NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Risk Management & Assurance

Strategy and Policy

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Contents

1. Executive Summary

The Risk Management & Assurance Strategy and Policy is a shared document, to be adopted across all workstreams within the Herefordshire & Worcestershire CCG.

This strategy sets out the CCG's overarching approach to the management of risk, both operational and strategic, ensuring an aligned and consistent approach across the organisation. The Governing Body will be aware of all significant risks and have sufficient information to enable them to make decisions on the implementation of appropriate controls and the allocation of required resources. In managing risks effectively, the CCG will be able to discharge statutory functions, while supporting quality improvement encouraging innovation and managing risk.

The Governing Body will use this strategy to ensure it meets their statutory requirements to comply with National Standards for Risk Management. The strategy details the approach necessary to demonstrate sound risk management practices are embedded throughout the organisation and reflect the CCG's Constitution, values and visions.

The CCG actively encourages a risk aware organisational culture that is open and supportive, while ensuring robust accountability. Organisational culture and the behaviours of leaders play a vital role in the development of good governance, as highlighted by the Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). It is important that we promote and embed a culture of transparency; openness and honesty throughout the CCG to ensure risks are properly identified, evaluated, documented and managed.

Every activity that the CCG undertakes, or commissions others to undertake on their behalf, brings with it some element of risk that has the potential to undermine, threaten or prevent the organisations from achieving its vision and corporate objectives. The Risk Management Strategy enables the CCG to have a clear view of the risks affecting each area of their activity, how those risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCG's objectives. It sets out the policy for the identification and management of county specific risks and those which relate to the whole STP footprint.

The significant risks that threaten the attainment of the CCGs underlying objectives, and how they have been managed are also reported each year in the Annual Governance Statement (part of the CCG's annual report).

Further information on the risk & assurance processes can be found on the CCG Hub pages or by contacting the CCG Corporate Team.

2. Introduction

2.1 Risk management can be defined "as a means of reducing adverse events occurring in organisations by systematically assessing, reviewing and then seeking ways to minimise their impact or possibly prevent their occurrence."

Risk management is one of the main components of Clinical and Corporate Governance; it requires us to:

- Understand risks that may prevent us from delivering our strategic objectives
- Undertake risk assessments to identify and manage risk and opportunities
- Have clear policies aimed at managing risks and grasping opportunities
- Have action plans and programmes in place to reduce risk.

The full benefits of risk management will only be obtained if there is a comprehensive and coordinated approach which is supported at every level of management throughout the CCG. This Guidance is intended to be used by all staff and departments in the organisation.

2.2 The Risk Management Strategy and Policy establishes a framework for the effective and systematic management of strategic and operational risks. It enables the CCG to have a clear view of the risks affecting each area of their activity, how those risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of corporate objectives. When embedded throughout the organisation, it will make a real contribution to the achievement of the organisation's corporate objectives.

2.3 The strategy applies to all the CCG's members and staff; and to those organisations providing support services who undertake functions on our behalf; it is not just the responsibility of one person or role within the organisations. Ensuring risks are managed effectively, consistently and systematically has become an integral part of everyday practice throughout the organisations.

2.4 From April 2020, the Herefordshire & Worcestershire CCGs merged and established a single management structure along with robust governance arrangements to oversee high quality and efficient commissioning and delivery. The CCGs developed shared objectives across the H&W STP footprint and as a result, key organisational strategies and processes underpinning the successful delivery of these objectives, have been reviewed and aligned. The CCG's risk management strategy outlines a single approach towards managing risks and the process underpinning the strategy.

2.5 'Risk Appetite is "an organisation's unique attitude towards risk taking, which in turn dictates the amount of risk that it considers acceptable". The Risk Appetite is the aggregated account of the Governing Body's willingness (to allow management) to manage/take risks in the pursuit of strategic objectives, within the context of the organisations risk capacity. It is the level, amount or degree of risk that the CCG is willing to accept and is a guide for staff on the escalation thresholds. The specific limits for the levels of risk are outlined in section 8.5.2 Risk Rating Categories and coupled with individual target risk scores in the risk register define the risk appetite.

2.6 While the Associate Director of Corporate Services is the executive lead for risk management, the Corporate Risk & Assurance Lead has been identified as being responsible for the day-to-day operational risk management process and to take the programme of work forward.

3. Purpose of the Strategy

3.1 The purpose of this Risk Management strategy is to:

- Define what risk management is about and what drives risk management within the CCG
- Outline how the strategy will be implemented
- Formalise the risk management process across the CCG - making it part of "business as usual"
- Identify the relevant roles and responsibilities for risk management within the CCG
- Ensure structures and processes are in place to support the assessment and management of both strategic and operational risks throughout the CCG
- Promote a culture of honest reporting and transparency which is upheld throughout the CCG to ensure risks are properly identified, documented, evaluated and managed
- Embed consideration and assessment of risk in all aspects of planning, commissioning and delivery
- Enable resources to be deployed effectively to manage risk
- 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, in line with the organisation's risk appetite
- Enable constant and consistent improvement of healthcare provision and patient experience
- Provide assurance to the public, patients, staff and partner organisations that the CCG is committed to managing risk effectively
- The risk management form part of the overall governance framework of the CCG and a suite of corporate policies and associated documentation can be sourced via the CCG website or Hub pages

4. Risk Definitions

4.1 Risk

4.1.1 The ICSA Health Service Governance Handbook states, "Risk refers to the possibility that something unexpected or unplanned for will happen. In many cases, risk is seen as the possibility that something bad might happen…this can be described as downside risk, because it is a risk that something will happen that would not normally be expected…Some risks are easy to recognise because they are always present and an NHS organisation may have had many years of experience in dealing with them…"

4.1.2 For a public body such as the Clinical Commissioning Group, risk can be further defined as anything that poses a threat to the achievement of corporate objectives, programmes and service delivery. This may include damage to the reputation of the Governing Body, which could undermine public confidence.

