NHS
North East Hampshire and Farnham
Clinical Commissioning Group

NORTH EAST HAMPSHIRE & FARNHAM CLINICAL COMMISSIONING GROUP

RISK MANAGEMENT POLICY
2016 - 2020

Document Control Sheet

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Committee	Audit & Risk
Related Documents:	

Section amended	By who and date

Contents

1. Strategic Statement

1.1 In NHS North East Hampshire and Farnham CCG (CCG) risk management is not seen as the responsibility of one role or one individual, it is seen as the responsibility of everyone.

1.2 The CCG is committed to ensuring that integrated risk management is key part of the CCG's role of improving the health of the local population and ensuring an outstanding level of patient safety through commissioning high quality services that meet the needs of local people. To this end:-

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

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

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

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

2. Introduction

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

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

2.2 To manage risk effectively, the commitment and participation of all staff and the support of the CCG Governing Body is required. The CCG's policy therefore involves creating an awareness and responsibility for the principles of risk management both as an organisation and as individuals working either for, or with the CCG.

3. Purpose and Objectives

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

- Enable the Governing Body to have an overview of the risks it faces, taking into account all aspects of its business, developing a risk-aware culture throughout the organisation
- Provide assurance to the Governing Body that actions are being taken to mitigate risks to acceptable levels
- Ensure a consistent approach to risk management across the organisation
- Detail the process, responsibilities and reporting structures

3.2 Our objectives are to:

- Establish a Governing Body Assurance Framework (GBAF) that identifies the strategic objectives of the CCG and lists the risks that could threaten their achievement and the actions planned to manage them
- Establish a Corporate Risk Register that describes and assesses the risks, as well as the planned controls to manage their impact, owned and overseen through approved processes across the CCG
- Establish an appropriate review process of both the GBAF and the Risk Register for the Audit & Risk Committee, Sub-Committees of the Governing Body and the Governing Body
- Embed a risk-aware culture in the organisation. This will include appropriate training for all members of staff and for the Governing Body and regular reporting
- Achieve a positive Head of Internal Audit Opinion on risk management processes for our Annual Governance Statement

4. The Governing Body Assurance Framework and Corporate Risk Register

4.1 A key element of the Risk Management Framework is the Governing Body Assurance Framework. The assurance framework is driven by the CCG's strategic objectives and provides the Governing Body with assurance that risks which threaten the achievement of those strategic objectives are being effectively managed.

4.2 The Governing Body Assurance Framework will be reviewed for assurance purposes by the Governing Body and Audit & Risk Committee on a regular basis.

4.3 The organisation maintains a central Corporate Risk Register which captures all risks and enables these to be analysed against the organisational objectives to ensure appropriate action is being taken to address risk and that lessons are being learned.

4.4 Each department/team may hold a risk register pertaining to their portfolio.

5. Accountability and Reporting Arrangements

5.1 Part of an effective risk management framework is having clear accountabilities for risk. Every member of staff employed by, or working on behalf the CCG has a collective and an individual responsibility for the management of risk.

5.2 Responsibilities of the Governing Body

5.2.1 The Governing Body is responsible for ensuring that there is an effective programme for managing all types of risk. In particular, it identifies risks, considers risk reduction plans and monitors progress on action plans.

5.2.2 The Governing Body is responsible for embedding risk management throughout the organisation.

5.2.3 The Governing Body will review risks identified as 'significant' by their score (15 and above) on the Corporate Risk Register, at each of its meetings.

5.2.4 The Governing Body will review the Assurance Framework (GBAF) a minimum of every six months.

5.2.5 The Governing Body is required to produce an Annual Governance Statement as a statement of assurance which explains the processes and procedures in place to enable the CCG carry out its functions effectively and in a controlled manner.

5.3 Responsibilities of Sub Committees of the Governing Body

5.3.1 All Committees and groups that support the Governing Body have a responsibility for:

- identifying risks
- assessing risks
- putting systems in place to mitigate risks and
- ensuring these are managed through their individual risk register which in turn forms part of the Corporate Risk Register.

5.3.2 All risks entered onto the Corporate Risk Register will be assigned to a committee reporting to the Governing Body.

5.3.3 Risk Registers will be a standing agenda item on the sub-committee to which they have been assigned so that the effectiveness of the risk reduction plans can be monitored and remedial action taken, if progress is slow.

