Item Number: 615

Meeting Title: Governing Body	Scarborough and Ryedale Clinical Commissioning Group
Meeting Date: 23rd January 2019	
Report's Sponsoring Governing Body Member: Philip Hewitson	**Report Author:** Head of Corporate Services

1. Title of Paper: Risk Management Framework

2. Strategic Objectives supported by this paper:

To create a viable & sustainable organisation, whilst facilitating the development of a different, more innovative culture.	☒
To commission high quality services which will improve the health & wellbeing of the people in Scarborough & Ryedale.	☐
To build strong effective relationships with all stakeholders and deliver through effectively engaging with our partners.	☐
To support people within the local community by enabling a system of choice & integrated care.	☐
To deliver against all national & local priorities including QIPP and work within our financial resources.	☒

Executive Summary:

The risk register is one of the major vehicles for managing the CCG's risks or in deed any reputable organisation, surrounding risks which may expose the CCG from achieving of the strategic goals of an organisation. The requirements to manage such risks are well documented from many established forums including;

- the Institute of Company Secretaries) and Administrators (ICSA)

and the

- the Chartered Institute of Public and Financial Accountants (CIPFA)

who are both recognised by the NHS as leaders in this field.

The risk register is not just a place to register all the problems an organisation may have, but a live document which should record, monitor, mitigate, progress and ultimately remove any such risks. To this end it must have a risk owner who is responsible for recording that risk and putting in place remedial actions to reduce that risk to an acceptable appetite for the CCG.

In addition the risk should be monitored at every committee meeting and be given updates on progress or not given by the risk owner. This can be done in a written exceptions report to the committee at each meeting and recorded in the minutes. This report with include any treads, significant changes and on any risk which have been identified for closure and removal for the said committee to approve this action, prior to transfer to the Closed Risk Register, this

necessary for audit purposes.

It should be remembered that when an action has occurred and nothing else can be done then it is no longer a risk, and should be removed from the risk register. This may be superseded by a risk as a fall out from the action.

The below document outlines the process which the new format will follow if approved and will replace the current Risk Management Framework Policy.

This process has been previously outlined and presented at all the CCG's committees and has been approved to be recommended for adoption by the Audit and Governance Committee in November 2018.

This risk management framework will work across numerous separate bodies if required to do so.

3. Risks relating to proposals in this paper:

Failure to manage all risks with due diligence

4. Summary of any finance / resource implications:

nil

5. Any statutory / regulatory / legal / NHS Constitution implications:

Good governance dictates that every organisation has an active risk register

6. Equality Impact Assessment Completed? (Yes/No/Not Relevant):

Not relevant

7. Quality Impact Assessment Completed? (Yes/No/Not Relevant):

Not relevant

8. Any related work with stakeholders or communications plan:

Not relevant

9. Recommendations / Action Required

Approve introduction of revised Risk Management Framework

10. Assurance

Prvide clear assurance that all risks are being monitored and managed in accordance with

current guidance.

For further information please contact:

Name: Robert Irwin
Title: Head of Corporate Services
Phone number: 07866 948619

Introduction

The risk register is one of the major vehicles for managing the CCG's risks or in deed any reputable organisation, surrounding risks which may expose the CCG from achieving of the strategic goals of an organisation. The requirements to manage such risks are well documented from many established forums including;

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- the Chartered Institute of Public and Financial Accountants (CIPFA) who are recognised by the NHS as leaders in this field.

The risk register is not just a place to register all the problems an organisation may have, but a live document which should record, monitor, mitigate, progress and ultimately remove any such risks. To this end it must have a risk owner who is responsible for recording that risk and putting in place remedial actions to reduce that risk to an acceptable appetite for the CCG.

In addition the risk should be monitored at every committee meeting and be given updates on progress or not given by the risk owner. This can be done in a written report or verbally the committee at each meeting or verbal and recorded in the minutes.

It should be remembered that when an action has occurred and nothing else can be done then it is no longer a risk, and should be removed from the risk register. This may be superseded by a risk as fallout from the action.

Any risk over the score of 15 should be transferred to the Corporate Risk Register for the information of the Governing body to either question or challenge that risk. Only risks over the rating of 15 should be on the risk register to be discussed at committee level and ultimately the Governing Body, and thereafter publicised.

The Committee and Governing body should ensure an action plan is in place to managed and if possible diminish that risk, reporting the progress of the risk on at least a monthly basis whilst remaining over at 15 or over rating. The Senior Risk Owner (SRO) can delegate to a manager to manage and report

on the risks, the SRO can delegate to a suitable manager to monitor and report on a risk on their behalf, but remain the ultimate person for that risk..