4.2 Strategic Risk

4.2.1 Strategic risks are directly linked to the achievement of the CCG's corporate objectives and are captured within the CCG's risk registers and identified as such in order that they can be cross referenced to the Governing Body Assurance Framework (GBAF).

4.3 Operational Risk

4.3.1 Operational risks are risks which are largely linked to team objectives and which, in their own right, don't represent a threat to the achievement of corporate objectives. They may however have the potential to do so if not adequately managed. These risks will be captured in the team/workstream risk registers and those with a significant risk rating will be referenced in the GBAF as appropriate.

4.4 Risk Management

4.4.1 Risk management is a proactive approach which aims to identify, assess and prioritise risk so as to minimise its negative consequences. Risk management is a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process in the way that will enable organisations to minimise losses and maximise opportunities. The five key steps to managing risk are as follows:

- Risk identification from hazards and threat events
- Risk assessment - evaluate the level of risk based on adequacy of existing controls
- Determine additional controls required
- Implement control measures and action plan
- Monitor controls, record & review assessment i.e. assurance.

5. Risk Management and Governing Body Assurance Process

5.1 Implementation of this strategy and policy is essential to achieving a robust and consistent risk management system throughout the organisation on which the commissioning of health care services for the population ultimately depends. All CCG staff should be aware of their responsibility with regards to risk management and take proactive steps to manage and mitigate any strategic or operational risks which threaten the achievement of the CCG's corporate objectives, or may have the potential to do so if not adequately managed.

- There is a single approach to risk management across the CCG, covering both county specific (place-based) and overarching CCG risks, which will be managed accordingly, noting that there are a significant number of strategic and operational risks linked to the CCG-wide objectives. These are managed through the following mechanisms:
- H&W CCG risk management strategy
- Single operational risk register with four distinct categories aligned to the committee structure, reported at CCG level
- Governing Body Assurance Framework with CCG-wide objectives and risks.

5.2 Partnership working is key to the CCG's achievement of corporate objectives. Examples of the CCG's key partners include the acute, community and mental health trusts, Local Authorities, voluntary organisations, non-statutory health service providers, patients, carer and user groups, as well as other local CCGs, the Commissioning Support Unit and NHSE/NHSI. It is therefore important that these organisations are sighted on CCG's key strategic and operational risks and that risk owners involve the appropriate organisations and their representatives in delivery of the appropriate mitigating actions. Conversely, the CCG should ensure that they are sighted on risks that partner organisations may have identified, particularly where such risks may impact upon commissioning activities.

6. Key Principles of the Risk Management Process

6.1 The risk management process observes the following principles:

- A culture where risk management is considered an essential and positive element in the provision of healthcare
- Risk reduction and quality improvement should be seen as integral and part of routine activities
- Risk management often works within a statutory framework which cannot be ignored
- A risk management approach should provide a supportive structure for those involved in adverse incidents or errors by enabling a no-blame culture
- Managing risk is both a collective and an individual responsibility
- Every organisation should strive to understand the causes of risk, and the importance of addressing issues
- Where organisations commission services on the CCG's behalf, the CCG must be sighted on any risks connected to the commissioning activity and record them as appropriate in line with this strategy

7. Identifying Risk

7.1 Risk identification is concerned with identifying events that can impact on the corporate objectives and delivery of services (strategic and operational) – 'what could happen'. This should be considered from both the positive and the negative effect and so ask 'what could happen if we do' as well as 'what could happen if we don't…', this will enable confident risk taking and exploitation of opportunities.

7.2 Strategic and operational risks can be identified by anybody, anywhere and risk identification and management should be an integral part of CCG's everyday activities. Some specific ways of identifying risks include:

- Horizon scanning
- Formal risks assessment exercise (for example health & safety)
- Lessons learnt following an incident or a complaint
- Discussion at a Governing Body/ Committee Level

- Completing/reviewing a Project Business Case
- Performance discussions with providers

7.3 Any new or emerging risks identified should be discussed within the team/department to agree the detail, including definition, potential impact and severity (score). If risk is deemed to be significant enough to be included on the CCG risk register, then authorisation should be confirmed via the Exec Lead or Associate Director.

7.4 All strategic and operational risks should have a link to corporate objectives. The achievement of objectives ultimately depends on the identification and successful management of associated risks.

7.5 To ensure a consistent and robust approach to risk descriptions or definitions it is advised that when a risk is identified the author/owner considers the following three parts: the 'Event', the 'Consequence' and the 'Impact'. The CCG has therefore adopted the following framework for the wording of each risk description:

DUE TO….. (describe the event)
THEN….. (describe the consequence)
RESULTING IN….. (describe the impact)

8. Risk Assessment/Evaluation

8.1 The risk assessment programme allows the CCG to:

- establish which hazards and risks are most serious and to whom or which function
- identify any existing controls and assess whether they are effective and adequate
- devise mitigating actions to further control the risk
- review the impact of mitigating actions and assurances

8.2 Once a strategic or operational risk is identified, it is important to establish the likelihood of a risk happening and the potential impact if it did occur. This is measured by using the following criteria:

8.3 Likelihood Scoring Criteria

Level	Title	Description	Probability
1	Rare	This will probably never happen/recur	< 5%
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so	5% to 15%
3	Possible	Might happen or recur occasionally	16% to 40%
4	Likely	Will probably happen/recur but it is not a persisting issue	41% to 75%
5	Almost Certain	Will undoubtedly happen/recur, possibly frequently	> 75%

8.4 Impact/Consequence Scoring

8.4.1 Impact scoring levels

Level	Title
1	Insignificant / Negligible
2	Minor
3	Moderate
4	Major
5	Catastrophic

8.4.2 In order to assist with the assessment and scoring of risks and ensure consistency of approach across the organisation, suggested risk impact scoring criteria is included within *Appendix 2.* The criteria are based on the type of risk, i.e. the workstream/area in which the risk is identified.

