NHS
Bury
Clinical Commissioning Group

Meeting: Governing Body			
Meeting Date	23 September 2020	**Action**	Approve
Item No.	8g	**Confidential**	No
Title	Risk Management Strategy		
Presented By	Lynne Ridsdale/Will Blandamer		
Author	Lisa Featherstone, Deputy Director		
Clinical Lead	N/A		

Executive Summary

The Risk Management Strategy has been cosmetically updated to reflect minor changes in role titles and responsibilities. The policy was reviewed by the Audit Committee on the 4th September 2020.

Given the intention to revisit Risk Management across the Bury CCG and Council partnership arrangements in the next 6 months, it is proposed that the Strategy is reviewed again in March 2021.

Recommendations

It is recommended that the Governing Body: -

- Approve the Risk Management Strategy.

Links to CCG Strategic Objectives	
SO1 People and Place To enable the people of Bury to live in a place where they can co-create their own good health and well-being and to provide good quality care when it is needed to help people return to the best possible quality of life	☒
SO2 Inclusive Growth To increase the productivity of Bury's economy by enabling all Bury people to contribute to and benefit from growth by accessing good jobs with good career prospects and through commissioning for social value	☒
SO3 Budget To deliver a balanced budget	☒
SO4 Staff Wellbeing To increase the involvement and wellbeing of all staff in scope of the OCO.	☒
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

NHS
Bury
Clinical Commissioning Group

Risk Management Strategy and Policy

Version:	3.1
Ratified by:	Governing Body
Date ratified:	23 September 2020
Author (s) :	Lisa Featherstone, Deputy Director Corporate Core Governance and Assurance Lynne Byers, interim Risk Manager
Responsible Committee / individual:	Governing Body
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Further information regarding this document

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This document should be read in conjunction with	• Health and Safety Policy • Information Risk Policy • Information Governance Incident Reporting Policy • Whistleblowing Policy • Emergency Planning and Resilience plan • Business Continuity Policy • Anti-Fraud Corruption and Bribery Policy • Complaints Policy • Incident Reporting and Investigation Policy
This document has been developed in consultation with	Audit Committee Mersey Internal Audit Agency Governing Body
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Version Control

Version History:

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1.0	tbc	
1.1	Draft document for discussion	August 2015
1.2	Feedback from Quality and Risk Committee	August 2015
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2.0	Governing Body	25th Nov 2015
2.1	Refreshed draft document for review by Audit Committee	07th June 2019
3.0	Approved by Governing Body	24th July 2019

3.1	Reviewed by Audit Committee and Governing Body	September 2020

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1.0 Introduction

1.1 NHS Bury Clinical Commissioning Group (CCG) is committed to a strategy that minimises risks to all its stakeholders through a comprehensive system of internal control, whilst providing maximum potential for flexibility, innovation and best practice in delivery of its strategic objectives.

1.2 Risk management, whilst driven by legislative requirement including The Management of Health and Safety at Work Regulations (1999) and the Corporate Manslaughter and Corporate Homicide Act 2007, is an integral part of good management practice.

1.3 Legislation requires all employers to undertake suitable and sufficient assessments of risks created by their activities, to take reasonable steps to protect employees, or anyone else who might be affected by their activities and to monitor and review risks at regular intervals to ensure that they remain accurate and valid.

2.0 Aims

2.1 This strategy builds on the work undertaken to date within Bury CCG to embed risk management as routine good practice throughout the CCG's activities and business processes. It sets out the plan for continued implementation and delivery of risk management across the CCG, whilst also taking into account the legislative framework that the organisation is bound by.

2.2 The aim of the risk management process is to provide a systematic and consistent integrated framework through which the CCG's strategic objectives are pursued. This involves the identification of risks; threats and opportunities, to achieving these objectives and taking steps to mitigate these risks.

2.3 Risk management underpins the CCG's objectives and enables the CCG to prioritise its risks so as to direct resources for managing risks effectively. As part of this the CCG undertakes to ensure that adequate provision of resources, including financial, personnel and information technology is, as far as is reasonably practicable, made available.

2.4 The strategy outlines the management structure, accountabilities and responsibilities in relation to risk management. It also details the processes involved and specifies the maintenance of the assurance framework, risk registers and associated action plans.

3.0 Scope

3.1 This strategy applies to all staff employed by and clinical leaders within NHS Bury CCG.

4.0 Definitions

4.1 The CCG defines risk and risk management in line with the AS/NZS ISO 31000:2009 as follows:

- Risk Management — the culture, processes and structures that are directed towards effective management of potential opportunities and adverse effects
- Risk Maturity — the measure of the systems and process in place for managing risk
- Risk Appetite — the level, amount or degree of risk that an organisation is willing to take in order to meet their strategic objectives
- Risk Management Process — the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk
- Risk — the chance of something happening that will have an impact upon objectives. It is measured in terms of likelihood and impact’
- Risk Register — A central repository which captures information such as risk likelihood, consequence, actions to mitigate and manage the risk for all identified risks. Risk registers will be maintained and reported at team, project, work-stream and corporate levels.
- CCG Risk Register(s) — Captures all risks irrespective of the risk score. These support the Corporate Risk Register and provide a summary of the actions required to reduce the level of risk to an acceptable level.
- Corporate Risk Register — Captures all risks which have a risk score of ≥15. This supports the Governing Body Assurance Framework and provides a summary of the actions required ~~and being taken~~ to reduce the level of risk to an acceptable level.
- Governing — An integral part of the system of internal control which

Body Assurance Framework	records the significant principal risks that could impact on the CCG achieving its strategic objectives. It summarises the sources of control that are in place or are planned to mitigate against them. Gaps are identified where key controls and assurances are not robust and actions to address these are implemented. The GBAF is a tool for providing assurance to the Governing Body.