5.3.4 Risks with an amber rating (scoring between 9 and 12) must be periodically reviewed ≤12 weeks.

5.3.5 The sub-committees have the delegated responsibility for risk rating and downgrading amber risks.

5.4 Responsibilities of the Senior Executive Team

5.4.1 The Senior Executive Team has responsibility for:

- Demonstrating leadership, active involvement and support for risk management

- Supporting the Governing Body in identifying the key strategic risks, evaluating them and ensuring adequate responses are in place and are monitored
- Ensuring that the Risk Management Strategy is applied consistently throughout the CCG
- Supporting escalation of risks to the Governing Body Assurance Framework

5.4.2 Each executive director (reporting line to the Chief Officer) and clinical director will be held to account for managing all risks within their scope of responsibility.

5.4.3 Risk ownership is assigned according to where responsibility exists for mitigating action. This means that the 'risk originator' i.e the person who identifies the risk, will not always be the 'risk owner'.

5.5 Responsibilities of the Audit and Risk Committee

5.5.1 The Audit & Risk Committee oversees the establishment and maintenance of effective systems of integrated governance and risk management across all areas of the CCG, ensuring that there are appropriate and adequate links between risk management, financial risk, corporate and clinical governance.

5.5.2 The Committee will review the Corporate Risk Register at each of its meetings and Governing Body Assurance Framework (GBAF) every quarter.

5.5.3 The Committee retains responsibility for reviewing the Risk Management Policy and making relevant recommendations prior to endorsement by the Governing Body.

5.6 Responsibilities of the Chief Officer (Accountable Officer for the Clinical Commissioning Group)

5.6.1 The Chief Officer has responsibility for ensuring there is an effective risk management system in place within the organisation, for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance.

5.6.2 The Chief Officer is specifically responsible for:

- Ensuring there is a Risk Management Policy in place
- Ensuring all managers and staff under their management control are aware of the Clinical Commissioning Group's Risk Management Policy and of their responsibility for implementing them
- Ensuring there is a Governing Body Assurance Framework, meeting best practice standards, that is reviewed by the Governing Body
- Ensuring that the Clinical Commissioning Group keeps an active risk register
- Ensuring that a Risk Management Framework is in place and in use.

5.7 Responsibilities of the Governing Body Chair (Clinical Lead)

5.7.1 The NEHF Clinical Commissioning Group Clinical Lead/Chair is specifically responsible for:

- Undertaking the role of Caldicott Guardian, overseeing information governance requirements.

- Health & Safety

5.8 Responsibilities of the Chief Finance Officer

5.8.1 The Chief Finance Officer will ensure:

- The effectiveness of the Clinical Commissioning Group's financial control systems
- Significant financial risks faced by the Clinical Commissioning Group are identified and managed effectively
- The Audit and Risk Committee and internal audit effectively perform their roles in assuring the Clinical Commissioning Group's system of internal control
- Robust Counter Fraud arrangements are in place

5.9 Responsibilities of the Director of Nursing & Quality

5.9.1 The Director of Nursing and Quality has responsibility for clinical governance and clinical risk management including:

- The professional lead responsible for safeguarding adults and children, infection prevention and control
- Managing and overseeing the performance management of serious incidents reported by the providers of health services commissioned by the CCG
- Ensuring that processes are in place to provide assurance with regard to clinical risk management within commissioned services, this includes, patient safety regarding commissioned services in line with local and national legislation and guidance

5.10 Responsibilities of Clinical Leads and Managers

5.10.1 All Clinical Leads and Managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility. This includes ensuring all staff within their teams are aware of, and implement this policy.

5.10.2 Managers are also responsible for ensuring that staff who are working within their teams are made aware of the risks within their work environment and of their personal responsibilities, and that all their staff receive appropriate information, instruction, and training to enable them to work safely.

5.10.3 These responsibilities extend to anyone affected by the Clinical Commissioning Group's operations, including contractors, members of the public, and visitors.

5.10.4 Managers are responsible for preparing specific departmental guidelines to ensure all necessary risk assessments are carried out within their directorate/department in liaison with relevant advisors where necessary, e.g. Health & Safety and Infection Control.

5.10.5 Leads and Managers are responsible for identifying and mitigating risk within all investment plans, business cases, and new projects initiated by the Clinical Commissioning Group and for managing agreed risk management control measures within their designated areas.