Included is a column for “Target Risk Assessment” which should indicate at what point the risk is acceptable as being manageable in the foreseeable future.

When a risk is increased on the register, a separate report is need to the committee to outline why the risk has increased providing the necessary evidence. It is then up to the committee to accept or reject that risk increase, and if necessary adding to the Corporate Risk Register or if sufficiently significant to the Board Assurance Framework. This should include the date and reference the necessary report substantiating this.

Changes

The following changes be made to the Committee Risk Register and if acceptable to all risk registers within the CCG:-

1. Corporate Service Manager to be the conduit and supply for all committee risk registers and the Corporate Risk Registers.
2. Each of the high level committees has its own risk register which in turn updated at every meeting and supplied to Corporate Services immediately after the meeting. Only risks over 15 will then be automatically elevated to the Corporate Risk Register. Thus at Committee and Governing Body level that only those deemed very important risks, are open to challenge and discussion.
3. When a risk is added to the risk register, a date of insertion needed to be added so that it can been seen how long the risk has been present. This could give information as to possibly reducing the rating. Risks over 12 months old should be deleted or modified to reflect the current business year; this demonstrates that risks are still pertinent to the current timeframe and not left in by error.
4. Risks 15 or over after one month should be accompanied by a written monthly report on progress by the Senior Risk Owner or suitable manager, this includes any risk which has progressed from a low rating but has increased to a rating 15 or over, which attracts a resume of why the risk has increased. This enables the relevant Committee to be aware of the increase and accept or reject the increase, and be aware of the situation and if necessary give direction.
5. Whilst the lead manager or Senior Risk Owner which the correct name is responsible for a risk, it is not expected that they should manage the risk month by month but could delegate the management to another manager to do so and if 15 or over, they then must supply a monthly monitoring report to the Corporate Services team, this demonstrates

that the risks are being managed and I nine with the recommendations of the above bodies and NHSE.

6. “Actions Required” needs to be amended to include “Actions Taken” to mitigate the risk and any intended actions to do the same. This should also outline the reasons why a risk has increased in the ratings and the date this occurred thereby documenting a clear commentary on progress or not.
7. There needs to be an additional column giving the date of the next update is due, so that the Corporate Services team can if necessary ensure required update reports are available for the Committee from the SRO or their delegated manager.
8. Each Committee should have its own risk register which is explored, if possible mitigated as to the level they see the risk at. The accepted register should then be returned to Corporate Services to allow any risks 15 or over to be elevated to the Corporate Risk Register for future challenge.
9. The Head of Corporate Services or their deputy should attend each committee meeting to ensure consistency and provide any advice needed to manage the risks and give an overall assessment of their risk register. This will be accompanied by an exceptions report outlining any treads or new risks which have occurred since the last meeting. Also include will be list of any risks which have been closed by the SRO since the last meeting. The committee should approve the closures and this be minuted. These risks will then be transferred to the closed risk register for audit purposes. These will not be represented at the Business Committee of the Governing Body meetings as this is responsibility of the owning committee.
10. The Corporate Risk Register to remain a standing item on the Business Committee agenda and the Senior Management Team agendas, the meeting before the Governing Body meeting. This will enable the contents to be an oversight of the issues before the Governing Body meeting and being disclosed on the CCG website.

Supporting Documentation

To enable the above to happen and support Governing Body members, Directors, and Managers the new Corporate Risk Register and Assurance Framework Policy will outline how to record and monitor risks. Contained within is clear step by step guidance, which requires action at identified steps and by who.

Included within the document which is in effect a management information system, is how to assess and manage risk at the various levels, with regular reports needed to be supplied at specific levels, for example anything above a

15 final score requires a monthly report to the Corporate Services Manager outlining what actions if any have been taken in the preceding month.

All risks confirmed by the Business Committee as 15 or above will be shown on the Corporate Risk Register which eventually could possibly be seen by the public.

This policy will also contain all committees Terms of Reference which should be reviewed every year, which will ensure that their renewal is manageable and reviewed in a timely manner.

Full training presentations have been assembled to present to all staff and a workshop will be arranged as soon as possible to the Governing Body, individual 1-2-1 sessions are available to another who requests one.

Conclusion

Whilst this may seem an increase in work, the majority will be by the Corporate Services Team and the actual risk register presented to the governing body and the public will be reduced in size and content, in addition be given in a clear manner, with all information present to be able to accept or challenge the risks displayed.

A full committee risk register will be made available for the agenda for each committee via the Corporate Service team or at any other time should they wish to see it. This will allow the committee to focus on the important issues.

I ask that this report be accepted and implemented.