5.0 Strategic Objectives

5.1 The Governing Body recognises that risk management is an integral part of good management practice, and to be most effective should become part of the organisation's culture.

5.2 The Governing Body is committed, through the Governance Framework and Committee structure, to ensuring that risk management forms a key element of its philosophy, practices and business plans, with responsibility for implementation accepted at all levels of the CCG.

6.0 Risk Management Objectives

6.1 This strategy builds on the work completed within Bury CCG to embed risk management as a core and central component of the CCG's activities. The main objectives is to ensure that Risk Management continues to be embedded across the organisation and driving the agenda and discussion both strategic and operational levels across the organisation.

6.2 The CCG will undertake an annual assessment of its maturity against an approved Risk Maturity Model and will determine appropriate actions to progress from its current position to *'risk enabled'* in accordance with Appendix A.

7.0 Risk Management Framework

7.1 Integrated risk management is a process through which the CCG will identify, assess, analyse and manage all risks and incidents at every level of the organisation, and aggregate the results at a corporate level. In practice this means:

- Integrating all risk management functions such as, complaints and compliance including incidents and other risks;
- Integrating risk management functions with service development and clinical governance activity to unify frameworks and improve outcomes for patients;

- Integrating all sources of information, both reactive (e.g. incidents) and proactive (e.g. risk assessments);
- Integrating systems of risk assessment to improve clarity and communication;
- Implementing a consistent approach to training, management analysis and investigation;
- Incorporating all risks into the processes for risk register development; and
- Integrating processes and decisions about risk into future business and strategic plans.

7.2 The risk management process will be used to:

- improve the ability of the CCG to meet its strategic objectives, priorities and vision;
- provide information to the Governing Body through the committee structure so that it can make informed decisions;
- manage the treatment of risk in a systematic way so that the organisation can determine acceptability of residual risks;
- initiate and monitor actions to prevent or reduce the consequences of risk to within the defined risk appetite of the CCG; and
- provide a comprehensive approach to improving patient and staff safety.

8.0 Risk Management Structure

8.1 All Committees of the CCG Governing Body are responsible for monitoring risks which are assigned to them, which will include strategic risks included on the Governing Body Assurance Framework as well as operational risks identified.

Governing Body

8.2 The Governing Body is responsible for:

- having overall accountability for the management of governance, risk and assurance, determining the strategic approach to risk and setting the risk appetite for the CCG;
- ensuring and approving the structure and framework for risk management;
- considering whether the CCG has implemented an effective system of internal control including appropriate risk management arrangements;
- regularly receiving and considering the Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR) which communicate and monitor the risks to the strategic objectives of the CCG; and
- monitoring the management of significant risks and seeking assurance that management decisions balance performance within appropriate limits defined by the CCG's Committees.

8.3 The Governing Body has delegated operational responsibility for delivery and scrutiny of the overarching risk management arrangements, including the GBAF and CRR to the Audit Committee.

Audit Committee

8.4 The Audit Committee is responsible for:

- being accountable to the Governing Body with overall assurances that the management of risk is effective;
- providing assurance to the Governing Body on the effectiveness and adequacy of the processes for managing principle risks and the risk management framework;
- ensuring that arrangements for risk management are appropriately and regularly included in the cycle of independent audits;
- review relevant Internal Audit Recommendations and ensure they are completed within the given deadlines.
- assist in the development of risk management structures, arrangements and capabilities within the CCG;
- challenging the way in which risk is managed, particularly where there is uncertainty or concerns over the effectiveness of existing arrangements;
- receiving and reviewing the GBAF and Corporate Risk Register at each meeting;
- ensuring, through scrutiny, that the GBAF and Corporate Risk Register are maintained and updated as and when required;
- supporting the closure of risks on recommendation of reporting Committees; and
- approving on behalf of the CCG those policies that fall within the remit of the Committee's Terms of Reference.

CCG Committees or Groups

8.5 Each Committee or Group will:

- have the authority to take appropriate actions to ensure that risks are mitigated and controlled and to advise the Audit Committee of any risks which cannot be mitigated;
- ensure the Audit Committee is kept informed of emerging risks which may impact on achievement of the CCG objectives
- ensuring that risks which are identified during the carrying out of its functions are assessed, recorded on the risk register, managed, reported and monitored effectively;
- review all new risks recorded on their registers to ensure that the consistency in risk rating is maintained and that action plans are in place to mitigate the effect of the risk;

- conduct “deep dive” reviews into risks to ensure all risks remain valid, are accurately assessed and risk owners are held to account in respect to management of risks; and
- ensure updates and lessons learned are shared where appropriate to enable collective and organisational learning.

9.0 Risk Management Roles and Responsibilities

9.1 For risk management to be part of operational activity throughout the CCG, it is important that individual accountability is clearly defined and that this is reflected in objective setting and performance reviews.

Accountable Officer

9.2 The Accountable Officer has responsibility for having an effective risk management system in place within the CCG, for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance.

9.3 The Accountable Officer is responsible for signing the Annual Governance Statement on behalf of the CCG, which outlines that appropriate strategies and internal controls have been in place, as part of the year end accounting and annual reporting process.

Joint Chief Finance Officer

9.4 The joint Chief Finance Officer holds responsibility for ensuring that there are effective systems for the management of financial stewardship of the CCG’s finances.

