NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Risk Management Strategy

Document Control Sheet

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Version 1.2	12/05/21	Presentation to Governing Body

The formally approved version of this document is that held on NHS Shropshire, Telford and Wrekin Clinical Commissioning Group's website at

www.shropshiretelfordandwrekinccg.nhs.uk

Printed copies or those saved electronically must be checked to ensure they match the current on line version.

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1 Introduction

In order to fulfill the CCG's mission statement it is important that we operate as a properly constituted organisation with appropriate governance arrangements. Through these arrangements, we will be able to deliver our statutory functions, strategic oversight, financial control and probity, as well as driving quality, encouraging innovation and managing risk.

There will be elements of risk in all activities we undertake or commission others to undertake on our behalf. These risks will have the potential to undermine, threaten or prevent the CCG achieving its mission statement and objectives. It is therefore essential that there is a clear Risk Management Strategy and processes in place to provide clarity of the risks affecting each area of its activity, how the risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives.

Ensuring risks are properly identified, evaluated, documented and managed effectively, consistently and systematically must continue to be an integral part of everyday practice throughout the CCG. It also requires a culture of transparency and honesty to be promoted and embedded throughout the CCG.

The processes described in this strategy ensure that risk management is integrated into all business decision making, planning, performance reporting and delivery processes, to support rigorous and innovative decision making in all aspects of the CCG's work.

2 Purpose

'Risk' is defined as the threat that an event or action will adversely affect an organisation's ability to achieve its objectives and to execute its strategies successfully. This includes both risk to the organisation and the risk to those individuals to whom the CCG owes a duty of care.

The Risk Management Strategy establishes a framework for the effective and systematic management of risk to the CCG. It will enable the CCG to have a clear view of the risks affecting each area of its activity; it will allow clarity on how the risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives. Implementation of this Strategy is essential to the continuance of the CCG achieving a robust risk management system throughout the organisation on which the quality of care to patients ultimately depends.

The purpose of this Risk Management Strategy is to:

- Define what risk management is about and what drives risk management within the CCG;
- Ensure structures and processes are in place to support the assessment and management of risks throughout the CCG;
- Outline how the strategy will be implemented;

- Identify the relevant roles and responsibilities for risk management within the CCG;
- Formalise the risk management process across the CCG, ensuring it continues to be part of normal business and delivers consistency of approach;
- Promote a culture of honest reporting and transparency which is upheld throughout the CCG to ensure risks are properly identified, documented, evaluated and managed.
- Assure the public, patients, staff, auditors and partner organisations that the CCG is committed to managing risk appropriately.

3 Approach

3.1 The strategy outlines an integrated approach to risk in that the processes in this strategy do not make distinctions in the methodology of approach between differing types of risk, i.e. clinical quality, financial, reputational and health and safety risks are examined using the same methodology.

3.2 By using a single approach to risk management, there is assurance that there is a consistent approach to the identification of risks and opportunities, making information from disparate disciplines comparable, and readily transferable through the hierarchy of monitoring and escalation to the Governing Body where necessary. It also gives the Governing Body assurance that risk is effectively managed and monitored by the Audit Committee.

3.3 The CCG Governing Body has defined its risk appetite, with due regard to the opportunities and risks to the delivery of its objectives and those that may affect day to day activities:

- We expect to fulfil our statutory and regulatory duties to maintain and improve quality and safety in our activities and those of the organisations we commission health care from.
- We will:
    - accept risk graded as very low;
    - avoid expenditure and use of resources on those graded low;
    - manage in a cost effective manner those graded moderate;
    - and robustly seek to reduce those graded high.
- We will not accept risks that have a material adverse impact on quality of healthcare, health inequalities or life expectancy.

4 Accountabilities, Roles and Responsibilities

The Strategy applies to all CCG staff members, contractors, Governing Body and Committee members; it is not just the responsibility of one person or role within the organisation. Ensuring risks are managed effectively, consistently

and systematically must remain an integral part of everyday practice throughout the organisation for everyone.

The following section defines the roles, responsibilities and lines of accountability of committees and key individuals relating to risk management.

