NHS
Wigan Borough
Clinical Commissioning Group

Risk Management Policy

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Contents

Introduction

1. Every activity that the CCG undertakes, or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to undermine, or prevent the organisation achieving its corporate objectives.

2. This document sets out the policy for the identification and management of risk within the CCG. The policy applies to all staff members of the CCG.

3. The Governing Body, Senior Leadership Team and Managers will ensure that risk management is a fundamental part of the CCG approach to the governance of the organisation.

4. It also recognises the commitment of the CCG to work with and support primary care and other independent contractors across the Wigan Borough.

5. The strategic direction within the CCG is focused on improvements in the local health system and will:

    - Foster an environment that promotes health and wellbeing and tackles inequalities;

    - Ensure that everyone in the Wigan Borough can access integrated services which are flexible and responsive to their needs, and

    - Commission services which deliver high quality, efficient and cost effective care.

Purpose

6. The purpose of the Risk Management Policy is to ensure that:

7. We are able to clearly describe the systems and processes in place for the management of risk within the organisation and are able to define the reporting relationships between the key committees with responsibility for the management of risk as detailed in the Governance Framework (Appendix 1.)

8. The CCG Governing Body is aware of all known significant risks. Having considered the evidence provided the Governing Body will be enabled to make decisions and allocate resources appropriately, in a prioritised way to allow for the effective management and mitigation of the risk/s to ensure insofar as is reasonably practicable that the organisation is able to fulfil its aims and meet its corporate priorities.

9. There is a clearly defined systematic and consistent approach towards the management and mitigation of risk which is reflected in our commissioned services.

10. The organisation is enabled to integrate risk management within services and departmental processes and effectively manage all known risks associated with the delivery of business priorities.

Associated Benefits

11. The Risk Management Policy will:

- Provide assurance in respect of compliance with statutory duties and national guidance.
- Support the achievement of the organisation's corporate priorities.
- Assist with the planning and commissioning of services to patients and carers, supporting a wider health economy approach.
- Support propriety and regularity of expenditure.
- Minimise waste, fraud, error and support the efficient and effective use of resources.
- Support the improvement and refinement of decision making.
- Support policy development.
- Assist with business continuity planning.
- Support improvements in project management.
- Support effective change management.

Scope and Risk Categories

12. The Risk Management Policy encompasses all types of risk inherent in the business activities of the organisation. The CCG has adopted the former National Patient Safety Agency (now part of NHS England) categories of risk with descriptors. (Appendix 3 for details.)

13. Risk identification and management applies to all levels of activity within the organisation. All members of staff have an important role to play in the identification, assessment, management and mitigation of risk.

Definitions and Glossary of Risk Management Terms

14. Appendix 5 contains the details of definitions based on the International Standards Organisation (ISO) 73:2009 & 31000 Risk Management.

Risk Management Responsibilities and Accountability

15. A key component of an effective risk management system is a clearly defined structure that performs a number of functions:

- Reviews and approves the Risk Management Policy.
- Scrutinises the system of Risk Management at a level appropriate to each element of the structure.

- Oversees and manages the process of Risk Management.
- Reinforces the CCG's commitment to commissioning safe and effective health care services on behalf of the population of Wigan Borough.

The Governing Body

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

    - Identifies risks to the achievement of its corporate priorities;
    - Monitors these in the Governing Body Assurance Framework;
    - Ensures that there is a structure in place for the effective management of risk throughout the CCG;
    - Receives regular reports from the Governing Body Committees identifying significant clinical and corporate risks;
    - Receives updates and reports from the Senior Leadership Team identifying significant risks and progress on mitigating actions, and
    - Demonstrates leadership, active involvement and support for risk management.

17. The Governing Body requires all staff to fulfil their responsibilities in relation to risk management. Whilst it is recognised that it is important to meet national targets and to remain in financial balance; this must not be achieved at the expense of the safety of staff, patients or service users. It is important that staff raise issues with their Manager or if appropriate to the circumstances the Senior Manager and/or the Senior Leadership Team if they feel that the qualitative aspects of any commissioned services are being compromised. The Policy and Procedure for Staff Raising Concerns ('Whistleblowing') provides further information.

Audit Committee

18. The Audit Committee is responsible for providing assurance to the Governing Body that the organisation has systems and processes in place to operate in a manner which demonstrates openness, probity and accountability. The CCG will ensure compliance with the Nolan 'Seven Principles of Public Life'. By receiving and approving the organisation's Annual Governance Statement the Audit Committee will confirm that effective internal controls are in place to merit public confidence.