Robert Irwin
Head of Corporate Services
4th January 2019

NHS
Scarborough and Ryedale
Clinical Commissioning Group

RISK MANAGEMENT and ASSURANCE FRAMEWORK POLICY
January 2019

Authorship:	Head of Corporate Services			
Committee Approved:	Audit and Governance Committee			
Approved date:	November 2018			
Review Date:	January 2022			
	Relevant	Screening	Full / Completed	Outcome
Equality Impact Assessment	*Yes/No*	*Yes/No*	*Yes/No*	*Issues Identified / No Issues Identified*
Sustainability Impact Assessment	*Yes/No*		*Yes/No*	*Issues Identified / No Issues Identified*
Privacy Impact Assessment	*Yes/No*	*Yes/No*	*Yes/No*	*Issues Identified / No Issues Identified*
Bribery Checklist	*Yes/No*		*Yes/No*	*Issues Identified / No Issues Identified*
Target Audience:	Staff			
Policy Reference No:	SCRCCG P418			
Version Number:	V.0.1			
Publication/Distribution	Website	Email Staff	Others (i.e. SBC)	
	Yes/No	*Yes/No*	*Yes/No*	

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by & Date	Date on Intranet
V0.1	Head of Corporate Services	Refresh	SMT January 2019	XX

Approval Record

Applicable ☒	Committee / Group	Consultation / Information/ Ratification	Date taken to group	Date last Approved
☒	Audit and Governance Committee	Information	26/10/18	
☐	Business Committee	Choose an item.		
☐	Communications and Engagement Committee	Choose an item.		
☐	Council of Clinical Representatives	Choose an item.		
☐	Finance and Contracting Committee	Choose an item.		
☒	Governing Body	Information	23/1/19	
☐	Quality and Performance Committee	Choose an item.		
☐	Remuneration Committee	Choose an item.		
☒	Senior Management Team	Ratification	14/1/19	
☐	All Employees	Choose an item.		
☐	Public	Choose an item.		
☐	Yorkshire and Humber Social Partnership Forum	Choose an item.		
☐	Other	Choose an item.		

Note: A new policy only needs to be ratified by the appropriate Committee (and the Governing Body if new) and for information only to the other committees after consultation.

Policies should following the following ratification process. The delegated committee for ratification is specified in Section 15.

Version control should also be managed as outlined below where x = current version number and y = the new version number.

Consultation and Ratification Process	Version Number
Reviewed policies should be circulated to staff for comment prior to ratification	V x.1
HR policies and policy changes directly impacting on staff should be sent to the Social Partnership Forum for Union consultation prior to ratification	V x.2
Reviews and minor amends should be ratified by the delegated Committee	V x.3
All new policies and policies where significant changes have been made should be ratified by the delegated Committee and Governing Body	V x.4
Ratified policy is circulated and published (if appropriate) on the website	V y.0

Contents

This policy has been assessed for the Data Protection Impact Assessment, Equality Impact Assessment and the sustainability Impact Assessment. These assessments are recorded in the relevant registers and available to view from Corporate Services team.

This policy complies with the Bribery Act as indicated on the Front Cover of this policy.

1 INTRODUCTION

1.1 Risk Management is not just the responsibility of one role or person within an organisation; it's everyone's responsibility'.

1.2 The Scarborough and Ryedale Clinical Commissioning Group (CCG) attaches great importance to the effective management of risks that may be faced by customers, service users, staff, members of the public and other stakeholders and by the CCG itself.

1.3 Supporting the quality of care delivered and the promotion of health across the health economy are both vital elements in the philosophy and culture of the CCG, which are embodied in its staff. Ensuring risks are managed effectively, consistently and systematically must become an integral part of everyday practice throughout the organisation.

1.4 It is imperative that a culture of transparency and honest reporting is promoted and upheld throughout the CCG to ensure risks are properly identified, evaluated, documented and managed, and where necessary shared with customers.

1.5 The CCG is committed to a strategy which minimises risks wherever possible. It provides a robust framework that is underpinned by the concepts of effective governance and other systems of internal control that enables the identification and management of acceptable and unacceptable risks.

1.6 To support the development of a proactive risk management approach across the organisation the CCG commits to:

- Embed effective organisational governance arrangements that respond to strategic change, secure the safety and experience for customers, service users and staff, and support high quality and effective service delivery;
- Accountability and Responsibility – from leading, and from supporting, staff;
- Performance Management and Compliance with NHS Regulatory Standards.

