Corporate	Risk Management Policy

Version Number	Date Issued	Review Date
V4	July 2017	July 2019

Prepared By:	Senior Governance Manager NECS
Consultation Process:	Internal NECS risk team review Internal CCG risk lead review Executive Committee Audit & Assurance Committee Governing Body
Formally Approved:	Executive in Common June 2017

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Document History

Version	Date	Significant Changes
1	28/02/2013	First issue
2	07/07/2014	Reviewed by CCG risk lead & NECS Senior Governance Manager CCG New ways of working governance structure updated Safeguard Incident Risk Management (SIRMS) Risk Register Standard Operating Procedure (SOP) added.
3	01.02.16	Policy reviewed no major changes Safeguard Incident Risk Management (SIRMS) Risk Register Standard Operating Procedure (SOP) updated.
4	27.06.17	Annual Review – Governance structure update page 9 Equality Analysis updated page 13

Equality Impact Assessment

Date	Issues
01/02/2016	See section nine of this document

POLICY VALIDITY STATEMENT

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Contents

1. Introduction

For the purposes of this policy, NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group will be referred to as "the CCG". This policy aims to set out the CCGs approach to risk and the management of risk in fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding within the organisation of an effective risk management policy and processes will ensure that the reputation of the CCGs is maintained and enhanced, and its resources are used effectively to reform services through innovation, large-scale prevention, improved quality and greater productivity.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

The purpose of this policy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The policy will:

- Set out an organisation wide approach to managing risk, in a simple, straightforward and clear manner the intentions of the CCG for timely, efficient and cost-effective management of risk at all levels within the organisation.

The aims of the Policy are summarised as follows:

- To ensure that risks to the achievement of the CCGs objectives are understood and effectively managed;
- To ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed;
- To assure the public, patients, staff and partner organisations that the CCG is committed to managing risk appropriately;
- To protect the services, staff, reputation and finances of the CCG through the process of early identification of risk, risk assessment, risk control and elimination.

This policy applies to all employees and contractors of the CCG. Managers at every level have an objective to ensure that risk management is a fundamental part of the approach to integrated governance. All staff at every level of the organisation are required to recognise that risk management is their personal responsibility.

Independent contractors are responsible for ensuring compliance with relevant legislation and best practice guidelines and for the development and management of their own procedural documents. Independent contractors are required to demonstrate compliance with risk management processes which are compatible with this policy.

2. Definitions

The following terms are used in this document:

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

- **Risk Appetite** is the organisation's unique attitude towards risk taking that in turn dictates the amount of risk that it considers is acceptable.

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

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

- **Residual Risk** is the risk remaining after the risk response has been applied.

Examples of the types of risk that the CCG might encounter and need to mitigate against include;

- **Corporate risks** – operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues.

- **Clinical risks** – associated with our commissioning responsibilities and including service standards, competencies, complications, equipment, medicines, staffing, patient information.

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

- **Financial** – associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the QIPP programme.

- **Environmental including health and safety** – ensuring the well-being of staff and visitors whilst using our premises.

3. Risk Management Framework

3.1 Whenever risks to the achievement of CCGs objectives have been identified, it is important to assess the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk assessment matrix is used, details of which are provided at Appendix A. The matrix is based on current national guidance, but has been adapted to suit the CCGs agreed risk appetite.

3.2 Using this standardised tool will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

3.3 Risks are assessed in terms of the likelihood of occurrence/re-occurrence and the consequences of impact. An initial risk rating is applied to the risk based on current controls. An action plan should be developed based on any gaps identified in putting control measures in place. The action plan will identify further mitigating action to ensure adequate controls are in place. Risks are reassessed to take account of the effectiveness of the controls i.e. whether they are considered to be satisfactory, have some weaknesses or to be weak. Reassessment will determine a residual risk rating.