Corporate Governance Committee (CGC)

19. The CGC is a Committee of the Governing Body and responsible for ensuring that the organisation has the essential components in place to promote effective governance through the development and implementation of a comprehensive system of internal control. The aim is to provide assurance on compliance with legislative and regulatory requirements and NHS England guidance. The Committee also links closely with the work undertaken by the Audit and Clinical Governance Committees. The Terms of Reference for the Committee are contained in the CCG's Governance Handbook.

Clinical Governance Committee (CLGC)

20. The CLGC, is a Committee of the Governing Body. In brief, the Committee provides assurance that effective governance arrangements are in place to ensure the commissioning and delivery of good quality, safe clinical healthcare services. The Committee's responsibilities include the co-ordination and prioritisation of resources to promote a robust culture of Clinical Governance across the whole health economy.

21. The Committee also focuses on engagement and communication with all care providers to ensure the identification of associated clinical risk/s and to ensure plans are in place to mitigate the risks, in so far as is reasonably practicable. This includes the identification of operational processes to ensure that contracts are performance -managed by the CCG. The Committee meets monthly and its Terms of Reference are contained in the CCG's Constitution.

Finance and Performance Committee (F&PC)

22. The F&PC is a Committee of the Governing Body. In brief the Committee is responsible for the establishment, implementation and monitoring of the CCG arrangements around Finance, Contracting and Performance, including cost improvement programmes (CIP). The Committee will also liaise with the Governing Body on any contractual or performance issues to ensure they are considered in contract negotiations. The Committee meets monthly and its Terms of Reference can be found in the CCG's Constitution.

Other Committees

23. Four other committees have been established by the Governing Body and focus on specific areas which have a key relationship to risk management:

    - Integrated Commissioning Committee
    - Remuneration Committee
    - Greater Manchester Joint Commissioning Board
    - Primary Care Commissioning Committee

24. The Chairperson's reports from each of the above Committees are received by the Governing Body.

Risk Management Responsibilities and Accountability – Individuals

25. Every member of staff has an individual responsibility for the management of risk and all levels of management must assist in implementing the risk management policy.

Accountable Officer

26. The Chief Officer holds the executive responsibility for Risk Management on behalf of the Governing Body which has a duty to comply with such generally accepted principles of good governance as are relevant to it (Section 14L of the NHS Act 2006 as amended by the Health & Social Care Act 2012). The Chief Officer is also the Governing Body designated lead for the Safeguarding Children and Adult agendas.

Senior Leadership Team

27. The Senior Leadership Team has a corporate responsibility to ensure that the Risk Management Policy is fit for purpose, that it is implemented effectively and that the controls are in place to illustrate that all reasonable care has been taken to manage risk proactively. The Senior Leadership Team will work collaboratively with the Assistant Director, Governance to populate the content of the Governing Body Assurance Framework (GBAF) (see section 8.6)

Service Development Footprint (SDF) Clinical Executives

28. The Clinical Executives will promote risk management processes with all CCG member practices. This ensures that practices continuously improve the quality of primary care and report risks to the CCG for assessment and mitigation.

29. Practices are actively encouraged to report incidents on the Ulysses reporting module as 'soft intelligence' for the CCG and this can then be used to support commissioning initiatives or risk assessments. This is in addition to any responsibilities member practices have to report risks to NHS England and the Greater Manchester Health & Social Care Partnership.

Chief Finance Officer

30. The Chief Finance Officer (CFO) will provide professional leadership for the finance and performance management functions within the CCG ensuring high standards of integrated financial planning and financial probity throughout the organisation.

31. The CFO promotes the effective application of the Risk Management system within his functions. As a member of the Governing Body, the CFO also participates fully in the corporate management and governance of the CCG and ensures that appropriate

reporting of risks is made to the Audit Committee. He also fulfills the role of Senior Information Risk Owner (SIRO).

Executive Director of Nursing and Quality

32. The Executive Director of Nursing and Quality is the corporate lead with designated responsibility for the Governance, Quality, Safety and Safeguarding agendas and as such is specifically responsible for progressing and improving patient safety and quality of services commissioned by the CCG, including:

    - Ensuring the provision of clinical leadership for the development and implementation of the Governing Body approved Strategy for Quality;
    - Overseeing an effective system of risk management and regulatory reporting including the Annual Governance Statement;
    - Ensuring that the required assurances are identified and captured; and that evidence on compliance is provided to the Governing Body through the Corporate and Clinical Governance Committees;
    - Acting as the CCG's Caldicott Guardian; and
    - Reporting to the CCG Governing Body on all corporate and clinical governance, quality and patient safety.