5.10.6 Where significant risks have been identified and where local control measures are considered inadequate, Leads and Managers are responsible for bringing these risks to the attention of the Senior Management Team.

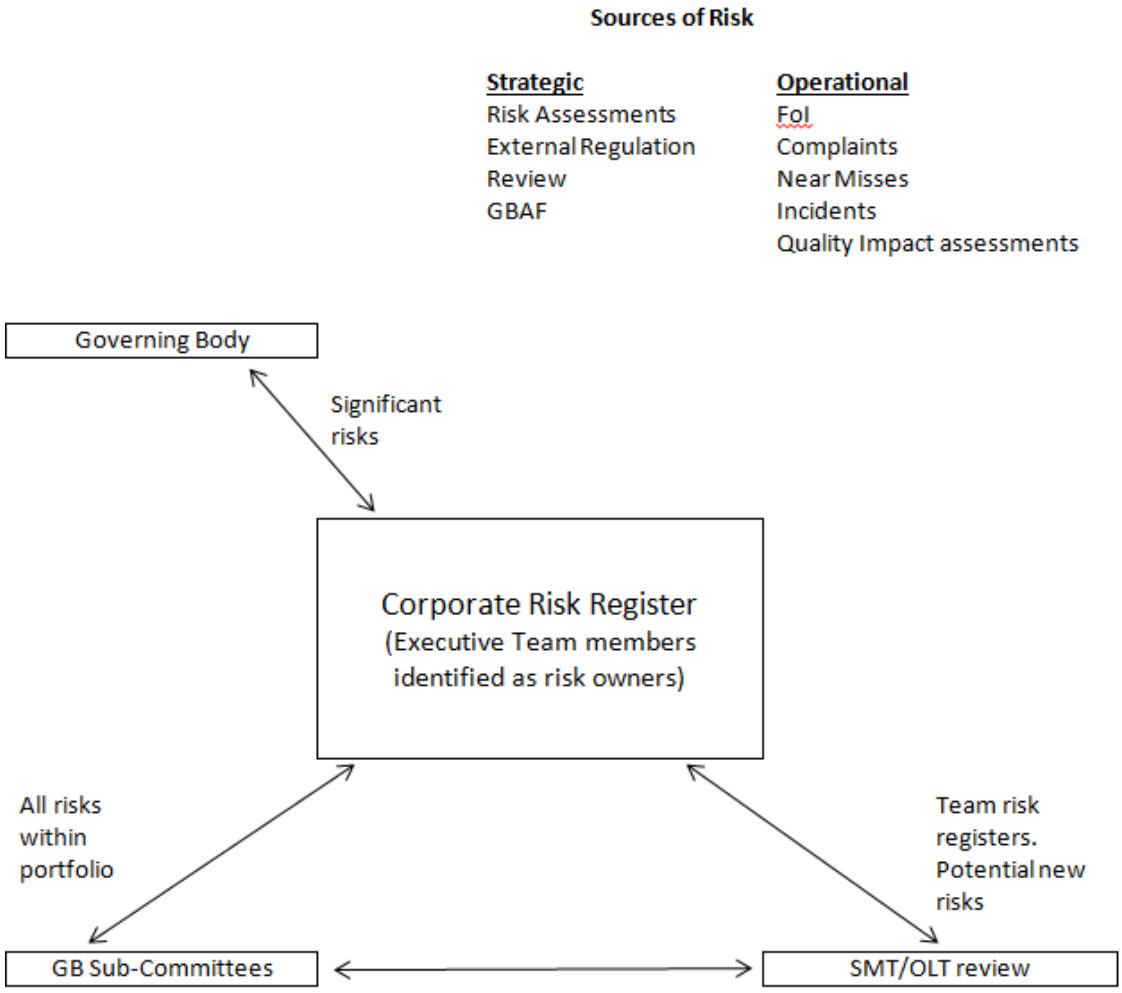
5.11 Responsibilities of all staff working for, or with the Clinical Commissioning Group (including contractors)

5.11.1 It is the responsibility of individual members of staff to be aware of the Clinical Commissioning Group's approach to risk management, including relevant policy on the reporting and management of risk.

5.11.2 All staff are responsible for identifying risks and raising them in the manner outlined in this Policy.

5.11.3 Staff will be expected to attend the required training events to ensure they understand fully their responsibilities under this Policy.

