NHS
South Tyneside
Clinical Commissioning Group

Risk Management Policy

Ratified	Audit & Risk Committee
Status	Final
Issued	September 2018
Consultation	Executive Committee
Equality Impact Assessment	Complete
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Author	Senior Governance Manager, Senior Governance Officer, North of England Commissioning Support Unit
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Where this is an update to an existing policy:

Previous policy:	CO14 Risk Management Policy
Issue date of previous policy:	August 2014
Location of previous policy in policy archive:	S:\Archive

Policy Validity Statement

This policy is due for review on the date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Version Control

Version	Release Date	Author	Update comments
V1	28.02.13	Liane Cotterill	Policy provided to Clinical Commissioning Group (CCG) as part of policy suite
V1.1	28.08.14	Debra Elliott	Risk assessment and assessment guidance and associated changes regarding the management of risk including risk appetite. Safeguard Incident Risk Management (SIRMS) Risk Register Standard Operating Procedure (SOP) added.
V2	23.09.15	Debra Elliott	Policy updates & amendments - version 2 See Appendix D
V2 Extension	12/12/17	Debra Elliott	Extension to policy (version 2) Extension requested to enable NHS England Risk Management Policy 2017 Updates to be discussed across NE CCGs with NECS Governance team to promote a common and collective approach to risk reporting and management in line with NHS England guidance
V2.1	20/12/17	Jonathon Millington	Formatting changes and Reference to General Data Protection regulation (GDPR) and updated on best practice recommendations.
V2.2	23/05/17	Wendy Marley	Amended training section following Governance and Assurance Internal Audit report that highlighted that annual training no longer takes place. Removed 'Provider Management' from list of CCG delivery areas. Updated Archiving section to refer to NHS England Records Management Code of Practice for Health and Social Care 2016
V2.3	10/09/2018	Wendy Marley	Appendix A updated consequence descriptors in line with NHS England policy and tailored to South Tyneside CCG's finance limits.

Approval

Role	Name	Date
Approval	Audit & Risk Committee	28.08.14 (V1.1)
Approval	Audit & Risk Committee	23.09.15 (V2)
Approval	Audit & Risk Committee	12/12/17 (V2 Extension)
Approval	Audit & Risk Committee	March 2018 (2.1)
Approval	Audit & Risk Committee	May 2018 (2.2)
Approval	Audit & Risk Committee	September 2018 (2.3)

Review

This document will be reviewed twelve months from its issue date and every two years after its first review.

Contents

1. Introduction

For the purposes of this policy, NHS South Tyneside CCG's will be referred to as "the CCG". This policy aims to set out CCG approach to risk and the management of risk in fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding within the organisation of an effective risk management policy and processes will ensure that the reputation of the CCG is maintained and enhanced, and its resources are used effectively to reform services through innovation, large-scale prevention, improved quality and greater productivity.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

The purpose of this policy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The policy will:

Set out an organisation wide approach to managing risk, in a simple, straightforward and clear manner the intentions of the CCG for timely, efficient and cost-effective management of risk at all levels within the organisation.

The aims of the Policy are summarised as follows;

- to ensure that risks to the achievement of the CCG's objectives are understood and effectively managed
- support for staff to understand their role and have a consistent approach to risk management
- to ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed
- to assure the public, patients, staff and partner organisations that the CCG is committed to managing risk appropriately
- to protect the services, staff, reputation and finances of the CCG through the process of early identification of risk, risk assessment, risk control and elimination

The principles are consistent with those within the NHS England's Risk Management Policy and Process Guidance issued January 2015.

This policy applies to all employees and contractors of the CCG. Managers at every level have an objective to ensure that risk management is a fundamental part of the approach to integrated governance. All staff at every level of the organisation are required to recognise that risk management is their personal responsibility.

Independent contractors are responsible for ensuring compliance with relevant legislation and best practice guidelines and for the development and management of their own procedural documents. Independent contractors are required to demonstrate compliance with risk management processes which are compatible with this policy.

