NHS
Southport and Formby
Clinical Commissioning Group

Title: Risk Management Strategy	
Scope: NHS Southport and Formby CCG	Classification: Strategy
Replaces: Risk Management Strategy of 2017 - 2019	
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Authorised by: CCG Audit Committee	Date: April 2017
To be read in conjunction with: Governance Policies	
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Version Control

Version	Date	Reviewed By	Comment
V2	06 Feb 17	Danielle Love	Updated to reflect new Committee risk register process Changes to job titles

Contents

1 Introduction

1.1 By its very nature the commissioning of healthcare carries risks. The Governing Body accepts the importance of the principles of risk management and recognises the value of taking a strategic, proactive, and comprehensive approach to the assessment and control of risk. Significant benefits can be achieved from this approach, from improving patient care and the safety of the working environment, to reducing levels of financial risk and loss for the CCG as a whole.

1.2 The CCG also recognises that due to a high reliance upon human intervention in the commissioning and provision of care, mistakes and errors can happen. Therefore a strategy and framework is required to deal with the hazards and risks associated with its main functions of commissioning high quality healthcare and improving the health of the local population. The strategy defines the CCGs commitment to developing an open, honest, inclusive and educative culture which encourages identification, reporting and avoidance of risk. It also brings clinical knowledge, understanding and perspectives to the heart of managing risk within the local health system.

1.3 The Risk Management Strategy therefore represents the CCG's corporate philosophy towards risk management and aims to provide assurance to the CCG Governing Body that risks are being consistently identified and managed.

2 Purpose, Philosophy & Principles

2.1 This strategy supersedes the 2015 version and is designed to provide a framework for the development of a robust risk management system across the CCG and thereby assisting the CCG in achieving its objectives. Each senior manager or clinical lead is expected to systematically identify and assess the risks associated with their key areas of work and manage them to ensure they do not impede the delivery of team or organisational objectives, and to record this activity on the Corporate Risk Register. Major risks identified as part of the risk assessment process will be integrated into the Governing Body Assurance Framework (GBAF) which the CCG Governing Body recognises as a tool to ensure the delivery of organisational objectives.

2.2 The CCG is committed to ensuring robust systems are in place to ensure high standards of risk management. A proactive structured and systematic approach supports informed management decision-making by providing a greater understanding of risks and their potential impact. Effective management of risks has the potential for reducing the frequency and severity of incidents, complaints and claims. The demarcation of risks into clinical quality, corporate and financial precludes a holistic view so it is proposed that CCG has a unified strategy for managing all risks. This approach should ultimately form an integral part of the business planning process.

3 Scope of the Strategy

3.1 This strategy relates to the management of risks faced by the CCG as a commissioner of services and applies from January 2017 to January 2019.

4 Risk Management Objectives

4.1 The CCG's specific risk management objectives are to:

- demonstrate the CCG Governing Body's support and commitment to the risk management agenda;
- be a fundamental part of the CCG's approach to integrated governance; (see Appendix A)
- continually develop the risk management strategy and ensure communication throughout the CCG;
- clearly define the stages within the risk management process;
- ensure compliance with all the relevant statutory and non-statutory standards relating to the assessment and control of risk;
- manage risks at a corporate and local level
- develop and maintain risk registers across the CCG by the ongoing implementing of a comprehensive risk assessment and grading system;
- provide an effective system to identify and eliminate or mitigate risk by appropriate means;
- ensure all governing body members and staff attend risk management training/development events to ensure full understanding of their responsibilities;
- develop a risk aware culture throughout the ccg which will embed the consideration and assessment of risk in all work activities;
- encourage a culture of 'fair blame', being transparent when things go wrong;
- ensure lessons are learned from good and deficient practice;
- agree and firmly establish clearly defined roles and responsibilities for the management of risk within the CCG;
- ensure all teams accept their responsibility for managing risk at a local level.

5 Organisation Arrangements and Management of Risk

Annual Governance Statement Governance Arrangements

5.1 As a statutory body the CCG is required to produce an Annual Governance Statement (or an equivalent statement of governance as may be specified by the Department of Health) which acts as a statement of assurance that appropriate strategies and policies and internal control systems are in place and functioning effectively, so that key risks which may threaten the achievement of strategic objectives are identified, recorded and minimised. Any significant issues identified in the Annual Governance Statement will be recorded on the Governing Body Assurance Framework and/or Corporate Risk Register.

6 Governing Body Assurance Framework (GBAF)

6.1 The GBAF is the process by which the CCG can demonstrate that it is doing its reasonable best to manage itself so as to meet its strategic objectives and protect patients, members, staff, visitors and other stakeholders against risk of all kinds.

6.2 The framework records the links between strategic objectives, key risks and key controls. It also indicates the sources of evidence or assurance, which support the controls, and identifies any gaps. The GBAF will be reviewed at internal business meetings of the Audit Committee following review by the Leadership Team and Corporate Governance Support Group. The Audit Committee will consider the risk management arrangements in place on an annual basis to provide assurances to the Governing Body that the systems and processes for review and scrutiny are robust. Exceptions identified on the GBAF will be reviewed at public Governing Body meetings and with a full review of GBAF on a bi monthly basis.

6.3 The Leadership Team is responsible for reviewing and updating the GBAF.

6.4 Whilst there are elements of duplication with the Governing Body Assurance Framework and Corporate Risk Register in terms of language and content, the two documents serve different purposes. The GBAF is a summary document which brings together a significant amount of information relating to strategic objectives. Its purpose is to provide the CCG Governing Body with assurance that risks to the delivery of organisational objectives have been identified and are being managed. It provides a list of the key pieces of evidence that the CCG Governing Body should use to gain this assurance. There is also an assessment of the strength of evidence provided. The ideal GBAF will contain a list of significant assurance evidence with no gaps identified in control or assurance, and all assurances provided rated as 'significant'.

7 Corporate Risk Register

7.1 The Corporate Risk Register (CRR) contains high level organisational risks with a mitigated risk rating of 12 or over, and any risks with a mitigated risk rating of 12 or over that have been escalated from the Committee Risk Registers. The risks contained in the CRR are more wide-ranging than those in the GBAF. The purpose of the CRR is to provide the Governing Body with a summary of the principal risks facing the organisation with a summary of actions needed and being taken to reduce the risks to an acceptable level. Where risks to achieving organisational objectives are identified within the CRR or Committee risk registers, they should be added to the GBAF. Likewise where gaps in control are identified in the GBAF these risks should be added to the CRR or Committee risk registers. The two documents therefore complement each other providing the Governing Body with assurance and action plans on risk management within the CCG.

7.2 The CRR is reviewed regularly by the CCG Leadership Team and at the internal business meeting of the Audit Committee, in addition to reviews by the Corporate Governance Support Group. The Audit Committee will review the risk management arrangements in place on an annual basis to provide assurances to the Governing Body that the systems and processes for review and scrutiny are robust. A full review of the CCR will be presented to the CCG Governing Body, alongside the GBAF at least twice a year at a public meeting. The process for populating and updating the Corporate Risk Register can be found in Appendix B.

