low</td>
<td>Refer to Lead Director for action. Managed by the Directorate. Quick, easy measures must be implemented immediately and further action planned for when resources permit. Managed by routine procedure. Reassess as appropriate. Actions managed locally. Possibly no actions required – risk accepted.</td>
</tr>
<tr>
<td>4-7</td>
<td>Moderate</td>
<td>Refer to Lead Director for action. Managed by the Directorate. Actions implemented as soon as possible but no later than a year. Appropriate controls to be implemented and monitored. Reassess regularly.</td>
</tr>
<tr>
<td>8-12</td>
<td>High</td>
<td>Refer to Associate Director of Governance &amp; Quality for action. Managed by the Directorate. Risks scoring equal to or greater than 12 to be reviewed by Governing Body. Take steps to make the situation safe. Implement available controls. Will require plan which sets out actions to be taken to reduce level of risk to be implemented as soon as possible and no later than 6 months.</td>
</tr>
<tr>
<td>15 – 25</td>
<td>Significant</td>
<td>Immediate action required. Refer to relevant Director for review. Managed by the Governing Body and the Directorate. All possible controls should be implemented immediately. Urgent action plan to be implemented and monitored by relevant committee (or other appropriate body). Must be reported to the Governing Body. 20+ risks will require immediate action by the Governing Body.</td>
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</tbody>
</table>

9.1 Process for Review and Monitoring of the Risk Register

Maintenance of the Risk Register will be undertaken by ensuring all risks are managed by their ‘Review Date”. Corporate audit of the Risk Register will determine performance in this respect. Review of risks must be undertaken within the Directorates who should ensure that all controls are in place and any actions necessary are properly recorded and met. Risk must be reviewed at least quarterly. The risk rating should gradually decrease from the initial score to meet the target score – the current score is the only rating that will change, for example:

<table>
<thead>
<tr>
<th>Time</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial risk</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>rating</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Current risk</td>
<td>12</td>
<td>8</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>rating</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Target risk</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>rating</td>
<td></td>
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</tbody>
</table>

If the current risk rating is not reducing then the actions that have been put in place to address the risk must be reviewed, as it would appear that the actions are not effective at reducing the risk.
9.2 Closing risks

An active Risk Register contains the risks that are relevant to the organisation that are being addressed. Once a risk has reached its target rating (and is at an acceptable level of risk) it may be closed after agreement at the Greenwich Executive Group Meeting (GEG).

In some cases the actions will reduce the risk but the residual level will remain high. If the conclusion of the Directorate is that no further action can be taken to reduce the risk, the recommendation to close it and accept the risk at the remaining level must be escalated to the GEG. If actions can be taken but these will be costly, all options must be escalated to the Governing Body for a decision on whether to accept the risk to the organisation or take further action.

Closed risks can always be accessed on the risk management database and re-opened if circumstances change. However, it is good practice to only close if the risk has been removed or is time-limited only.

10. Governing Body Assurance Framework (GBAF)

In 2002/03 National Guidance required all NHS Bodies to set up an Assurance Framework, which includes the active involvement of nominated Boards and Audit Committees.

The Governing Board Assurance Framework (GBAF) is a high level document that records the principal risks that could impact on the CCG achieving its strategic objectives. It is a structure which enables the organisation to focus on those risks that might compromise achieving the organisation’s strategic objectives and map out both key controls that should be in place to manage these objectives and confirm that the Governing Body has gained sufficient assurance about the effectiveness of the controls.

The Audit Committee Handbook (2005) identified the Board Assurance Framework as the key source of evidence that links strategic objectives to risks and assurances, and the main tool that the Governing Body should use in discharging its overall responsibility for internal control. The 2005 Audit Handbook identifies that the Audit Committee should include review of the Board Assurance Framework as a fundamental tool for the identification and control of risks.
10.1 Functions of the Governing Board Assurance Framework (GBAF)

The GBAF will provide the following:

- A simple but comprehensive method for the effective and focused management of the principal risks that arise in the CCG
- A structure for the evidence to support the Statement of Internal Control
- Simplified Board Reporting and prioritisation, which in turn allows more effective performance management
- Means of reporting key information to Boards but only when the GBAF is maintained as a dynamic document
- Identification of which of the organisation’s objectives are at risk because of the inadequacies in the operation of controls or where the organisation has insufficient assurance
- Structured assurances about where risks are being managed effectively and that objective are being delivered.
- A means for the Governing Body to determine where to make the most efficient use of their resources and address the issues identified in order to improve the quality and safety of care.
- Identification of priorities for the Governing Body, to provide confidence that the organisation is able to understand its capacity to deliver and is able to assess realistically the risks the organisation faces and the assumption this is based on.