Deputy Director Corporate Core Governance and Assurance

9.5 The Deputy Director Corporate Core Governance and Assurance holds responsibility for ensuring that there are effective systems and processes for the management of risk, including a robust governance framework, Governing Body Assurance Framework and Corporate Risk Register for the CCG.

9.6 Senior Information Risk Owner (SIRO)

The SIRO will have lead responsibility for information risk and information risk management within the organisation.

Members of Executive Management Team

9.7 All executive members of the ~~CCG~~ Executive Management Team are accountable for the management of risk within their area of responsibility. This includes:

- ensuring that this strategy and associated policies, procedures and guidelines are implemented within their areas of responsibility;
- reviewing the Governing Body Assurance Framework and Corporate Risk Register risks relating to their team;

- ensuring all risks within their scope of responsibility are identified, assessed and included on the risk register; and
- providing assurance to the Committees overseeing each risk, as appropriate

Heads of Service

9.8 All Heads of Service are responsible for ensuring all areas under their area of accountability are contributing to the team's risk register.

Line Managers

9.9 All line managers will fulfil their statutory obligations for the management of risk within the workplace by conducting assessments for all work-based activity.

All Employees

9.10 All Employees are responsible for the day-to-day management of risks of all types within their areas of responsibility and control. They are responsible for their own working practice and behaviour in accordance with contracts of employment and individual job descriptions.

9.11 Additionally, employees have a duty to comply with the CCG's strategies, policies and procedures.

9.12 Staff members who are required to be registered with a professional body must act at all times in accordance with that body's code of conduct and rules.

Risk Manager

9.13 The Risk Manager will support the development and integration of risk management across the organisation.

9.14 The Risk Manager will be responsible for validating any new risks identified and will provide constructive challenge to the risk owners in respect of the description, scoring, target delivery dates, mitigating actions and risk review date for each risk identified before it is added onto the CCG's electronic Risk register (Pentana software system).

9.15 The Risk Manager will provide assurance that all risks are monitored and managed accordingly and will provide specialist advice and guidance in respect to the electronic software system used to manage and report risks within the CCG.

9.16 The risk manager will also ensure that all users of the CCG risk management system are appropriately informed, trained and able to update the electronic system and produce reports as required.

Risk Owners

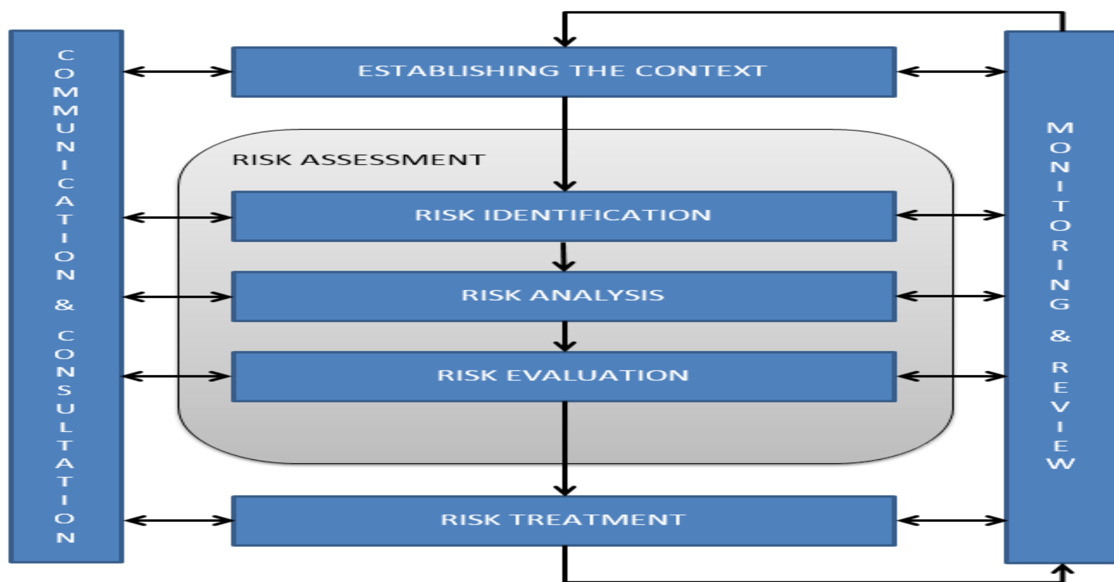
9.16 Risk owners will be assigned for each identified risk and will have overall responsibility for the risk and ensuring actions are implemented. For principal risks in the GBAF, this will be a member of the ~~CCG~~ Executive Management Team.

Action Owners

9.17 Owners will be assigned to each action identified to support the treatment of risk. They are responsible for ensuring actions are completed in a timely manner and updates are incorporated into the covalent system as necessary.

10.0 Risk Management Processes

10.1 Risk Management is a continual cycle which takes a systematic approach as outlined below:



Risk Identification

10.2 Identification of risk is the first part of an effective risk management strategy. Risk identification establishes the organisations exposure to risk and uncertainty. There is no one correct way to identify risks and the use of different methods by different staff groups, is more successful.

10.3 Examples of the types of risk that the CCG might encounter and need to mitigate against include, but are not limited to:

- Strategic — A significant risk that will impact on the delivery of the strategic objectives
- Corporate — Risks associated with the fulfilling of statutory duties and associated accountabilities
- Operational — A key risk which impacts on the delivery of team

	objectives and associated operational delivery
• Financial	Associated with the achievement of planned surpluses, reduction in costs and revenue growth
• Reputational	Associated with the quality of services, communication with customers, staff and stakeholders
• Environmental	Risks associated with the well-being of staff and visitors whilst using CCG premises
• Clinical	Risks relating to the direct care of the patient and the standards of care received on the patient's journey through the organisation

10.4 The CCG also recognises that risks can arise from both internal and external source. Examples are outlined at Appendix B; however, this is not an exhaustive list.