8 Committee Risk Registers

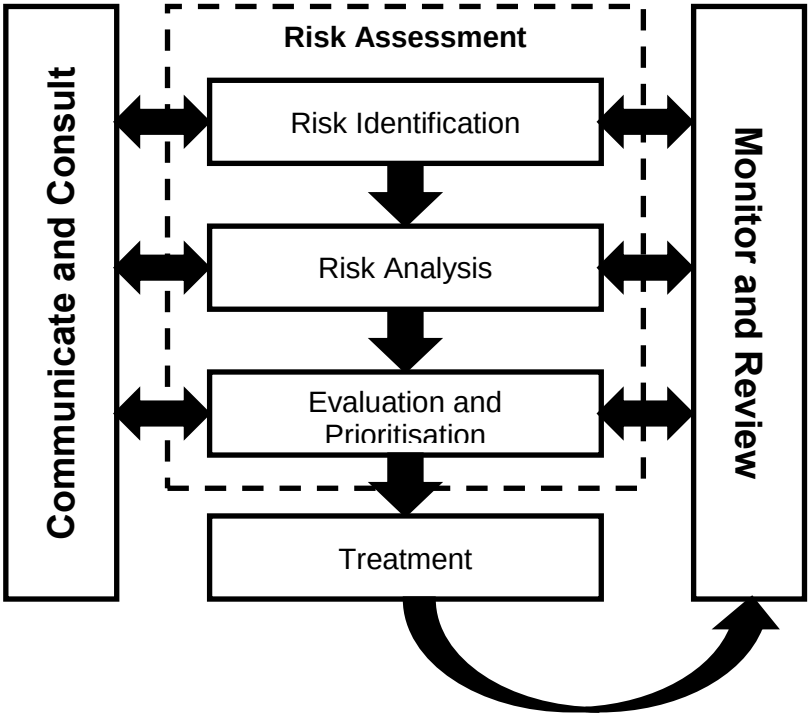
8.1 Each committee will hold a committee risk register, which will manage and maintain the committee's operational risk. Committees will regularly review their risks registers, any risks logged that have a mitigated risk rating of 12 or over will be escalated onto the CRR via the Corporate Business Manager.

9 Audit Committee

9.1 The Audit Committee has powers to establish sub groups to review risk registers and other integrated governance matters as appropriate. The CCG already has in place the Corporate Governance Support Group to support the risk management processes. This group reports directly to the Joint Quality Committee and to the Audit Committee in respect of matters relating to risk as required.

10 The Risk Management Framework

10.1 The CCG has adopted the risk management framework described in the NHS Executives Controls Assurance risk management standard. This draws on the main components of risk strategy, that is risk identification, risk analysis, evaluation and prioritisation and risk treatment.



11 Risk Identification

Incident & Near Miss Reporting

11.1 The reporting of incidents and near misses by CCG members and staff is an efficient and effective system for identifying risk. This allows rapid alert to ascertain why and how incidents occurred, and facilitates a fast response in the case of adverse events, which may lead to a complaint or litigation. It enables lessons to be learnt and therefore prevent recurrence. This is best achieved in a supportive management environment where a 'fair blame' culture is advocated and makes explicit the circumstances in which disciplinary action may be considered.

11.2 All incidents and near misses will be reported and managed using the CCG's incident reporting system in line with the Policy and Procedure for the Reporting and Management of Incidents and Near Misses.

11.3 All incidents will be graded at source and as a result of a local investigation, local management (when appropriate) will ensure controls are put into place and advise Senior Management of the risk treatment and controls accordingly. Each incident will be assigned to an incident manager who will be responsible for reviewing the grading applied and ensuring that if necessary the Chief Officer is informed of the incident. Training will be provided to enable staff to grade incidents at source.

12 Risk Assessment

12.1 In order to anticipate, rather than react to risks identified, a formal mechanism for risk assessment will be adopted.

12.2 The aim of a risk assessment is to determine how to manage or control the risk and translate these findings into a safe system of work that is then communicated to the appropriate level of management.

12.3 A risk assessment is a careful examination of what could go wrong. Assessors need to weigh up whether there are sufficient controls in place, and if not they must establish the extent of control and ensure that action is proportionate to the level of risk.

12.4 Risk assessments are subjective; therefore, a team of no less than three people should undertake the risk assessment, including preferably the relevant senior manager or lead clinician to ensure ownership of the risks within their own area of responsibility.

12.5 All risks are graded using the risk grading matrix. A copy of the Risk Grading Matrix can be found in Appendix D.

13 Risk Grading and Analysis (Acceptable Levels of Risk)

13.1 It is accepted that it is neither realistic nor possible to totally eliminate all risk. It is however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated.

13.2 The CCG utilises an accepted system for grading risk (see Appendix D), which takes into account parameters that include probability of occurrence and impact on the organisation. A grading system enables a method of quantification which can be used to prioritise risk treatment at all levels. Incidents and risks are graded according to the CCG's risk grading matrix which considers the actual consequence of the incident or potential consequence of the risk and the likelihood of occurrence or recurrence. The grading results in a level of risk to the organisation.

13.3 The risk grading system also covers the different grades of incidents. The level of authority required for managing the different grades of incidents will be described in detail in the incident reporting policy. The following table indicates the authority levels required to act in accordance with the quantification of risk.

CCG Members / Staff	CCG Locality Leads /Manager	CCG Senior Management	CCG Governing Body Level

				Management
Insignificant	✓	✓	✓	X
Low	✓	✓	✓	X
Moderate	x	✓	✓	✓
Major	x	x	✓	✓

14 Risk Evaluation and Prioritisation

14.1 The criteria used to evaluate risk covers the following:

- acceptance criteria within the organisation, i.e. operational standards;
- cost benefit analysis, i.e. balance of cost against the potential benefits;
- human issues, i.e. pain and suffering;
- legislative constraints, i.e. meeting statutory requirements.

15 Risk Treatment

15.1 During the process of risk assessment, analysis and evaluation it is possible to identify controls in place or required to reduce or eliminate risk. These control strategies cover a number of possible solutions, as described below:

- risk avoidance – discontinuing a hazardous operation/activity;
- risk retention – retaining/accepting risks within financial operations;
- risk transfer – the conventional use of insurance premiums;
- risk reduction – prevention/control of any remaining residual risk.

15.2 Once controls, in place or required, have been identified the risk must be re-graded in order to establish whether the action proposed is adequate and will reduce the residual risk to an acceptable level. These controls and further treatments may be cost neutral or require action that requires investment. At this point it is imperative that action plans are submitted as part of the CCG's usual process for service planning.

15.3 Risks should continue to be monitored by the relevant Team to ensure that the controls remain effective, once the actions have been implemented and the risk has been eliminated the risk may be closed on the risk register and the reasons for the closure recorded in the narrative of the risk register to provide an auditable trail. The CCG recognises that in some cases high risks may be long standing which cannot be reduced to an acceptable level for a number of reasons, and even having been reviewed and accepted by the Governing Body, these risks shall remain upon the Corporate Risk Register and exception reported to Governing Body to serve as a reminder that the risks are still significant.

16 Risk Management and Review

16.1 Through a process of audit and monitoring the CCG will undertake a review of the risk control measures regularly. It is anticipated that risk control and monitoring measures will include some or all of the following:

- aggregated statistical and trend reporting of incidents, complaints and claims to the CCG Governing Body and relevant committees, including the corporate governance support group;
- audit of implementation of the range of risk management policies, procedures and guidelines throughout the organisation;

- ongoing review of Committee risk registers;
- annual review of the risk management strategy;
- monitoring of the audit committee and other minutes;
- audits undertaken by internal and external auditors;

17 Communication and Consultation

17.1 Expert advice is available internally through the Chief Delivery and Integration Officer, through Commissioning Support Services and externally from specialist advisers dependent upon the type of risk being considered. For advice regarding external advice, this is available through the Chief Delivery and Integration Officer. Consideration should be given as to who needs to be informed of the Risk. Internally this process should following the process detailed within Appendix B. Consideration should also be given as to whether any external stakeholders should also be informed as the impact may affect the achievement of their objectives e.g. Sefton Council.

18 Risk Prevention

18.1 The CCG has adopted a proactive and reactive approach to risk. The population of risk registers with the further development of appropriate action plans will provide the CCG with greater knowledge of where risks lie. As systems and processes become further defined, the CCG will become more sophisticated in its approach to essential risk prevention.