2. Definitions

The following terms are used in this document:

- **Risk** is the chance that something will happen that will have an impact on the achievement of the CCG. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring)
- **Risk Appetite** the organisation's unique attitude towards risk taking that in turn dictates the amount of risk that it considers is acceptable
- **Risk Management** is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects
- **Risk Assessment** is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk
- **Residual Risk** the risk remaining after the risk response has been applied

Examples of the types of risk that the CCG might encounter and need to mitigate against include:

- **Corporate risks** – operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues
- **Clinical risks** – associated with our commissioning responsibilities and including service standards, competencies, complications, equipment, medicines, staffing, patient information
- **Reputational risks** – associated with quality of services, communication with public and staff, patient experience
- **Financial** – associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme
- **Environmental including health and safety** – ensuring the well-being of staff and visitors whilst using our premises

3. Risk Management Framework

3.1 Whenever risks to the achievement of CCG's objectives have been identified, it is important to assess the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk matrix is used, details of which are provided at Appendix A CCG Risk Assessment and Escalation Process. The matrix in the assessment guidance is based on current national guidance, but also adapted to suit the CCG risk appetite.

3.2 Using this standardised tool will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

3.3 Risks are assessed in terms of the **likelihood** of occurrence/re-occurrence and the **consequences** of impact. In order to arrive at an overall risk rating of the residual risk, the risk is rated to take account of the effectiveness of the controls, i.e. whether they are considered to be satisfactory, have some weaknesses or to be weak. This then provides the overall residual risk rating. Once the residual risk rating is determined an action plan identifying further mitigating action is put in place. An overview of five categories of risk (See Appendix A for full details):

- **Catastrophic** – the consequence of these risks could seriously impact upon the achievement of the organisation's objectives, its financial stability and its reputation. Examples include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability
- **Major** – these are significant risks that require prompt action. With a concerted effort and a challenging action plan, the risks could be realistically reduced within a realistic timescale
- **Moderate** – these risks can be realistically reduced within a realistic timescale through reasonably practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements
- **Minor** – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department
- **Negligible** – these risks cause minimal or limited harm or concern

3.4 Once the category of risk has been identified, this then needs to be entered onto the CCG's risk register. Please refer to section 7.7 below for further guidance on risk registers.

3.5 Any risk that is identified through the risk assessment process (as well as the incident reporting system) and which the CCG is required legally to report will be reported accordingly to the appropriate statutory body, e.g. Health and Safety Executive or Information Commissioner.

3.6 There are a number of ways in which risks can be managed, including

- **Avoiding the risk** by not undertaking the activity generating the risk
- **Eliminating the risk** where this is possible and cost effective through the use of control measures
- **Reducing the risk** to an acceptable level if it can't be eliminated

- **Transferring the risk** either fully or in part to another body – this may not always be possible where the organisation retains statutory responsibility. Examples of transferred risk would be insurance arrangements, e.g. the NHS Litigation Authority, where the payment of premiums means that in the event of a claim arising it is the NHSLA that bears the financial risk, or through contractual arrangements, partnerships or joint working where there is shared risk etc.
- **Monitoring the risk** but taking no action, particularly where it is a relatively low risk or cannot be eliminated, reduced or transferred.

3.7 Risk Appetite

3.7.1 The CCG endeavours to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However there is the recognition that by understanding the organisation's 'risk appetite', this will ensure the CCG supports a varied and diverse approach to commissioning, particularly for practices to work proactively to improve efficiency and value.

3.7.2 Risk appetite is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time. It can be influenced by personal experience, political factors and external events. Risks need to be considered in terms of both opportunities and threats and should not be confined to money. They will also invariably impact on the capability of the CCG, its performance and its reputation.

3.7.3 The Governing Body will set boundaries to guide staff on the limits of risk they are able accept to in the pursuit of achieving its organisational objectives. The Governing Body will set these limits annually and review them as appropriate.

3.7.4 The Governing Body will set these limits based on whether the risk is:

- A threat: the level of exposure which is considered acceptable
- An opportunity: what the Governing Body is prepared to put 'at risk' in order to encourage innovation in creating changes

3.8 Risk Register

3.8.1 Current and potential risks are captured in CCG's Risk Registers and include actions and timescales identified to minimise such risks. The risk register is a log of risks that threaten the organisation's success in achieving its aims and objectives and is populated through the risk assessment and evaluation process.

3.8.2 If a risk materialises whilst it is being managed through the risk register, it should be recorded as an incident. Management of risks and incidents through SIRMS is interdependent since risks can be identified through the monitoring of incident themes and trends. If a particular type of incident continues to occur, this is an indication that there is a risk that requires management through the risk register.