10.5 Once a risk has been identified the Risk Owner will be required to complete the Corporate Risk Identification Proforma as outlined at Appendix C.

Risk Analysis

10.6 Once risks are identified, further evaluation is required to establish the exposure of the CCG to risk and uncertainty. The outcome of the risk analysis is used to rate the significance of the risk and prioritise risk treatment.

Risk Evaluation and Scoring

10.7 The CCG has determined that the National Patient Safety Agency (NPSA) 5x5 matrix at Appendix D will be the risk analysis tool used to ensure that each risk is evaluated in a consistent way, however has made some modifications to the descriptors included in respect to consequence (C) levels.

10.8 Risks are scored in relation to the Consequence (C) they would have and the Likelihood (L) of them occurring, taking into account the effectiveness of the controls in place to manage the risk.

10.9 Using the risk matrix, a 'colour' and 'grade' is established for each risk which also determines the management, reporting and prioritisation of actions.

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Impact / Consequence	5	Severe	5	10	15	20	25
	4	High	4	8	12	16	20
	3	Moderate	3	6	9	12	15

	2	Minor	2	4	6	8	10
	1	Very Low	1	2	3	4	5

10.10 For each risk not adequately controlled, an action plan to treat the risk is required.

Treating Risk

10.11 Risk treatment involves developing a range of options for mitigating the risk, assessing those options, and then preparing and implementing action plans.

10.12 In treating risks, the CCG may take one of the following approaches:

- Transfer — implementing ~~a~~ treatment / action plan that shares or transfers the risk to another party or parties, such as outsourcing the management of physical assets, developing contracts with service providers or insuring against the risk. The third-party accepting the risk should be aware of and agree to accept this obligation

- Terminate — deciding not to proceed with the activity that introduced the unacceptable risk, choosing an alternative more acceptable activity that meets business objectives, or choosing an alternative less risky approach or process

- Treat — implementing ~~a~~ treatment / action plan that is designed to reduce the likelihood or consequence of the risk to an acceptable level, where elimination is considered to be excessive in terms of time or expense

- Tolerate — making an informed decision that the risk rating is at an acceptable level or that the cost of the treatment outweighs the benefit. This option may also be relevant in situations where a residual risk remains after other treatment options have been put in place. No further action is taken to treat the risk, however, ongoing monitoring is recommended

Risk Review and Management Responsibility

10.13 Each risk will be assigned a risk owner at the point of identification.

10.14 Risks should be reviewed by the risk owner as a matter of good practice at a frequency that is determined by the risk assessment and linked to the overall risk score.

10.15 Actions to mitigate and further control the risk should be added to the Pentana risk management software system. Action owners may be different from the risk owner and will be responsible for ensuring actions are completed in accordance with the agreed timescales.

10.16 All updates, including progress against mitigating actions and changes to the risk score will be recorded on the covalent system.

10.17 Clear lines of responsibility and delegated authority have been agreed, based on the risk score, for the management and review of risk, as follows, however all risks must be included on the Pentana system:

<table>
<tr><th>Level of Risk</th><th>Management Responsibility</th><th>Reviewed By</th><th>Risk Register</th></tr>
<tr><td>1-3 (Very Low)</td><td>Individuals</td><td>Appropriate Committee

Individual level review</td><td rowspan="3">Operational / Workstream / Team / Project /

(as appropriate)</td></tr>
<tr><td>4-6 (Moderate)</td><td>Line Managers</td><td>Appropriate Committee

Team level review</td></tr>
<tr><td>8-12 (High)</td><td>Heads of Service</td><td>Appropriate Committee</td></tr>
<tr><td>New severe risks 15-25</td><td>Head of Service</td><td>Deputy Director Corporate Core Governance and Assurance</td><td>Corporate Risk Register</td></tr>
<tr><td>15-25 (Severe)</td><td>Governing Body</td><td>~~CCG~~ Executive Director

Audit Committee</td><td>Corporate Risk Register</td></tr>
</table>

10.18 The Governing Body may at any time have sight of the full risk register of the CCG.

Risk Appetite and Tolerance

10.19 Risk appetite is the level, amount or degree of risk that an organisation is willing to take in order to meet their strategic objectives.

10.20 The CCG recognises that there may be a different level of risk appetite for different risks. For example, the CCG is averse to reputational damage but willing to accept a level of financial loss.

10.21 Whilst the CCG is committed to reducing all risks to levels as low as reasonably practicable, it will however tolerate overall levels of risk where action to mitigate further is not cost effective or reasonably practicable.

10.22 The CCG may take considered risks where the long-term benefits outweigh the short-term losses and there is sufficient evidence which demonstrates the skills, ability and knowledge are in place to support and manager the risk to support innovation and maximise opportunities for overall improvement.

Risk Registers

10.23 The risk register is a tool used by the CCG to effectively capture, manage and escalate those risks which have been identified which may prevent delivery of the CCG's Strategic Objectives and associated operational delivery plans.

10.24 The CCG uses Pentana, an electronic software system, to capture its risks. This is accessible corporately for population, interrogation and reporting with specialist advice and guidance available from the Risk Manager.

10.25 All risks, which should be aligned to the Strategic Objectives, either directly or through associated sub-objectives, will be captured through this system. Reports will be produced at a Corporate, Business, Team, Workstream and Project level as required.