4.1 NHS Shropshire, Telford and Wrekin CCG Governing Body:

The Governing Body has ultimate responsibility for approving and monitoring the CCG's risk management processes.

To meet this requirement the Governing Body will:

- Agree the CCG's strategic objectives and review them regularly.
- Approve a Risk Management Strategy
- Establish and maintain a structure as set out in the Strategy for the effective management of risk throughout the CCG.
- Seek assurance from the Audit Committee via regular reporting, on the risks and progress on mitigating actions articulated in the Board Assurance Framework and Directorate Risk Registers.
- Review this Strategy every three years.

4.2 Audit Committee:

The Audit Committee will focus on the effectiveness of the risk management systems and processes created as part of an effective system of internal control that have been approved by the CCG Governing Body. It is responsible for assessing the effectiveness of the risk management framework: Board Assurance Framework, Directorate Risk Register and Primary Care Commissioning Risk Register, and in particular the adequacy of the implementation of this Strategy and of risk management across the CCG.

The Audit Committee will:

- Review the Board Assurance Framework, Directorate Risk Register and Primary Care Commissioning Risk Register on a regular basis (at least twice a year).
- Provide assurance to the CCG Governing Body regularly (at least twice a year) of the effectiveness and adequacy of risk management processes.
- Review and approve the Risk Assessment Code of Practice that sits below the Risk Management Strategy.
- Receive and consider reports from other committees as applicable.
- Review internal and external sources of information to provide adequate assurance that risks are being appropriately mitigated.
- Review this Strategy every three years and submit to the CCG Governing Body for approval.

4.3 All Committees:

All committees of the CCG have a responsibility to actively identify and seek mitigating actions for risks that arise within their area of responsibility as set out in their terms of reference.

All Committees will be responsible for:

- Identifying any risks arising in the course of their deliberations and recording them as appropriate on either the Board Assurance Framework or Directorate Risk Registers.
- Identifying and implementing or overseeing implementation of mitigating actions where the identified risk/s are within the Committee's areas of responsibility.
- Ensuring the appropriate transfer of responsibility for identifying and implementing mitigating actions where the identified risk/s are not within the Committee's areas of responsibility.
- Regularly reviewing identified risks and the impact of mitigating actions where these are within the Committee's area of responsibility and reporting progress/assurance, or by exception limited assurance via Chair's report to the Governing Body or Audit Committee as applicable.

4.4 Accountable Officer

- Ensuring that Directors identify risks, where applicable, and they report them on either Board Assurance Framework (BAF) or appropriate Directorate Risk Registers (DRR).
- Ensuring that Directors provide updated risk information on the BAF and DRR for reporting to the Audit Committee, other Committees and Governing Body in a timely way.

4.5 Managers (including Directors)

- Managers are responsible for the effective management of risks in their related areas and should ensure the implementation of the CCG's Risk Management Strategy and Risk Assessment Code of Practice 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 in functions for which they are accountable are identified and managed and mitigating actions implemented.
- Ensuring identified risks, where applicable, are reported on either Board Assurance Framework or appropriate Directorate Risk Registers and updated as applicable.
- 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, incidents, risk assessments is disseminated throughout the organisation.

4.6 CCG Staff:

Risk management is not simply a corporate function; it is the responsibility of all staff to ensure that, to prevent harm, aid innovation and avoid challenge by the Department of Health or by claim or court action, risks to safety and effective working and potential improvements are fully identified and action taken to mitigate wherever possible.

All staff working for the CCG will:

- Be aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others and to comply with appropriate CCG rules, regulations, policies, procedures and guidelines.
- Be familiar with the Risk Management Strategy and Risk Assessment Code of Practice and comply with the requirements stated in each.
- Identify and report risks to their manager or Director.
- Reporting incidents and complaints as applicable in line with established processes.
- Co-operating with others in the management of risks identified within the CCG.
- Taking action to protect themselves and others from risk.