1.7 This Framework has been updated to reflect the NHS England Risk Management Strategy & Policy. It will be reviewed annually or when procedural, legislative or best practise changes occur. The Risk Management Framework should be seen as part of a collective assurance framework to be used in conjunction with other CCG policies, in particular:

- Standing Orders and Standing Financial Instructions
- Adverse Incident Reporting Policy
- Assurance Framework and Risk Register Guidance

1.8 Other Policies and procedures outline specific guidelines in respect of safety for service users, staff and visitors and should be referred to as appropriate.

1.9 An internal control system is key to managing risk, providing reasonable assurance to all stakeholders that there is a systematic process for identifying, evaluating and prioritising the extent of risks and managing them efficiently, effectively and economically. It is

widely recognised that an effective planned, organised and controlled approach to risk management is a cornerstone of sound management practice.

1.10 The CCG Executive Team is supported by a governance structure within which responsibility for managing risks and reporting them lies. The Executive has three principal roles:

- To ensure delivery of key corporate objectives [**STRATEGY**]
- To provide overall leadership to the organisation within a clear framework of values and behaviours [**GOVERNANCE**]
- To make sure that appropriate systems and controls are in place to deliver the objectives [**ASSURANCE**]

1.11 The work of the Executive is supported in this respect by the Senior Management Team of the CCG, who have the responsibility to monitor, scrutinise and challenge.

1.12 The CCG's risk appetite (see Glossary) will be determined on a periodic basis in line with the review of this framework, cognisant of the developing and maturing of the CCG's risk assessment regime.

1.13 The Risk Management Framework and related policies, as well as the Risk Register, have been developed to support the CCG's overall Assurance Framework and to ensure actual and potential risks within the organisation are identified and action taken to eliminate or mitigate the potential impact on service users, staff and the CCG.

1.14 This Framework sets outs the responsibilities and the reporting structures in place, and applies to all areas of the CCG, both clinical and non-clinical controlled approach to risk management is a cornerstone of sound management practice.

2 ENGAGEMENT

2.1 Explain which groups and/or individuals have been involved in the development of the policy and the outcomes. This could include – staff, unions, other internal departments, external organisations, service users, members of the public.

3 IMPACT ANALYSES

3.1 Equality

3.1.1 In developing this policy, an Equality Impact Analysis (EIA) has been undertaken and the results are published with this policy on the CCG website. As a result of the initial screening, the policy does not appear to have adverse effects on people who share protected **characteristics** and no further actions are recommended at this stage. The details are held on the Equality Impact Assessment register held by Corporate Services.

3.2 Sustainability

3.2.1 The policy has been assessed against the CCG's sustainability themes using a sustainable impact assessment (SIA) and there is no anticipated detrimental impact. The

details are held on the Sustainability Impact Assessment register held by Corporate Services.

3.3 Bribery Act 2010

3.3.1 The Bribery Act **does not apply** to this policy.

3.4 Privacy Impact Assessment

3.4.1 A privacy impact assessment has bene undertaken in accordance with the Data Protection Act 2018 and the Information Commissioner's Office guidance and this document has no impact on privacy. The details are held on the Privacy Impact Assessment register held by Corporate Services.

4 SCOPE

4.1 This policy applies to:-

- All employees of the CCG
- CCG Governing Body
- Contracted third parties (including eMBED and agency staff)
- Students and trainees
- Staff on secondment and other staff on placement with the CCG.

5 POLICY PURPOSE AND AIMS

5.1 The purpose and objectives of this policy are to protect the CCG along with its customers, service users, staff and other stakeholders, as well as the assets of the CCG, whilst ensuring delivery of its strategic and corporate objectives which are:

- To obtain an enhance perception of the CCG by the public we serve.
- To develop a more efficient organisation and reduce overhead costs.
- To continue to enhance our operating model and working practices during 2018/19
- To improve staffs perception that they are a valued part of the organisation.

5.2 The CCG adopts a systematic process of risk assessment based on the standard matric (see Appendices 2 and 4)

5.3 This process enables the assessment and the prioritisation of risks and allows for the identification of risks which would be considered unacceptable to the organisation. Informed decisions on acceptable risks will reflect the financial capacity to fund or manage the risk, the impact on service provision and extent of risk control possible.

5.4 Arrangements for validating and managing the treatment of risks are secured at Director level, however, decisions on the management of unacceptable risk, which cannot be managed corporately, the Audit Committee will monitor the threats to achieving the strategic objectives by monitoring those risks recorded on the Corporate Risk Register.

5.5 When determining the risk exposure, reference should be made to national/authoritative standards wherever possible e.g. NHSLA, CQC, DoH.

5.6 The CCG recognises the concept of systems failure and latent issues, which expose individuals and the CCG to unavoidable risk. The CCG also recognises that human error can occur and promotes a culture of openness.