8.5 Risk Scoring Matrix

8.5.1 Once the likelihood and the impact score have been established, a total risk score can be determined in line with the scoring matrix below:

		Impact				
		1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Likelihood	5 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

8.5.2 Risk Rating Categories

The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and where it should be reported to. These categories (i.e. Red, Amber, Yellow. Green) are in line with partner organisations across H&W.

Current risk score	How the risk should be managed	Who to make aware
High **15-25**	Requires active management and clear action plan, assurance to Governing Body. High impact / High likelihood: risk requires active management to manage down when possible and maintain exposure at an acceptable level.	Audit Committee and CCG Governing Body. Lead committee responsible for functional risk register where risk resides
Medium **8-12**	Clear action plan and assurance to lead committee. Significant impact, likely to occur requires clear actions to mitigate risk, without which could become an 'extreme risk'	GB Committees responsible for functional risk register where risk resides
Low **4-6**	Contingency plans. A robust contingency plan may suffice together with early warning mechanisms to detect any deviation from profile.	Reviewed by risk owner(s) and team/workstream. Oversight from SRO
Remote **1-3**	Review periodically. Risks are unlikely to require mitigating actions, but status should be reviewed frequently to ensure conditions have not changed.	Reviewed by risk owner(s) and team/workstream. Oversight from SRO

9. Governing Body Assurance Framework

9.1 The HM Treasury Guidance on Assurance Frameworks (2012) defines an 'assurance framework' as: "A structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect."

9.2 The Governing Body Assurance Framework (GBAF) provides a structured approach to management of the corporate objectives, by workstream, describing what optimum success looks like and the principal risks and gaps threatening the achievement. Each objective is given an assurance rating and rationale to confirm the current status. Each workstream is assigned to Executive Leads and are proactively managed by individual committees. The Audit Committee takes a lead role in reviewing the adequacy of the Assurance Framework. The Governing Body has an overarching responsibility for monitoring risks contained within the GBAF.

9.3 Levels of assurance will be attributed to each area when it is reviewed and are displayed in the table below. These levels of assurance will be applied in all cases and when being determined should consider the overall position in terms of delivery against the objective and the controls in place to manage/mitigate.

Assurance Level	Description
High	Taking account of the issues identified, the Governing Body can take substantial assurance that the responses upon which the organisation relies to manage this area are suitably designed, consistently applied and effective.
Medium to High	Taking account of the issues identified, the Governing Body can take reasonable assurance that the responses upon which the organisation relies to manage this area are suitably designed, consistently applied and effective. However further action could be taken to improve the effectiveness and efficiency of responses.
Medium	Taking account of the issues identified, whilst the Governing Body can take some assurance that the responses upon which the organisation relies to manage this area are suitably designed, consistently applied and effective. Action needs to be taken to ensure this risk is managed.
Low to Medium	Taking account of the issues identified, whilst the Governing Body can take limited assurance that the responses upon which the organisation relies to manage this area are suitably designed, consistently applied and effective. Action must be taken to ensure this risk is managed.
Low	Taking account of the issues identified, the Governing Body cannot take assurance that the responses upon which the organisation relies to manage this area are suitably designed, consistently applied or effective. Urgent action must be taken to ensure this risk is managed.

9.4 The CCG's corporate objectives are identified and agreed by the Governing Body at the start of each financial year. These are underpinned by both CCG-wide and local (county specific) deliverables. Executive leads are then supported in scoping risks to the delivery of the objectives.

9.5 The draft Assurance Framework is presented to committees in April and May for comment and approval. Executive leads and Committees focus their attention on ensuring that controls and assurances are in place and that mitigating action plans with clear timescales and outcomes are identified.

9.6 The GBAF is a key document for ensuring that the Audit Committee and CCG Governing Body are:

- Updated on progress against the organisations' corporate objectives and the mitigation of the associated key risks
- Assured that the controls, actions and assurances in place are sufficient to manage and mitigate risks
- Aware of areas of concern for which they may request additional assurances. Please see section 14.3.2 for further detail on how such concerns may be identified

9.7 Individual Committees and Executive Leads are responsible for assessing and reviewing risks for which they are responsible on at least a bi-monthly basis.

9.8 The GBAF is continually reviewed and updated and is informed by and interlinked with the Risk Registers. All high rated risks relating to the workstream area, and therefore having the potential to compromise delivery, will be referenced.

10. Risk Registers

10.1 Staff should report any operational risks or potential risks to their line manager.

10.2 Risks should be discussed within teams, and the likelihood and potential impact of the risk should be established using the risk assessment matrix (see section 8.5 above). The directorate Exec Lead or Associate Director should then decide if the risk should be included/escalated to the CCG risk register.

10.3 Each team/workstream will have a nominated risk lead(s) responsible for the recording and updating of risks identified and owned by that team. There are four operational risk registers contained within the main risk register spreadsheet covering the following areas:

- Quality & Performance
- Finance
- Primary Care & Medicines Optimisation
- Corporate & Strategy

10.4 Each operational risk needs to be recorded on the appropriate risk register as a CCG-wide or county specific risk together with existing controls, mitigating actions and assurances and must include a timescale for expected completion of mitigating actions. Each risk is assigned to the risk lead who is responsible for updating the risk register. An executive lead as well as a committee or a sub-committee overseeing the risk is also allocated to the risk. Each committee or sub-committee will periodically review those risks for which they are responsible, ensuring that appropriate controls mitigating actions and assurances are in place and considering the impact of these upon the risk score and the consequent level of assurance against achievement of the year end success outcomes. Any new risks will be considered as part of this process. Once actions are complete and the risk has been mitigated, which would be reflected by the risk score falling in line with the target score, it should be closed or resolved on the risk register; not deleted. The risk can then be subsequently reopened, should it re-materialise. Please see *Appendix 3* – Risk Management Flow Chart.

