NHS
Chorley and South Ribble
Clinical Commissioning Group

RISK MANAGEMENT STRATEGY 2022

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Version Control

Version	Date	Author	Status	Comment / Details of Amendments
0.1		Lisa Stott	Draft	Policy drafted
1.0		Lisa Stott	Final	Policy approved by Audit Committee
1.0		Lisa Stott	Final	Policy ratified by Governing Body
1.1		Lisa Featherstone	Draft	Full rewrite of Strategy to address gaps and merge with Risk Management Policy
1.2	20/10/14	Lisa Featherstone	Draft	Updated to reflect feedback from MIAA review
1.3	07/11/14	Lisa Featherstone	Draft	Recommended by the Audit Committee for Governing Body approval
2.0	26/11/14	Lisa Featherstone	Final	Approved by the Governing Body
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5.0	27/03/19	Sarah Mattocks	Draft	Updated following KPMG audit. Submitted to Audit Committee for recommendation to the Governing Body
6.0	05/03/21	Sarah Mattocks	Draft	Strategy updated with; QPC and PVC responsibilities, audit feedback, removal of IBP update meeting, GGI risk appetite matrix, and executive lead for risk amended from Chief Finance and Contracting Officer to Director of Quality and Performance
7.0	23/03/22	Sarah Mattocks	Final	Policy approved by the Governing Body to rollover until 30 June 2022 or CCG closedown, whichever is first, unless there is change in policy or good practice or if anything is identified through an internal audit.

Circulation List

Prior to Approval, this strategy was circulated to the following for consultation:

- Audit Committee

Following Approval this strategy Document will be circulated to:

- All staff

Equality Impact Assessment

This document has been impact assessed by the CCG. No issues have been identified in relation to Equality, Diversity and Inclusion.

Contents

1.0 Introduction

1.1 NHS Chorley and South Ribble 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 objectives.

1.2 Risk management, whilst driven by legislative requirements including The Health and Safety at Work Act (1974) 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 provides a framework in relation to the implementation and delivery of risk management across the CCG, whilst also taking into account the legislative framework that the organisation is bound by. 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.

2.2 The aim of the risk management process is to provide a systematic and consistent integrated framework through which the CCG's objectives are pursued. This involves the identification of risks; threats and opportunities to achieving the CCG's objectives and taking steps to mitigate these risks. To support this, the strategy will also outline the risk appetite of the organisation as per section 9.18.

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 employees, contractors and Governing Body members including elected and non-elected members of Chorley and South Ribble CCG. The roles covered by this strategy will hereafter be referred to as CCG representatives.

The strategy is relevant to all matters that affect the CCG including transformation programmes with other organisations and hosted arrangements.

4.0 Definitions

4.1 The CCG defines risk and risk management in line with the Australia and New Zealand standard AS/NZS 4630, advocated by the National Patient Safety Agency for identifying and measuring risk and in line with the HM Treasury Orange Book 2004. Specific definitions are as follows:

• Risk	the chance of something happening that will have an impact upon objectives. It is measured in terms of likelihood and impact.
• Risk Management	the culture, processes and structures that are directed towards effective management of potential opportunities and adverse effects
• Risk Appetite	the level, amount or degree of risk that an organisation is willing to take in order to meet their strategic objectives
• Risk Maturity	the relative measure of the systems and process in place for managing risk
• Risk Register	A central repository which captures information such as risk likelihood, consequence, actions to mitigate and manage the risk. Risk registers will be maintained and reported at operational, project corporate and strategic levels.
• Corporate Risk Register (CRR)	Captures all risks which have a risk score of 15 or greater.
• Governing Body Assurance Framework (GBAF)	An integral part of the system of internal control which 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.
• Assurance	Provides confidence or guarantee that a risk is being managed appropriately
• Control	Measures which prevent or reduce the risk. Once actions on

	risk assessments are completed these will become controls.
• Risk score	An overall measurement of the severity level of a risk. All risks are scored using the National Patient Safety Agency 'Risk Matrix for Risk Managers' (2008) (see appendix C for full matrix). The CCG also utilises a high/medium/low risk scoring system when referring to the financial and operational risk of project delivery. The detail of this approach is included at section 7.7 of this strategy.