3.8.3 If a risk materialises whilst it is being managed through the risk register, it should be considered whether it needs removing from the risk register. Reasons for occurrence should be analysed and evidence established as to whether a trend of similar incidents exists, that need to be managed through the risk register. If the risk is certain to materialise again or has the potential to re-occur, the risk should remain on the risk register for on-going management in order to ensure that underlying causes are addressed. If there is no chance it could happen again, the risk should be closed with an explanation that the incident management process is being followed in order to invoke actions to deal with consequences. A risk materialisation flowchart is attached at Appendix B.

3.8.4 The risk that has materialised should be recorded as an incident in SIRMS and the CCG's incident management process should be followed. See policy CO08 Incident Reporting and Management Policy.

3.8.5 Incident reports are reviewed at the CCG's committees, and this provides an opportunity for themes and trends to be picked up. The Audit and Risk Committee and Governing Body receive a report on a 6 monthly basis about non-clinical incidents. The Quality and Patient Safety Committee receives quality reports about clinical incidents reported by member practices. These reports might indicate that there is a strategic risk e.g. if a lot of practices are regularly reporting incidents around ambulance response times or referral problems. This is the most likely way that risks will be identified from incidents. It is highly unlikely that anything reported by CCG staff will become a risk e.g. information governance or health & safety incidents, although not impossible.

3.8.6 In addition to reports that are provided to the CCG's committees, the clinical quality team will share information with the governance team to allow them to assess whether there may be any risks that require management through the risk register. Information will be shared with the Director of Operations and Operations Manager.

3.8.7 The register contains a local record of all current and potential risks for each area or function that the CCG is accountable for, as identified by the appropriate function lead(s). The Registers are updated on a monthly basis and are reviewed on a quarterly basis as delegated by the Governing Body.

3.8.8 NECS produce the monthly risk register/exception report the day after deadline for risk register updates if there are any outstanding issues or overdue risks an escalation process is implemented. The escalation process is outlined in Appendix C STCCG Risk register escalation of overdue risks process flow chart

3.8.9 There is separate guidance which provides further detail and advice on the completion of risk registers, supported by a training programme for the leads involved in their completion. The Safeguard Incident & Risk Management System (SIRMS) Risk Register Standard Operating Procedure can be accessed via the CCGs internet.

4. Duties and Responsibilities

Council of Practices	The Council of Practices has delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Officer	The Chief Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements. In accordance with the Scheme of Delegation, the Director of Operations has responsibility for Strategic Risk Management including the Governing Body Assurance Framework.
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

5. Implementation

5.1 This policy will be available to all staff for use and be available through the intranet and public websites for the CCG.

5.2 The CCG has adopted a standardised framework for the assessment and analysis of all risks encountered in the organisation and which is set out in this policy. The implementation of this policy is achieved through the completion of the risk register. It is also supported by a detailed reporting structure through its various committees and which are described in the policy. Directors and senior leads will be responsible for ensuring the policy is implemented in their areas of responsibility and compliance with this policy may be monitored through a process of auditing as set out by the Governing Body.

5.3 The Governing Body has overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:

- Identifies risks to achievement of its delivery areas
- Identifies risks associated with transitional arrangements
- Monitors these via the Assurance Framework
- Ensures that there is a structure in place for the effective management of risk through the CCG
- Approves and reviews risk management policy on an annual basis
- EXTREME risks across all registers are reported to the Governing Body on a quarterly basis
- EXTREME, HIGH and MODERATE risks across all registers will be reported to the Audit and Risk Committee on a quarterly basis.
- EXTREME, HIGH and MODERATE quality and safeguarding risks will be reported to each formal meeting of the Quality and Patient Safety Committee with a view to their more in-depth consideration LOW risks will be considered solely at team level and overseen by the relevant lead Director
- Demonstrates leadership, active involvement and support risk management

5.4 The CCG will produce and maintain a Governing Body Assurance Framework (AF). The AF forms part of the overall governance arrangements of the CCG and is a key component of the organisation's internal control arrangements. The AF forms a significant part of the assurance given by the Chief Officer in the Annual Governance Statement. It will be prepared at the start of each financial year when the organisation's strategic objectives are known. It should be prepared with the involvement of senior leaders, reviewed by the Audit and Risk Committee. It will also be approved by the Governing Body and reviewed by it at least six monthly.