10.5 Although each operational risk is reviewed and managed by the appropriate risk owner, team and committee/sub-committee, it is essential that the same process is followed across the organisation and all operational risks are captured. Filtered reports for each team/committee will be extracted from the main register and this process will be managed by the corporate team. To ensure that no risks are missed out or duplicated, it is crucial that the risk registers are carefully managed at all times.

11. Project risks

11.1 Effective risk management significantly contributes towards successful completion of projects which in turn support the delivery of CCG's corporate objectives. The CCG operates a large number of projects at any one time and these can vary significantly in importance, duration and organisational impact. By their nature, projects often carry a large number of detailed risks which impact upon project delivery. Where appropriate these risks should be recorded, monitored and reported via the Verto system against the relevant

project. Where a risk is deemed to exceed the life of the project or has an organisation-wide impact, it should then be captured on the CCG risk register.

11.2 Any STP/ICS programme risks identified will be assessed in terms of impact at a CCG level. They will be cross referenced and reported as appropriate.

12. Serious Incidents

12.1 The CCG maintains a risk management database which allows reporting of clinical and non-clinical incidents and near misses.

12.2 The CCG will provide information on patient safety incidents through the National Learning System (NRLS) and to the National Patient Safety Agency. The Executive Nurse will be responsible for ensuring patient safety incidents are reported accordingly.

12.3 The CCG will ensure the implementation and embedding of good practice by:

- Promoting the use of guidelines and protocols
- Ensuring that staff undertake continuing professional development activity and awareness training.

13. Risk Mitigation

13.1 The CCG will ensure appropriate mitigating actions along with timescales for delivery and leads for each action are identified by the relevant senior manager and approved. Delivery of these actions will be regularly monitored to ensure they are positively impacting upon risks and supporting a reduction in risk score.

13.2 Where mitigating actions have been successfully undertaken and have produced a clear, consequential impact in reducing the risk, they will be documented as controls. The effectiveness of controls will be tested and challenged by the Audit Committee.

13.3 The CCG will ensure that commissioned services and their staff learn from knowledge they have obtained through clinical and non-clinical risks and all staff will be engaged in the continuing professional development process.

14. Accountabilities, Roles and Responsibilities

14.1 Managing clinical and non-clinical risk is accepted as a key organisational responsibility and is an integral part of management systems and processes. The following section defines the roles, responsibilities and lines of accountability of committees and key individuals relating to risk management. Appendix 1 sets out the CCG's Committee Structure.

14.2 **Governing Body**

14.2.1 The CCG through the Accountable Officer is ultimately responsible and accountable for the comprehensive management of risks.

14.2.2 The ICSA Health Service Governance Handbook states that the "Governing Body is responsible for risk at a high level, but responsibilities for the management of risk are delegated to executive management. The Governing Body should decide the level of risks that are acceptable at a strategic level, and should ensure that the management team consider risk in the decisions that they make."

The 2014 FRC guidance describes the Governing Body's responsibilities for an organisation's overall approach to risk management and internal control as follows:

- ensuring the design and implementation of appropriate risk management and internal control systems that identify the risks facing the company and enable the board to make a robust assessment of the principal risks
- determining the nature and extent of the principal risks faced and those risks which the organisation is willing to take in achieving its strategic objectives (determining its 'risk appetite')
- ensuring that appropriate culture and reward systems have been embedded throughout the organisation
- agreeing how the principal risks should be managed or mitigated to reduce the likelihood of their incidence or their impact
- monitoring and reviewing the risk management and internal control systems, and the management's process of monitoring and reviewing, and satisfying itself that they are functioning effectively, and that corrective action is being taken where necessary; and
- ensuring sound internal and external information and communication processes and taking responsibility for external communication on risk management and internal control

The guidance goes on to recommend questions that the Governing Body should consider throughout the year:

- How effectively have the risks been assessed and the principal risks determined?
- How have they been managed or mitigated?
- Have the necessary actions been taken promptly to remedy any significant failings or weaknesses?
- Do the causes of the failing or weakness indicate poor decision-taking, a need for more extensive monitoring or a reassessment of the effectiveness of management's on-going processes?

The CCG Governing Body therefore has a duty to assure itself that there are adequate processes and controls in place to mitigate risks and the impact they have on the organisations and its stakeholders in delivering to its objectives. The Governing Body will:

- Agree the CCG's key objectives and review these on an annual basis
- Determine the risk appetite for the CCG
- Support the identification of principal risks which may prevent the achievement of corporate objectives
- Receive and consider risk management reports from teams and Committees responsible for identifying significant risks and progress on mitigating actions in relation to key strategic programmes

- Monitor strategic risks identified within the Governing Body Assurance Framework (GBAF); noting actions taken by committees and reviewing any areas of concern raised by Audit Committee
- Put in place a structure for the effective management of risk throughout the CCG

14.3 Audit Committee

14.3.1 The Audit Committee will focus on the adequacy of the risk management systems and processes as part of an effective system of integrated governance. It is responsible for assessing the effectiveness of the Governing Body Assurance Framework and in particular the adequacy of the implementation of this Risk Management Strategy, and of effective risk management across the organisation.