Assistant Director of Governance

33. The Assistant Director of Governance holds the operational responsibility for corporate risk management, as delegated from the Accountable Officer. The Assistant Director of Governance will as part of their portfolio:

    - Provide specialist Risk Management expertise and support to the Governing Body, Executives, Managers and all CCG staff;
    - Lead the co-ordination, implementation and evaluation of risk management systems including the Risk Management Policy, GBAF and Ulysses Safeguard system;
    - Provide assurance to the Governing Body that the organisational approach to risk management is compliant with national legislation, regulation and NHS guidance.

Associate/Assistant Directors and Managers

34. Associate/Assistant Directors and Managers are required to:

- Implement the Risk Management Policy within their sphere of responsibility, and to promote risk management principles and risk awareness amongst all staff groups.
- Ensure that appropriate and effective risk management systems and processes are in place.
- Make use of and where necessary produce local procedures or desk top instructions to assist in the assessment and processing of risks.
- Ensure the completion and timely (minimum quarterly) review of risk assessments and risk reduction action plans through the Ulysses Safeguard System.
- Monitor all identified risks, and bring any high/extreme risks to the attention of the Assistant Director of Governance or Associate Directors.
- Communicate and promote all appropriate information and training to staff, including sub-contractors, visitors, and the public.
- Recommend and ensure that there are adequate resources to provide safe and secure systems of work.
- Ensure that appropriate induction and mandatory training is accessed by employees and a record of attendance made on personal files to support and underpin safe systems of work.
- Monitor standards of clinical performance where required.

Staff

35. Staff are required to:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under the current legislation and regulations. Also to take reasonable care of their own safety and all others that may be affected by the organisation’s business activities.
- Report all incidents/accidents and near miss events ensuring compliance with the incident reporting policy.

- Be responsible for attending induction, mandatory and relevant education and training events and maintaining a personal record of such as this evidence will be required to support the performance development process.

- Participate in the risk management process, including the risk assessment process within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.

- Be aware of the Risk Management Policy, organisational policies and the department/service local procedures and ensure compliance.

Contractor/s, Agency and Locum Staff

36. Managers must ensure that where they are employing or contracting agency and locum staff they are made aware of and adhere to, all relevant policies, procedures and guidance of the CCG, including the Health and Safety Policy and the Incident Reporting Policy and Procedure. The Contactor/s, Agency and Locum staff must ensure they;

    - Take action to protect themselves and others from risks, and

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

Risk Management Process

37. The Risk Management Policy should be referred to regarding the systematic identification and analysis of all risks. The risk management process adopted by the CCG is based on the ISO 31000:2009 standard, Risk Management – Principles and Guidelines.

38. Risk management arrangements apply to all staff employed by both the CCG as well as contractors working on behalf of the organisation. In implementing an organisation wide risk management process, managers must ensure that the staff within their sphere of responsibility are able to recognise potential risks and are encouraged and reminded to report all untoward or near-miss events in line with the organisation's Incident Reporting Policy. The policy is available and accessible via SharePoint.

39. The Senior Leadership Team must ensure the implementation and application of this policy within their sphere of responsibility and are expected to take a proactive lead in ensuring that risk management is a fundamental part of the total approach to quality, corporate governance and the organisation's Annual Governance Statement.

40. The risk management framework (Appendix 2) will be reviewed in response to changes in national and local requirements, and will also be subject to a review by the Corporate Governance Committee periodically.

Risk Assessment (Ulysses Safeguard)

41. Risks are identified through feedback from many sources, such as, corporate objectives, proactive risk assessments, incident reporting and trends, complaints, legal claims, patient and public feedback, stakeholders/partnership feedback and internal and external assurance assessments.

42. Through the services and management teams, the organisation has systems in place to identify risks, assess their impact and devise strategies to manage and evaluate them. This system provides a central steer whilst supporting local ownership in managing and controlling risks to which the organisation may be exposed.

43. For risk assessments, the organisation has adopted the Health and Safety Executive's (HSEs) risk assessment model which is supported by NHS England (formerly the NPSA). This principle uses a numerical scale based on a 5 x 5 matrix, in accordance with guidance as fully detailed at Appendix 3.

Governing Body Assurance Framework (GBAF)

44. The GBAF is a means of identifying and quantifying strategic and other corporate risks within the organisation and is the means by which the Governing Body monitors and controls the risks which may impact on the organisation's capacity to achieve its objectives.

45. The GBAF identifies the principal objectives of the organisation and the principal risks related to the delivery of these objectives. Key controls are made explicit together with the assurances on these controls. In addition, the Framework will identify linkages with inter-related areas of assurance.