4.6 Commissioning support, Collaborative Commissioners, Contractors, Agency and locum staff

Managers must ensure that where they are outsourcing, employing or contracting agency and locum staff that are made aware of, and adhere to, all relevant policies, procedures and guidance of the CCG, including incident reporting and health and safety.

They should also:

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

4.7 Staff responsible for Risk Management

Accountable Officer: the Accountable Officer has responsibility for ensuring the CCG has a programme of risk management and is responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support.
- Ensuring an appropriate committee structure is in place, with regular reports to the CCG Governing Body.
- Ensuring that a senior manager is appointed with managerial responsibility for overseeing the risk management process.
- Ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG.

Director of Corporate Affairs: is the senior manager responsible for risk management, specifically to:

- Ensuring effective risk management systems are in place throughout the CCG
- Ensuring the Board Assurance Framework and Directorate/Primary Care Commissioning Risk Registers are frequently reviewed and updated.
- Ensuring there is appropriate external review of the CCG's risk management systems, and that this is reported to the Audit Committee and CCG Governing Body.
- To provide advice and guidance on the contents of this strategy and the Risk assessment Code of Practice for Managers and members of staff.

5 Risk Management Processes

5.1 Risk Management Framework

The CCG has in place a Board Assurance Framework (BAF), supported by the Directorate Risk Register (DRR) which are the mechanisms used to record high level strategic and operational risks and opportunities across all functions of the CCG, including delegated co-commissioning of primary care

The BAF and DRR are linked to the defined objectives of the CCG, the Primary Care Commissioning Risk Register (PCCRR) is linked to the defined objectives of the Primary Care Strategy and together reflect the risk appetite of the organisation.

5.2 Risk Identification

Identification of risk is the first part of an effective risk management strategy. A strong organisational commitment to risk management will ensure that risks identified at all levels of the CCG are properly managed. The CCG has both a proactive and reactive approach to identifying risk. The proactive approach includes the use of the risk assessment process set out in the CCG's Risk Assessment Code of Practice, and then implementation of mitigating actions arising from the assessment. The reactive approach includes responding to information, which could be internally or externally generated, for example complaints, claims, audit findings, service development or redesign, incident reporting from providers, contract activity information.

All staff, managers and Directors are required to identify risk specific to their own areas of responsibility and report or/and record these and then analyse, evaluate and manage them or accept them.

The strategy outlines a risk management system which requires all risk to be identified using the same methodology, regardless of which function of the CCG the risk sits i.e. financial, human resources, reputational management, quality, commissioning, contract monitoring.

In addition, executive summary reports taken to the Governing Body and committees require authors to identify any risks or opportunities in the content of the report that may need highlighting and or adding to the Board Assurance Framework or Directorate Risk Register.

5.3 Risk Assessment

The same simple process, documented in the Risk Assessment Code of Practice and using a single matrix for measuring impact and likelihood, will be used for identifying and grading risks in the BAF, DRR, PCCRR and for assessing risks and opportunities throughout the CCG (including health and safety risks):

- Identify – sets out to identify the exposure to uncertainty. The identification process can be both proactive and retrospective. Risk assessments will be undertaken (as set out in the Risk Assessment Code of Practice which can be found as a separate document on the CCG's website), both proactively and retrospectively, to explore risks and relating to a specific activity, project or plan. Some of these will be conducted jointly with other stakeholders, e.g. the local authority and patient groups.
- Analyse – once risks have been identified each one will be analysed by assessing both what the consequence/impact and the likelihood would be of it occurring, this is set out in detail in the Risk Matrix in appendix 2.
- Evaluate – using the single grading risk matrix in appendix 1 as a simple approach to quantifying risk. The matrix defines qualitative measures of consequence (severity) and likelihood (frequency or probability) using a simple 1 – 5 rating system. This can then be used as the basis of identifying and analysing risk. The risk score is Consequence x Likelihood.