19 Legal Liabilities and Property Losses

19.1 The CCG is a member of the Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties (LTPS) and Property Expenses Scheme (PES) that are administered by the NHS Litigation Authority (NHSLA). Funding is on a pay as you go basis and contributions are based on a range of criteria such as NHS income, numbers of staff and property values.

19.2 Commissioned services such as those provided by secondary care providers, independent contractors and their employees are not directly employed by the CCG and therefore are required to make their own indemnity arrangements. The CCG has responsibility to ensure that governance principles and risk management systems are being developed and applied by all providers. It is therefore possible for negligence proven in the course of a claim to in part be attributed to CCG commissioning the care if the CCG has failed to take reasonable steps to assure itself of the quality of standards of its provider. In these circumstances it is important that the CCG is able to demonstrate that it has taken all reasonable steps, i.e. monitoring performance, to assure itself of the quality of care provided.

19.3 The CCG has established Quality and Performance Review Groups that monitor the quality of contracted provider services and the Quality Committee and Governing Bodies receive reports on performance across all areas.

20 Roles and responsibilities:

20.1 All those working within the CCG have a responsibility to contribute, directly and indirectly to the achievement of the CCG's objectives through the efficient management of risk. It is also important to make explicit how the responsibility of the individual contributes to the lines of management accountability through to the CCG Governing Body.

20.2 There are five identifiable tiers within the CCG:

- Governing Body Level Management
- Leadership Team management
- Senior Management
- Locality Leads/ Managers
- All Members and Staff

21 Governing Body Level Management

21.1 Chief Officer

21.1.1 The Chief Officer has ultimate responsibility for risk management, for meeting all statutory requirements and adhering to guidance issued by NHS England. As such, the Chief Officer must take assurance from the systems and processes for risk management. The CCG will ensure that reporting mechanisms clearly demonstrate that the Chief Officer is informed of significant risk issues. The reporting mechanism will include the presentation of minutes and reports to the CCG Governing Body by the Audit Committee.

21.1.2 It is the responsibility of the Chief Officer and Senior Management Team to ensure that the standards of risk management are applied at all levels within the CCG and that assurance mechanisms are in place to assure the CCG Governing Body that risk is being managed effectively.

21.2 Chief Delivery and Integration Officer

21.2.1 The Chief Delivery and Integration Officer Governing Body and has clear responsibility for governance and risk management. They will ensure that risk management arrangements are controlled and monitored through robust audit processes. They are the key contact for the auditors. The Chief Delivery and Integration Officer is invited to attend the Quality Committee and Audit Committee on a regular basis.

21.3 Chief Finance Officer

21.3.1 The Chief Finance Officer has overall fiscal responsibility in the CCG and is responsible for ensuring that the CCG carries out its business within sound financial governance and that risk management arrangements are controlled and monitored through robust accounting mechanisms that are open to public scrutiny on an annual basis. They will seek the Chief Internal Auditor's opinion on the effectiveness of internal financial control. The Chief Finance Officer is in attendance/an ex-officio member of the Audit Committee and a member of the Quality Committee. In addition they will be ultimately responsible for any financial implications of plans to minimise risk and the method for incorporating these into business planning.

21.4 Escalation (Leadership Team)

21.4.1 The CCG operates an 'escalation System', which enables any issue with the potential to post a significant risk to the CCG, to be brought immediately to the attention of the

Leadership Team without using the formal committee route. The decision to use this route must be approved by a member of the Leadership Team

21.5 CCG Governing Body

21.5.1 The CCG Governing Body recognises that risk management is a fundamental part of good governance and to be effective it is essential that risk management processes are integral to the CCG's culture. The Governing Body is therefore committed to ensuring that risk management forms an integral part of the CCG's philosophy, practices and business plans. Risk management is not viewed or practised as a separate programme and responsibility for implementation is accepted at all levels of the CCG.

21.5.2 The CCG Governing Body will ultimately carry responsibility for monitoring and overseeing risk that is relevant to the nature of its duties and responsibilities; however, the CCG Governing Body has delegated responsibility to the Audit Committee to take an overview of all risk and report directly to the Governing Body. The Audit Committee has responsibility for ensuring the arrangements in place are effective. The CCG will ensure that all Governing Body members receive Risk Management Training as part of their induction or refresher training.

21.6 Audit Committee

21.6.1 The Audit Committee has delegated authority from the CCG Governing Body to ensure that risk management is embedded throughout the CCG, including monitoring of all specialist groups with responsibility for risk. The Committee is under the chairmanship of a Lay Member, with additional lead clinician input and high-level representation from the CCG management team. The Committee is charged with the responsibility for ensuring effective risk management systems are in place across the CCG. The Committee will have the option to establish specialist risk management groups to consider specific areas of risk in more detail on the Committee's behalf if it wishes to do so. The Audit Committee reports to the Governing Body. For further information on the role of the Audit Committee please see Appendix E.

21.6.2 The Audit Committee is responsible for providing the Governing Body with assurance that an effective system of integrated governance, risk management and internal control, across the whole of organisation's activities which support the achievement of the organisation's objectives is in place. In particular the Committee reviews the adequacy and effectiveness of the Quality Committee's arrangements, all risk and control related disclosure statements, particularly the Annual Governance Statement, and the underlying assurance processes which indicate the degree of the effectiveness of the management of principle risks. .

21.7 Joint Quality Committee

21.7.1 The Joint Quality Committee is charged with the responsibility approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes, approve the arrangements for handling complaints and to approve the CCG's arrangements for engaging patients and their carers in decisions concerning their healthcare. . For further information on the role of the Joint Quality Committee please see Appendix F

21.7.2 The CCGs Internal Serious Untoward Incident Review Group meets on a frequent basis and forms a sub group of the Joint Quality Committee, reporting into it on a bi-monthly

basis. For further Information regarding the Role of the Internal Serious Untoward Incident Review Group please see Appendix G.

21.8 Senior Management Support

21.8.1 The CCG Chief Integration and Delivery Officer will, in conjunction with the Chief Finance Officer, ensure effective management support for governance and risk either internally or from Commissioning Support Services.

21.9 Corporate Support Team and Quality Team

21.9.1 The Chief Delivery and Integration Officer has overall operational responsibility for delivery and review of the risk management strategy, however is supported by the Corporate Governance Manager and Corporate Business Manager to operationally co-ordinate the delivery of risk management systems and policies within the CCG. They also have responsibility for the risk education programme across in the CCG.

21.9.2 The Corporate team, in conjunction with the Quality team will provide the Chief Nurse and Quality Officer with regular information on Serious Incidents reported from commissioned services across Sefton. They will also support the Chief Nurse and Quality Officer in identifying patient safety issues and health and safety & security. They will also manage the Incident Reporting System for both CCG and ensure regular reporting to the Governing Body via the Chief Nurse and Quality Officer

21.10 Other Specialist Expertise:

21.10.1 Expertise in specific areas of risk may be obtained from a number of sources, both internal and external, such as:

- Governance / Quality Leads at NHS England and Commissioning Support Services
- Health and Safety Lead from Commissioning Support Services
- Occupational Health Manager from locally commissioned service.
- Local Counter Fraud Specialist (LCFS)
- NHS Litigation Authority (NHSLA)
- Health & Safety Executive (HSE)

21.11 NHS England and CCG Chief Nurse and Quality Officer

21.12 As the successor body to the National Patient Safety Agency (NPSA), NHS England co-ordinates the reporting and learning of adverse events occurring in the NHS. The CCG reports all notifiable Patient Safety incidents to NHS England via the National Reporting and Learning System (NRLS) and promotes and monitors compliance with Safety Alerts issued by NHS England. The Chief Nurse and Quality Officer will maintain effective liaison with the governance structures, committees and other groups within the Local Office of NHS England in relation to quality and patient safety.