46. The GBAF also provides a structure for the evidence to support the Annual Governance Statement.

47. The information recorded on the GBAF will be maintained by the Assistant Director of Governance. On a quarterly basis the Assistant Director/Risk Owner will be required to provide position statements and update the risk status in respect of progress against the risk reduction action plans. The position statements provided by the Risk Owner will be collated by the Assistant Director of Governance and reported on a quarterly basis to the Corporate Governance Committee, Audit Committee and regularly to the Governing Body.

Governing Body Assurance Framework (workflow)

Corporate Objectives	*What the organisation aims to deliver*
	
Sub Objectives	*Detailed workstreams designed to deliver corporate objectives*
	
Principal Risks	*What could prevent the objectives and workstreams being achieved – these are rated 1 to 5 dependant on impact/consequence*
	
Key Controls	*What controls/systems we have in place to assist in securing delivery of the objective – the likelihood of the risk occurring is also rated 1 – 5 following identification of the controls actively in place*
	
Gaps in Control	*Where we are failing to put controls/systems in place or where we are failing in making them effective*
	
Positive assurances	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*
	
Gaps in assurance	*Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
	
Action Plans	*An action plan to improve key controls that will manage principal risks, and gain assurances where required*

Operational Risk Registers

48. Operational Risk Registers which are held on the Ulysses Safe Guard System, often referred to as local risk registers are developed and maintained by the service managers with assistance from Risk Management.

49. Performance, activity and assurance on control will be reported to the relevant Committee. Any risks graded as high or extreme will be escalated onto the GBAF. Risks rated as extreme will be reported through the responsible Committee directly to the Governing Body.

Defining Acceptable/Target Risk/ Risk Appetite

50. It is important to differentiate between risks in order to prevent all risks becoming a "top priority". The CCG therefore uses a risk rating system, which, through a matrix, classifies both risk/s and untoward incidents into categories of severity (Appendix 3).

51. Between the extremes of catastrophic risk and almost no risk, the categorisation process will inevitably contain a subjective element. Therefore, managers undertaking the risk assessment process should seek specialist advice to help resolve any uncertainties and ensure as much consistency as possible.

52. The CCG uses a structured approach to risk assessment whereby the severity of the risk is determined on the basis of the likelihood of the risk occurring and the consequences (or impact) of the risk should it occur.

53. The methodology identifies measurable criteria for the likelihood of a risk occurring ranging from Remote to Almost Certain. There are also measurable criteria to assess the consequences should an identified risk actually occur.

    - Impact on the individual
    - Impact on the organisation
    - Number of persons involved
    - Potential for complaint/ litigation
    - Potential cost

54. The overall impact of the risk is taken from the highest scoring risk area.

55. The risk matrix enables the severity of the risk to be determined from the assessments of likelihood and consequence and expressed as a colour. A traffic light system enables risks from different areas to be compared and the information used to guide management actions and resource allocation.

56. Acceptable or Target Risk/s following risk assessment can be defined as follows:

    - The likely consequences are insignificant.
    - A higher risk consequence is outweighed by the chance of a much larger benefit.
    - The occurrence is remote.

- The potential financial costs of minimising the risk outweigh the cost consequences of the risk itself.
- Mitigation of the risk could lead to further unacceptable risks in other ways.

57. Therefore it is possible that a risk with a high numerical value may be acceptable to the organisation, but that decision must be taken at Governing Body/Senior Management level as defined in Appendix 3. The risk appetite is allocated a numerical value and also known as the target risk referred to in the GBAF.

Incident Reporting

58. Incident reporting underpins an effective risk management strategy. The positive benefit here is that the material provides a rich source of information from which to learn and improve systems and processes.

59. All staff will be informed and involved with this process where possible and receive feedback on serious incidents and any near miss events reported.

60. As with the risk management module, incident reporting is processed through the Ulysses Safeguard system. The input to Ulysses is completed by staff and line managers. Depending on the status of the incident, the Governance Team will review the process and outcome. The CCG's incident reporting policy on SharePoint should be referred to for detailed guidance.

Policy and Procedure for Raising Concerns ('Whistleblowing')

61. If staff are concerned that there are very serious risks in the organisation, which they have raised through the normal management channels without any response, it would then be appropriate for them to progress these concerns via the Policy and Procedure for Staff Raising Concerns ('Whistleblowing'), this policy is available for download via SharePoint.

Training

62. To ensure the successful implementation and maintenance of the Risk Management Strategy and Policy, the Governing Body members, managers and staff will receive risk management training linked to the responsibilities of their roles and responsibilities as defined within the individual job specifications/post outlines.