6. Training Implications

The Director of Operations will ensure that the necessary training or education needs and methods required to implement the policy and procedure(s) are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

The training required to comply with this policy is key to the successful implementation of this policy and embedding a culture of risk management in the organisation. Through a training and education programme staff will have the opportunity to develop more detailed knowledge and appreciation of the role of risk management. Training and education in risk management will be offered through regular staff induction programmes and a rolling programme of risk management and training programmes.

7. Related Documents

7.1 Other related policy documents

- NHS England policies
  - 10.1 POL - 1015 Risk Management Policy & Process Guide
  - 10.3 POL - 1002 Health & Safety: Policy & Corporate Procedures
  - 10.4 POL - 1003 Incident management: Policy & Corporate Procedures
  - 10.5 POL - Business Continuity Policy: Policy & Corporate Procedures

7.2 Legislation and statutory requirements

This Risk Management policy is developed with reference to NHS England publications and publications of expert bodies on governance and risk management:

- Data Protection Act 1998 to be superseded from May 2018 by the General Data Protection Regulation (GDPR)
- Principles and framework contained in the legislation including:
  Health and Safety at Work Act 1974
- Principles contained within the Information Governance toolkit
- Risk Management Matrix for Risk Managers National Patient Safety Agency (NPSA) (2008) ISO 31000 -2009

7.3 Best practice recommendations

- NHS Audit Committee Handbook 3rd edition (2014)
- Building the Assurance Framework: A practical Guide for NHS Boards March 2003. Gate log Reference1054
- Integrated Governance Handbook 2006 & The new Integrated Governance Handbook 2016:
- Intelligent Commissioning Board (2006 & 2009)
- Making a Difference – Review of Controls Assurance Gateway Ref. No. 4222
- NHS Litigation Authority – CNST Risk Management Standards (2013)
- Governing the NHS: A guide for NHS Boards (2003)
- Taking it on Trust – Audit Commission (2009) Institute of Risk Management
- The Healthy NHS Board: Principles for Good Governance (2010)
- Quality Governance in the NHS National Quality Board - A guide for provider boards (2011)
- HM Treasury guidance, Management of Risk: Principles and Concepts (2004)

8. Monitoring, Review and Archiving

8.1 Monitoring

The Governing Body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

8.2 Review

8.2.1 The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

8.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Governing Body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

8.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

8.3 Archiving

The Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

9. Equality Analysis

Partners in improving local health

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	**Senior Governance Officer, NECS**
Title of service/policy/process:	**CO14 - Risk-Management-Policy**
Existing: ☑ New/proposed: ☐ Changed: ☐	
What are the intended outcomes of this policy/service/process? Include outline of objectives and aims	
This policy aims to set out the CCG's approach to risk and the management of risk in fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding within the organisation of an effective risk management policy and processes will ensure that the reputation of the CCG is maintained and enhanced, and its resources are used effectively to reform services through innovation, large- scale prevention, improved quality and greater productivity.	

Who will be affected by this policy/service /process? (please tick)

☑ **Staff members**
☑ **Other**

If other please state:

Patients, Staff from other organisations, Public.

What is your source of feedback/existing evidence? (please tick)

☐ **National Reports** ☑ **Staff Profiles**
☐ **Staff Surveys** ☑ **Complaints/Incidents**
☐ **Focus Groups** ☑ **Previous EIAs**
☑ **Other**

If other please state:

- **Feedback from committee meetings where incidents are discussed**
- **Staff who contact the NECS Governance Sections for help and assistance where required**

Evidence	What does it tell me? (About the existing policy/process? Is there anything suggest there may be challenges when designing something new?)
National Reports	**NA**
Staff Profiles	**NA**
Staff Surveys	**NA**
Complaints and Incidents	**Buy in from reporters and managers**
Staff focus groups	**NA**
Previous EIA's	**NA**
Other evidence (please describe)	**NA**

STEP 2 - IMPACT ASSESSMENT

What impact will the new policy/system/process have on the following staff characteristics: (Please refer to the 'EIA Impact Questions to Ask' document for reference)
Age A person belonging to a particular age
None
Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
Positive impact, incidents will be reviewed and actions will be put in place to mitigate any further risk. Staff can get assistance to report and manager an incident from the NECS Governance Team if required.
Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self-perception.
None positive impact the policy enables this group to report risks
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
None
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.
None
Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
Positive impact, any risk to this group can be reported
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
Positive impact, any risk to this can be reported
Sex/Gender A man or a woman.
Positive impact, any risk to this can be reported
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
Positive impact, any risk to this can be reported
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
Positive impact, any risk to this can be reported

STEP 3 - ENGAGEMENT AND INVOLVEMENT

How have you engaged with staff in testing the policy or process proposals including the impact on protected characteristics?
No impact on the human rights of the public, patients or staff, all citizens rights respected in the incident process.
Please state how staff engagement will take place:
Via bulletins, communications, training sessions and contact with members of the NECS Governance Team who are always contactable for help and assistance.