The GBAF therefore, forms part of the annual operating plan review and incorporates new or revised corporate objectives.

10.2 Governing Body use of the GBAF

The Governing Body will use the GBAF to consider the following:

- The adequacy of controls to mitigate the identified risks
- The adequacy of assurances on the operation of those controls
- The development of the CCG’s appetite for risk and its corporate approach to risk management
- Areas that require further control which could then be used to highlight areas for further discussion
- Areas that require further assurances of the effectiveness of the control which could highlight a set of points for more detailed discussion at the Audit Committee
- The allocation of resources to reach a control and assurance level that the Governing Body considers appropriate and reasonable
- The executive to executive challenge on the identified risks and control
- Lay member challenges to executives on the robustness of assurances

The consideration for the whole GBAF by the Governing Body should take part at least quarterly. The above points should form part of the high level review. Quarterly review of the prioritised sections of the GBAF will demonstrate the embedded nature of the GBAF and overtime, identify a timetable of expected assurances at each committee meeting.
10.3 Audit Committee use of GBAF

The Audit Committee will use the GBAF to consider the following:

- The programme for both internal and external audit reviews- thereby providing assurance on the operation of controls
- The annual Audit Committee report to the Governing Body on the effectiveness of the system in place to control risk
- Challenging the executives on the robustness of controls and assurances, using the assurance elements of the document
- Commissioning reviews to address a gap in control or a gap in assurance

The GBAF should be considered in its entirety by the Audit Committee.

11. Governance Structure

Greenwich CCG’s governance structure supports effective risk management.

11.1 Governing Body

Overall responsibility for risk management rests with the Governing Body. The Governing Body is committed to an open and honest approach in all practices and therefore expects CCG employees and member practices to acknowledge that risks can be identified and managed if everyone adopts the same approach.

The Governing Body will:

- Discharge its functions in respect both by setting and monitoring compliance with requirements for Risk Management within the CCG and by directing a framework for the robust identification, measurement, mitigation and monitoring of strategic risks and any significant non-strategic risks.
- Approve strategies which aim at delivering corporate objectives.
- Provide governance, overall leadership to the CCG within a clear framework of values and behaviour.
- Ensure that appropriate systems and controls are in place to ensure delivery. strategic objectives. These frameworks should increase the probability of anticipating unpredictable risks.
- Seek assurance that effective controls are in place to mitigate risk. Where this assurance cannot be provided, the Governing Body will issue instructions to address the risk and identify responsible persons to lead the actions. In extreme circumstances, the Governing Body will need to decide whether the continuation of a particular service presents too great a risk to the organisation.
- Approve the GBAF and the organisation’s Risk Register at the start of the financial year and review both against specific risks each quarter as well as directing the Audit Committee to review specific risks detail as set out in the annual schedule of risk review.
- Invite independent Risk Management experts (external auditors) to the Audit Committee meetings as appropriate. Risks to the organisation’s objectives will be communicated and monitored via the GBAF and organisation’s Risk Register to the Governing Body. The Governing Body will be alerted to high scoring risks as and when required. The Governing Body receives minutes from its sub-committees and bi-monthly GBAF reports.
The Governing Body will be provided with accurate and relevant information on which to base decision-making. Where a new risk emerges that is of significant importance, it will be escalated to the Governing Body immediately, irrespective of the committee structure.

The Governing Body includes GP members. These GP members have clinical portfolios that support the risk management process to ensure high quality services to secure best outcomes for the local population. Appendix 3 lists the clinical portfolios held by the Governing Body GP members.