5.0 Risk Management Objectives

5.1 The CCG is committed to ensuring Risk Management is embedded across the organisation and driving the agenda and discussion at a strategic level.

5.2 The CCG will undertake an annual assessment of its risk maturity facilitated by an internal audit and will determine appropriate actions to progress from its current position.

5.3 The CCG aims to ensure all risks are captured on its risk registers and that these are managed appropriately in line with this strategy.

6.0 Risk Management Framework

6.1 Integrated risk management is a process through which the CCG will identify, assess, analyse and manage all risks for 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 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.

6.2 The risk management process will be used to:

- improve the ability of the CCG to meet its strategic aims/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.

7.0 Risk Management Structure

7.1 All Committees of the CCG Governing Body are responsible for reporting, and where appropriate monitoring risks which arise from the remit of that committee; additionally the Audit Committee has further responsibilities for the operational processes used in the management of risk.

Governing Body

7.2 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;
- Owning the Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR).
- Monitoring management of significant risks and seeking assurance that management decisions balance performance within appropriate limits defined by the CCG's Committees.

7.3 The Governing Body has delegated the scrutiny of the overarching risk management arrangements, including the GBAF and CRR to the Audit Committee.

Audit Committee

7.4 The Audit Committee is responsible for:

- Providing assurance to the Governing Body on the effectiveness and adequacy of the processes for managing principle risks and the risk management framework;
- Challenging the way in which risk is managed, particularly where there is uncertainty or concerns over the effectiveness of existing arrangements;
- Ensuring that arrangements for risk management are appropriately and regularly included in the cycle of independent audits;
- Being accountable to the Governing Body with overall assurances that the management of risk is effective;

- Receiving and reviewing the GBAF and CRR at each meeting in order to ensure that the processes used to manage these risks are adequate and effective;
- Reviewing on behalf of the CCG those policies that fall within the remit of the Committee's Terms of Reference, and making recommendations to the Governing Body on the approval of these.

Quality and Performance Committee

7.5 The Quality and Performance Committee gain assurance that; the Integrated Business Plan is being delivered and remedial action taken as necessary, progress is being maintained against key national, regional and local targets for service improvement, with a particular focus on external regulatory requirements, and monitor provider contract performance, productivity and efficiency programmes and overall use of resources. As part of this scope exceptions are reported against risk management under the following circumstances:

- Project delivery is off-track
- Providers failing to meet constitutional targets
- Providers failing to meet the desired level of quality against national benchmarks
- Any other factor within the remit of the committee terms of reference

7.6 The Quality and Performance Committee will also receive the GBAF and Corporate Risk Register (for those that pertain to the committee) at each formal meeting. This helps to ensure that it remains a 'live' document by the committee linking its agenda items to risks on the GBAF where appropriate.

7.7 Patient Voice Committee

The purpose of the Patient Voice Committee is to provide the CCG Governing Body with strategic leadership, assurance and scrutiny in relation to its duties to involve patients and the public in shaping NHS services (as outlined in section 242 (1b) of the National Health Service Act 2006, the Equality Act 2010 and other relevant legislation). The Patient Voice Committee will also receive the GBAF and Corporate Risk Register (for those that pertain to the committee) at each formal meeting. This helps to ensure that it remains a 'live' document by the committee linking its agenda items to risks on the GBAF where appropriate.

8.0 Risk Management Roles and Responsibilities

8.1 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.

Chief Officer

8.2 The Chief 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.

8.3 The Chief 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.

Director of Quality and Performance

8.4 The Director of Quality and Performance holds responsibility for ensuring that there are effective systems and processes for the management of risk, including a robust governance framework, GBAF, and CRR for the CCG, and financial stewardship of the CCG's finances.