21.13 CCG Managers and Locality Leads

21.13.1 They will ensure that:

- The risk management strategy is implemented within their area of control and promotes risk management as a key management responsibility.
- Risk management responsibilities are properly assigned and accepted at all levels.

- All risks associated with their area of responsibility are risk assessed and the results of these assessments and resulting control mechanisms are recorded on the Team Risk Registers as relevant. Control procedures will be periodically reviewed for continued effectiveness.
- A periodic review of the effectiveness of risk management within their area of responsibility is undertaken and action taken to eliminate deficiencies.
- Information, instruction and training are delivered to members / staff appropriate to the findings of risk assessments.
- Safe systems of work are in place and that effectiveness is periodically monitored.
- Outcomes of risk assessments are used as part of the service planning process to assist with planning and resource allocation.
- Information captured by complaints, litigation and incident reporting is used as a means of continuous monitoring and review, leading to risk reduction in services within their area.
- Bringing any significant risks which have been identified, and where local controls are considered to be potentially inadequate to the attention of the appropriate Committee for addition to the Committee risk register or to the Leadership Team for escalation to the CRR.
- All staff within the CCG will access mandatory risk management training in line with the CCG's mandatory training policy.

21.14 All CCG Members and staff

- Risk management will form part of their daily duties. All will be able to identify and assess risk; take action to reduce risks to an acceptable level and inform appropriate lead clinicians and managers of unacceptable risks.
- All will be required to participate in activities, which are commensurate with the CCG's risk management arrangements and statutory requirements.
- All have a responsibility to report incidents, which is a key source of information for clinicians and managers on the nature and level of adverse activity within their sphere of responsibility.
- Be aware of emergency procedures e.g., resuscitation, evacuation and fire precaution procedures.
- Will attend risk management training as relevant to their role set out in the CCG's Mandatory Training Policy.

21.15 Commissioned services, Independent Contractors and their Employers

21.15.1 Whilst there is no obligation to adopt the CCG Risk Management Strategy, if they do commissioned services will be contributing to the reduction of risk across the area as a whole, and to the improvement of patient and staff safety. In addition, following these procedures will assist in complaint handling, reduce litigation and may assist in the defence of any claims should they arise.

21.16 Responsibilities of Contractors, agency and locum staff

21.16.1 Contractors and agency staff working for the CCG are bound by the contents of this Strategy and will be expected to comply with all relevant policies and procedures. Information and training will be provided as necessary to enable contractors and agency staff to fulfil this responsibility.

22 Definitions

Risk management:

22.1 Risk management is a framework for the systematic identification, assessment, treatment and monitoring of risks. Its purpose is to prevent or minimise the possibility of recurrence of risks and their associated consequences, which have potentially adverse effects on the quality of care, both directly provided and commissioned, and safety of patients, staff and visitors, and the financial management of the organisation. It encompasses culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

22.2 Risk: the possibility of incurring misfortune or loss or failing to take advantage of potential opportunities. Risk = consequences x likelihood

22.3 Acceptable' risk - it is not feasible to eliminate or avoid all risks and there are some risks identified which require the CCG to go beyond reasonable action to reduce or eliminate. Where the 'cost' to the organisation to reduce the level of risk outweighs the adverse consequences of the risk occurring, the risk would be considered 'acceptable' to the CCG.

22.4 'Manageable' risk - some risks identified can be realistically managed, or reduced, within a reasonable, acceptable timescale through cost-effective measures; these are considered 'manageable' risk.

22.5 'High' risk - these are risks which if they occur will have a serious impact on the CCG and threaten the achievement of its objectives. Risks identified as 'high' should be reported on the Team Risk Register and / or if necessary they should also be escalated to the Senior Management Team via the Early Warning System.

23 Consultation, approval and ratification process

23.1 The policy has been developed and based on good practice in the area of risk management and is presented to the CCG Audit Committee for approval.

24 Review and revision arrangements

24.1 The strategy will be considered and reviewed by the CCG Governing Body every two years or sooner in response to changes in NHS requirements, audits or best practice.

25 Dissemination and Implementation:

25.1 For the strategy to be effective the CCG will:

- review every two years its Risk Management Strategy to ensure it meets the needs of the CCG and the changing environment;
- ensure the risk management services provided meet the needs of the organisation and develops in line with changing requirements;
- continue the development and delivery of an education and training programme which assists members and assist in identifying and managing risk and in complying with the CCG risk management policies.
- ensure that systems capture data effectively;
- monitor risk management key performance indicators, such as those suggested listed in Appendix H, to measure the performance of the CCG's risk management process. The

efficacy and usefulness of these indicators will be reviewed by the Chief Delivery and Integration Officer and the Quality Committee. Consequently they will continue to be refined and developed;
- encourage the flow of information via risk registers, and disseminate good practice in this regard, within and across the CCG;
- develop a risk aware culture amongst members and staff through CCG briefings, literature, induction programmes, mandatory training and use of the CCG intranet site.

25.2 The Chief Delivery and Integration Officer will ensure that the Strategy is communicated throughout the CCG via the CCG website and intranet, relevant bulletins, and in induction and mandatory training. CCG Governing Body members and senior managers will be responsible for ensuring their respective teams aware of their responsibilities in relation to this strategy.

26 Education and Training

26.1 The following training will be available on an ongoing basis:

- risk management mandatory training to promote ownership of the Risk Management Strategy, including providing guidance on incident reporting, root cause analysis, risk assessment and the risk registers, and based upon the training needs analysis of all staff.
- risk management is included in induction training.
- on an ad hoc basis as identified in personal development plans.

27 Document Control

27.1 The Chief Delivery and Integration Officer is responsible for storing current, and archiving, versions of the Risk Management Strategy.

28 Monitoring compliance with and effectiveness of the policy

28.1 The success of risk control measures must be monitored in an appropriate manner to provide information to guide future developments. There are various ways in which the CCG assesses and monitors risk. Reactive monitoring occurs through the incident and near miss reporting and monitoring of complaints and claims. Proactive monitoring of adherence to procedures occurs through audit, workplace inspections, staff surveys and performance indicators.

28.2 The CCG committee structure will provide a vehicle for monitoring risk management activity. The Audit Committee is responsible for managing areas of concern on the Corporate Risk Register and will receive information from the incident reporting system and consider policy changes as a result of information from incident reporting.

28.3 Senior Managers shall hold staff to account for ensuring compliance with the strategy within their locality / service area. An effective way of ensuring the strategy is adopted into the culture of the CCG is via the appraisal process when reviewing performance e.g. against the Knowledge and Skills Framework outline. A suggestion of evidence to be looked for is in KSF Dimension Health Safety and Security Levels 1-3.