  In the first instance risks are measured with existing controls in place and then finally what controls need to be in place to reduce the risk to an acceptable level. The subsequent risk ratings using the risk matrix in appendix 1 are recorded in the appropriate document (either the Board Assurance Framework, Directorate Risk Register, Primar Care Commissioning Risk Register, service area Risk Register or project risk register). This process creates a manageable programme of risk management.
- Control – this is the process of selecting and implementing appropriate actions and controls to modify the risk. Mitigation options include:
  - accepting the risk
  - accepting the risk supplemented by contingency plans if deemed necessary,
  - treating the risk in an appropriate way to constrain the risk to an acceptable level - i.e. mitigation
  - actively taking advantage regarding the uncertainty as an opportunity to gain a benefit
  - terminating the activity giving rise to the identified risk where this is possible or appropriate.

  Where the risk needs to be mitigated, the actions taken and who will undertake them and by when, are also recorded on the appropriate document.

  Risks graded very low and low (1 – 6) will be accepted without significant effort to address them and this will be done by the manager

of the service area. If low graded risks can be readily addressed with very limited resources this may be undertaken.

Risks graded moderate and significant (between 8–10) must be notified to the respective Director by the Manager of the Service. These more operational risks should be recorded in the Directorate Risk Register/ or the Board Assurance Framework for strategic risks. Reasonable effort will be put into addressing risks graded moderate, especially where they have the ability to affect significant numbers of patients or staff. Action plans will be drawn up to mitigate, at least to the level of moderate, risks graded high/extreme.

Risks graded high (12 – 15) must be notified to the Director. These risks may be added to the Board Assurance Framework or the Directorate Risk Register.

Risks graded severe (above 20) must be notified to the Director and Accountable Officer. These risks must be added to the Board Assurance Framework.

Action plans will be drawn up to mitigate, at least to the level of moderate, risks graded high/extreme. If the risk poses an imminent danger then the Director and or the Accountable Officer will report to Governing Body members immediately.

Acceptance of risk – the general principle to follow when determining if a risk identified requires ongoing actions and review is that the benefit of taking the risk outweighs the risk itself. If the risk in its current situation outweighs the benefit this implies that either:

- The activity that creates the risk should be ceased or
- Further mitigating controls to reduce the consequence or likelihood are necessary.

Any further mitigating controls will have a burden attached to them, normally financial, but could be a reduction in service or other aspect. The burden must be commensurate with the controls to be introduced, and the risk itself, i.e. a large cost for a small gain in risk reduction would not be acceptable.

Taking risks is part of everyday life and has many benefits. An organisation cannot be innovative without taking risks. The risk management framework provides CCG staff with a tool to manage risks in a controlled way. Accepting risk should not be seen as a failure to manage risk.

- Review - risk score and actions need to be regularly reviewed to ensure they have produced the expected result, and if they have not for further actions to be identified for implementation or consideration of accepting the risk. Review will be undertaken by the manager of the service liaising with their Director. The Director/Accountable Officer individually will review their specific risks on both the Board Assurance Framework and Directorate Risk Register and feed changes to the Director of Corporate Affairs, who will collate, report and highlight changes to the Executive team in the first instance before onward

reporting to Audit Committee and then by exception to CCG Governing Body via the Audit Committee Chair's report.

Individual committees are also expected to review the risks that form part of their responsibility.

Where review highlights the need to accept a risk the Director will provide narrative in the specific document that explains the rationale for the acceptance and this then goes to Executive team and Audit Committee for consideration and agreement.

Risks may be escalated between the Board Assurance Framework and the respective risk registers. The process for this is shown in appendix 3. There are exceptions to this process, where the Board or Committee, Accountable Officer or Director reviewing the risk feel that the risk would be better managed at a different level. This should be documented.

Examples include:

Reduction in level – the risk rating indicates a high residual risk that the CCG does not have the opportunity to control. All risk reduction controls are proven to be effective. Raising the level of risk that may only have a risk rating warranting Directorate Risk Register but it may have an effect on the delivery of key principles so it could be escalated to the Board Assurance Framework so that the Governing Body is assured that the risk will be managed effectively as part of the delivery of objectives.