11.2 Audit Committee
The Audit Committee’s primary role is to conclude upon the adequacy and effective operation of the organisation’s overall control system, in particular:
- Monitoring, scrutinising and challenging the work and conduct of the committee within their respective areas of responsibility.
- Reviewing the GBAF to ensure there is appropriate spread of objectives and that the main inherent/residual risks have been identified as well as new risks. It should ensure that the processes and format remain relevant and effective for the organisation.
- Assessing and reporting on the suitability of the format and processes of the GBAF will provide a sound basis for the Audit Committee to comment on key aspects such as:
  - Whether the objectives of the framework are appropriate for the organisation.
  - That controls in place are sound and complete.
  - That assurances are reliable and of good quality.
  - That the data that the assurances are based on is sound and accurate.
- All risk and control related disclosure statements (in particular 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.
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Counter Fraud and Security Management Service.
- Monitoring implementation of action plans that have been drawn up to cover gaps in controls, assurances and reports to management.

The Audit Committee meets on a quarterly basis.

11.3 Quality Committee
The key function of the Quality Committee is to assure the Governing Body that the quality of services delivered to patients across the domains of patient experience, patient safety and quality of clinical effectiveness in provider services is maintained. The Quality Committee will meet bi-monthly.

NHS Greenwich CCG
Integrated Risk Management Framework (May 2017)
The Quality Committee (as stated within the NHS Greenwich CCG Constitution) also undertakes the following functions in relation to risk management:

- Undertake a lead role in identifying, measuring and monitoring relevant clinical commissioning risks.
- To approve the Clinical Commissioning Group’s risk management arrangements.
- To approve the Clinical Commissioning Groups arrangements (for risk sharing and risk pooling with other organisations e.g. pooled funds with other clinical commissioning groups or pooled budgets under Section 75 of the NHS Act 2006).
- Oversee annual risk and clinical governance development plans and annual report in accordance with National Reporting requirements.
- Provide regular reports to the CCG Governing Body and as required to the Audit Committee.
- Review the Quality Report prior to submission to the CCG’s Governing Body to ensure it is receiving appropriate and accurate information on patient safety, quality, information governance, performance and risk management of commissioned services.
- Approve and oversee the implementation and review of policies to improve quality and reduce risk.

The Quality Committee will also support the development and reviews of the annual Quality Accounts from the main contracted providers, oversee the process for distribution of service alerts for independent contractors, reviews the Quality Report, the quarterly complaints report and receives assurance and information on:

- Information Governance
- Serious Incidents and Complaints
- Safeguarding Adults
- Safeguarding Children
- Medicines Management

11.4 Finance, Performance and QIPP (FPQ) Committee

The Finance, QIPP and Performance Committee’s role is to provide assurance and advise the Governing Body on all matters relating to Finance, Performance and QIPP and make recommendations to the Governing Body. The committee will meet monthly and reports to the Governing Body.

- Review, monitor and evaluate all aspects of financial risk management and to consider risk management arrangements.
- Receive the Financial Risk Register, carry out risk assessments and seek assurance that financial risks and non-financial risks to QIPP and performance are identified, managed and reviewed effectively.
- Ensure financial risk is an implicit part of reviewing performance, creating and reviewing business plans.
- Ensure consistency of approach with other commissioners (BBG/Local Authority/NHSE).
Ensure appropriate recovery plans are in place where performance deviates and recommend approval of strategies to the CCG Governing Body.

Escalate any concerns about delivery to the Governing Body and ensure that the Risk Register and the GBAF updated to reflect the in-year position.

11.5 Staff Health and Well Being Committee

The Staff Health and Well-being Group includes management and staff side and reviews health and safety matters in accordance with the Safety Representatives and Safety Committee Regulations (SRSCR 1977). The work of the group is concerned with:

- The promotion of co-operation between management and staff in instigating, developing and carrying out measures to ensure the health and safety of staff and visitors.
- The board will seek the controls necessary to mitigate the risk where health and safety risks are identified. Where this is not possible the risk will be escalated.
- The Staff Health & Well-being Board reports to the Quality Committee.