There are five categories of risk:

- **Catastrophic** – the consequence of these risks could seriously impact upon the achievement of the organisation's objectives, its financial stability and its reputation. Examples include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability.
- **Severe** – these are significant risks that require prompt action. With a concerted effort and a challenging action plan, the risks could be realistically reduced within a realistic timescale.
- **Moderate** – these risks can be realistically reduced within a realistic timescale through reasonably practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements.
- **Minor** – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department.
- **Negligible** – these risks cause minimal or limited harm or concern.

3.4 Once the category of risk has been identified, this then needs to be entered onto the CCG risk register. Please refer to section 3.7 below for further guidance on risk registers.

3.5 Any risk that is identified through the risk assessment process (as well as the incident reporting system), and which the CCG is required legally to report, will be reported accordingly to the appropriate statutory body, e.g. Health and Safety Executive or Information Commissioner

3.6 **Risk Appetite**

3.6.1 The CCG endeavours to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However there is the recognition that by understanding the organisations 'risk appetite', this will ensure the CCG supports a varied and diverse approach to commissioning, particularly for practices to work proactively to improve efficiency and value.

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

3.6.3 The Governing Body will set boundaries to guide staff on the limits of risk they are able to accept in the pursuit of achieving its organisational objectives. The Governing Body will set these limits annually and review them as appropriate.

3.6.4 The Governing Body will set these limits based on whether the risk is:

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

3.7 **Risk Register**

3.7.1 Current and potential risks are captured in the CCG Risk Register and include actions and timescales identified to minimise such risks. The risk register is a log of risks that threaten the organisation's success in achieving its aims and objectives and is populated through the risk assessment and evaluation process.

3.7.2 The register contains a local record of all current and potential risks for each area or function that the CCG is accountable for, as identified by the appropriate function lead(s). The registers are reviewed and updated monthly by risk owners and reviewed bi-monthly by Governing Body.

3.7.3 There is separate guidance which provides further detail and advice on the completion of risk registers, supported by a training programme for the leads involved in their completion. The Safeguard Incident & Risk Management System (SIRMS) Risk Register Standard Operating Procedure can be accessed via the CCGs internet. The document contains a New Risk Form which should be completed on identification of a risk and forwarded to the relevant Risk Owner.

3.8 The detailed governance structure that supports implementation of the risk management policy is set out in section 5.3.

4. Duties and Responsibilities

Council of Members	The Council of Members have delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Operating Officer	The Chief Operating Officer supports the Chief Clinical Officer by leading on risk management and has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements
Chief Finance Officer	The Chief Finance Officer has overall responsibility for ensuring the risk management process is robust and adhered too. And ensuring that risk registers are maintenance and updating in a timely manner and that risk reports actually reflect the CCG risk profile, including the assurance framework.
Directors	The Directors have responsibility for ensuring their individual risk registers are maintained and updated.
Heads of Service	The Heads of Service have a responsibility to support their directors to maintain and update their individual risk registers working closely with the chief finance officer to ensure a transparent and consistent approach to risk management across the CCG in partnership with key stakeholders.