STEP 4 - METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform staff of the policy?
☑ **Verbal – through focus groups and/or meetings** ☑ **Verbal - Telephone** ☐ **Written – Letter** ☑ **Written – Leaflets/guidance booklets** ☑ **Email** ☑ **Internet** ☑ **Other**
If other please state: **Via SIRMS (Safeguard Incident and Risk Management System)**

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
1. Continuous improvement of the risk reporting & management processes. Particular emphasis being made on making the process as user friendly as possible.	Buy in of all staff in the organisation

STEP 6- ACTION PLAN

Ref no.	Potential Challenge/ Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date
NA		All	**Risk Management Training to staff and incident managers to promote quality of risk reporting & data**	Positive - increased by in and awareness of process	**WM**	**Ongoing**
NA		**All**	**E-learning tool developed for risk awareness.**	Positive - increased by in and awareness of process	**WM**	**Ongoing**

Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?
NA	SIRMS users / Committee Members	CCG risk lead & Director of Operations.	Evaluation of training

SIGN OFF

Completed by:	**Wendy Marley**
Date:	**23/05/2018**
Signed:	***Wendy Marley***
Presented to: (appropriate committee)	**Audit and Risk Committee**
Publication date:	**September 2018**

Appendix A

Risk assessment and escalation process

Step 1: Determine the consequence score

This is offered as guidance when completing a risk assessment, either when an incident has occurred or if the consequence of potential risks is being considered.

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Note consequence will either be negligible, minor, moderate, major or catastrophic.

Table 1: Consequence score

	Impact score (consequence/severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Descriptor	**Negligible (very low)**	**Minor (low)**	**Moderate (low)**	**Moderate (high)**	**High**
Operational	Minor reduction in quality of treatment or service. No or minimal effect for patients / customers	Single failure to meet national standards of quality of treatment or service. Low effect for small numbers of patients / customers	Repeated failure to meet national standards of quality of treatment or service. Moderate effect for multiple patients / customers if unresolved.	Ongoing non-compliance with national standards of quality of treatment or service. Significant effect for numerous patients / customers 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.
Reputational	Not relevant to mandate priorities. No adverse media coverage. 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 patient / customer confidence.
Financial	Known or expected risk between £100k and £250k Unforeseen risk between £50k and £100k	Known or expected risk between £250k and £500k Unforeseen risk between £100k and £250k	Known or expected risk between £500k and £1m Unforeseen risk between £250k and £350k	Known or expected risk between £1m and £1.5m Unforeseen risk between £350k and £750k	Known or expected risk over £1.5m Unforeseen risk over £750k

Step 2: Determine the likelihood score

Now determine what is the likelihood of the impact occurring.
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. The frequency-based score will either be classed as rare, unlikely, possible, likely or almost certain.

Table 2: 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

Step 3: Assigning a risk rating

Now apply the consequence and likelihood ratings to give you a risk rating for each of the risks you have identified. Calculate the risk rating by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

Table 3: Risk rating = consequence x likelihood (C x L)

	Likelihood score				
Consequence score	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

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

Green	1 – 3	Low
Yellow	4 – 6	Moderate
Amber	8 – 12	High
Red	15 - 25	Extreme

Step 4: Control measures

Consider the control measures that should be in place to mitigate the risk. Identify and record any gaps in controls.

Step 5: Assessing the effectiveness of control(s)

For each of the risks (and especially extreme and high risks) identify the controls that are in place. For example, in an operational setting and where an incident may have occurred, the controls may take the form of a policy, guideline, procedure or process, etc. For risks that have been identified as preventing achievement of organisational objectives then the control is likely to be a management action plan.