29 Associated documentation

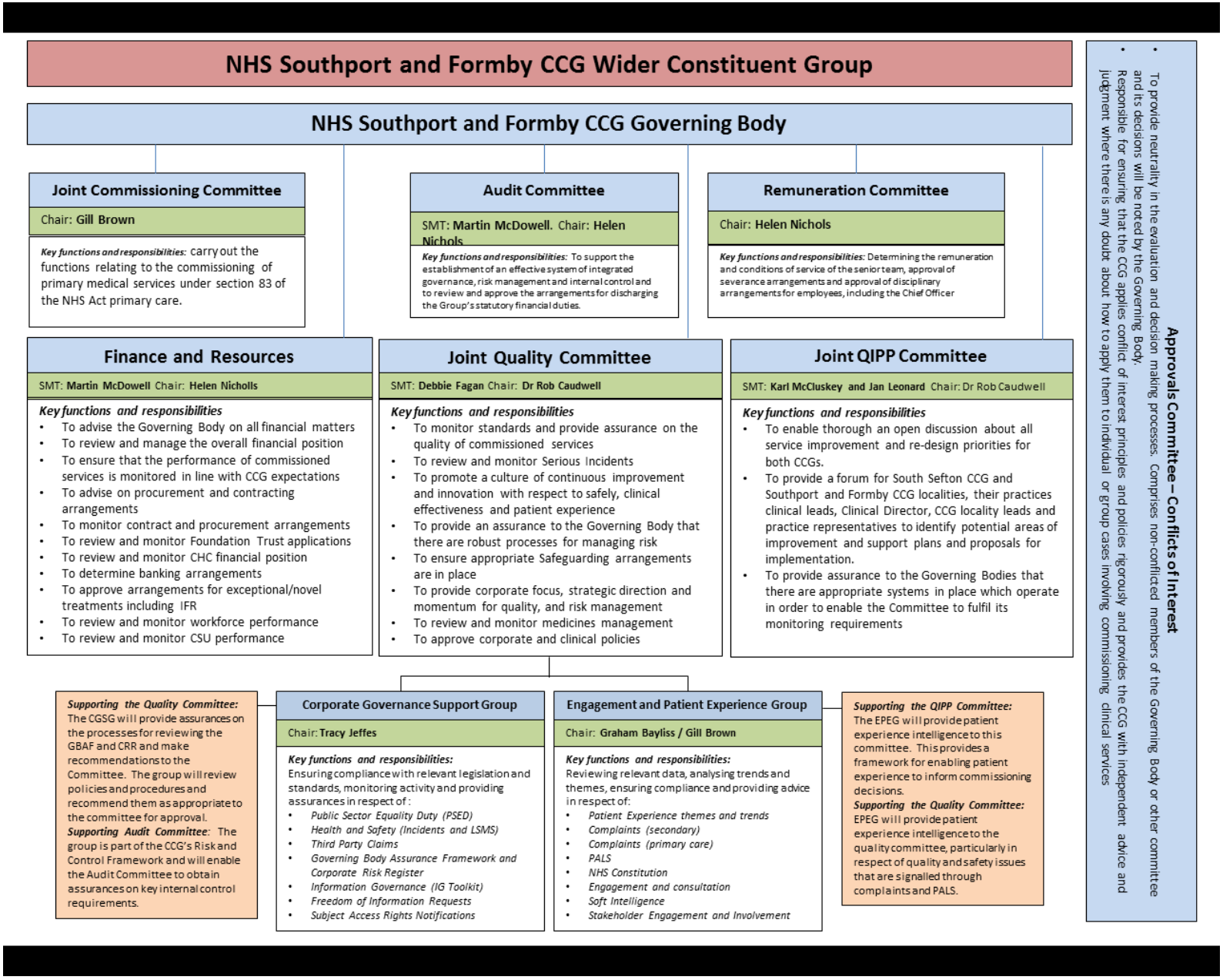
29.1 The Risk Management Strategy is to be followed within the context of the CCG's overarching strategy.

29.2 A range of documents other policies will be regularly reviewed, amended and if appropriate approved adopted by the CCG Governing Body or relevant CCG Committee. Such policies include:-

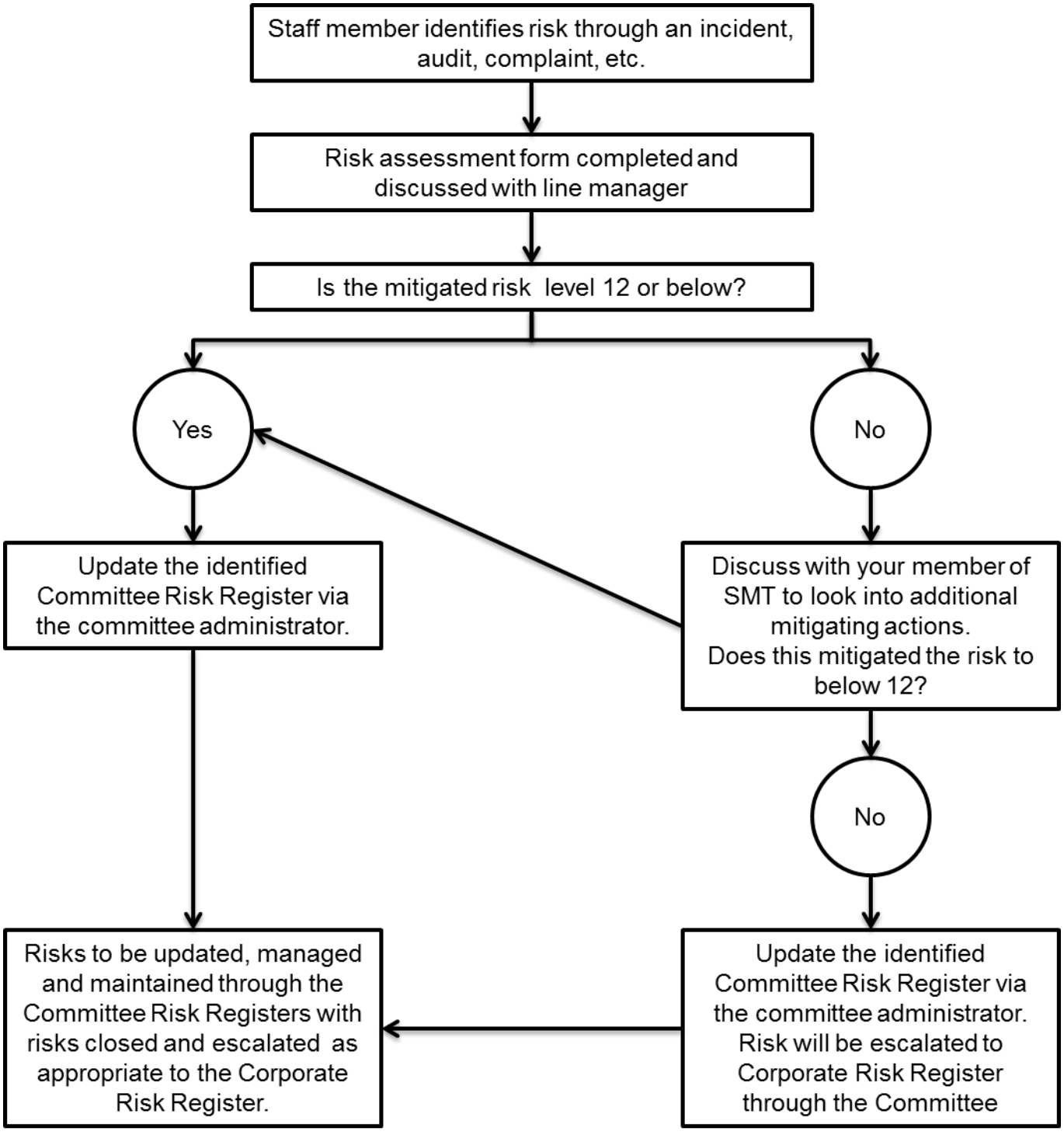
- policy & procedure for the reporting and management of incidents & near misses;
- policy & procedure for the management of claims;
- complaints comments & concerns policy;
- policy & procedure for the root cause analysis of incidents, complaints and claims;
- health and safety policy;
- moving and handling policy;
- lone workers policy;
- control of substances hazardous to health (coshh) policy;
- management of violence and aggression policy;
- infection control strategy;
- steis reporting procedure;
- whistleblowing policy;
- and any other relevant document.