10.26 The Risk Manager is responsible for validating the risk evaluation, scoring, assignment of risk owner, mitigating actions and risk review date and will provide constructive challenge to ensure the risk owner continues to manage and mitigate the risk accordingly.

10.27 Any new risk scored at a level 15 or above must be notified to the Deputy Director Corporate Core Governance and Assurance as soon as possible.

10.28 All risks scored at a level 15 or above will be included in the Corporate Risk Register and reported to the Audit Committee and Governing Body.

10.29 Following review by the Audit Committee, risks may be recommended for addition to the GBAF where there is concern that the controls, assurance or mitigating actions are not sufficient and have the potential to adversely impact on the delivery of the Strategic Objectives.

Monitoring and Reporting

10.30 Risk Registers will be reviewed, monitored, challenged and reported at the appropriate level in accordance with the CCG's risk structure as set out in this strategy.

10.31 A review date appropriate and relevant to the level of risk and supporting actions must be set by the risk owner.

10.32 Monitoring will be undertaken by the Risk Manager, to ensure that all risks are managed in accordance with their review date.

10.33 Risk Registers will be produced for review at team, project, workstream, committee, corporate and GBAF level as follows:

Risks Included	Risk Register	Reviewed By	Frequency
All relevant to team	Team	Head of Service	Monthly
All relevant to project / workstream	Project / Workstream	Project Owner / Project Management Office	At each meeting
All relevant to Committee	Committee	Committee	At each meeting
New severe risks with a score ≥15	Corporate	Deputy Director of Business Delivery	As identified
All risks with a score ≥15	Corporate	Audit Committee Governing Body	At each meeting (Quarterly) Next meeting subsequent to review by Audit Committee
All principal risks to the Strategic Objectives	GBAF	Audit Committee Governing Body	At each meeting (Quarterly) Next meeting subsequent to review by Audit Committee

10.34 The risk rating should gradually decrease from the residual risk score (current score with controls) towards the target risk score. Where this is not reducing, the actions to mitigate the risk will need to be reviewed to ensure they are appropriate. This will be discussed through the appropriate channels and escalated to Audit Committee as appropriate.

10.35 Where review and challenge indicates that the score is likely to increase, ~~changes in risk,~~ this should be captured through the Pentana system and will be escalated in accordance with the management responsibility set out in this strategy.

10.36 Any risk that moves to a 'severe' level of risk should be notified to the Deputy Director Corporate Core Governance and Assurance.

10.37 The CCG will use the GBAF and CRR as the main tools for demonstrating that the principal risks to the strategic objectives are being managed effectively and will submit updated documents to each Audit Committee and Governing Body Meeting.

Closing Risks

10.38 The risk register will contain all the risks relevant to the CCG, its strategic objectives and associated operational risks ~~identified~~ that have been identified, are current and are being managed.

10.39 Once a risk has reached its target rating and is at an acceptable level of risk, the risk owner can recommend closure of the risk.

10.40 The decision to close the risk must be submitted to the Audit Committee for review, by the Risk Owner and supported by the referring Committee.

10.41 The Audit Committee decision on the closure of risk is final.

10.42 Where actions have reduced the risk, but the residual risk remains severe (15-25) and it is agreed that no further action can be taken to reduce the risk, the recommendation to close it whilst accepting the level of residual risk must be escalated to the Governing Body.

10.43 Risks may also be recommended for closure following a deep dive or the annual re-calibration exercise even where it has not reached target level. A supporting rationale for closure must be provided to the audit Committee.

Managing Risk across Organisational Boundaries

10.44 The CCG recognises that risk is increased when working in partnership or across organisational boundaries.

10.45 The CCG is committed to working closely and collaboratively with its partner organisations to ensure that clarity of role, responsibility and accountability exists where risks occur.

10.46 The CCG will endeavour to involve organisations in all aspects of risk management as appropriate.

10.47 Where partnership agreements are developed, risk management will be specifically addressed, and the statement will be explicit in detailing how the risk management structures and systems link to the organisation, including how decisions will be made and which partner will lead on all or specific risks.

10.48 The CCG will further develop its Risk Management arrangements, taking account of the wider Greater Manchester Health and Social Care Partnership oversight, the

working relationship and reporting requirements of the Locality Care Organisation and the emerging developments of the One Commissioning Organisation between the CCG and Local Authority.

11.0 Implementation and Distribution

11.1 The Risk Management Strategy and Policy will be published as part of the CCG's Publication Scheme following approval and will be available to all staff on the website and shared drives.

12.0 Training

12.1 Training to ensure competency at all levels is recognised as one of the most cost-effective controls for good risk management.

12.2 A Training Needs Analysis (TNA) will be undertaken on an annual basis to determine the needs of the CCG and training will be made available reflective of the findings of the TNA through either on-line resources and / or workshops tailored specifically to reflect the audience, specific roles, level of accountability and authority.

12.3 Risk Management Training will form part of the CCG's mandatory training requirements.

12.4 Training records will be held corporately, and an update will also be provided to the Audit Committee.

13.0 Monitoring

13.1 The Risk Management Strategy and Policy be reviewed on an annual basis or earlier where changes in legislation or organisational structure occur.

13.2 The Governing Body will approve the Risk Management Strategy and Policy on recommendation from the Audit Committee.

13.3 Independent assurance will be sought when required, through internal audit arrangements, to assess the effectiveness of the CCG's risk management arrangements and adherence to this Strategy and Policy.