14.3.2 The Audit Committee will:

- Review the establishment and maintenance of an effective system of risk management across the whole of the CCG's activities and support the achievement of its objectives

- Review the Governing Body Assurance Framework on a bi-monthly basis; with specific focus upon reviewing the actions taken by individual committees and identifying any gaps/areas of concern where further investigation may be required. This may be evidenced in various forms including:

    - Increases in risk score
    - Risk score is 100% greater than the target score for a period of 3 months or longer
    - Outstanding mitigating actions or actions not positively impacting upon risk score
    - Notable and sustained gaps in controls and assurances
    - Failure to meet year end success outcomes

- Though the committee's primary role is centred upon reviewing the adequacy and robustness of the overarching risk management framework, should Audit Committee identify any concerns on the basis of the parameters outlined above, individual risks may be examined in greater detail and assurances requested

- Receive a summary risk register report in order to gain assurance that the process for the management of operational risks is robust. Similar to the Board Assurance Framework, specific focus will be placed upon actions taken by individual committees and any areas of concern identified will be explored further

- Receive reports from the executive lead for risk management, the Associate Director of Corporate Services, who will be responsible for ensuring that the CCG complies with the policies and practices laid down

- Cite any particular areas of concern within the Audit Committee summary report that is submitted to Governing Body

- Review internal and external sources to provide adequate assurance that risks are being appropriately controlled

- Ratify the Risk Management Strategy and Policy

- Ensure that risk management processes are embedded throughout the organisation

- Satisfy itself that the CCG has adequate arrangements in place for countering fraud including an appropriate suite of policies

14.4 Internal Audit

14.4.1 Internal audit will agree (jointly with the Audit Committee) a programme of audits which assess the adequacy of existing controls in place to counteract the risks affecting the organisation. This programme should be reflective of the risk evaluation contained within the GBAF and the risk register.

14.5 Committees

14.5.1 Whilst the Governing Body will review the GBAF in its entirety and Audit Committee will focus on the effectiveness of risk management systems and processes, individual committees will be required to review the risk register risks which fall within their respective remits. Review of some operational risks may be delegated to individual sub-committees, as detailed within the committees' terms of reference. The corporate team will work with teams to produce tailored reports from the risk register extract to enable individual committees to:

- Review those risks which fall within the remit of the committee, including associated controls and assurances
- Consider and comment on the CCG's current performance in relevant areas
- Consider the impact of mitigating actions, controls and assurances on the current risk score
- Review whether the management of risks is having a positive impact upon the achievement of corporate objectives and deliverables
- Report back to the Audit Committee as appropriate

14.6 Accountable Officer

14.6.1 The CCG's Accountable Officer has overall accountability for the management of risk and is responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support
- Ensuring an appropriatecommittee structure is in place, with regular reports going to the Governing Body
- Ensuring that directors and senior managers are appointed with managerial responsibility for risk management
- Ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG

14.7 Associate Director of Corporate Services

14.7.1 The Associate Director of Corporate Services is the countywide executive lead for risk management and is responsible for:

- Ensuring risk management systems are in place across the CCG
- Ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the Governing Body

14.8 Corporate Risk & Assurance Lead

14.8.1 The Corporate Risk & Assurance Lead has been identified as being responsible for the day-to-day operational risk management process and to take the programme of work forward, specifically:

- Implementation of the Risk Management strategy
- Ensuring the Governing Body Assurance Framework is regularly reviewed and updated
- Overseeing the management of risks as determined by the Audit Committee
- Ensuring risk action plans are put in place and are regularly monitored and implemented
- Providing training and advice on managing risks as appropriate, which may include face to face (or virtual) sessions and provision of guidance and materials via the CCG Hub (intranet)

14.9 Chief Nurse & Director of Quality

14.9.1 The Chief Nurse & Director of Quality are responsible for overseeing patient safety and clinical governance within the CCG, including:

- Providing clinical leadership for the development and implementation of the quality assurance plan and the quality strategy
- Ensuring the effective delivery of clinical care, including clinical audit, evidence based medicine and national and local guidelines in commissioned services
- Reporting to the Governing Body on patient safety and clinical governance matters

14.10 Chief Finance Officer

14.10.1 The Chief Finance Officer is responsible for progressing financial risk management and for ensuring that effective risk management and risk sharing arrangements are in place.

14.11 Executive Leads

14.11.1 Executive leads should incorporate risk management within all aspects of their work. They are accountable for the effective management of risks in their related areas. Executive leads should direct the implementation of the CCG Risk Management Policy by:

- Demonstrating personal involvement and support for the promotion of risk management
- Ensuring that staff accountable to them are aware of and understand risk management in their areas of responsibility

- Ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable
- Ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis
- Ensuring risks are escalated where they are of a strategic nature
- Ensuring that learning from events and risk assessments is disseminated throughout the organisation

14.12 Risk Leads

14.12.1 Each workstream/team will have a risk lead(s) who will be responsible for the risk register for their area ensuring that risks are recorded accurately, reviewed and updated regularly and reported through to the appropriate committees/colleagues for review and assurance.

14.13 Risk Owners

14.13.1 The risk owner is the point of contact for each risk, who is responsible for coordinating efforts to mitigate and manage the risk with all colleagues involved with that concern.

14.13.2 The responsibilities of the risk owner are to ensure that:

- Risks are identified, assessed, managed and monitored
- Risks are clearly articulated in the appropriate risk register
- Appropriate level of risk scoring is determined
- Gaps in mitigation and monitoring activities are remediated
- The status of mitigation and monitoring efforts are communicated

14.14 Managers and staff

14.14.1 Managers need to familiarise themselves with the risk management guidance and the risk register. They should understand how the risk register is maintained and how the risks are rated. Managers must ensure that all staff are made aware of risk issues and the need to identify and raise risks that they encounter in their work.

14.14.2 Where staff are involved in management of projects and where these risks have wider implications or exceed the duration of the project, they must be also entered on the organisations' risk register as an operational risk.

14.14.3 All staff have a duty under legislation to take reasonable care of their own safety and the safety of others and to comply with appropriate CCG regulations, policies, procedures, guidelines and statutory and mandatory training requirements.