29.3 These policies will be published the CCG Intranet site once adopted.

Appendix A – Southport and Formby CCG Governance Structure



Appendix B – Populating Risk Registers (Committee or Corporate)



Appendix C – CCG Risk Assessment Log

Part 1 – Risk Identification
Section 1 – Process/Project/Activity Description

CCG Work Area (e.g. Finance, Quality, Meds Mgmt, P/Care, Commissioning):	Link to Corporate Objective (only if applicable):
CCG Lead:	Responsible Committee:

Section 2 – Risk Identification

Risk no.	Risk description / Rationale for Inclusion	Existing control measures	Likelihood	Consequence	Risk Level LxC
1.					
2.					
3.					
4.					

Assessor's Name:	Date of assessment:
Job title/role:	Date of re-assessment:
Assessor's signature:	Date added to Corporate Risk Register (if applicable):

Part 2 – Risk Action Plan
(To be completed and attached to Risk Assessment Form)

Risk no. (from Above)	Link to CCG Objective (if applicable)	Recommended actions (including any additional resources identified)	Lead Officer	Action by when?	Residual Risk Score (LxC)
1.					
2.					
3.					
4.					

Appendix D – Risk Grading Matrix

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

Risk	Score	Colour
Insignificant	1 - 3	
Low	4 - 6	
Moderate	8 - 12	
High	15 - 25	

Significant risk

Significant Risk

A risk which attracts a score of 12 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Corporate Risk Register.

Consequence Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	**Negligible**	• None or very minor injury. • No financial loss or very minor loss up to £100,000. • Minimal or no service disruption. • No impact but current systems could be improved. • So close to achieving target that no impact or loss of external reputation.
2	**Minor**	• Minor injury or illness requiring first aid treatment e.g. cuts,bruises due to fault of CCG. • A financial pressure of £100,001 to £500,000. • Some delay in provision of services. • Some possibility of complaint or litigation. • CCG criticised, but minimum impact on organisation.
3	**Moderate**	• Moderate injury or illness, requiring medical treatment (e.g. fractures) due to CCG's fault. • Moderate financial pressure of £500,001 to £1m. • Some delay in provision of services. • Could result in legal action or prosecution. • Event leads to adverse local external attention e.g. HSE, media.

Consequence Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
4	**Major**	• Individual death / permanent injury/disability due to fault of CCG. • Major financial pressure of £1m to £2m. • Major service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £100,000 not covered by NHSLA. • Risk to CCG reputation in the short term with key stakeholders, public & media.
5	**Catastrophic**	• Multiple deaths due to fault of CCG.• Significant financial pressure of above £2m.• Extended service disruption/closure in commissioned healthcare services CCG accountable for.• Potential litigation or negligence costs over £1,000,000 not covered by NHSLA.• Long term serious risk to CCG's reputation with key stakeholders, public & media.• Fail key target(s) so that continuing CCG authorisation may be put at risk.

Likelihood Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	**Rare**	• The event could occur only in exceptional circumstances. • No likelihood of missing target. • Project is on track.
2	**Unlikely**	• The event could occur at some time. • Small probability of missing target. • Key projects are on track but benefits delivery still uncertain. • Less important projects are significantly delayed by over 6 months or are expected to deliver only 50% of expected benefits.
3	**Possible**	• The event may occur at some time. • 40-60% chance of missing target. • Key project is behind schedule by between 3-6 months. • Less important projects fail to be delivered or fail to deliver expected benefits by significant degree.
4	**Likely**	• The event is more likely to occur in the next 12 months than not. • High probability of missing target. • Key project is significantly delayed in excess of 6 months or is only expected to deliver only 50% of expected benefits.
5	**Almost Certain**	• The event is expected to occur in most circumstances. • Missing the target is almost a certainty. • Key project will fail to be delivered or fail to deliver expected benefits by significant degree.

Appendix E – Audit Committee Terms of Reference

1. Authority

1.1. The Audit Committee shall be established as a committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body.

1.2. The principal functions of the Committee are as follows:

a) To support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the Group's activities to support the delivery of the Group's objectives.

b) To review and approve the arrangements for discharging the Group's statutory financial duties.

c) To review and approve arrangements for the CCG's standards of Business Conduct including:
   a. Conflicts of Interest (CoI)
   b. Register of Interests (RoI)
   c. Codes of Conduct

d) To ensure that the organisation has policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and to approve such policies.

2. Membership

2.1. The following will be members of the Committee:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience and Engagement)
- Secondary Care Doctor
- Practice Manager Governing Body Member.

2.2. A Vice Chair will be selected by the Committee from within its membership.

2.3. Other officers required to be in attendance at the Committee are as follows:

- Internal Audit Representative
- External Audit Representative
- Counter Fraud Representative
- Chief Finance Officer

2.4. The Chair of the CCG will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

2.5. Other senior members of the Group may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Officer.

2.6. At least once a year the Committee should meet privately with the external and internal Auditors. Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Audit Committee.

2.7. Members are expected to personally attend a minimum of 75% of meetings held.

2.8. Relevant Officers from the CCG may be invited to attend dependent upon agenda items. Officers from other organisations including the Commissioning Support Unit (CSU) and from the Local Authority team may also be invited to attend dependent upon agenda items.

3. Responsibilities of the Committee

The Audit Committee is responsible for:

3.1. reviewing the underlying assurance processes that indicate the degree of achievement of the Group's objectives and its effectiveness in terms of the management of its principal risks;

3.2. ensuring that there is an effective internal audit function which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, the Chief Officer and the Group;

3.3. reviewing the work and findings of the external auditors and consideration of the implications of management responses to their work;

3.4. reviewing policies and procedures for all work relating to fraud and corruption as set out by the Secretary of State Directions and as required by NHS Protect;

3.5. reviewing findings of other assurance functions (where appropriate) and consider the implications for governance arrangements of the Group (e.g. NHS Resolution [formerly NHS Litigation Authority], Care Quality Commission etc.);

3.6. monitoring the integrity of the financial statements of the Group and to consider the implications of any formal announcements relating to the Group's financial performance;

3.7. responding on behalf of the Governing Body, to any formal requirements of the Group in relation to the audit process (e.g. the report from those charged with governance);

3.8. monitoring and review of the CCG Governing Body Assurance Framework (GBAF) to support the CCG's integrated governance agenda.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone).

4.1. To review and recommend approval of the detailed financial policies that are underpinned by the Prime Financial Policies within the Group's Constitution to the Group's Governing Body.

4.2. Approve Risk Management arrangements.

4.3. To review and approve the operation of a comprehensive system of internal control, including budgetary control, which underpin the effective, efficient and economic operation of the group.

4.4. To review and approve the annual accounts.

4.5. To review and approve the Group's annual report on behalf of the Governing Body

4.6. To review and approve the arrangements for the appointment of both internal and external audit and their annual audit plans.

4.7. To review and approve the arrangements for discharging the Group's statutory financial duties.

4.8. To review and approve the Group's Counter Fraud and Security Management arrangements.

4.9. To review the circumstances relating to any suspensions to the Group's constitution (as set out in the Scheme of Delegation and Reservation) and to report to the Governing Body and Wider Membership Council on the appropriateness of such actions

4.10. To undertake annual review of its effectiveness and provide an annual report to the Governing Body to describe how it discharged its functions during the year.

5. Administration

5.1. The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

5.2. The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

5.3. The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

6. Quorum

6.1. The Audit Committee Chair (or Vice Chair) and one other member will be necessary for quorum purposes.

6.2. The quorum shall exclude any member affected by a Conflict of Interest under the NHS Southport and Formby CCG Constitution. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

7. Frequency and notice of meetings.

The Audit Committee shall meet on at least four occasions during the financial year. Internal Audit and External Audit may request an additional meeting if they consider that one is necessary.