Table 4: Assessing the effectiveness of control(s)

Review the control(s) for each of the risks and apply the following criteria:

Satisfactory:	Controls are strong and operating properly, providing a reasonable level of assurance that objectives are being delivered.
Some Weaknesses:	Some control weaknesses/inefficiencies have been identified. Although these are not considered to present a serious risk exposure, improvements are required to provide reasonable assurance that objectives will be delivered.
Weak:	Controls do not meet any acceptable standard, as many weaknesses/inefficiencies exist. Controls do not provide reasonable assurance that objectives will be achieved.

Step 6: Align the risk to corporate objective/delivery area

The risk should be aligned to the delivery area that it will impact on.
South Tyneside delivery areas are:

1. Performance
2. Finance & QIPP
3. Organisational
4. Quality and Safeguarding

Step 7: Align to objective

The risk should be aligned to the organisational objective that it will impact on.
South Tyneside objectives are:

1. Achieving commissioning objectives as specified in commissioning plan 2014/15 – 2019/20 and BCP Plan.
2. Maintaining financial balance.
3. Ensuring the commissioning and delivery of quality and safe services, including meeting our safeguarding responsibilities.

Step 8: Developing an action plan
An action plan must be developed for all risks with a score of 15 or above. However, it is useful to develop an action plan regardless of risk score in order to record progress on control measures and who is responsible for carrying them out.

Step 9: Determine the frequency of review
The frequency of review should also be specified as this will need to be added to SIRMS 'Review Details' section by choosing the appropriate option from the drop down list.

Risk Updates

Risks should be reviewed and updated on a regular basis.

Please follow the guidance below:

- Before entering your update, ensure you have created a new version by clicking on 'New Version'.

- Scroll down to 'Controls and Assurances', click on each control measure in turn and edit to enter the assurance against each control. You will also need to alter the control effectiveness accordingly. You can also enter any new controls. *NB: As long as you have created a new version you can overwrite the assurance from the previous version as this will be archived in the previous version, and will provide an audit trail of progress. This will ensure that only the current position is seen on the printed risk register.*

- Scroll down to 'Action Plan', add any 'New' actions and update any existing actions by clicking on each action in turn and edit to provide an update on progress where possible. *NB: Please ensure you provide your update in the 'Progress' section.*

- Scroll down to 'Review Details', click on 'New' and enter the actual 'Review Date' (you can use the calendar for this). Please also enter the name of the person the risk was 'Reviewed By'. Then, in 'Details of Review' please describe what has been updated, e.g. controls and assurances; action plan; changes to residual risk rating. This section can also be used to highlight where (i.e. which committee) the risk will be discussed and also if closure is recommended.

- Scroll down to 'Residual Risk Rating' and where appropriate enter/amend the residual consequence and likelihood scores. Remember, this should correspond with the 'Risk Level' at the top of the form.

Residual risk rating

This is the consequence and likelihood after the control measures have been applied and actions on the action plan have been implemented. Taking into account the initial risk rating and the assessment of the effectiveness of the control together, you can now assess the residual risk that needs to be managed. The consequence and likelihood ratings should be applied, as in table 3 above.