14.15 Commissioning Support, Collaborative Commissioners, Contractors, Agency and Locum Staff

14.15.1 Managers must ensure that where they are outsourcing, employing or contracting agencies and locum staff, these are made aware of and adhere to all relevant policies, procedures and guidance of the CCG.

14.15.2 They should also:

- Take action to protect themselves and others from risks
- Bring to the attention of others the nature of risks which they are facing in order to ensure that they are taking appropriate protective action

15. Monitoring the Effectiveness of the Strategy and Policy

15.1 Regular reports are received by the CCG's Governing Body as well as individual committees. The Associate Director of Corporate Services assumes overarching, executive responsibility for ensuring that the organisations adopt sound risk management practices, which is consistent with the principles outlined within this policy.

15.2 The Audit Committee will regularly review the effectiveness of the strategy and report back to the Governing Body.

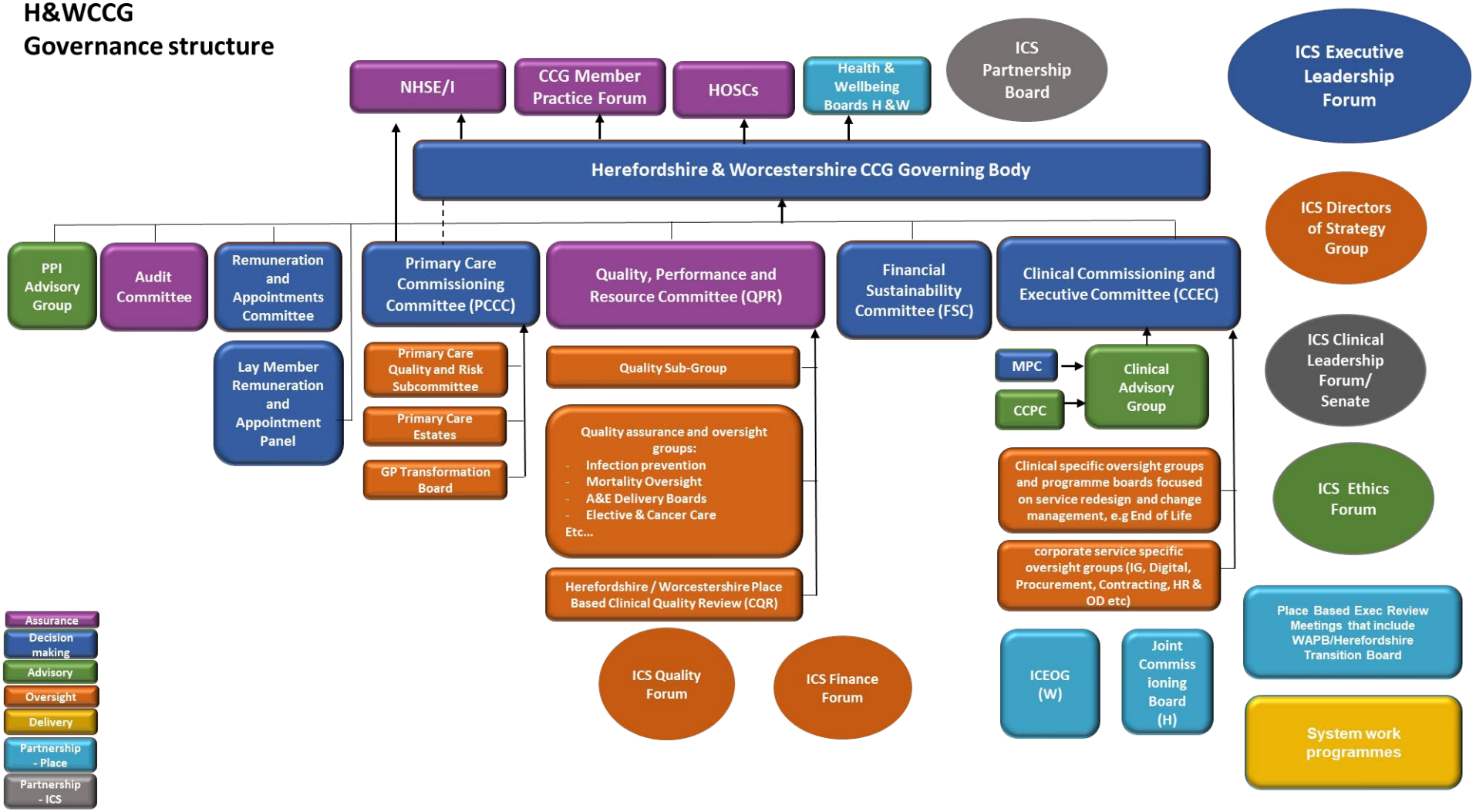
15.3 Committee effectiveness reviews are undertaken annually for all key committees. The effectiveness of and compliance with the risk management strategy is tested as part of this exercise.

15.4 The Strategy & Policy Implementation plan was completed in 2019/20, referred to in Appendix *5*. Further consideration will be given to this during transition to an ICS.

16. Equality and Diversity

16.1 In applying this strategy and policy, the CCG will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to discriminating on the basis of background, trade union membership, or any other personal characteristic.