12. Individual Accountabilities and Responsibilities

12.1 Chief Officer (CO)

The Chief Officer has overall responsibility and a duty to ensure the following:

- Effective risk management arrangements within the CCG
- Overall responsibility for the maintenance of financial and organisational controls, along with the Governing Body
- Take executive responsibility for ensuring that there are effective systems and processes in place for the management of environmental risk.
- Be the Accountable Officer for Business Continuity and Emergency Planning within the CCG.

12.2 Chief Financial Officer (CFO)

The Chief Financial Officer holds responsibility for:

- Ensuring that there are effective systems and processes for the management of financial risk, QIPP performance and for stewardship of NHS Greenwich CCG’s finances.
- Advising on financial risks, investigating incidents of fraud and corruption and directing the audit and verification of the Governing Body’s risk management arrangements.

12.3 Director of Integrated Governance

The Director of Integrated Governance holds responsibility for:

- Ensuring that there are effective systems and processes for the management of risk.
- Specifically ensuring safeguarding risks are identified and managed via the corporate Risk Register.
• Overview of the GBAF. Risks identified through providers (via CQRG and Quality Committee) are reported within regular Quality Reports to the Governing Body.

• Vice Chair of the Quality Committee to ensure clinical and executive oversight of quality issues raised.

• Emergency Planning and Business Continuity within the CCG and representing the CCG at the Local Health Resilience Partnership (LHRP).

In line with operational functions, the Director of Integrated Governance is also the Senior Information Risk Officer (SIRO) responsible for:

• Information governance, data security, data quality and the management of risk involved with these areas.

• Ensuring that information risk management is incorporated into the CCG’s risk management framework and where required will review and agree action in respect of identified information risks.

• Take ownership of the risk assessment process for information risk, including a review of an annual information risk assessment to support and inform the annual Governance Statement; ensuring that Greenwich CCG’s approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.

• Provide a focal point for the resolution and/ or discussion of information risk issues.

• The Director of Integrated Governance works closely and is advised by the Caldicott Guardian (Lead GP Clinical Commissioner) on risks related to information governance.

12.4 Director of Commissioning
The Director of Commissioning holds responsibility for:

• The executive responsibility for the risks to delivery of commissioned services.

• Risks relating to clinical services provided by the CCG such as Continuing Health Care.

• Service re-design risks and informing the Governing Body of any risks relating to contracts and new projects.

12.5 Associate Director of Integrated Governance
The Associate Director of Quality & Governance is responsible for:

• Ensuring that the Governing Body is aware of all legal and statutory responsibilities and guidance and that appropriate action is underway to enable compliance.

• The implementation, co-ordination and monitoring of risk management activity within the organisation, together with the strategic oversight of the Director of Integrated Governance.

• Ensuring that systems and processes are in place for the continuous effective management of risk in line with this framework, and National Risk Management Standards.
• Reviewing risk management performance through the interrogation and trend analysis of incident reporting and data held in the organisations Risk Management Database.
• Work jointly with the Director of Integrated Commissioning to ensure risks reported through providers via Clinical Quality Review Groups (CQRG) and the Quality Committee, are captured within regular Quality Reports to the Governing Body.
• Reviews high scoring risks on the corporate Risk Register and will, when necessary, ask Directors, managers or clinicians to attend appropriate review meetings to provide assurance that risks are being addressed.

12.6 Patient Safety Manager
The Patient Safety Manager is responsible for:

• Reviewing all serious incidents and Never Events reports and ensures that recommendations from these reports are appropriate and implemented.
• Working closely with the Safeguarding Lead nurses on Serious Incidents and or serious case review (SCR) management and associated risk reporting.
• Seeking assurance on behalf of the CCG that providers are managing patient safety effectively and reports to the Quality Committee.
• Reviewing risk management performance through the interrogation and trend analysis of incident reporting and data held in the organisations Risk Management Database.
• Following up on risks reported on the Risk Register with the relevant responsible director or associate directors to review risk levels and action plans and update this on Datix.
• Provide risk reports to the GEG and Governing Body at each meeting.
• Provide risk reports to the appropriate committee that has oversight of the monitoring of risk and action plans such as the Quality Committee, the Joint Safeguarding Group (JSG), the Finance, Performance and QIPP (FPQ) Committee and the Audit Committee.