63. A process should be held annually where the Governing Body identifies its corporate objectives and the GBAF is populated. In addition, risk management training will be provided on a tri-annual basis.

64. Managers will receive risk management training in accordance with the organisation's training needs analysis. This programme will include as a minimum:

    - Principles of risk management;
    - Undertaking risk assessments, and
    - Incident investigation and review.

65. All staff will receive training on incident reporting, this will form part of the organisation's induction and mandatory training. Additional training will be provided as and when identified. General awareness raising for staff will also be undertaken through staff safety bulletins, team briefings, and the inclusion of relevant documents on the Intranet.

Partnership Risks

66. The CCG often uses partnership working to deliver its objectives, priorities and services, it is essential that:

    - The risks associated with working in partnership with other organisations have been identified. Some of these risks may be managed through formal contracts and partnership agreements;
    - Partnerships must have proven risk management systems in place, and
    - A risk assessment must be carried out prior to entering into any partnership to identify any potential risk/s and these should be monitored throughout.
    - There must also be set periodic reviews with partners to ensure that risk reduction actions plans (outlined from the risk assessment process) are effective in mitigating the associated risks in so far as is reasonably practicable.

Internal Performance Process

67. Through a structured reporting process, the Governing Body will monitor the effectiveness of the risk management system as follows:

    - CCG Annual Report.
    - Annual Governance Statement.
    - Governing Body Assurance Framework
    - Corporate Governance Reports to Committee
    - Clinical Quality Reviews (CQR's) - Provider reports.
    - Operational Risk Registers.
    - Serious Incidents (SIs) - Performance and Exception Reports
    - Incident Summary Reports

- Informal and Formal Complaints and Litigation/Claims.
- Internal and External Audit Reports.
- Minutes from the related Committees.
- Performance Reports
- Policies and procedural guidance

Communication with Stakeholders

68. Systems of communication with stakeholders are in place to contribute to the minimisation of reputational risk to the organisation. These include a public website, public Governing Body meetings and the Annual General Meeting.

69. The following methods are used by the organisation to ensure that this Risk Management Policy is communicated both internally and externally:

    - The Risk Management Policy will be presented to the Corporate Governance Committee for approval.
    - The Risk Management Policy following approval will be circulated to all CCG staff mailboxes. Service and Departmental Managers will be requested to raise awareness of the Risk Management Policy via team briefings.
    - The Risk Management Policy will be placed on the Intranet and the public website.

Lessons Learned

70. The CCG recognises that effective risk management requires not only the mitigation of the risk ratings through effective management of all known risks, but also must be embedded through the continued development of the organisational learning culture.

71. The CCG will promote the lessons learned from our risk management activities i.e.; incident reporting, complaints management, litigation/claims and audits etc. through the reporting mechanisms to the Governing Body and relevant Committees/Groups.

72. Service and Departmental representatives on the respective Committees/Groups are then expected to cascade the information to staff via Service and Departmental meetings. The Governance Team will also cascade information via safety bulletins and training sessions. The CCG will share learning with our healthcare partners and where practicable and relevant involve other stakeholders.

Implementation, Monitoring and Review Arrangements

73. The implementation of this Risk Management Policy will assist in enhancing and promoting the commissioning and delivery of good quality, safe services. This will be used alongside the GBAF, and include training and support in order to provide an improved awareness of the measures needed to prevent, control and contain risk.

74. The CCG will ensure that the Risk Management Policy is communicated both internally and externally. The CCG monitors and reviews its performance in relation to the management of risk, and the continuing suitability and effectiveness of the systems and processes in place to manage risk through the oversight of the CCG Governing Body, Senior Leadership Team and the Governing Body Committees as detailed at Appendix 1.