8.5 The Director of Quality and Performance is also the Senior Information Risk Owner (SIRO).

Members of Management Executive Team

8.6 All members of the Management Executive Team (MET) 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 GBAF and CRR relating to their team (transformation and delivery, quality and performance, finance and contracting)
- ensuring all risks are identified, assessed and included on the risk register;
- providing assurance to the committees overseeing each risk, as appropriate

Heads of Service

8.7 All Heads of Service are responsible for ensuring all areas under their area of accountability are contributing to the operational and project risk registers as appropriate.

Line Managers

8.8 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 CCG Representatives

8.9 All CCG representatives 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 behavior in accordance with contracts of employment and individual job descriptions.

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

8.11 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 Owners

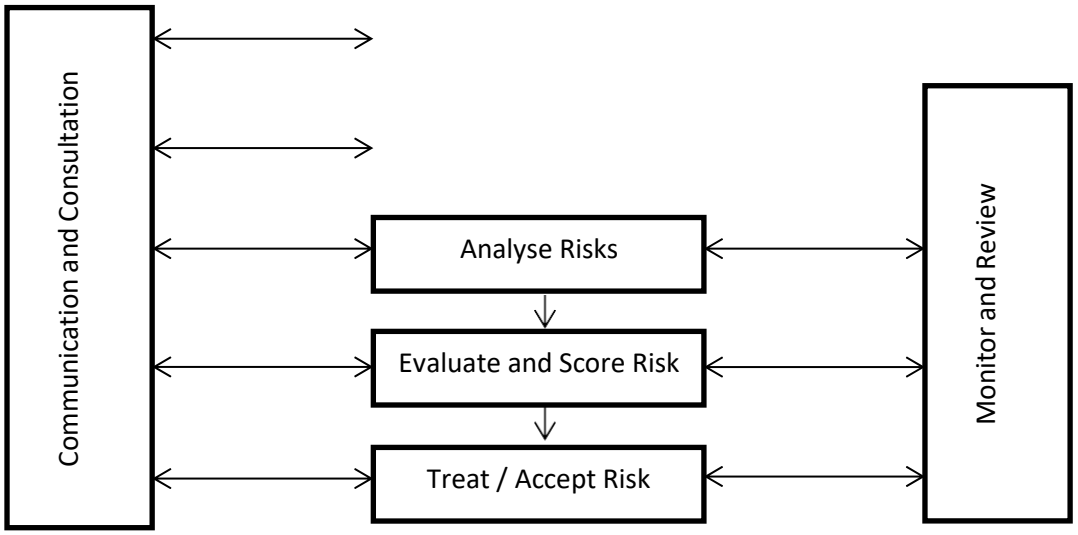
8.12 Risk owners will be assigned for each identified risk and will have overall responsibility for the risk and ensuring actions are implemented. For principal risks in the GBAF, this will be a member of the Senior Management Team. The table at section 9.15 of this strategy outlines the management responsibility levels for all risks.

Action Owners

8.13 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 risk register as necessary.

9.0 Risk Management Processes

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



Risk Identification

9.1 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.

9.2 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, CCG representatives and stakeholders
- Environmental — Risks associated with the well-being of CCG representatives and visitors whilst using CCG premises

9.3 The CCG also recognises that risks can arise from both internal and external sources. Examples are outlined at Appendix A, however this is not an exhaustive list.

Risk Analysis

9.4 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

9.5 The CCG has determined that the National Patient Safety Agency (NPSA) 5x5 matrix[1] at Appendix B will be the risk analysis tool used to ensure that each risk is evaluated in a consistent way.

[1] A risk matrix for risk managers, available at; http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/

9.6 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.

9.7 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
Consequence	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

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

Treating Risk

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

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

- Transfer — implementing a strategy 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 strategy 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. This is supported by the CCG's risk appetite and tolerance statement which can be found in section 9.18 of this strategy

- Accept — making an informed decision, that despite all of the controls in place to mitigate the risk, and despite the completion of all planned actions, a risk will still remain but will be mitigated to a level that the organisation can accept.