8. Reporting

The ratified minutes of Audit Committee will be submitted to the Governing Body. Exception reports will also be submitted at the request of the Governing Body. The ratified minutes will also be sent to the Quality Committee to support its role in monitoring the Group's integrated governance arrangements.

9. Conduct

9.1. All members are required to maintain accurate statements of their register of interest with the Governing Body. Members of the committee should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting or at the beginning of each meeting. The Chair shall consider such notices in accordance with NHS Southport and Formby CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

9.2. All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

10. Date and Review

Date:	**April 2017**
Version Number:	**4**
Future Review dates	April 2018 April 2019

Appendix F – Joint Quality Committee Terms of Reference

The Committee shall be established as a joint committee of NHS Southport and Formby CCG and NHS South Sefton CCG.

The committee is established in accordance with the Legislative Reform (Clinical Commissioning Group) Order 2014[1] and the associated enabling provisions of set out in Section 23.4 of NHS South Sefton CCG Constitution[2] and Section 6.6 of NHS Southport and Formby CCG Constitution[3].

The main functions of the Quality Committee are:

- to monitor standards and provide assurance on the quality of commissioned services, by the CCG to ensure that local and national standards are met
- to promote a culture of continuous improvement and innovation with respect to safely, clinical effectiveness and patient experience

The Committee's key responsibilities are to:

- Ensure all decision making is consistent with the CCGs QIPP priorities
- approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes
- approve the arrangements for handling complaints
- approve the CCG's arrangements for engaging patients and their carers in decisions concerning their healthcare
- approve the arrangements for handling complaints
- approve arrangements for supporting NHS England in discharging its responsibilities to secure continuous improvement in the quality of general medical services in conjunction with the CCG and NHSE Joint Commissioning Committees
- Approve and monitor the arrangements in respect of Safeguarding (children and adults)

1. Principal Duties

The principal duties of the Committee are as follows:

1.1. to ensure effective management of clinical governance areas (clinical governance, information governance, research governance and health and safety) and corporate performance in relation to all commissioned services

1.2. To ensure appropriate arrangements are in place, in respect of medicines management including safety, effectiveness and cost.

1.3. to work in conjunction with the relevant committees in ensuring that quality and safety are an integral feature of the strategic planning process

1.4. to receive, scrutinise and monitor progress against reports from external agencies, including, but not limited to, the Care Quality Commission, Monitor and Health and Safety Executive

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[1] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292808/Legislative_Reform__Clinical_Commissioning_Groups__Order_2014-revised_dr....pdf
[2] *Ibid* at page 29
[3] *Ibid* at page 17

1.5. receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans

1.6. to ensure that patient experience and patient informs the business of the committee through the establishment of appropriate sub groups and associated reporting arrangements

1.7. to have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of Never Events and informing the CCG Governing Body of any escalation or sensitive issues in good time.

1.8. to work collaboratively to identify and promote "best practice", the sharing of experience, expertise and success across the CCG and with key stakeholders

1.9. to monitor the CCG Quality Performance Dashboard and drive year-on-year improvement in performance. The Committee will agree what information, reports, notes or minutes from other committees or CSU colleagues that it needs to see on a regular or ad hoc basis and ensure they are scrutinised

1.10. to establish sub-groups or task and finish groups as and when appropriate to assist the Committee discharge its duties effectively. These groups will be required to report to the Quality Committee by submission of key issues reports as stipulated by the Quality Committee.

1.11. support the Governing Body to meet its Public Sector Equality Duty

1.12. promote research and the use of research across the organisation

1.13. promote education and training across the organisation

1.14. support the improvement of primary medical services and primary care quality in liaison with the CCG and NHSE Joint Commissioning Committees

1.15. to review and approve arrangements for the proper safekeeping of records.

1.16. the Quality Committee shall monitor the effectiveness of meeting the above duties by:

- reviewing progress against its own programme of business agreed by the Governing Body
- producing an annual report for the CCG Governing Body

2. Membership

2.1. The following will be members of the Committee:

- CCG Clinician (Chairing to be rotated on a basis to be agreed by the committee, between a South Sefton CCG clinician and a Southport and Formby CCG Clinician)
- Clinical Governing Body Member (S&F)
- Clinical Governing Body Member (SS)
- Practice Manager Governing Body Member (S&F)
- Practice Manager Governing Body Member (SS)
- Chief Finance Officer or nominated deputy
- Chief Nurse and Quality Officer or nominated deputy
- Clinical Director Lead for Quality (S&F)
- Clinical Director Lead for Quality (SS)

- Lay member for patient and public involvement (S&F)
- Lay member for patient and public involvement (SS)
- CCG Head of Commissioning

The Chief Officer shall be an ex-officio member

The following leads have an open invitation for each meeting of the Quality Committee:

- Designated Professional Safeguarding Children and Head of Adult Safeguarding.
- Programme Lead for Quality and Safety
- Commissioning Support Unit Quality Leads
- Locality Managers

2.2. All Members are required to nominate a deputy to attend in their absence. Deputies must be of sufficient seniority to support decision making and therefore must only be permitted if they are a member of the Leadership Team or the Senior Management Team. Deputies will count towards the quorum.

2.3. All members are expected to attend a minimum of 60% of meetings held.

2.4. Minutes and papers shall also be sent for information to CCG Chair who shall have a standing invitation to attend committee meetings.

3. Chair

3.1. The Committee has a joint Chair that shall Chair the committee on a rotational basis. A vice chair shall be selected from within the membership.

4. Quorum

4.1. The quorum shall consist of the

- Chair of the Quality Committee or Vice Chair.
- 1 x lay member (S&F)
- 1 x lay member (SS)
- 1 x CCG Officer (SS)
- 1 x CCG Officer (S&F)
- 1 x governing body clinician (SF)
- 1 x governing body clinician (SS)

4.2. As per the NHS Southport and Formby CCG Constitution and NHS South Sefton Constitution, the quorum shall exclude any member affected by a Conflict of Interest. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

5. Voting

5.1. Each substantive member shall have one vote on all general business items of the committee.

5.2. For decisions requiring a vote on a proposal the Lay Member for the respective CCG shall have the casting vote.

6. Frequency of Meetings and Reporting Arrangements

6.1. The Committee will meet at least 10 times per year and submit the ratified minutes of its meeting to the next available CCG Governing Bodies, copies of minutes shall also be made available to the Audit Committee upon request.

6.2. The Committee will submit an annual report to the CCG Governing Bodies.

7. Conduct

7.1. All members are required to maintain accurate statements of their register of interest with the Governing Body. Members should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting or at the beginning of each meeting. The Chair shall consider such notices in accordance with NHS Southport and Formby CCG and NHS South Sefton procedure for the management of Conflicts of Interest as set out in the Constitution and in set out in the guidance issued by NHSE in June 2016.

7.2. All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

8. Secretarial Arrangements

8.1. PA to the Chief Nurse and Quality Officer shall provide secretarial support to the Committee.

8.2. The agenda for the meetings will be drawn up with the Chair of the Committee.

8.3. The agenda and papers for meetings will be distributed one week in advance of the meeting.

8.4. The minutes of the meeting will be produced in 10 working days.

9. Date and Review

Date:	**July 2016**
Version Number:	**8**
Future Review dates	September 2017 September 2018 September 2019

Appendix G – Serious and Untoward Incident Group Terms of Reference

1.0 AUTHORITY AND PURPOSE

1.1 As per the requirements of the NHS England Serious Incident Framework (March 2015) commissioners are accountable for quality assuring the robustness of their Providers' Serious Incident investigations and the development and implementation of effective actions, by the Provider, to prevent recurrence of similar incidents.

1.2 NHS Southport and Formby Clinical Commissioning Group (CCG) Internal Serious Review Group (SIRG) is responsible for ensuring a robust quality assurance process is in place for the closure of Serious Incidents on behalf of the CCG Governing Body.