Appendix 1 - Governance Structure



Appendix 2 - Risk Criteria

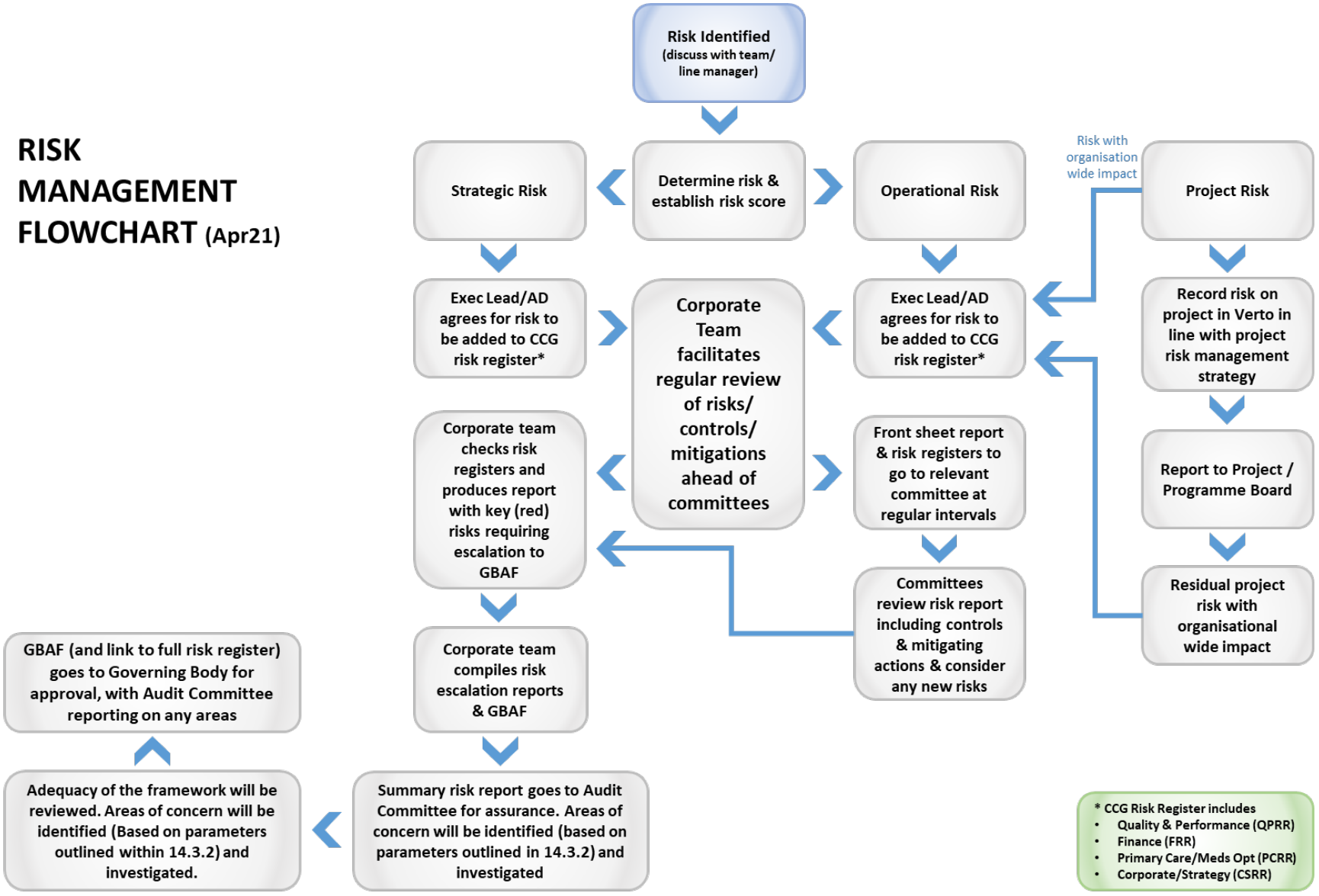
Risk Impact Scoring Criteria

All staff involved in the management of risks are required to use the following criteria to rate the severity of the risk in question. This will afford consistency across the organisation.