6. Risk Management Process



6.1 The diagram above demonstrates the structure of the Corporate Risk Register. The most significant risks on the Corporate Risk Register (those rated 15 and above, red rating) will be reviewed by the Governing Body at each of its meetings. Each sub-

Committee reviews its own risks on the Corporate Risk Register at each of its meetings.

6.2 Once a risk has a significant grading, a mitigating action plan must be in place within 4 weeks and the risk must be periodically reviewed by the executive team ≤4 weekly.

6.3 The Operational Leadership Team will review the Corporate Risk Register at its monthly meeting in order to determine progress, recommend any changes in scoring and identify controls and actions required. Their findings will be reported to SMT/individual Directors in order to support the progress of actions as detailed in 6.1 and 6.2.

7. Risk Source

7.1 Strategic risks are likely to be identified through the annual development of the Governing Body Assurance Framework (GBAF), from external regulation and independent assessment, and via executive team risk assessments.

7.2 Operational risks are most likely to be identified through adverse incident reporting, workplace/clinical area risk assessments, quality impact assessments and through intelligence gathered from Freedom of Information (FOI) Act requests and complaints.

7.3 Any individual identifying a risk should complete the Risk Register Form (appendix 4) and pass this to the Governance Team or any member of the Operational Leadership Team to discuss at their next meeting. Copies of the form can be found on the CCG's intranet.

8. Risk rating

8.1 In keeping with the National Patient Safety Agency's risk matrix, scoring of risk is based on likelihood of an event occurring multiplied by impact (consequence). Tables of which can be viewed at Appendix 1

8.2 The total score of likelihood multiplied by impact provides the overall level of risk.

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

Low Risk	1-3	Medium Risk	4-6	High Risk	8-12	Extreme Risk	15+

8.2.1 Risk Level – Low and Moderate/Green and yellow

These represent low levels of opportunity/threat and actions shall be limited to contingency planning rather than active risk management action. Risks shall be recorded on the Team Risk Register. Risk level shall be monitored as part of the 'local' risk register review.

8.2.2 Risk Level – High/Amber

These represent medium levels of opportunity/threat which may have a short-term impact on strategic objectives. Risks in this category shall have actions defined on the risk register with an action plan for risk treatment. Risks shall be recorded on the appropriate risk register and reviewed at appropriate meetings and relevant committees with responsibility for risk management. The risk level shall be monitored as part of regular review together with the status of controls in place and risk treatment.

8.2.3 Risk Level – Extreme/Significant/Red

These represent higher levels of opportunity/threat which may have a major or long term impact on benefits realisation, organisation objectives and which may also impact on Strategic objectives and outcomes positively or negatively. Risks in this category will be overseen by the Governing Body with individual risk owners assuming responsibility for the management and mitigation of the risk.

8.3 The risk matrix is used to identify and to prioritise risks by their risk score (i.e. consequence x likelihood).

8.4 Risks are coded red, amber or green (RAG) according to severity. However it must be noted that the risk scores are not intended to be a precise mathematical measure of risk. Any concerns must be escalated as part of the normal management process.

8.4 All risks will be included in the risk register and if rated as significant (red rating) will be brought to the attention of the Governing Body. In this way the organisation can be assured that it has oversight of all serious strategic and operational, clinical and non-clinical risks affecting the CCG.

8.5 All risks with a significant risk rating should be considered by the Governing Body as a standing agenda item.

9. Risk De-escalation

9.1 The formal process of approval to de-escalate a significantly graded risk is reserved for the Governing Body only, albeit this is likely to be based on a sub-committee recommendation.

9.2 In the event that Governing Body members require more detailed assurance regarding plans to reduce a risk register entry, the executive director 'risk owner' would be tasked with submitting a written paper to the next meeting of the Governing Body, or appropriate sub-committee to which the issue has been delegated.

PART II – External/Internal Factors

A. Partnership Working

i) In commissioning quality services, the CCG needs to be aware of accountability arrangements and the management of risks in partnerships.

ii) There is a need to ensure clear lines of accountability and responsibility for staff working across partner organisations.

iii) Where the CCG hosts a service on behalf of other organisations, risk reporting will form part of the 'expected' reporting requirements – feeding into relevant risk registers and assurance frameworks as applicable.

iv) Where other CCGs host service on behalf of North East Hampshire and Farnham patients the CCG will ensure that risk reporting forms part of their 'expected' reporting requirements.

v) Each Head of Department will be responsible for ensuring escalation to the corporate risk register when required.