1.3 The SIRG is responsible for reviewing and scrutinising all investigations and action plans received from Providers following Serious Incidents which meet the Type 1 and Type 2 definition detailed within the 'Procedure for the management of Serious Incidents'. These are:

- **Type 1:** Provider declared (Single Agency)
- **Type 2:** Provider declared (Multi Agency)

1.4 The SIRG is a sub-group of the CCG Quality Committee which reports to the Governing Body. Both the Quality Committee and the Governing Body will receive regular reports.

1.5 The Chief Nurse and Quality Officer holds board level accountability for the CCG Serious Incident Process and will delegate authority in the management of the process

2.0 FUNCTIONS

2.0 The Serious Review Group is responsible for:

- reviewing and scrutinising all root cause analysis of all Type 1 and Type 2 Serious Incidents in any Provider where the CCG has responsible and or co-ordinating commissioning responsibility;
- pro-actively ensuring all Serious Incidents are fully investigated to identify the root causes using established assurance frameworks;
- ensure that serious incidents which are being considered by Local Safeguarding Children Board, Safeguarding Adult Boards and or Community Safety Partnership Group, which may be subject to parallel processes remain open with the oversight of the Designated Nurse for Safeguarding Children / Adults as appropriate;
- monitoring the quality of investigations received;
- supporting timeliness of responses to investigations, prompting Providers if delays are occurring;
- seeking assurance that agreed actions have been completed within the appropriate time scales;
- assuring that there are not systemic failures throughout the whole Provider organisation through the detailed review of reports and the clinical expertise of the Review Group members;
- linking themes and trends to performance within Providers and any on-going quality concerns;
- authorising the closure of Serious Incidents if satisfied that the investigation report and action plan meets the required standard.

3.0 Reporting, tracking and monitoring

3.1 The NHS England Serious Incident Framework states that incidents can be closed before all actions are complete but there must be mechanisms in place for monitoring on-going investigation.

3.2 The Serious Incident Review Action tracker, detailing meeting attendees and outcomes, will be produced following the weekly meetings. This will be circulated to all regular meeting attendees and other key managers.

3.3 Within the action tracker, action plans which require additional, focused follow up will be noted. This ensures that the fundamental purpose of investigation (i.e. to ensure that lessons can be learnt to prevent similar incidents recurring) is realised. This information can also be used to contribute to the planning and content of unannounced visits to commissioned Providers.

3.4 Themed reports for Serious Incidents will be produced on a quarterly basis by the Programme Manager – Clinical Quality and presented to the membership.

3.5 The group will also report training needs, relevant findings, themes and trends to the Chief Nurse and Quality Officer ahead of Clinical Quality Performance Meetings with the Provider.

4.0 SERIOUS CASE REVIEWS / LEARNING REVIEWS (CHILDREN) / SAFEGUARDING ADULT REVIEWS / DOMESTIC HOMICIDE REVIEW

4.1 All Serious Case Reviews / Learning Reviews (children) / Safeguarding Adult Reviews / Domestic Homicide Reviews, which have been declared as an NHS South CCG Serious Incident on STEIS are also to be presented at the Serious Incident Review Group.

4.2 Whilst not responsible for closing theses Reviews, the forum has responsibility for developing knowledge of Serious Incidents themes and trends across Providers. Consideration of the review documentation contributes to wider learning.

4.3 The Incident will remain open on STEIS until the review processes has been completed.

4.4 Upon conclusion of a CCG declared Serious Case Review / Learning Review (children) / Safeguarding Adult Review / Domestic Homicide Review and following review by the SIRG, the Serious Incident Review Group can authorise closure on STEIS. The CCG Designated Nurse for Children and Adults will be included as part of the SIRG membership to support closure and wider learning.

5.0 MEMBERSHIP

5.1 The membership of the Serious Incident Review Group will comprise of:

- Chief Nurse and Quality Officer, NHS Southport and Formby CCG
- Programme Manager – Clinical Quality, NHS Southport and Formby CCG
- NHS Southport and Formby CCG GP Clinical Lead – Southport and Ormskirk Hospitals NHS Trust
- NHS South Sefton CCG GP Clinical Lead – Merseycare NHS Foundation Trust
- West Lancashire CCG
- Secondary Care Doctor, NHS Southport and Formby CCG
- Practice Nurse Facilitator, NHS Southport and Formby CCG
- Mental Health Programme Manager, NHS Southport and Formby CCG

- Unplanned Care Lead, NHS Southport and Formby CCG
- Designated Nurse Safeguarding Children
- Designated Nurse Safeguarding Adults

5.2 In addition to the above members, other key staff will be invited to attend as required to meetings, for example, Medicines Management.

5.3 The Chief Nurse and Quality Officer within the Quality Team may attend any SIRG's on an ad hoc basis as they wish. The meeting may proceed with either the Programme Manager – Clinical Quality or the GP Clinical Lead but must be cancelled or rescheduled if neither can attend.

6.0 FREQUENCY OF MEETINGS

6.1 The SIRG meetings will be held monthly. The meetings will be scheduled for two hours but can be longer if required.

6.2 The papers for each meeting will be available 5 working days ahead of each meeting to allow the attendees to prepare for the meeting discussion. For each Serious Incident, the papers will include:

- Action Tracker
- Serious Incident Report
- Root Cause Analysis
- Serious Incident Action Plan

The Programme Manager – Clinical Quality will predominately present Serious Incidents for closure. There will, be an opportunity on the agenda to discuss and seek guidance regarding Serious Incidents for which the closure/management is not straightforward, advice is required regarding how to proceed and/or the Serious Incident management needs to be escalated.

6.3 Decisions on whether to close incidents will require the consensus of the group and as a minimum at least one clinical and one other member of the group.

7.0 FREQUENCY OF REVIEW

7.1 Terms of Reference will be reviewed in 12 months or before if necessary to maintain the effectiveness of this group.

Appendix H – Risk Management Performance Indicators

Performance Indicator	Lead for compiling data
Incident Reporting	
No. of incidents & near misses reported this period compared to previous periods	Chief Nurse and Quality Officer
% of directorates reporting incidents & near misses	
No. (%) of incidents with actions recorded	
No. (%) of incidents closed with no action recorded	
No. (%) of incidents ongoing for more than 3 months	
Average severity rating of incidents and near misses	
No. (%) of patient safety incidents uploaded to the NPSA NRLS	
Risk Register	
No. of risks added to the Risk Registers	Chief Delivery and Integration Officer
No. of risks closed on the Risk Registers	
No. (%) of red risks on the Risk Registers	
No. (%) of Team with 'live' Risk Registers (i.e., reviewed on a monthly basis)	
Risk Management Training	
% of Staff who are up to date with their mandatory risk management training	HR Team at Commissioning Support Unit
Complaints	
No. of formal complaints relating to Commissioned Services received (NOTE – as of 1 April 2009 any verbal complaints not resolved within 24 hours are now logged as a formal complaint)	Chief Delivery and Integration Officer
No. (%) of complaints acknowledged within 3 working days	
No. (%) of complaints answered within an agreed timescale	
No. (%) of complaints with an initial incident reporting form	
No. (%) of complaints referred to the Ombudsman	
Claims	
No. of claims	Commissioning Support Unit
No. (%) of claims in which an initial incident form was completed	
No. (%) of letters of claim acknowledged within 14 days	
StEIS (Serious Incidents)	
No. of StEIS incidents reported to the CCG	Chief Nurse and Quality Officer
No. (%) of StEIS incidents acknowledged within 3 days	
No. (%) of completed investigation reports received within agreed timescales	
No. (%) of investigation reports reviewed within 10 working days	