5.4 Recording risk

Risks above a certain level as specified in appendix 2 will be recorded on either the Board Assurance Framework (BAF) which is used to record high level strategic risks. The BAF is supported by the Directorate Risk Register (DRR) with operational risks recorded here. The CCG has a separate risk register for primary care that sits below the Directorate Risk Register which feeds up into the Directorate Risk Register if risks require escalation, because it undertakes this responsibility under delegated authority from NHS England on its behalf. Therefore it simplifies the reporting and recording of these risks specifically, but still allows cross referencing between the two risk registers if required.

A description of the template for recording risk on the BAF/DRR and an example is shown in appendix 3.

5.5 Process for Review and Monitoring of Risk

Maintenance of the BAF/DRR or any other risk register kept for low or very low risks will be undertaken by ensuring all risks are managed by their review date which will be entered onto the risk register. The risk rating should gradually decrease from the initial score to meet the target score – the current score is the only rating that will change. If the current score is not reducing then the actions that have been put in place to address the risk must be reviewed, as it would appear that the actions are not effective at reducing the risk. Or alternatively the target risk score has been set too low to achieve.

The risk owner for each risk will be accountable for ensuring each risk is reviewed and monitored at least quarterly and this is documented in the risk register. The risk owner will also be responsible for ensuring the controls are in place and any actions necessary are properly recorded and met.

The Director of Corporate Affairs will provide corporate oversight of timely reviews by risk owners and present the BAFF/DRR to the Executive meeting on a regular basis prior to presentation to Audit Committee.

The Board through the Audit Committee is responsible for corporately monitoring the BAF/DRR.

5.6 Closing risks

An active BAF or risk register contains the risks that are relevant to the organisation that are being addressed. Once a risk has reached its target rating (and is at an acceptable level of risk) it may be closed after agreement at the Audit Committee and Governing Body. Once closed the risk should be taken off the active BAF or risk register and added to an archive version. On the active BAF or risk register a line should be left in, giving details of the risk reference and description, when it was closed and which committee/Board agreed to it.

5.7 Other Assurance Activities

There are a number of functions / activities, required by best practice, legislation or regulation, undertaken, unless stated, which form part of the structure of risk management for the CCG, these include:

- Incident management and triangulation
- Claims management
- Recommendation monitoring, including: audit and higher level enquiry recommendations.
- Complaints and PALs management

6 Related Documents

The following documents contain information that relates to this policy:

Risk Assessment Code of Practice

Maternity Risk Assessment Code of Practice

Mental Wellbeing and Resilience Risk Assessment

Display Screen Equipment Policy

Health and Safety Policy

Office Safety Policy

Fire Policy

Serious Incident Policy

Incident Reporting Code of Practice including NHS to NHS Concerns

Business Continuity Plan

Complaints Policy

7 Dissemination

This strategy will be:

- placed on the website and
- distributed to Governing Body members, Directors and staff by the Director of Corporate Affairs, with an explanation of what is expected of them.

8 Advice and Training

Advice/one to one training will be provided via the Director of Corporate Affairs where appropriate.

9 Review, Reporting and Compliance Monitoring

This strategy will be reviewed every three years by the CCG Governing Body on the advice of the Audit Committee.

Risk management reporting will, in the main be received by the Audit Committee, with exception reporting to the Governing Body; consequently the committee will have responsibility for ensuring that effective compliance is maintained.

10 Glossary

Name	Description	Statutory / Regulatory / Best Practice
Assurance		
Assurance:	provides confidence, freedom for doubt, confidence	Acknowledged best practice is to ensure that, as part of governance processes and via an audit committee, the governing body receives sufficient assurance, through principally its risk management mechanisms that risks and legislative or regulatory challenges are adequately controlled.
Risk Management		
Risk:	The chance of something happening that will have a detrimental impact upon objectives, which is measured in terms of consequences and likelihood	
Opportunity:	The chance of something happening that will have a positive impact upon objectives, which is measured in terms of consequences and likelihood	
Risk management processes:	is the identification, assessment, and prioritization of risks (defined in ISO 31000 as the effect of uncertainty on objectives, whether positive or negative) followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events or to maximize the realization of opportunities. Risks can come from uncertainty in financial markets, project failures (at any phase in design, development, production, or sustainment life-cycles),	Acknowledged best practice in all businesses, regulatory requirement of the Department of Health, absence of compliance will not stand any organisation in good stead if there is court action, claims or inspection. Requires a competent person / expert to undertake / lead.