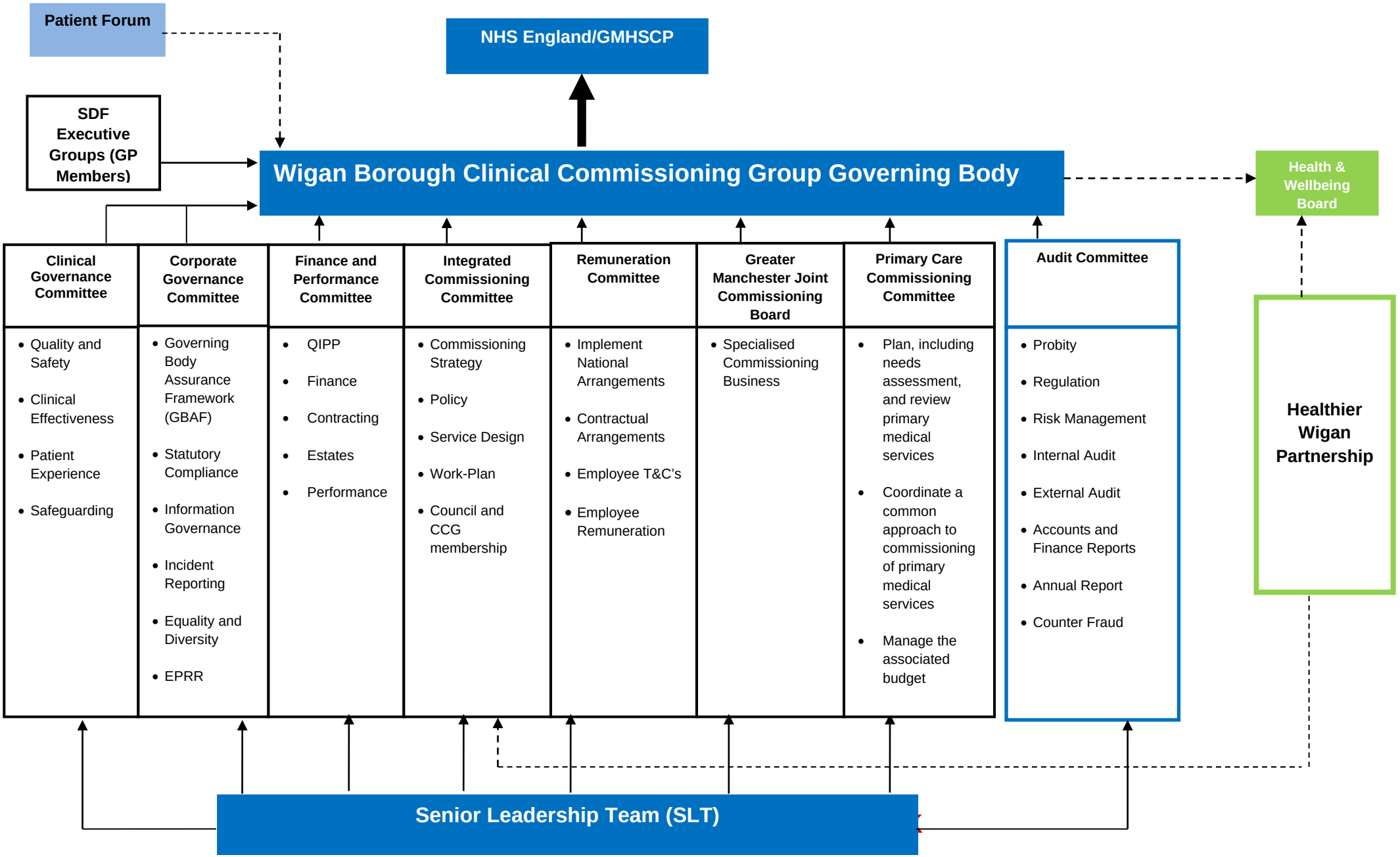
Equality and Diversity Statement

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

Relationship with other Organisational Policies, Procedures and Documents

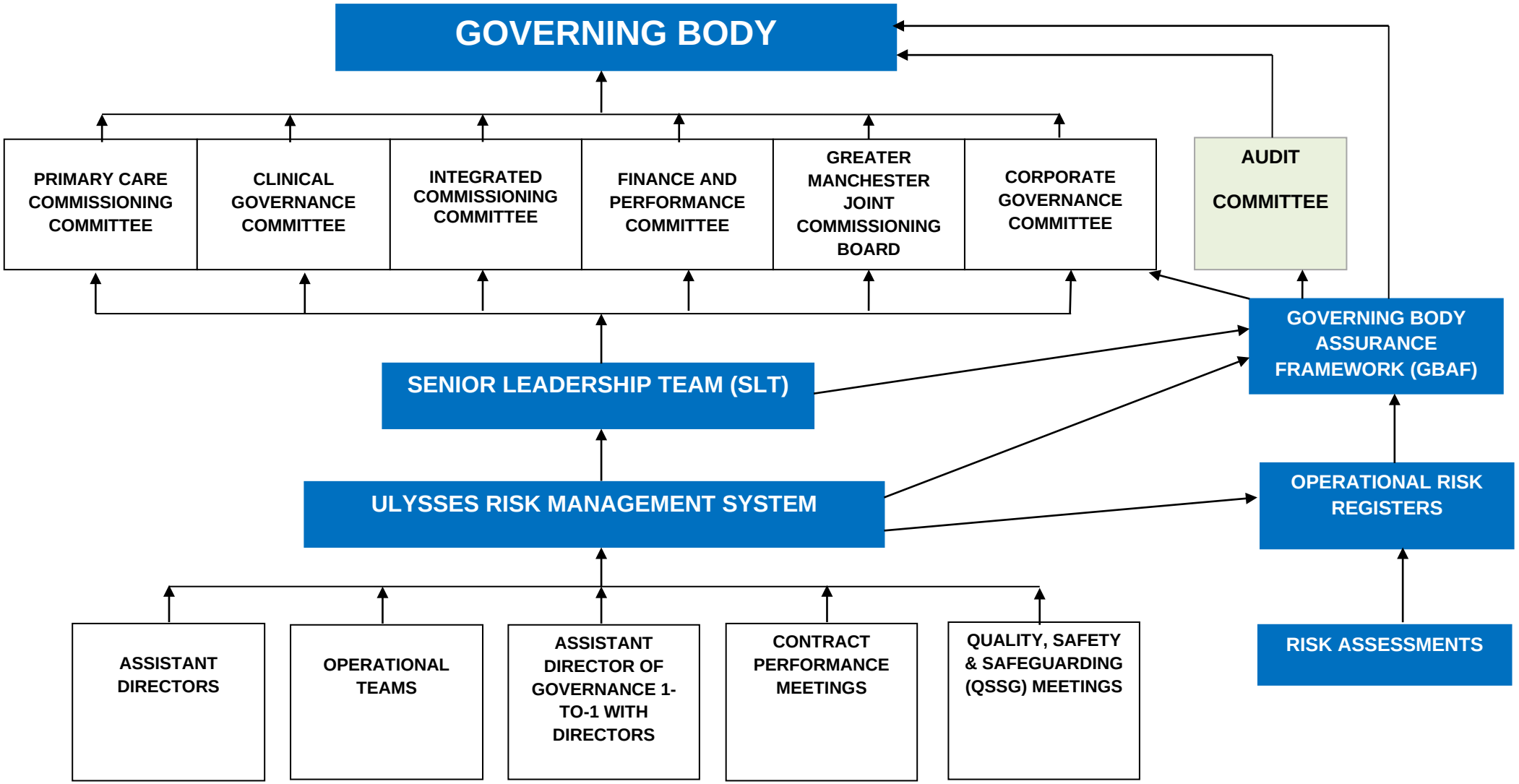
- Complaints Policy and Procedure
- Health and Safety Policy
- Incident Reporting Policy and Procedure
- Policy and Procedure for Staff Raising Concerns ('Whistleblowing)

CCG GOVERNANCE FRAMEWORK



RISK MANAGEMENT FRAMEWORK

Appendix 2



Appendix 3

RISK ANALYSIS EVALUATION (Input to Ulysses System)

ANALYSIS:

First Stage: Qualitative Measures of Risk *(The Consequence or Impact)*

LEVEL	IMPACT	EXAMPLES OF DESCRIPTORS (please refer to local policy)	Applicable/ Non-applicable
1	**Almost None**	▪ No injuries (*No treatment/intervention required/given, no time off work*) ▪ Patient Safety Incident resulting in 'no harm' (*including near miss event*) ▪ Insignificant impact upon service provision (*Loss/interruption not exceeding 1 hour*) ▪ None or minimal financial loss/cost	