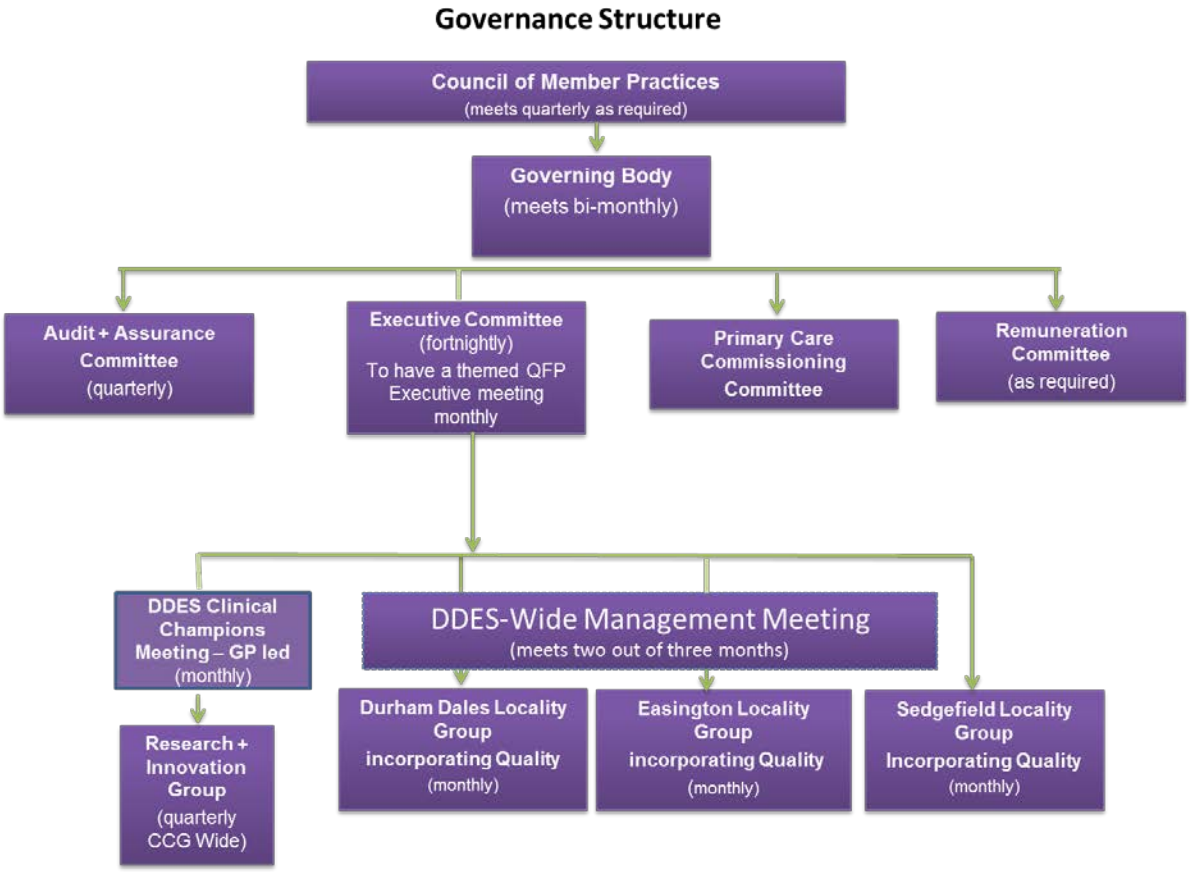
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.
North of England Commissioning (NECS)	NECS Senior Governance Manager and Senior Governance Officer will provide risk management support and advice.

5. Implementation

5.1 This policy will be available to all staff for use through the intranet and public websites for the CCG.

5.2 The CCG have adopted a standardised framework for the assessment and analysis of all risks encountered in the organisation and which is set out in this policy. The implementation of this policy is achieved through the completion of the risk register. It is also supported by a detailed governance structure through its various committees/groups and which are described in the policy. Directors and heads of service will be responsible for ensuring the policy is implemented in their areas of responsibility and compliance with this policy may be monitored through a process of auditing as set out by the Governing Body.

5.3 The detailed governance structure that supports implementation of the risk management policy is set out below.



- The Governing Body has been delegated overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the CCG 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. The Governing Body will set these limits annually and review them as appropriate.

- The Governing Body monitors high level, principal risks relating to the achievement of the strategic objectives through the Governing Body Assurance Framework.

- The Risk and Assurance Committee is responsible for reviewing and providing assurance to the Governing Body on the systems in place across the CCG for governance and risk management including internal control.

- The Executive Committee is responsible for ensuring that all risks are identified, addressed and reported to the Governing Body as appropriate.