Risk Review and Management Responsibility

9.11 Each risk will be assigned a risk owner at the point of input onto the risk register.

9.12 The minimum frequency of risk review is determined by the risk rating as follows:

Level of Risk	Review frequency
1-3 (low)	Annually
4-6 (moderate)	Annually
8-12 (high)	Quarterly
15-25 (significant)	Monthly

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

9.14 All updates, including progress against mitigating actions and changes to the risk score will be recorded on the risk register.

9.15 Clear lines of responsibility and delegated authority have been agreed, based on the risk score, for the management and review of risk, as follows (please note that the GBAF is exempt from the below, because despite the rating of these risks they will be owned by a member of the MET):

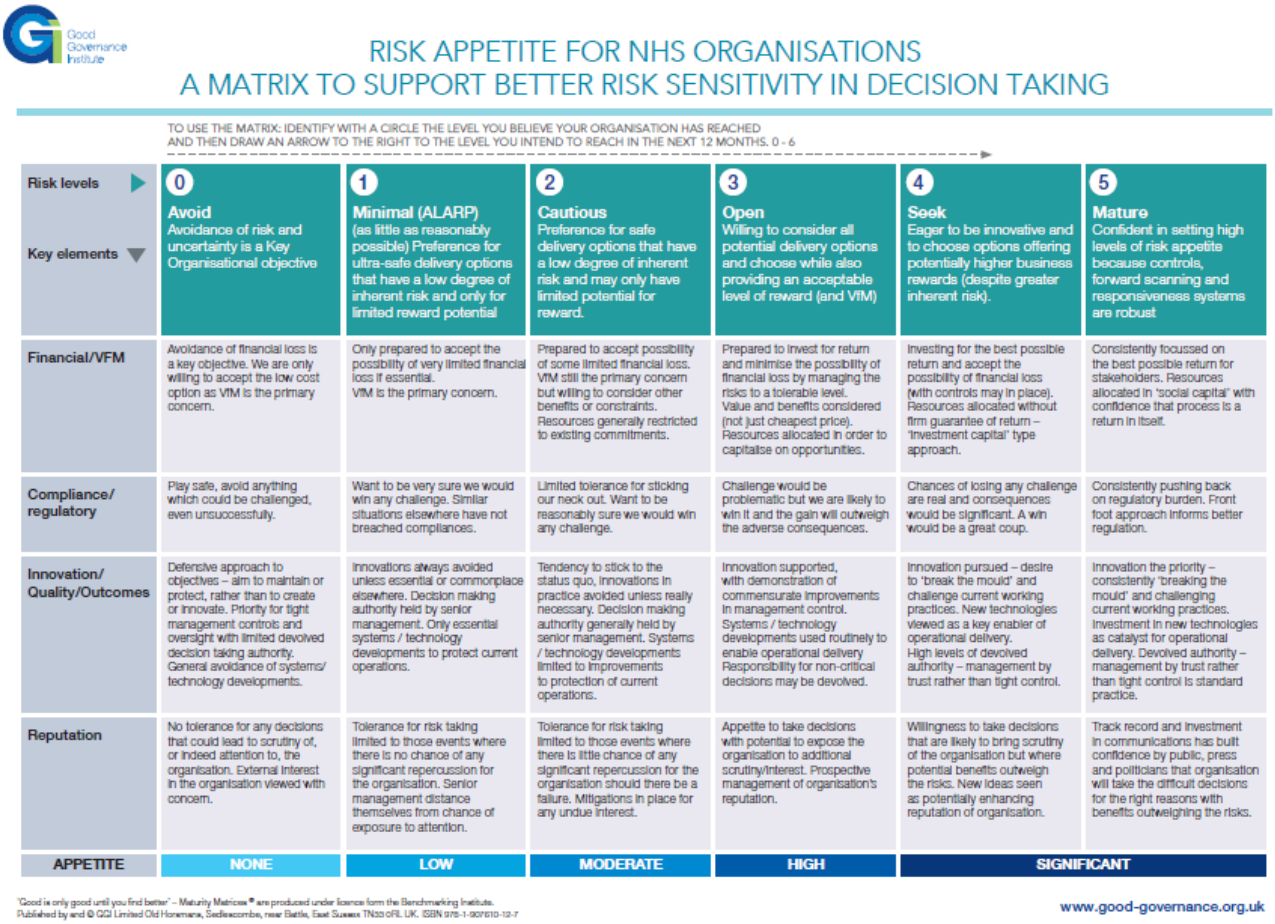
Level of Risk	Management Responsibility	Reviewed By	Risk Register
1-3 (low)	Individuals	Individual level review	operational/ project (as appropriate)
4-6 (moderate)	Line Managers	Team level review	
8-12 (high)	Heads of Service	Team level review	
15-25 (significant)	Senior Management Team	Audit Committee & Governing Body	Corporate Risk Register