	legal liabilities, credit risk, accidents, natural causes and disasters as well as deliberate attack from an adversary, or events of uncertain or unpredictable root-cause.	
Risk management strategy:	describes the mechanisms used to manage risk throughout an organisation.	Regulatory and best practice. Requires a competent person / expert to undertake / lead.
Risk appetite / risk culture:	a statement of the degree of residual risk that the governing body feels is acceptable to carry without reduction together with those it feels must be mitigated to the lowest possible level.	Best practice. Requires a competent person / expert to undertake / lead.
Risk register:	mechanism used to evaluate risks and opportunities that are significant enough to affect the delivery of the organisation's objectives.	Regulatory and best practice. Requires a competent person / expert to undertake / lead.
Risk assessment:	a single mechanism for identifying risks and opportunities that affect activities throughout an organisation, e.g. a new project in development, commissioning decision making, safety of staff and assets.	Statutory requirement of the Health and Safety at Work Act, regulatory and best practice. Requires a competent person / expert to undertake / lead.
Risk matrix:	a single matrix for grading all risk activity, which can be a matrix based upon best practice or simple RAG rating, which maps consequence against likelihood.	Best practice. Requires a competent person / expert to undertake / lead.

Appendix 1: Risk Matrix

The risk evaluation matrix is a simple approach to quantifying risk by defining qualitative measures of consequence (severity) and likelihood (frequency or probability) using a simple 1 – 5 rating system. This allows the construction of a risk matrix, which can be used as the basis of identifying and analysing risk. The risk score is Consequence x Likelihood.

Consequence (severity)

	Consequence score (severity levels) and examples of descriptors				
Domains	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Extreme**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of petients
Quality/ complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint Local resolution Single failure to meet standards Minor implications for patient safety unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal Complaint Local Resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted upon	Non compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment /services Gross failure of patient safety if findings not acted upon Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational/ development/ staffing/ competence	Short term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces 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/key training	Uncertain delivery of key objective/service due to lack fo staff Unsafe staffing level or competence (>5 days) Loss fo key staff Very low staff morale No staff ateending mandatory/key	Non-delivery of key objective/ services 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

				training	ongoing basis
Statutory duty/ Inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendation/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severity critical report
Adverse publicity	Rumours Potential for public concern	Local media coverage Short term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation MP concerned (questions raised in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10-25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Financial Risk in relation to CCGs	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
Service/ business interruption/ Environmental impact	Loss/Interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/ interruption of >1 day Moderate impact on environment	Loss/ interruption of > 1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood (frequency or probability)