14.0 Links to Other Strategies / policies

14.1 The Risk Management Strategy links to the following key documents:

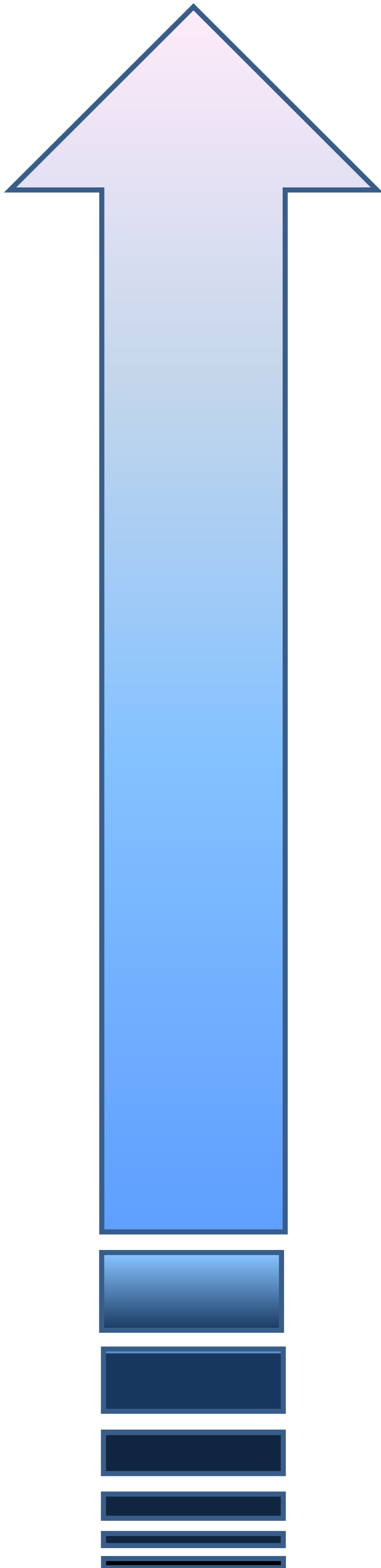
- Health and Safety Policy

- Information Risk Policy
- Information Governance Incident Reporting Policy
- Whistleblowing Policy
- Emergency Planning and Resilience Plan
- Business Continuity Policy
- Anti-Fraud Corruption and Bribery Policy
- Complaints Policy
- Incident Reporting and Investigation Policy

15.0 References

- A Risk Management Standard, AIRMIC, ALARM, IRM (2002),
- AS/NZ ISO 31000:2009, (2009)
- Building the Assurance Framework: A Practical Guide for NHS Boards, DoH, (2003),
- The Risk Management Process, Federation of European Risk Management Associations (FERMA), 2005
- Risk Management Model (HSG65), Successful Health & Safety Management, HSE, 2006
- Corporate Manslaughter and Corporate Homicide Act, 2007
- A Risk Matrix for Risk Managers, NPSA, 2008
- ISO 31000 Risk Management Principles and guidelines
- GGI Board Briefing: Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, January 2012

Appendix A : Risk Maturity Definitions



Level 5: Risk Enabled

- Driven by the Governing Body.
- Staff at all levels actively consider issues of risk in all areas of activity and develop control and assurance processes to manage those risks
- Risk management fully embedded into the operations

Level 4: Risk Managed

- Staff throughout the organisation are aware of the importance and the organisations approach to risk
- Approach to risk management developed and communicated

Level 3: Risk Defined

- The organisation has considered risk management and put in place strategies led by the risk team
- Strategy and policies in place and are communicated
- Risk appetite is defined