2	**Minor**	▪ Minor injury or illness (*First aid treatment, time off work not exceeding 3 days*) ▪ Patient Safety Incident resulting in 'low harm' (*as defined by NHS England)* ▪ Minor impact upon service provision *(Loss/interruption not exceeding 8 hours)* ▪ Low financial loss/cost	
3	**Moderate**	▪ Moderate Injury *(Medical attention required, time off work 4 -14 days, RIDDOR)* ▪ Patient Safety Incident resulting in 'moderate harm' (*as defined by NHS England)* ▪ Small patient numbers affected ▪ Moderate impact on service provision *(Loss/interruption not exceeding 24 hours)* ▪ Moderate financial loss/cost	
4	**Major**	▪ Major injuries/long term incapacity/disability (*Time off work in excess of 14 days)* ▪ Patient Safety Incident resulting in 'serious harm' (*as defined by NHS England)* ▪ Major impact upon service provision (*Cancellation of service or loss/Interruption not exceeding 1 week* ▪ Major financial loss/cost	
5	**Catastrophic**	▪ Death/permanent injuries/irreversible health effects ▪ Patient Safety Incident resulting in death or major permanent incapacity ▪ Large numbers of patients affected ▪ Catastrophic impact upon service provision *(loss/Interruption exceeding 1 week/ or/permanent loss of a service or facility)* ▪ Huge financial loss/cost	