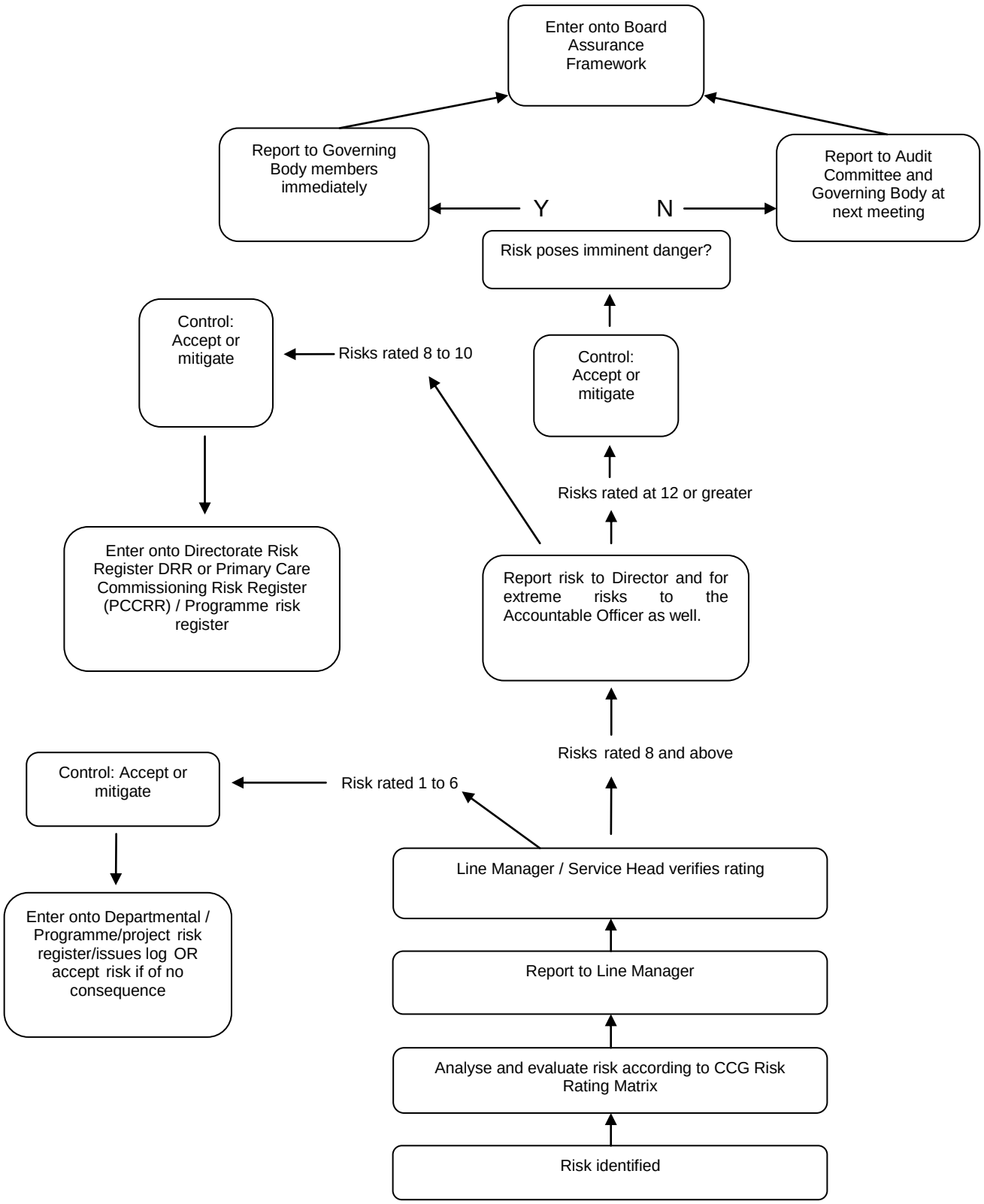
Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it happen/does it happen?	This will probably never happen/ recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	<0.1 per cent	0.1 – 1 per cent	1 – 10 per cent	10 – 50 per cent	>50 per cent

Risk Score (Consequence x Likelihood)

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
1 Negligible	**1 VERY LOW**	**2 VERY LOW**	**3 VERY LOW**	**4 LOW**	**5 LOW**
2 Minor	**2 VERY LOW**	**4 LOW**	**6 LOW**	**8 MODERATE**	**10 MODERATE**
3 Moderate	**3 VERY LOW**	**6 LOW**	**9 MODERATE**	**12 HIGH**	**15 HIGH**
4 Major	**4 LOW**	**8 MODERATE**	**12 HIGH**	**16 HIGH**	**20 EXTREME**
5 Catastrophic	**5 LOW**	**10 MODERATE**	**15 HIGH**	**20 EXTREME**	**25 EXTREME**

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

Appendix 2: Risk Escalation Process Map



Appendix 3: BAF/DRR Template

BAF/DRR template showing content structure:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Risk ID	Objective	Opened/added by/ ref to provider BAF	Risk title and description	Opportunity	Existing key controls	Existing sources of assurance	Gaps in controls/ assurances	Risk Score (consequence x likelihood)	Risk Score Trend	Action plan/cost/action lead/review date/sufficient mitigation	Target risk score for end of financial year	Director or risk owner	Risk Owner	Committee/ GB oversight	Amendments: name and date
	Objective 1: To improve commissioning of effective, safe and sustainable services, which deliver the best possible outcomes, based upon best available evidence														

Column 1 – unique number reference given sequentially

Column 2 – Cross reference risk to the objective it would prevent the CCG achieving

Column 3 – Who/What added the risk and when, and what external risk registers it maps to

Column 4 – Summary title of risk and then fuller description of risk

Column 5 – Summary of the opportunity the risk may present

Column 6 – Summary of the controls already in place when the risk was identified and subsequently updated on review.