9.16 Project risks will be considered at all levels on the form 1 used to approve the implementation of the project. Once a form 1 has been approved the risks pertaining to the project which score 9 or above, or have an impact score of 4 or more, will have a full risk assessment completed and will be added to the CCG project risk register.

9.17 The Governing Body may at any time request sight of the full risk register of the CCG.

Risk Appetite and Tolerance

Risk appetite is the level, amount or degree of risk that an organisation is willing to tolerate in order to meet their objectives. The CCG utilizes the Good Governance Institute matrix for risk appetite:



RISK APPETITE FOR NHS ORGANISATIONS
A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

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Risk appetite statement:

9.19 The CCG has no appetite for fraud and zero tolerance for regulatory breaches.

The CCG has zero tolerance for safeguarding, information governance, and reputational risk

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 is not cost effective or reasonably practicable.

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, knowledge are in place to support and manager the risk to support innovation and maximise opportunities for overall improvement.

The GBAF will measure each risk against its appetite so that when it is used to drive the Governing Body meetings, members are reminded of the risk tolerance that has been set.

Risk Registers

9.20 The risk register is a tool used by the CCG to effectively capture, manage and

escalate those risks which have been identified and may prevent delivery of the CCG's Strategic Objectives and associated operational delivery plans.

9.21 The CCG holds four key risk registers which are;

- Governing Body Assurance Framework: this contains the significant principal risks that could impact on the CCG achieving its strategic objectives
- Corporate Risk Register: this contains all risks with a score of 15 or greater
- Project risk register: this contains all risks associated with the CCG's integrated business plan
- Operational risk register: this contains all other areas of risk

9.22 Any risk scored at a level 15 or above will be included in the CRR and reported to the Audit Committee and Governing Body meetings.

9.23 Following review by the Audit Committee, risks may be added 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.

9.24 Ratings are assigned against project risks as follows:

- High – There is a high probability that this project will not be delivered within the agreed timescales.
- Medium - There is a possibility that this project will not be delivered within the agreed timescales.
- Low - We have every confidence in the ability to deliver this project within the agreed timescales.

9.25 The Group will also ensure that all new projects consider the risks involved. To capture this, a risk section is included in the Outline Business Case (form 1) template. Once a form 1 has been approved the risks pertaining to the project which score 9 or above, or have an impact score of 4 or more, will have a full risk assessment completed and will be added to the CCG project risk register. The project leads will continually review the risks to identify mitigations and actions to reduce the risk and ensure that all risks are escalated if required.

Monitoring and Reporting

9.26 Risk Registers will be reviewed, monitored, challenged and reported at the appropriate level in accordance with the table at 9.15.

9.27 Monitoring will be undertaken by the governance team, to ensure that all risks

are managed in accordance with their review date.

9.28 The risk rating should gradually decrease towards the target risk score as the planned actions start to be completed. Where this is not reducing, the actions to mitigate the risk will need to be reviewed to ensure they are appropriate.

9.29 Where review and challenge indicates that the score is likely to increase or decrease, this should be managed in accordance with the responsibility set out at 9.15.

9.30 Any risk that moves to a corporate level of risk should be notified to the governance team immediately.

9.31 The CCG will use the GBAF as the main tool 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.

9.32 The GBAF is a 'live' document which is updated to reflect changes in the risks as they occur. In this respect the risks are reviewed by the executive team and then submitted to the Quality and Performance Committee to enable any issues within the remit of the committee to be captured within the GBAF prior to its submission to the Audit Committee and Governing Body.