Second Stage: Qualitative Measures of Risk *(The Likelihood of Occurrence)*

LEVEL	LIKELIHOOD	EXAMPLES OF DESCRIPTORS (please refer to local policy)	Applicable/ Non-applicable
1	**Rare**	This will probably never occur/recur - not expected to recur for years *(Adequate level of control. E.g. effective policy, training, supervision etc. is in place)*	
2	**Unlikely**	Not expected to happen/recur - not expected to occur more than annually *Defined safe systems of work, occasional exposure etc.*	
3	**Possible**	Might happen or recur - expected to occur at least monthly *Poor supervision, non-secure controls etc.*	
4	**Likely**	Will probably happen/recur - expected to occur at least weekly *Poor training, lack of supervision or ineffective controls etc.*	
5	**Almost Certain**	Will undoubtedly happen/recur, - expected to occur at least daily *No control measures, constant exposure etc.*	

Third Stage: Qualitative Measures of Risk & Action Required *(Risk Evaluation)*

CONSEQUENCES	LIKELIHOOD OF A REPEAT				
	Rare (1)	Unlikely (2)	Possible (3)	□□□□□Likely (4)	Almost Certain (5)
Almost None (1)	**1**	**2**	**3**	**4**	**5**
Minor (2)	**2**	**4**	**6**	**8**	**10**
Moderate (3)	**3**	**6**	**9**	**12**	**15**
Major (4)	**4**	**8**	**12**	**16**	**20**
Catastrophic (5)	**5**	**10**	**15**	**20**	**25**

EXTREME RISK	**15 - 25**	**Immediate Action Required by Director – Reportable to the Governing Body**
HIGH RISK	**8 - 12**	**Attention Needed By Senior Management – Reportable to Governing Body Committee**
MEDIUM RISK	**4 - 6**	**Management by Line or Service Manager**
LOW RISK	**1 - 3**	**Manage By Routine Policies/Procedures/Processes/Systems**

AS/NZS ISO 31000:2009, Risk Management

Appendix 4

Risk Categories

Risk Category	Definition
Change	Risks that programmes and projects do not deliver the agreed benefits on time and within agreed budgets and/or introduce new or changed risks that are not identified and managed.
Clinical	Risks that arise directly from the provision and delivery of healthcare. This includes clinical errors and negligence.
Financial	The effective management and control of the finances of the organisation. The risk events can range from insufficient funding, poor budget management, mismanagement of assets and liabilities and failure to collect due revenues.
Governance	The establishment of an effective organisational structure with 'clear lines of authorities and accountabilities'. The risk events can include inappropriate decision making and delegation of authorities, lack of appropriate tone set by leadership and lack of Governing Body cohesiveness. All can result in sub optimal performance and losses.
Information and Technology	Day-to-day concerns the organisation may be confronted with as it strives to deliver its objectives. They can include events such as technical breakdown, loss of hard or soft copy data, failure by partners to deliver service, irretrievable breakdown of a partnership, failure to effectively manage internal change etc.
Legal and Compliance	Health and Safety compliance, consumer protection, data protection, employment practices, failure to comply with employment legislation, management of complaints and claims.
Operations	Day-to-day concerns the organisation may be confronted with as it strives to deliver its objectives. They can include loss of staff to process failures. It covers risk events such as failure by partners to deliver on contractual/service agreements, irretrievable breakdown of a partnership, failure to effectively manage internal change etc.
People	Insufficient human capital (capacity and capability), inappropriate staff behaviour. These risks can have a significant impact on the performance and reputation of the organisation.
Corporate	The long term strategic objectives of the organisation. They can be affected by external factors such as the economy, political environment, technological change, changes in customer needs, legal and regulatory changes, and missing opportunities. The strategic risks are in the main significant risks that have the potential to impact on the organisation as a whole. They are also in some cases cross cutting risks that impact across the organisation rather than just one area.

Appendix 5

Definition of Terms/Glossary

Assurance	An evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework
Exposure	The consequences, as a combination of impact and likelihood, which may be experienced by the organisation if a specific risk is realised
Horizon Scanning	Systematic activity designed to identify, as early as possible, indicators of changes in risk.
Risk	Uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of likelihood and impact, including perceived importance
Risk Appetite	The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time. It can also be expressed in numerical terms as the target risk rating.
Risk Assessment	The evaluation of risk with regard to the impact if the risk is realised and the likelihood of the risk being realised.
Risk Management	All the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

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