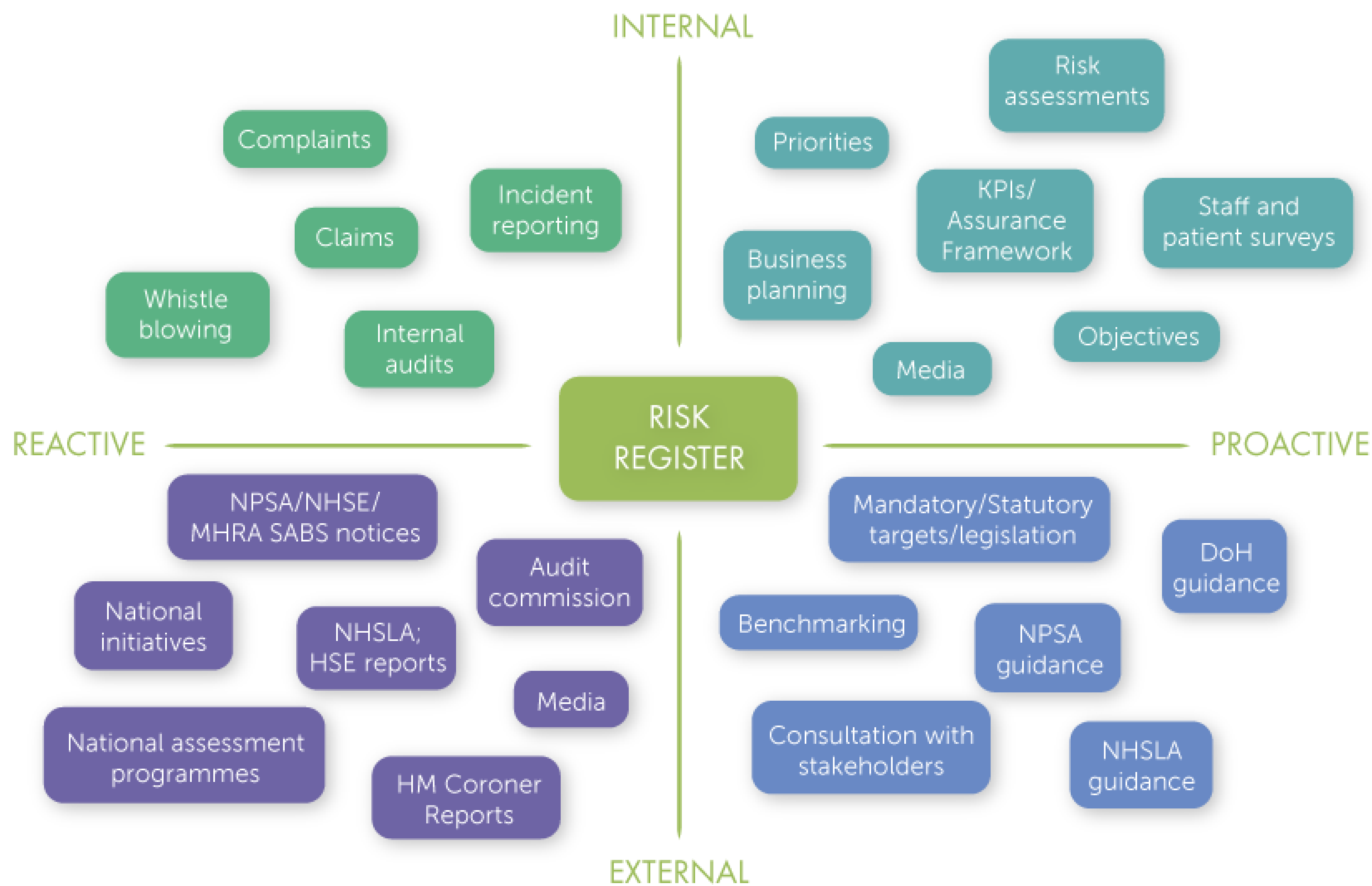
Level 2: Risk Aware

- The organisation is aware of risk management responsibilities and needs to embed systems
- Scatters silo-based approach to risk management

Level 1: Risk Naïve

- The organisation has little or no awareness of the importance of risk management
- No formal approach developed for risk management

Appendix B: Sources of Risk



Appendix C: Corporate Risk Identification Pro-forma

Corporate Risk Identification Pro-forma					
Date Risk Identified	**xxx**	**Risk Title**	**xxx**	**Source of Risk**	
Responsible Committee/Workstream (see drop down list tab for options under key assurance internal list)	xxx				
Risk Statement *Describe the cause* *Describe the risk* *Describe the impact*	Because ... There is a risk that …. Resulting in …..				
Managed By		**Assigned To**	**xxx**	**Clinician**	
Prime Strategic Objective					
NPSA Domain 1		**NPSA Domain 2**		**NPSA Domain 3**	
***Impact* risk scores for each domain chosen** *Comparable scores*					
Impact Descriptors *Choose from the matrix*	xxx		xxx		xxx
Significant Issues *Describe the triggers*	. xxx . xxx . xxx				

Risk Title	Cause	Risk	Effect
Failure to deliver the National A&E Target	Because patients are experiencing longer delays in A&E,	There is a risk that patient experience and treatment outcomes will be impacted upon due to treatment delays	Resulting in poor provider performance and breaches in statutory duty
Business Case Not Signed Off	Because the business case has not been signed off due to unavailability of senior staff	There is a risk that the design stage will not commence as planned on 1st May 2017	Resulting in a delay to the overall project schedule of 4 weeks
System Testing	Because of the need to add an extra function to the design	There is a risk that the systems testing may be late	Resulting in a delay to the project schedule of 6 weeks

Current Existing Controls *Describe the controls that address the causes. Describe the prime deliverable of each control*	**Current Source of Assurance** *Where can you gain evidence that the risk is being monitored for effectiveness (e.g.Groups, Committees)*	**Current Gaps in Controls / Gaps in Control** *Describe if there are any weaknessess / failings or outstanding items to be addressed from the current controls / assurances.*
. xxx . xxx . xxx . xxx	. xxx . xxx . xxx . Xxx	**Gaps in current controls:** . xxxx . xxxx . xxxx . xxxx **Gaps in current assurances:** . xxxx . xxxx . xxxx . xxxx

Identify further actions to mitigate the risk
Note: If not captured under current controls include actions to mitigate against the issues and gaps identified

Action Title *What additional actions are required to reduce this risk to its aceptable target level*	**Key progress note**	**Due date**	**Assigned to**	**% Progress**
xxx	xxx	xxx	xxx	xxx
xxx	xxx	xxx	xxx	xxx
xxx	xxx	xxx	xxx	xxx

NPSA scoring Matrix must be used to determine the level of risk
(If the risk is cross cutting choose the domain which is the most concern - refer back to the comparable risks scores at row 8)

Original Risk - *no controls*				**Current Risk -** *with controls*			**Target Risk** *- acceptable level of risk*				**Next Risk Review**
Date Risk Identified	Impact	Likelihood	Rating	Impact	Likelihood	Rating	Impact	Likelihood	Rating	Target Date	
xxx			0			0			0	xxx	**xxx**