12.7 Compliance Manager
The Compliance Manager is responsible for:

• Ensuring optimum performance of risk management utilising the corporate Risk Register and may provide support and assistance in producing reports as required.
• Acting on behalf of the Associate Director of Quality & Governance in fulfilling the statutory patient safety, quality and operational responsibilities on a day-to-day basis, through the implementation of the Framework.
• Approving Equality Impact Assessments on all policies and ensure equality analysis has been applied.
• Advising on all Health & Safety Legislation, Codes of Practice and EC Directives, ensuring Health & Safety associated Risk Assessments and Safety Audits are undertaken and added to the Risk Register.
• Ensuring the organisation completes any recommendations provided through internal or external audit on this framework.
• Ensuring optimum performance of risk management utilising the Risk Register and may provide support and assistance in producing reports as required.
12.8 All Directors and Associate Directors
Directors and Associate Directors have a duty to:

- Ensure that this framework and associated policies, procedures and guidelines are implemented within their areas of responsibility.
- Ensure that, where appropriate, an investigation is carried out as soon as possible after an incident to establish the root cause of the incident and to formulate a corrective action plan to prevent recurrence.
- Monitor the progress of any corrective action plan, ensuring that agreed timescales are met.

12.9 Line Managers
Managers will fulfil their statutory obligations for the management of risk within the workplace by:

- Conducting assessments for all work-based activity and foster a culture of risk awareness throughout their division.
- Setting a high standard of proactive risk management and be seen as exemplar role models for all staff.

12.10 All Staff
All staff have a duty to comply with the organisation’s policies and procedures. Staff who require registration with a professional body must act at all times in accordance with that body’s code of conduct and rules. Members of the Governing Body are expected to comply with the Governing Body Code of Behaviour.

Specifically, all staff must:

- Comply with the risk management and health and safety arrangements appropriate to the work task being undertaken.
- Report to their line manager any deficiencies that could impact upon the health, safety and welfare of individuals (patients, staff, contractors, etc.). Be aware that they have a statutory duty to take reasonable care for their own safety and the safety of all others that may be affected by their actions or inaction.
- Report all incidents/accidents and near misses using the Incident Reporting System (Datix) in conjunction with reference to the local Incident Reporting Policy.
- Escalate to a senior manager by the quickest means possible incidents where serious harm has occurred or the potential for serious harm exists.
- Where necessary, raise concerns about conduct or performance of services or individuals where this presents a risk (whistle blowing).
- Not intentionally or recklessly interfere with or prejudice equipment that has been provided for the safety of them or others.
- Participate as directed by line management in any training deemed necessary to effectively manage risk.
- Comply with all NHS Greenwich CCG rules, regulations and instructions to protect the health, safety and welfare of anyone affected by the business of the organisation. Health & Safety compliance is governed by the Health & Safety at Work Act 1974 and expert health and safety guidance is delivered to staff through a contract with Oxleas NHS Foundation Trust.
- Be familiar with the NHS Greenwich CCG Integrated Risk Management Framework and Service/Department procedures, local arrangements for safe systems of work and other internal arrangements and controls, and comply with these.
- Neither intentionally, nor recklessly, interfere with or misuse or fail to use when required, any equipment provided for the protection of safety and health as pursuant to the Health & Safety at Work Act (1974).
- Be aware of emergency planning, business continuity and resilience procedures for their directorates and responsibilities in relation to resuscitation, evacuation and fire precaution procedures.
- Comply with mandatory training programmes.

12.11 Trade union and staff association
All recognised Trade Union and Staff Associations may nominate safety representatives in accordance with national policy. Representatives must provide notification of their appointment to the Chief Operating Officer. Human Resources will maintain a register of safety representatives and this will be made available to all staff. Registered safety representatives will be entitled to such time off and facilities as necessary for the effective performance of their duties.