B. Commissioned Services

i) The Governing Body must be informed of, and where necessary, consulted on all significant risks that arise from the service level agreements with other healthcare and service providers including any Commissioning Support Unit used by the CCG.

ii) The failure of a commissioned service to deliver services as agreed would be a significant threat to the achievement of the objectives of NEHF Clinical Commissioning Group. Therefore risks associated with the any contractual or service agreement must be systematically identified, assessed and analysed in the same way as other risks to the organisation with clear accountabilities defined. Risk associated with Service Level Agreements will feature in the risk register to enable the Governing Body to be fully informed on the risk profile of the organisation. This includes organisations working on behalf of the Clinical Commissioning Group (e.g. Commissioning Support Units).

C. Control of Risk

i) Each year the Chief Officer is required to provide to the Governing Body, stakeholders and public an *Annual Governance Statement* which forms part of the CCG's Annual Report. This is a statement of assurance that appropriate policies and processes are in place and that internal control systems are functional and effective in order to manage key risks to the organisation. The Audit & Risk Committee should recommend the Statement for approval by the Governing Body before inclusion in the Annual Report.

ii) The *Governing Body Assurance Framework (GBAF*) is a high level summary document which brings together the principal risks that directly relate to the strategic objectives, together with their controls and current status

iii) Its purpose is to provide the Governing Body with assurance that that risk to the delivery of organisational objectives have been identified and are being managed.

iv) The framework records the links between strategic objectives, risk, controls and sources of assurance. Sources of assurance can include:

- External Bodies/Inspections (NHS England, NHS Litigation Authority, Health & Safety Executive)
- External Alerts/Guidance (Central Alerting System, NICE guidelines)
- External Audit
- Internal Governance Arrangements
- Internal Monitoring Arrangements
- Internal Audit

D. Monitoring & Compliance

Committee	Report Title	Report Details	Timeframes
Governing Body	Significant Risks register	Risks scoring 15+	Every meeting
	Governing Body Assurance Framework (GBAF)	Full framework document with risks linked to strategic objectives	Every 6 months
	Annual Governance Statement (Annual Report)	Statement from Chief Officer	Yearly
Audit & Risk Committee	External Audits/Inspections	Feedback from outcome of inspections/audits	Every meeting
	Internal Audits	Feedback from reports	Every meeting
	Corporate Risk Register	All CCG risks	Every Meeting
	GBAF Review	Updated GBAF document	Quarterly
Governing Body Sub-Committees	Corporate Risk Register	Those risks within the Committee portfolio	Every meeting
Senior Management Team	Risk Report	Specific risks highlighted by the Operational Leadership Group	As required
Operational Leadership Group	Corporate Risk Register	Review of the Corporate Risk Register	Every Meeting

E. Reporting Performance

i) Through a structured reporting process NEHF Clinical Commissioning Group will monitor the effectiveness of its Risk Management arrangements through:

- Clinical Commissioning Group Annual Report
- Annual Governance Statement
- Governing Body Assurance Framework

- Risk Management Reports
- Corporate Risk Register
- Internal and External Audit Reports
- Minutes from related committees and groups
- Performance Reports

F. Equality & Diversity

14.1 In keeping with North East Hampshire and Farnham Clinical Commissioning Group's commitment to equality and diversity, this Risk Management Policy has been screened for impact on equality and a summary analysis is attached.

14.2 The screening identified that the policy is intended to have a positive impact on Clinical Commissioning Group employees, individuals from member practices and third parties with whom the Clinical Commissioning Clinical Commissioning Group works. No gaps or challenges have been identified. The equality analysis will be reviewed each time this document is reviewed, or earlier if negative impacts are identified.