Date Approved by Risk Manager / Risk Owner /Clinician	**xxx**	**Signed**	**xxx**

Appendix D: Risk Matrix 2019/20

Quantitative Measure of Risk – Consequence Score

	Impact / Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Very Low**	**Minor**	**Moderate**	**High**	**Severe**
Service Quality – Patient Safety	Minor injury or illness requiring no medical attention and no long-term impact.	Minor injury or illness requiring minor medical intervention with impact limited to 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4–14 days. Increase in length of hospital stay by 4–15 days. RIDDOR/agency reportable Incident. An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients
Service Quality – Clinical Effectiveness	Minor breach of guidance – no impact on patient outcomes.	Breach leading to minor harm or impact on patient outcomes for an individual or a small number of patients	Significant breach of guidance leading to moderate harm for an individual or small number of patients.	Significant breach leading to serious harm (as defined by the SI framework) for an individual or group of people.	Significant breach leading to fatality or permanent disability.
Service Quality – Patient Experience	Minor inconvenience to single individual.	Minor inconvenience too many individuals, significant inconvenience to single individual.	Significant inconvenience to many individuals, patient experience impact on health outcomes for a few.	Patient experience impact on health outcomes for a significant number.	Fatality or permanent disability.
Service Quality – Operational	Minor reduction in quality of treatment or service. No or minimal effect for patients.	Single failure to meet national standards of quality of treatment or service. Low effect for a small number of patients if unresolved.	Repeated failure to meet national standards of quality of treatment or service. Moderate effect for multiple patients if unresolved.	On-going non-compliance with national standards of quality of treatment or service Significant effect for numerous patients if unresolved.	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for a large number of patients if unresolved.
Health Inequalities	Possible increase to inequalities.	Probable small increase to inequalities.	Probable significant increase to inequalities.	Actual small increase to inequalities.	Actual substantial increase to inequalities.
Health Improvement	Possible slowing of decline of prevalence.	Probable slight slowing in rate of improvement in death rates. No decline or significant slowing in prevalence.	Probable significant slowing in improvement of death rates. Slight increase in prevalence.	Slight increase in death rates. Substantial increase in prevalence.	Substantial increase in death rates.
Operational and Legal Compliance	No or minimal impact or breach of guidance /statutory duty. Minor breach of standards with no impact on organisation.	Breach of statutory legislation. Breach of broader health standards or minor targets.	Single breach in statutory duty. Breach leading to discussion with National Commissioning Board (NCB).	Multiple breaches in statutory duty. Breach leading to DH improvement team intervention. Breach leading to threat of court action.	Multiple breaches in statutory duty. Breach leading to court action against executive.

	Impact / Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Very Low**	**Minor**	**Moderate**	**High**	**Severe**
Financial Balance / Claims	<£50,000 loss. Small loss risk of claim remote.	£50,001 - £250,000 loss. Claims less than £10,000.	£250,001 - £1M loss. Claims between £10,000 & £100,000.	£1,000,001 - £3M. Claims between £100,000 & £1 million.	>£3M. Claims >£1million.
Financial Governance	Isolated technical breach with minimal impact.	Numerous minor technical breaches. Technical breach leading to financial loss.	Limited assurance on single key financial systems.	Failure to get Statement on Internal Control agreed. Fraud leading to imprisonment of staff member. No assurance on single key financial system. Limited assurance on multiple systems.	Fraud >£2million. Investigation by the National Audit Commission. No assurance on multiple financial systems.
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage. No impact on delivery of objectives.	<5 per cent over project budget / Schedule slippage. Minor impact on delivery of objectives.	5–10 per cent over project budget / Schedule slippage. Moderate impact on delivery of objectives.	10–25 per cent over project budget / Schedule slippage. Key objectives not met.	>25 per cent over project budget / Schedule slippage. Failure of strategic objectives impacting on delivery of business plan.
Information and Technology (Information Governance)	Minor technical breaches of standards not directly impacting on members of the public.	Single loss of data or other breach affecting a single individual.	Multiple losses of data or other breaches of governance standards impacting on small numbers of people. Single loss of data impacting on many people.	Multiple losses of data or other breaches of governance standards each impacting on hundreds of individuals.	Breach leading to court action against executive.
Reputation	Complaint /concern only. Not relevant to mandate priorities. No adverse media. No negative recognition from the public.	Minor impact on achieving mandate priorities. Low level of adverse media coverage. Small amount of negative public interest.	Moderate impact on achieving mandate priorities. Moderate amount of adverse media coverage. Moderate amount of negative public interest.	High impact on achieving mandate priorities. High level of adverse media coverage. Negative impact on public confidence.	Mandate priorities will not be achieved. National adverse media coverage. Total loss of public confidence.
Service Business Interruption	Loss/interruption for >1 hour.	Loss /interruption for >8 hours.	Loss /interruption for >1 day.	Loss /interruption for >1 week.	Permanent loss of service or facility.
Staff Safety and Wellbeing	Minor cuts and bruises. Isolated incidence of low morale.	Medical treatment required. Less than three days' absence. Low morale among a number of staff groups.	Single admittance to hospital for less than 24 hours. Absence of three days or longer. Sickness rates increasing.	Single fatality or permanent disability. Rapid increase in sickness rates threatening service delivery.	Multiple fatalities or cases of permanent disability.

	Impact / Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Very Low**	**Minor**	**Moderate**	**High**	**Severe**
People and Change (Human resources/ organisational development/staffing/ competence)	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory training.	Uncertain delivery of key objectives due to lack of staff. Unsafe staffing level (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/ key training.	Non-delivery of key objective / service due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an ongoing basis.

Qualitative measure of risk – Likelihood score

Descriptor	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency Time framed descriptors	Not expected to occur for years	Expected to occur annually	Expected to occur monthly	Expected to occur weekly	Expected to occur daily
Frequency Broad descriptors	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not occur
Probability	<15%	15-39%	40-59%	60-79%	=>80%

Quantification of the Risk – Risk Rating Matrix

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Impact / Consequence	5	Severe	5	10	15	20	25
	4	High	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Very Low	1	2	3	4	5