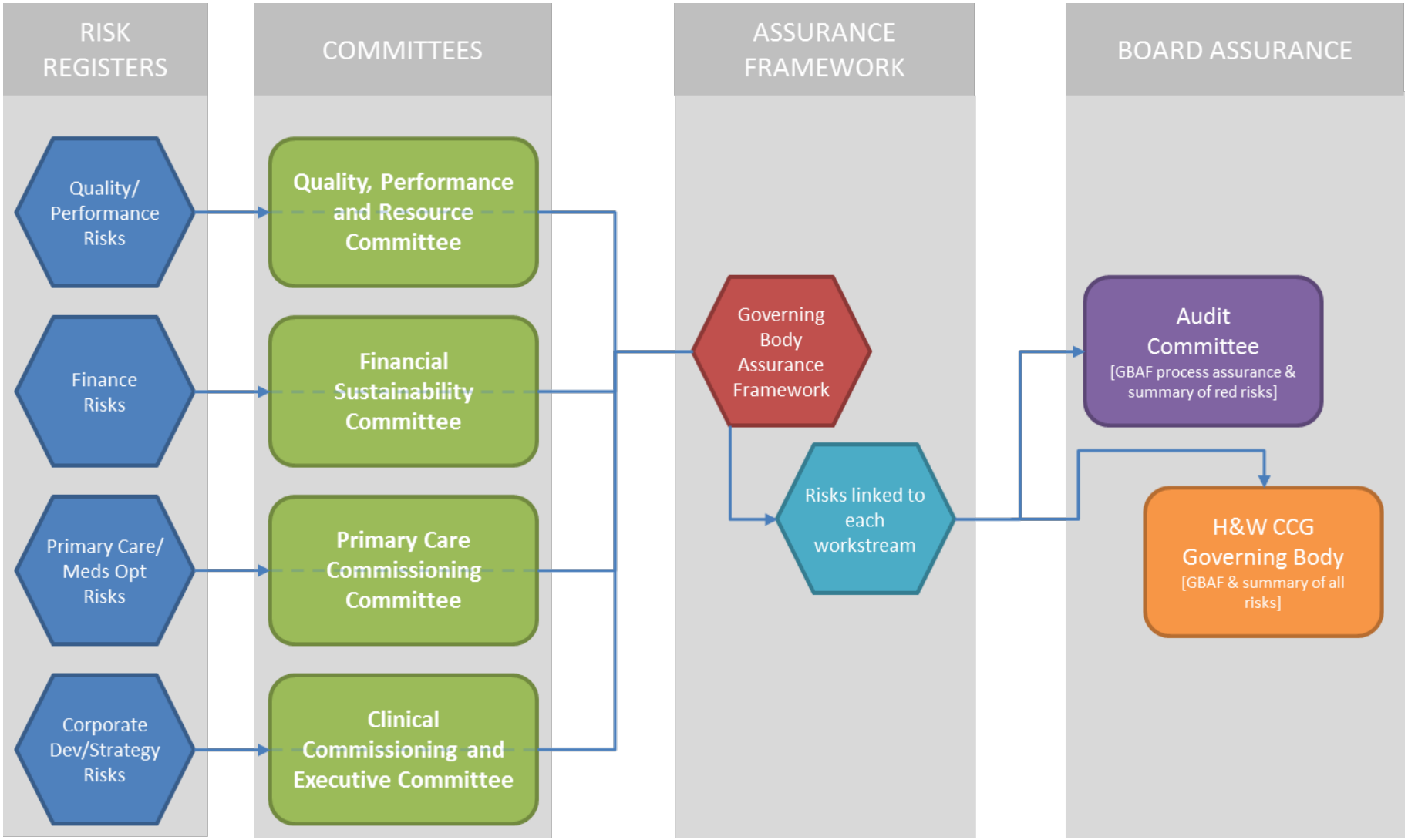
Types	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Patient Safety / Safeguarding	Minimal injury requiring no/minimal intervention. Mortality rates or serious incidents which require routine monitoring.	Major injury or illness, requiring minor intervention. Mortality rates within normal limits or individual serious incidents that require monitoring.	Moderate injury requiring professional intervention. An increasing mortality rate or serious incident/never event trend requiring monitoring with action plan to mitigate risk.	Major injury leading to long-term incapacity/disability. Increased mortality rates or serious incident/never event trend indicating urgent interventions e.g. improvement plan/contractual action.	Incident leading to death. Increased mortality rates or serious incidents/never event trend indicating failure of service to deliver patient safety requiring immediate intervention, e.g. suspension of service or escalation.
Quality / Patient experience	Peripheral element of treatment or service suboptimal. Unsatisfactory patient experience not directly related to patient care.	Overall treatment or service suboptimal. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved. Unsatisfactory patient experience – readily resolvable.	Treatment or service has significantly reduced effectiveness. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on. Mismanagement of patient care – short term effects.	Non-compliance with national standards with significant risk to patients if unresolved. Low performance rating. Critical report. Mismanagement of patient care – long term effects.	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. Totally unsatisfactory patient outcome or experience.
Service Redesign	Insignificant cost increase. Minimal project timescale slippage.	< 5% over project budget. Minor project timescale slippage.	5-10% over project budget. Moderate project timescale slippage.	1—25% over project budget. Major project timescale slippage. A key objective not met.	>25% over project budget. Catastrophic project timescale slippage. Multiple key objectives not met.
Commissioning (including Primary Care)	Some minor impact to the quality and cost effectiveness of commissioning. Manageable within project/team/work stream.	Minor impact on quality and cost effectiveness of commissioning activities. Less than 2 week delay to milestones/plans.	Short term impacts to quality and cost effectiveness of commissioning. Resources used from other parts of the organisation.	Significant delays or quality reduction in provision of effective commissioning across multiple work streams (<1 month delay to work stream).	Realisation of risk would prevent the Group from delivering significant services through its contracts with providers to the public.
Delivery of Services / Strategic	No impact on ability to operate local services.	Could threaten the efficiency of effectiveness of some services but dealt with internally.	Severe disruption to a service. Non achievement of local delivery plan.	Loss of a service. Loss of stars / reduction in score in national performance review.	Threatens the viability of the organisation.

Types	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Financial (based on c£2bn budget for 20/21)	Overspend of < £24k Loss of <0.1% of budget	Overspend of £24k – £240k Loss of 0.1% – 0.25% of budget	Overspend of £240k - £2.4m Loss of 0.25% – 0.5% of budget	Overspend of £2.4m - £12m Loss of 0.5% – 1% of budget	Overspend of > £12m Loss of > 1% of budget
Staffing / Human Resources	Short-term low staffing level that temporarily reduces services quality (<1 day). No impact on staff morale	Low staffing level that reduces the service quality (>1 day). Staff dissatisfaction	Late delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (1-5 days). Low staff morale. Poor staff attendance for mandatory key training. Increased staff sickness and absenteeism.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory key training.	Non-delivery of key objective/service due to lack of staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory/key training on an on-going basis. Inability to recruit or retain. Industrial action.
Reputation	Rumours. Potential for public concern. No impact on the reputation of the CCG	Local media coverage. Increase in patient/customer complaints or staff dissatisfaction. Short term reduction in public confidence.	Negative Local media coverage. Greater scrutiny by external bodies (e.g. NHSE) Moderate loss of public confidence in the CCG.	National media coverage with < 3 days service well below reasonable public expectation. Intervention by NHSE. Long term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectations. External investigation (CQC, HSE, Police). Replacement of Board. MP concerned (questions in House). Total loss of public confidence in the organisation.
Legal	No breaches of law or local procedures / standards.	Breaches of local procedures / standards.	Breaches of regulation national procedures / standards.	Breaches of law punishable by fines.	Breaches of law punishable by imprisonment.

Appendix 3 – Risk Management Framework



Appendix 4 – Risk & Assurance Process



Appendix 5 – Implementation Plan

Full review and alignment was carried out during the merger process.

Appendix 6 – Equality Impact Assessment

An Equality Impact Assessment was completed in November 2019, with no impacts identified during the review. Full details available on request.