Closing Risks

9.33 The risk register will contain all the risks relevant to the CCG, its strategic objectives and associate work-streams that are being addressed.

9.34 Once a risk has reached its target rating and is at an acceptable level of risk, and all agreed actions have been completed it may be closed.

9.35 The decision to close any risks on the CRR must be submitted to the Management Executive Team. by the Risk Owner.

9.36 Where actions have reduced the risk but the residual risk remains at a corporate level and it is agreed that no further action can be taken to reduce the risk, the recommendation to close it whilst accepting the risk must be approved by the Management Executive Team.

9.37 Each GBAF risk will be considered as an accepted risk. The GBAF will document this assessment.

9.38 All risks with a score of 15 or above and all accepted risks will be submitted to the Audit Committee for scrutiny and to receive assurance on the process followed to

come to this decision.

Managing Risk across Organisational Boundaries

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

9.40 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.

9.41 The CCG will endeavor to involve organisations in all aspects of risk management as appropriate.

9.42 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.

10.0 Implementation and Distribution

10.1 The Risk Management Strategy will be published as part of the CCGs publication project following approval.

10.2 It will also be available to all CCG representatives and the public on the CCG website.

11.0 Training

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

11.2 Training will be made available based on the need of individual roles as appropriate. The governance team will provide support to all staff in the management of risk.

11.3 Training records will be held by the governance team.

12.0 Monitoring

12.1 The Risk Management Strategy is a rolling two year document. It will be reviewed earlier where changes in legislation or organisational structure occur or where best practice is identified.

12.2 The Governing Body will approve the Risk Management Strategy on recommendation from the Audit Committee.

12.3 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.

13.0 Links to Other Strategies / policies

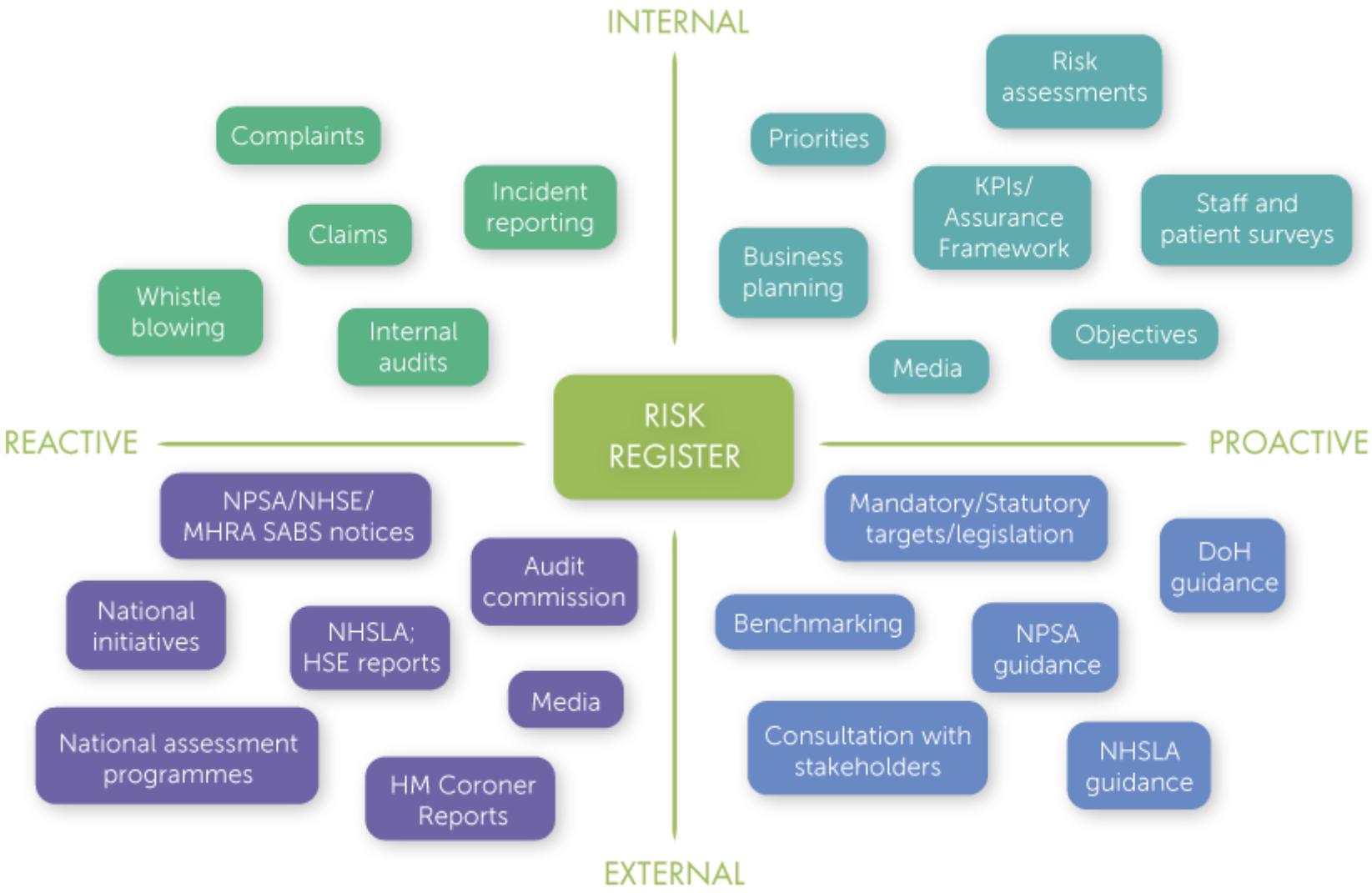
13.1 The Risk management Strategy links to the following key documents:

- Incident, Accident and Near Miss Policy
- Health and Safety Policy
- Information Governance Strategy, Framework and Policy
- Whistleblowing Policy
- Emergency Planning Resilience and Response Policy
- Business Continuity Management Policy
- Anti-Fraud, Bribery and Corruption Policy and Response Plan
- Customer Care Policy
- Claims Policy

14.0 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 201

Appendix A : Sources of Risk



Appendix B : Risk Matrix

Quantitative Measure of Risk – Consequence Score

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) 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 on	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/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces 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 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 Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
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

Qualitative measure of risk – Likelihood score

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/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

Quantification of the Risk – Risk score

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

Appendix C – Risk assessment form

Chorley and South Ribble Clinical Commissioning Group
Greater Preston Clinical Commissioning Group

GENERIC RISK ASSESSMENT FORM

This form is to be used for identification and mitigation plans for any risk within the organisation.

RISK INFORMATION	
Date:	**Risk reference (for governance team use)**
Risk description (brief description to populate the CCG Risk Register): There is a risk that: CAUSE If this occurs this may result in: EFFECT	
Have any incident forms been completed regarding this risk? Yes / No (Delete as appropriate)	
Which staff groups were involved in the assessment?	
Existent control measures: (measures which prevent or reduce the risk)	
Existent assurance measures: (confidence or guarantee that a risk is being managed appropriately)	
Gaps in Control: (measures which are needed to prevent or reduce the risk but are not yet in place)	

Gaps in assurance: (confidence or gurantee which is needed but not yet in place)

Risk Owner
Name:
Job title:
Department:

Initial Risk Rating (please refer to risk scoring matrix in appendix B)

Domain Descriptor
Used For Final Score

Consequence Score **(C)**
Likelihood Score **(L)**

Risk Score **(C x L)**

Target Risk Rating (once all actions complete)

Domain Descriptor
Used For Final Score

Consequence Score **(C)**
Likelihood Score **(L)**

Risk Score **(C x L)**

Action Plan

Further to the existing control measures, please outline here what additional actions could mitigate this risk once completed.

Issue	Action	Responsible person	Due date	Is this an action also on the Integrated Business Plan? (answer yes/no)
i.e. Explain what the issue is (there is a lack of… The department does not…)	*i.e. …to be established, …to be reviewed...to develop a*			