14.3 Appendix 2 details the Equality Impact Analysis

Appendix 1: Risk Scoring Matrix

Likelihood scoring descriptors:

Likelihood Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	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/ circumstances	Will undoubtedly happen/ recur possibly frequently

Severity/Consequences scoring descriptors

	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 required	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 sub-optimal Informal complaint/inquiry	Overall treatment or service sub-optimal 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 significantly reduced effectiveness Formal complaint (stage 2). Local resolution -potential to go to independent review. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review Low performance rating. Critical report	Incident leading to totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1day). 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 attendance for mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence. Loss of several key staff No staff attending Mandatory training/ key training on an ongoing basis
Statutory duty/ Inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory Legislation. Reduced performance rating if unresolved	Single breech in statutory duty. Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating. Critical report	Multiple breeches in statutory duty. Prosecution Complete systems change required Zero performance rating. Severely critical report
Adverse publicity/ Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House).Total loss of public confidence
Business objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1m 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) >£1m
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

Appendix 2 – Equality Impact Assessment

EQUALITY IMPACT ANALYSIS

Title of policy/programme/service being analysed Risk Management Policy	
Author: Justina Jeffs, Interim Governance Support	**Assessor: Justina Jeffs**
Director: Roshan Patel, Chief Finance Officer	**Date of Assessment: August 2016**
Equality Act Duties	
Relevance of the document against the duties of the Equality Act: This should include which aspects of a policy, service, function, etc. are relevant to which duties.	
Disability	No impact
Sex	No impact
Race	No impact
Age	No impact
Gender Reassignment	No impact
Sexual Orientation	No impact
Religion or belief	No impact
Marriage and Civil Partnership	No impact
Pregnancy and Maternity	No impact
Carers	No impact
Please state the aims and objectives of this work How is this proposal linked to the organisation's Business Plan and Strategic Objectives Statutory Duty which links directly to the achievement of the CCG's Strategic Objectives and safe working	
Who is likely to be affected? e.g. staff, patients, service users Staff	
What evidence do you have of the potential impact (positive and negative)? The Policy is part of the governance framework documents of the CCG which are established to protect staff and the work they carry out	
Gaps in evidence of potential impact Audit of implementation	
Document Consultation Audit & Risk Committee	
Action planning for improvement N/A	

Appendix 3: Glossary

Risk Management Framework – is the essential supporting structure and systems for risk including resources, plans, strategies, structures, policies and tools.

Risk - is the possibility that loss or harm will arise from a given situation. In the context of this Strategy, this encompasses anything from the, possibility of injury to an individual member of staff, to anything which impacts upon the Clinical Commissioning Group's loss of opportunity or ability to fulfil its aims and objectives.

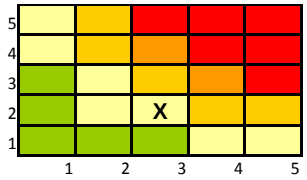
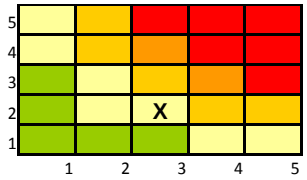
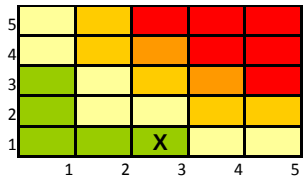
Risk Management - may be defined as a proactive approach to the:

- identification of risks;
- assessment of the likelihood and impact of risks;
- elimination of those risks that can be reasonably and practicably eliminated and
- control of those risks that cannot be eliminated by reducing their effects to an acceptable level.

Risk management is an integral part of the corporate assurance programme, a process designed to provide evidence that an NHS organisation is doing its "reasonable best" to achieve its objectives. (DH Building the Assurance Framework: *A practical guide for NHS Boards)*

Internal Control – any action taken to manage risk, these actions may be taken to manage either the impact if the risk is realised, or the frequency of the realisation of the risk.

Appendix 4

North East Hampshire and Farnham CCG - Risk Register Form		
Risk Type		
Risk Name		
Risk Description / Impact		
Initial Risk Assessment		
Risk Score: Consequence	3 Moderate	
Risk Score: Likelihood	2 Unlikely	
Gross Risk Score:	6	
Controls in Place		
Current Risk Assessment		
Risk Score: Consequence	3 Moderate	
Risk Score: Likelihood	2 Unlikely	
Gross Risk Score:	6	
Additional risk reduction plan		
Target Risk Score		
Risk Score: Consequence	3 Moderate	
Risk Score: Likelihood	1 Rare	
Target Risk Score	3	
Lead Manager		
Lead Executive		
Committee		
Date Risk was Identified	(DD/MM/YYYY)	
Review Date	(DD/MM/YYYY)	
Progress		

**** Please be advised that the light blue squares contain a drop down list to be selected and B7 contains a formula****
****Please email the completed form to …… ****