Column 7 – Summary of the assurances already in place when the risk was identified and subsequently updated on review.

Column 8 – Summary of the gaps in appropriate controls/assurances at the time the risk is identified and subsequently updated on review.

Column 9 – Using the risk matrix an evaluation of the consequence and likelihood of the current risk taking into account the existing controls and assurances.

Column 10 – Add in a trend arrow to show if risk rating has stayed the same, increased or reduced from last reporting review.

Column 11 – Using the gaps in controls and assurances in column 7 identify actions required to fill those gaps and also to achieve the target rag rating in column 10 which reflects the point that the risk will be accepted. This should also document the review date.

Column 12 – Evaluate the target risk score at which point the risk will become acceptable.

Column 13 - Director identified – this is the person who will be accountable for coordinating strategic delivery of the mitigating actions

Column 14 - Risk Owner identified – this is the person who will be accountable for coordinating operational delivery of the mitigating actions (applicable to ERR only)

Column 15 – Identify here which Committee or if GB will maintain regular oversight and receive regular reporting on risk.

- GB – Governing Body
- QS – Quality and Safety Committee
- F – Finance Committee
- PC – Primary Care Commissioning Committee
- AC – Audit Committee
- SCC – Strategic Commissioning Committee
- AIC – Assuring

Column 16 - Audit trail of amendments to the risk record.

EQUALITY IMPACT ASSESSMENT

Stage 1 Initial screening

Name of the proposed policy/service/function: Risk Management Strategy 2021-23

Author(s) of the policy/service/function: Alison Smith, Director of Corporate Affairs

Directorate: Corporate Affairs **Date created:** April 2021 **Date for review:** April 2023

The main aims of the policy or proposed policy/service/function:

The strategy documents the CCG's approach to risk management for 2021-23

The intended objectives and outcomes of the policy/service/function:

The strategy documents the CCG's approach to risk management for 2021-23

Does the policy/service/function affect any of the following groups of people? (Y or N)

Group	Positive impact	Negative impact	Why? (Please explain your reasons. This section must be completed)
Race	X		Risk management is a mechanism that provides the opportunity for identification of areas in the organisation commissioning processes or internal business processes where equality issues may be hidden to be exposed and actions to mitigate them undertaken.
Gender	X		See above.
Disability	X		See above.
Sexual orientation	X		See above.
Age	X		See above.
Religion or belief	X		See above.
Gender reassignment	X		See above.
Marriage and Civil Partnership	X		See above.
Pregnancy and Maternity	X		See above.

NOTE:

Positive impact – there may be a positive impact on any of the groups above in relation to promoting equal opportunities and equality. For example, a targeted programme for black and minority ethnic women would have a positive effect on that group compared to white women and all men. It is not, however, necessarily an adverse impact on white women and men.

Negative impact – there may be a negative impact on any of the groups (i.e. disadvantage them in any way). An example of this would be that if an event were to be held in a building with no loop facilities a negative and adverse impact would affect attendees with a hearing impairment

What evidence has been used to screen the policy? (e.g. monitoring data, consultation, focus groups, local population data): Risk assurance activity is all inclusive; all matters will be treated equally.
What monitoring arrangements are in place for the future? This report supports the Audit Committee in providing assurance of compliance with the Risk Management Strategy and related codes of practice.

If no negative or adverse impact has been identified please sign off and the process ends here.

Signature: Alison Smith	**Date: 08/04/2021**

If a negative or adverse impact has been identified please proceed to Stage 2