5.4 The CCG governance infrastructure supports and enables effective risk management. The Executive Committee, chaired by the Chief Clinical Officer, has overall responsibility for overseeing the implementation of this policy. The committee will also:

- review all risks on the risk register and monitor progression of stated action on a monthly basis;
- review trend analysis for all risks;
- ensure the established processes to manage risk by each team/committee is in place and provide support for action where necessary;
- ensure the processes for managing risk within the CCG are clearly understood, appropriately delegated and effective;
- escalate issues to the governing body as appropriate, in particular the identification of new, significant risk or areas of concern of risks graded high or extreme to the governing body; and

5.5 Significant CCG projects / work streams require project / programme leads to ensure there are arrangements in place to develop, maintain and regularly review a project risk register to ensure effective management of risk. Red risks (graded as extreme or high) should be escalated to the CCG risk register if they are likely to impact on the CCG strategic objectives.

5.6 Assurance Framework

The CCG will produce and maintain a Governing Body Assurance Framework (AF). The AF forms part of the overall governance arrangements of the CCG and is a key component of the organisation's internal control arrangements. The AF forms a significant part of the assurance given by the Accountable Officer in the Annual Governance Statement. It will be prepared at the start of each financial year when the organisation's strategic objectives are known. It should be prepared with the involvement of senior leaders, reviewed by the committee with oversight for it (e.g. the Audit & Assurance Committee). It will also be approved by the Governing Body and reviewed by it at least six monthly

6. Training Implications

The Chief Operating Officer will ensure that the necessary training or education needs and methods required to implement the policy and procedure(s) are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

The training required to comply with this policy is key to the successful implementation of this policy and embedding a culture of risk management in the organisation. Through a training and education programme staff will have the opportunity to develop more detailed knowledge and appreciation of the role of risk management. Training and education in risk management will be offered through regular staff induction programmes, annual mandatory training sessions and a rolling programme of risk management and training programmes.

7. Related Documents

7.1 Other related policy documents

NHS England policies

- Risk Management Policy
- Health & Safety: Policy & Corporate Procedures
- Incident management: Policy & Corporate Procedures
- Business Continuity Policy: Policy & Corporate Procedures

CCG Corporate Policies

7.2 Legislation and statutory requirements

This risk management policy is developed with reference to Department of Health publications and publications of expert bodies on governance and risk management:

- Data Protection Act 1998
- Principles and framework contained in the legislation including: Health and Safety at Work Act 1974
- Principles contained within the Information Governance toolkit
- Risk Management Matrix for Risk Managers National Patient Safety Agency, (NPSA) (2008) ISO 31000 -2009

7.3 Best practice recommendations

- NHS Audit Committee Handbook (2011)
- Building the Assurance Framework: A practical Guide for NHS Boards March 2003. Gate log Reference1054
- Integrated Governance Handbook 2006
- Intelligent Commissioning Board (2006 & 2009)
- Making a Difference – Review of Controls Assurance Gateway Ref. No. 4222
- NHS Litigation Authority – CNST Risk Management Standards Governing the NHS: A guide for NHS Boards (2003)
- Taking it on Trust – Audit Commission (2009) Institute of Risk Management
- The Healthy NHS Board: Principles for Good Governance (2010)

8. Monitoring, Review and Archiving

8.1 Monitoring

The governing body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

8.2 Review

8.2.1 The governing body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

8.2.2 Staff who becomes aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

8.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

8.3 Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

9. Equality Analysis

Partners in improving local health

North of England Commissioning Support

Equality Impact Assessment- Staff Policy

Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
Advance equality of opportunity between people who share a protected characteristic and those who do not
Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	**Debra Elliott**
Title of service/policy/process:	**Corporate Policy** **Risk Reporting & Management**
Existing: x **New/proposed:** ☐ **Changed:** ☐	
What are the intended outcomes of this policy	
This policy provides information and guidance to staff working within the CCG to report and manage risk.	
Who will be affected by this policy	
x Staff members **x Other** **If other please state:** **Patients, Staff from other organisations, Public.**	
What is your source of feedback/existing evidence?	
☐**National Reports x Staff Profiles** ☐**Staff Surveys x Complaints/Incidents** ☐**Focus Groups** ☐**Previous EIAs** **NECS & CCG joint working**	
If other please state: • **Feedback from committee meetings where incidents are discussed** • **Staff who contact the NECS Governance Sections for help and assistance where required**	