Risk Management Action Guide

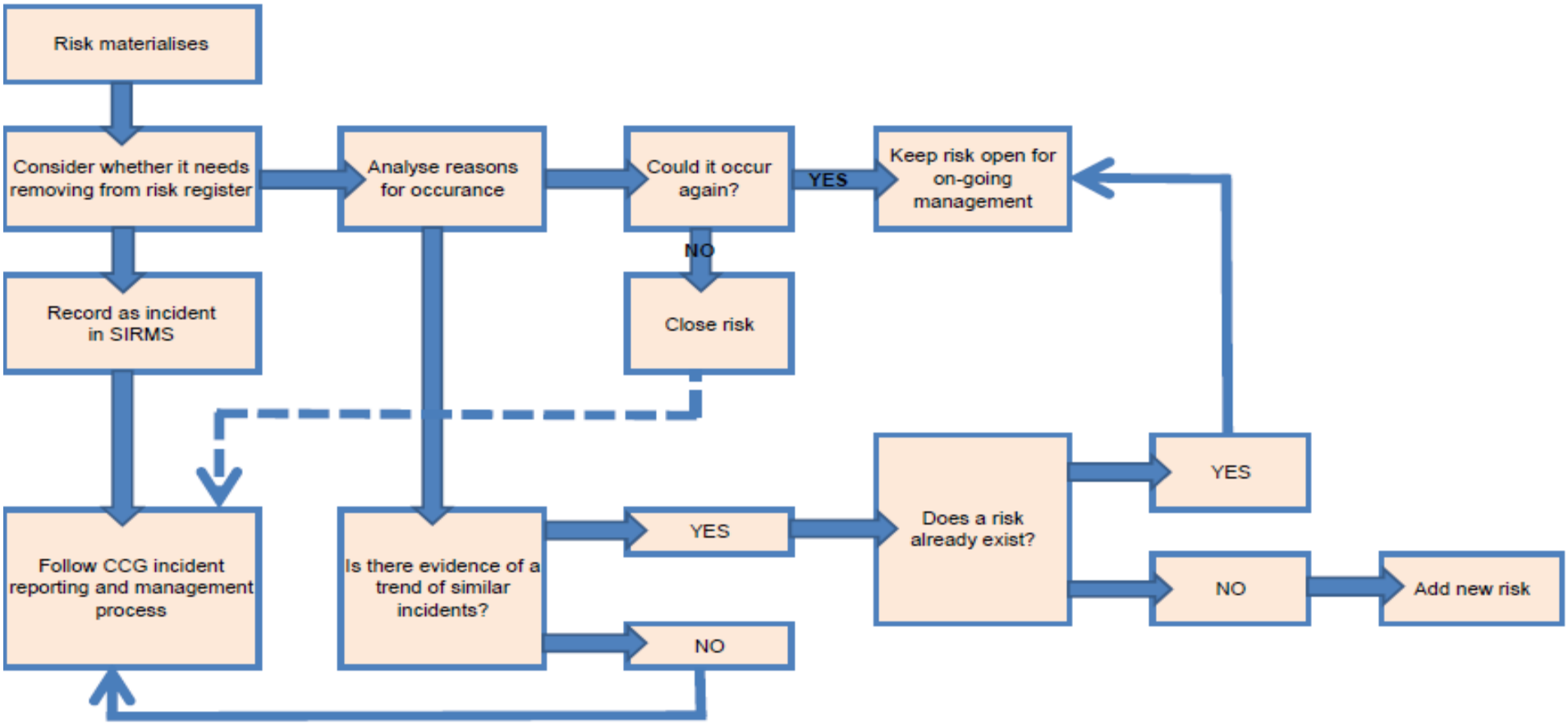
Where risks have been identified and scored, then the following escalation arrangements should be used.

The table below provides a suggested action guide for the management of a risk:

Risk Rating	RAG Rating	Action	Level of Authority
25	Red	Halt activities **IMMEDIATELY** and review status	Warrants Chief Officer attention
15 -20	Red	Significant probability that major harm will occur if control measures are not implemented **URGENT** action required. Director may consider limiting or halting activity	Warrants Director attention
8-12	Amber	Unacceptable level of risk exposure which requires constant monitoring and controls at Directorate level	Warrants Director attention
4-6	Yellow	Moderate probability of moderate harm if control measures are not implemented. Action in mediate term	Warrants Head of Service/Senior Lead Attention
1-3	Green	The majority of control measures are in place. Harm severity is small. Action may be long term	Warrants manager attention

Appendix B

Risk Materialisation Flowchart



Appendix C

STCCG Risk Register Escalation of Overdue Risks Process Flowchart

NECS produce risk register/exception report the day after deadline for risk register updates

Operations Manager review above to identify any risks with review overdue or missing information

If there are any issues Operations Manager to contact risk owners and lead directors to ask that risks are again reviewed and updated with a deadline of two working days

NECS produce a further risk register following day

Risk register reviewed again and any outstanding issues escalated to Director of Operations

Appendix D

Risk Management Policy version 2.2 May 2018

Updates and Amendments summary

Page & section	Updates & amendments	Reason
p. 12 6.	**Updated** - Training and education in risk management will be offered through regular staff induction programmes and a rolling programme of risk management and training programmes.	Amended training section following Governance and Assurance Internal Audit report that highlighted that annual training no longer takes place.
p. 14 8.3	**Updated -** Records Management code of practice for Health and Social Care 2016	Updated Archive section to reflect new records management code of practice issued in 2016.
p. 26	**Updated –** Removed 'Provider Management' from list of CCG delivery areas.	Head of Operations agreed at risk review meeting on 02/05/18 that 'Provider Management' deliverables would fall under 'Performance' delivery area.
p. 22	**Updated –** Consequence descriptors	Head of Operations agreed at regional CCG governance meeting to adopt the new consequence descriptors in line with NHS England policy.