12.12 Employee Health Management Service (CSU)
The Employee Health Management Service is responsible for the active implementation of risk assessment and risk management associated with the maintenance of employee health, including advice on the management of any uncontrolled risk as it relates to staff.

13 Training and Awareness
The Integrated Risk Management Framework will be available on the CCG intranet. All staff are encouraged to access this and familiarise themselves with the framework whilst developing an understanding of what is expected of them in line with risk management within the CCG.

To enable the Integrated Risk Management Framework to be fully implemented, workshops will be set up ad hoc on request from managers for appropriate staff.

14 Organisational Culture
GCCG’s culture is such that it encourages openness, transparency and candour throughout the system about matters of concern. This is in line with the recommendations from the Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). Where risk is created by deliberate failure to adhere to policy or acting outside professional codes of conduct, action may be taken against individuals under the disciplinary committee. Greenwich CCG fosters a risk aware culture shared by all in the services in putting the patients first.

To support the culture of listening, learning and responding within the organisation, the CCG will:
- Be open and fair.
- Approach all incidents, complaints and issues fairly and equally.
• Ensure transparency in the review of incidents and complaints and other issues and transfer the learning both internally and externally.
• Ensure all staff are aware of this strategy and processes and all other associated policies that complement robust risk management and internal control within the CCG.
• Support and advise staff with matter relating to risk management.
• Provide relevant training and information resources.
• Acknowledge reports received and provide feedback on actions and decisions to demonstrate that the CCG has listened.
• Ensure there is a framework through which staff can raise concerns, malpractice and impropriety in a supportive manner.
• Respond to gaps in policy and processes to improve outcomes, experience and the overall management of risk.

In light of the Francis Report, NHS Greenwich CCG aims to focus on the following 2 key areas set out within it:
1. Ensure that all providers of NHS care are appropriately delivering safety standards
2. A focus on listening to patients and staff working inclusively as a member organisation.

15 Monitoring and Review
Greenwich CCG recognizes that risk management processes are continually evolving and the systems must be reviewed in light of changes in the CCG’s environment, operations, best practice, guidance and legislation. In light of this, the Integrated Risk Management Framework will be reviewed annually for

• The continuing suitability and effectiveness of the systems and processes in place (including the effectiveness through the organisational programme of internal audit).
• Ensure the Governing Body will sign-off the GBAF on an annual basis and the Quality Committee will approve (on behalf of the Governing Body), the Annual Governance Statement.
The following table shows the processes that the CCG will follow in terms of monitoring compliance with this framework:

**Fig 4: Monitoring Schedule**

<table>
<thead>
<tr>
<th>Measurable Policy Objective</th>
<th>Monitoring/Audit</th>
<th>Frequency of monitoring</th>
<th>Responsibility for performing the monitoring</th>
<th>Monitoring reported to which groups/committees, including responsibility for reviewing action plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of high level risks</td>
<td>Greenwich Board Assurance Framework (GBAF) Corporate Risk Register</td>
<td>Monthly</td>
<td>Director of Integrated Governance &amp; Associate Director of Quality &amp; Governance</td>
<td>• Governing Body&lt;br&gt;• Greenwich Executive Group (GEG)&lt;br&gt;• Finance, Performance and QIPP (FPQ) Committee&lt;br&gt;• Quality Committee</td>
</tr>
<tr>
<td>Review of open and closed risks to ensure appropriate management</td>
<td>Risk Register</td>
<td>Monthly</td>
<td>Director of Integrated Governance &amp; Associate Director of Quality &amp; Governance</td>
<td>• Governing Body&lt;br&gt;• Greenwich Executive Group (GEG)&lt;br&gt;• FPQ Committee&lt;br&gt;• Quality Committee</td>
</tr>
</tbody>
</table>

16 **Key Related Documents and References:**
The Risk Management Strategy links with the following:
- Serious Incident Policy
- Claims Management Policy
- Complaints Management Policy
- Whistle Blowing Policy
- Counter Fraud and Corruption Policy
- Health and Safety Policy
- Business Continuity and Emergency Planning Policy