Evidence	What does it tell me? (About the existing policy/process? Is there anything suggest there may be challenges when designing something new?)
National Reports	**NA**
Staff Profiles	**NA**
Staff Surveys	**NA**
Complaints and Incidents	**Buy in from reporters and managers**
Staff focus groups	**NA**
Previous EIA's	**NA**
Other evidence (please describe)	**NA**

 **STEP 2 - IMPACT ASSESSMENT**
What impact will the new policy/system/process have on the following staff characteristics: (Please refer to the 'EIA Impact Questions to Ask' document for reference)
Age A person belonging to a particular age
None
Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
Positive impact, incidents will be reviewed and actions will be put in place to mitigate any further risk. Staff can get assistance to report and manager an incident from the NECS Governance Team if required.
Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self-perception.
None positive impact the policy enables this group to report incidents
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
None
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.
None
Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
Positive impact, an incident can be reported should it occur
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
Positive impact, an incident can be reported should it occur
Sex/Gender A man or a woman.
Positive impact, an incident can be reported should it occur
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
Positive impact, an incident can be reported should it occur
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person

Positive impact, an incident can be reported should it occur

 **STEP 3** - ENGAGEMENT **AND INVOLVEMENT**

How have you engaged with staff in testing the policy or process proposals including the impact on protected characteristics?
No impact on the human rights of the public, patients or staff, all citizens rights respected in the incident process.
Please state how staff engagement will take place:
Via bulletins, communications, training sessions and contact with members of the NECS Governance Team who are always contactable for help and assistance.

 **STEP 4 - METHODS OF COMMUNICATION**

What methods of communication do you plan to use to inform staff of the policy?
x Verbal – through focus groups and/or meetings X Verbal - Telephone **☐Written – Letter x Written – Leaflets/guidance booklets** **X Email x Internet ☐Other**
If other please state: **Via SIRMS**

 **STEP 5 - SUMMARY OF POTENTIAL CHALLENGES**

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
1 Continuous improvement of the risk reporting & management processes. Particular emphasis being made on making the process as user friendly as possible.	Buy in of all staff in the organisation

STEP 6- ACTION PLAN

Ref no.	Potential Challenge/ Negative Impact	Protected Group Impacted (Age, Race etc.)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date
NA		All	**Risk Management Training to staff and incident managers to promote quality of risk reporting & data**	Positive - increased by in and awareness of process	**DE**	**Ongoing**
NA		**All**	**E-learning tool developed for risk awareness.**	Positive - increased by in and awareness of process	**DE**	**Ongoing**
NA		**All**	**E- learning tool to be developed for incident managers**	Positive - increased by in and awareness of process	**DE**	**Ongoing**

Ref no.	Who have you consulted with for a solution? (users, other services, etc.)	Person/ People to inform	How will you monitor and review whether the action is effective?
NA	SIRMS users / Committee Members	CCG risk lead & Head of Corporate Services Management Business Lead and Operational Lead	Evaluation of training

SIGN OFF

Completed by:	**Debra Elliott**
Date:	**14/06/2017**
Signed:	**Debra Elliott**
Presented to:	**Executive in Common**
Publication date:	**27/06/2017**

Appendix A

Risk assessment and escalation process

Step 1: Determine the consequence score

This is offered as guidance when completing a risk assessment, either when an incident has occurred or if the consequence of potential risks is being considered.

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. Note consequence will either be negligible, minor, moderate, major or catastrophic.

Table 1: Consequence score

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence score (severity levels) and examples of descriptors				
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Step 2: Determine the likelihood score

Now determine what is the likelihood of the impact 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. The frequency-based score will either be classed as rare, unlikely, possible, likely or almost certain.