**References:**
- British Standards Institution *BS EN 31010:2010 Risk Management: Risk Assessment Techniques.*
- *Civil Contingencies Act (2004).*
- Healthcare Quality Improvement Partnership & Good Governance Institute *Good Governance Handbook.*
• Good Governance Institute, 2009 *Board Assurance Frameworks: a Simple Rules Guide for the NHS (version 2.1)*.
• NHS National Patient Safety Agency, 2008 *A risk matrix for risk managers*.
• NHS Commissioning Board (2013) SI Guidance.
• National Quality Board (2011) *Maintaining and Improving Quality during the transition: safety effectiveness, experience*.
When current risk score matches target risk score, close risk at formal review. If target risk score cannot be reached but no further action can be taken, escalate the risk with proposal for closure and the reasons to the Greenwich Executive Group (GEG).
# APPENDIX 2: Risk Appetite for NHS Organisations

<table>
<thead>
<tr>
<th>Risk levels</th>
<th>Avoid</th>
<th>Minimal</th>
<th>Cautious</th>
<th>Open</th>
<th>Seek</th>
<th>Mature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key elements</td>
<td>Avoidance of risk is a key element of organizational objective</td>
<td>Preference for ultra-safe delivery options that have low degree of inherent risk and only for limited reward potential</td>
<td>Preference for safe delivery options that have low degree of inherent risk and may only have limited potential for reward</td>
<td>Willing to consider all potential delivery options and choose while also providing an acceptable level of reward</td>
<td>Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)</td>
<td>Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust</td>
</tr>
<tr>
<td>Financial/VFM</td>
<td>Avoidance of financial loss is a key objective. Only willing to accept the low cost option. VFM is the primary concern</td>
<td>Only prepared to accept the possibility of some financial loss if essential</td>
<td>Prepare to accept possibility of some limited financial loss. Willing to consider other benefits or constraints. Resources generally restricted to existing commitments</td>
<td>Prepared to invest for return and minimize the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalize on opportunities</td>
<td>Investing for the best possible return and accept the possibility of a financial loss- with controls in place. Resources allocated without firm guarantee of return-</td>
<td>Consistently focused on the best possible return for stakeholders. Resources allocated in ‘social capital’ with confidence that process is a return in itself</td>
</tr>
<tr>
<td>Compliance or Regulatory</td>
<td>Avoid anything which could be challenged, even unsuccessfully. Play safe</td>
<td>Want to be very sure we will win any challenge. Similar situations elsewhere have not breached compliances</td>
<td>Limited tolerance for sticking our neck out. Want to be sure we will win any challenge</td>
<td>Challenge would be problematic but we are likely to win and the gain will outweigh the adverse consequences</td>
<td>Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.</td>
<td>Consistently pushing back on regulatory burden. Front foot approach informs better regulation</td>
</tr>
<tr>
<td>Innovation/Quality Outcomes</td>
<td>Defensive approach to objectives- aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance systems/technology developments</td>
<td>Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems/technology developments to protect current operations.</td>
<td>Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/technology developments limited to improvements to protection of current operations</td>
<td>Innovations supported, with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.</td>
<td>Innovation the priority- consistently ‘breaking the mould’ and challenging current work practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority- management by trust rather than tight control.</td>
<td>Innovation the priority- consistently ‘breaking the mould’ and challenging current work practices. Investment in new technologies as catalyst for operational delivery. Devolved authority- management by Trust rather than tight control is standard practice</td>
</tr>
<tr>
<td>Reputation</td>
<td>No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organization. External interest in the organisation viewed with concern</td>
<td>Tolerance for risk taking limited to those events where there is no chance of any significant repercussions for the organisation. Senior management distance themselves from chance of exposure to attention</td>
<td>Tolerance of risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest</td>
<td>Appetite to take decisions with potential to expose the organization to additional scrutiny/interest. Prospective management of organisation’s reputation</td>
<td>Willingness to take decisions that are likely to bring scrutiny of the organization but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation or organisation</td>
<td>Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks</td>
</tr>
</tbody>
</table>