Table 2: Likelihood score

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.

Step 3: Assigning a risk rating

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

Table 3: Risk rating = consequence x likelihood (C x L)

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

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

Green	1 – 3	Low
Yellow	4 – 6	Moderate
Amber	8 – 12	High
Red	15 - 25	Extreme

Step 4: Control measures

Consider the control measures that should be in place to mitigate the risk. Identify and record any gaps in controls.

Step 5: Assessing the effectiveness of control(s)

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

Table 4: Assessing the effectiveness of control(s)
Review the control(s) for each of the risks and apply the following criteria:

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

Step 6: Align to corporate objective

The risk should be aligned to the corporate objective that it will impact on. DDES Corporate Objectives are:

1. Access to safe, high quality services.
2. Development and delivery of commissioning plans.
3. Effective internal and external engagement including communications.
4. Effective governance arrangements and organisational development.
5. Contract management and performance against key targets.

Step 7: Developing an action plan

An action plan must be developed for all risks with a score of 15 or above. However, it is useful to develop an action plan regardless of risk score in order to record progress on control measures and who is responsible for carrying them out.

Step 8: Frequency of review

The frequency of review should also be specified as this will need to be added to SIRMS 'Review Details' section by choosing the appropriate option from the drop down list.

Risk Updates

Risks should be reviewed and updated on a regular basis.

Please follow the guidance below:

Before entering your update, ensure you have created a new version – this can be done in two ways:

1. If your 'Risk Level' has changed as a result of review you should change the risk level to ensure it corresponds with the residual risk rating that has been applied. This will automatically create a new version.

2. If your 'Risk Level' remains the same following review you should click on 'New Version'.

- Scroll down to 'Controls and Assurances', click on each control measure in turn and edit to enter the assurance against each control. You will also need to alter the control effectiveness accordingly. You can also enter any new controls. *NB: As long as you have created a new version you can overwrite the assurance from the previous version as this will be archived in the previous version, and will provide an audit trail of progress. This will ensure that only the current position is seen on the printed risk register.*

- Scroll down to 'Action Plan', add any 'New' actions and update any existing actions by clicking on each action in turn and edit to provide an update on progress where possible. *NB: Please ensure you provide your update in the 'Progress' section.*

- Scroll down to 'Review Details', click on 'New' and enter the actual 'Review Date' (you can use the calendar for this). Please also enter the name of the person the risk was 'Reviewed By'. Then, in 'Details of Review' please describe what has been updated, e.g. controls and assurances; action plan; changes to residual risk rating. This section can also be used to highlight where (i.e. which committee) the risk will be discussed and also if closure is recommended.

- Scroll down to 'Residual Risk Rating' and where appropriate enter/amend the residual consequence and likelihood scores. Remember, this should correspond with the 'Risk Level' at the top of the form.

Residual risk rating

This is the consequence and likelihood after the control measures have been applied.

Taking into account the initial risk rating and the assessment of the effectiveness of the control together, you can now assess the residual risk that needs to be managed. The consequence and likelihood ratings should be applied, as in table 3 above.

Risk Management Action Guide

Where risks have been identified and scored, then the following escalation arrangements should be used.

The table below provides a suggested action guide for the management of a risk:

Risk Rating	RAG Rating	Action	Level of Authority
25	Red	Halt activities **IMMEDIATELY** and review status	Warrants Chief Operating Officers / Directors attention
15 -20	Red	Significant probability that major harm will occur if control measures are not implemented **URGENT** action required. Director may consider limiting or halting activity	Warrants Director attention
8-12	Amber	Unacceptable level of risk exposure which requires constant monitoring and controls at Directorate level	Warrants Director attention
4-6	Yellow	Moderate probability of moderate harm if control measures are not implemented. Action in mediate term	Warrants Head of Service/Senior Lead Attention
1-3	Green	The majority of control measures are in place. Harm severity is small. Action may be long term	Warrants manager attention