**APPETITE**

- NONE: organisation viewed with concern
- LOW: external attention to, the organization, could lead to scrutiny of, or indeed involve the organisation
- MODERATE: organisation will take the difficult decisions for the right reasons with benefits outweighing the risks
- HIGH: potentially enhancing reputation or organisation
- SIGNIFICANT: organisation will take the difficult decisions for the right reasons with benefits outweighing the risks
Appendix 4 - Equality & Equity Impact Assessment & EDS2 Checklist

This is a checklist to ensure relevant equality and equity aspects of proposals have been addressed either in the main body of the document or in a separate equality & equity impact assessment (EEIA)/equality analysis. It is not a substitute for an EEIA which is required unless it can be shown that a proposal has no capacity to influence equality. The checklist is to enable the policy lead and the relevant committee to see whether an EEIA is required and to give assurance that the proposals will be legal, fair and equitable. The word proposal is a generic term for any policy, procedure or strategy that requires assessment.

<table>
<thead>
<tr>
<th>Challenge questions</th>
<th>Yes/No</th>
<th>What positive or negative impact do you assess there may be?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the proposal affect one group more or less favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Pregnancy and Maternity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Sex</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Gender and Gender Re-Assignment</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Marriage or Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Sexual orientation (including lesbian, gay bisexual and transgender people)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Disability (including learning disabilities, physical disability, sensory impairment and mental health problems)</td>
<td>No</td>
<td></td>
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<tr>
<td>2. Will the proposal have an impact on lifestyle? (e.g. diet and nutrition, exercise, physical activity, substance use, risk taking behaviour, education and learning)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3. Will the proposal have an impact on social environment? (e.g. social status, employment (whether paid or not), social/family support, stress, income)</td>
<td>No</td>
<td></td>
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<tr>
<td>4. Will the proposal have an impact on physical environment? (e.g. living conditions, working conditions, pollution or climate change, accidental injury, public safety, transmission of infectious disease)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. Will the proposal affect access to or experience of services? (e.g. Health Care, Transport, Social Services, Housing Services, Education)</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

By using evidence and insight to assess and grade our equality performance, NHS Greenwich can generate much of the information we will require to demonstrate compliance with the PSED.
checklist is to enable the policy lead and the relevant committee to see if a particular policy or project will provide the relevant evidence to assist NHS Greenwich CCG meet the set out EDS goals to achieve better outcomes for patients and staff. Please assess your policy, project or service against the following:

<table>
<thead>
<tr>
<th>The goals and outcomes of EDS2</th>
<th>Description of outcome</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better health outcomes</strong></td>
<td>1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities</td>
<td>No</td>
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<tr>
<td></td>
<td>1.2 Individual people’s health needs are assessed and met in appropriate and effective ways</td>
<td>No</td>
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<td></td>
<td>1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td>
<td>No</td>
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<tr>
<td></td>
<td>1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td>
<td>No</td>
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<tr>
<td></td>
<td>1.5 Screening, vaccination and other health promotion services reach and benefit all local communities</td>
<td>No</td>
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<tr>
<td><strong>Improved patient access and experience</strong></td>
<td>2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>2.2 People are informed and supported to be as involved as they wish to be in decisions about their care</td>
<td>No</td>
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<tr>
<td></td>
<td>2.3 People report positive experiences of the NHS</td>
<td>No</td>
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<tr>
<td></td>
<td>2.4 People’s complaints about services are handled respectfully and efficiently</td>
<td>No</td>
</tr>
<tr>
<td><strong>A representative and supported workforce</strong></td>
<td>3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfill their legal obligations</td>
<td>No</td>
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<tr>
<td></td>
<td>3.3 Training and development opportunities are taken up and positively evaluated by all staff</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source</td>
<td>No</td>
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<tr>
<td></td>
<td>3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td>
<td>No</td>
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<tr>
<td></td>
<td>3.6 Staff report positive experiences of their membership of the workforce</td>
<td>No</td>
</tr>
<tr>
<td><strong>Inclusive leadership</strong></td>
<td>4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination</td>
<td>No</td>
</tr>
</tbody>
</table>

**Policy Author**
Signature: [Signature]
Date: 07/11/2016

**Equalities Lead**
Signature: [Signature]
Date: 07/11/2016