5.7 In summary the CCG's overall risk management priorities are:

Risk Management Priority	**Development required**
To develop a risk awareness culture throughout the CCG	Incorporate risk management as part of the induction programme for all new staff
To embed consideration and assessment of risk in all aspects of planning, delivery and contracts	Continue to embed risk management training for all managers and staff, including Governing Body and Lay members
To maintain effective organisational structure for risk management so that a consistent approach is taken	Ensure that risk registers and mitigation action plans are implemented and monitored in all areas and kept up to date. This will be achieved through regular reviews of all risks at Governing Body- Committee, SMT and function levels with achievable target dates. Applying findings of independent reviews by other external assessment processes. Reviewed by internal audit
To ensure there is continued progress in the implementation of effective risk management across the organisation.	CCG Governing Body, Audit and Governance Committee and SMT will review relevant risk registers at their meetings. Incorporated risk management into senior managers (Band 8a to Governing body) annual staff appraisals. Make Risk management a regular item on each committee (with risks) with sufficient time to discuss Ensure that strategic plans, business plans and projects properly address and record risks.
To manage risks to the reputation of the CCG and its members.	Manage public relations and the image of the CCG. Effective external and internal communications via newsletters, website, and publications. Actively promote public and patient involvement. Actively promote partnership working.

6 RISK REGISTER

6.1 The Risk Register will be held at corporate level and will be reviewed for completeness, accuracy and consistency by the Senior Management Team.

6.2 Escalation of local risks (Team/Function) to corporate level is completing a form (APPENDIX 3) a risk rating 15 and above and be will be communicated to the Director for Finance re and highlighted to Senior Management team and Business Committee.

6.3 Any opportunities for improvement in controls and assurances are translated into action plans under specific named managerial control so that monitoring, tracking and reporting can be supported with clear target dates and milestones where appropriate.

6.4 Risk Identification

6.4.1 Risks will be identified in several ways; however, this should always be in the context of achieving a strategic, corporate, or departmental objective:

- As part of reviewing national, strategic, corporate, function, specialty, personal objectives
- Through adverse incident, near miss reporting and incident investigation (the objective will be to secure against a repeated similar event, Root Cause Analysis – see below)
- From complaints and claims (as above)
- By staff identifying risks in their work area
- As a result of the systematic CCG wide risk assessment process
- As a result of external reviews and audits.

6.4.2 Risks identified must be captured on the CCG Risk Register. Managers should ensure that staff with responsibility for updating and maintaining the system are provided with training and that regular reviews take place of the information held on the system.

6.4.3 Each risk will have a nominated lead officer and Director with responsibility for the on-going update and review of individual risks. Strategic risks will be the responsibility of the Managing Director, although day to day management may be delegated to another Lead Director.

6.4.4 Once a risk has been identified and accepted in a committee, it will be the responsibility of the chair to mitigate or accept that risk and ensure a risk assessment form (appendix 30 has been submitted to the Corporate Service team as soon as practicable.

6.5 Risk Analysis

6.5.1 The CCG has agreed risk assessment tools which allow for the continuous and systematic analysis of likelihood and consequence in determining the severity of risk. The tools allow for assessment of risk across the range of clinical and non-clinical issues within the corporate objectives and SIPs. In analysing risk it is important that the risk context is considered including stakeholders, service users, public, staff and health economy partners. The risk assessment form and matrix can be found at Appendix 2 and 3. Root Cause Analysis (RCA) is a method of problem solving aimed at identifying the root causes of untoward incidents or events in order to prevent them from re-occurring. The Practise of RCA is predicated on the belief that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the

immediately obvious systems. RCAs should be a carried only by suitably trained managers form a difference team.

6.5.2 The CCG is committed to directing resources towards those measures that are corrective, with the aim of reducing the likelihood of the problem recurrence. However, it is recognised that complete prevention of recurrence by a single intervention is not always possible; therefore RCA is an iterative process and a tool for continuous improvement, helping to identify risks that need to be escalated.

6.6 Risk Treatment and Management (action planning)

6.6.1 The risk register system also allows for the development of action plans to address any gaps which have been identified as part of the risk assessment process. Each Risk is assigned to a Director or Operational Lead, allowing for ownership of the associated actions and changes to be made in line with circumstances. Where actions are identified, a date is included for the action to be completed.

6.7 Risk/Issues Log

6.7.1 The CCG recognises that its relationships with other agencies may lead to the identification of risks that are not within the control or indeed the responsibility of the CCG itself. However, where risks involving or directly affecting external organisations are identified, a log will be maintained recording when and with whom the risk has been shared, and whether the risk has been accepted by that organisation.

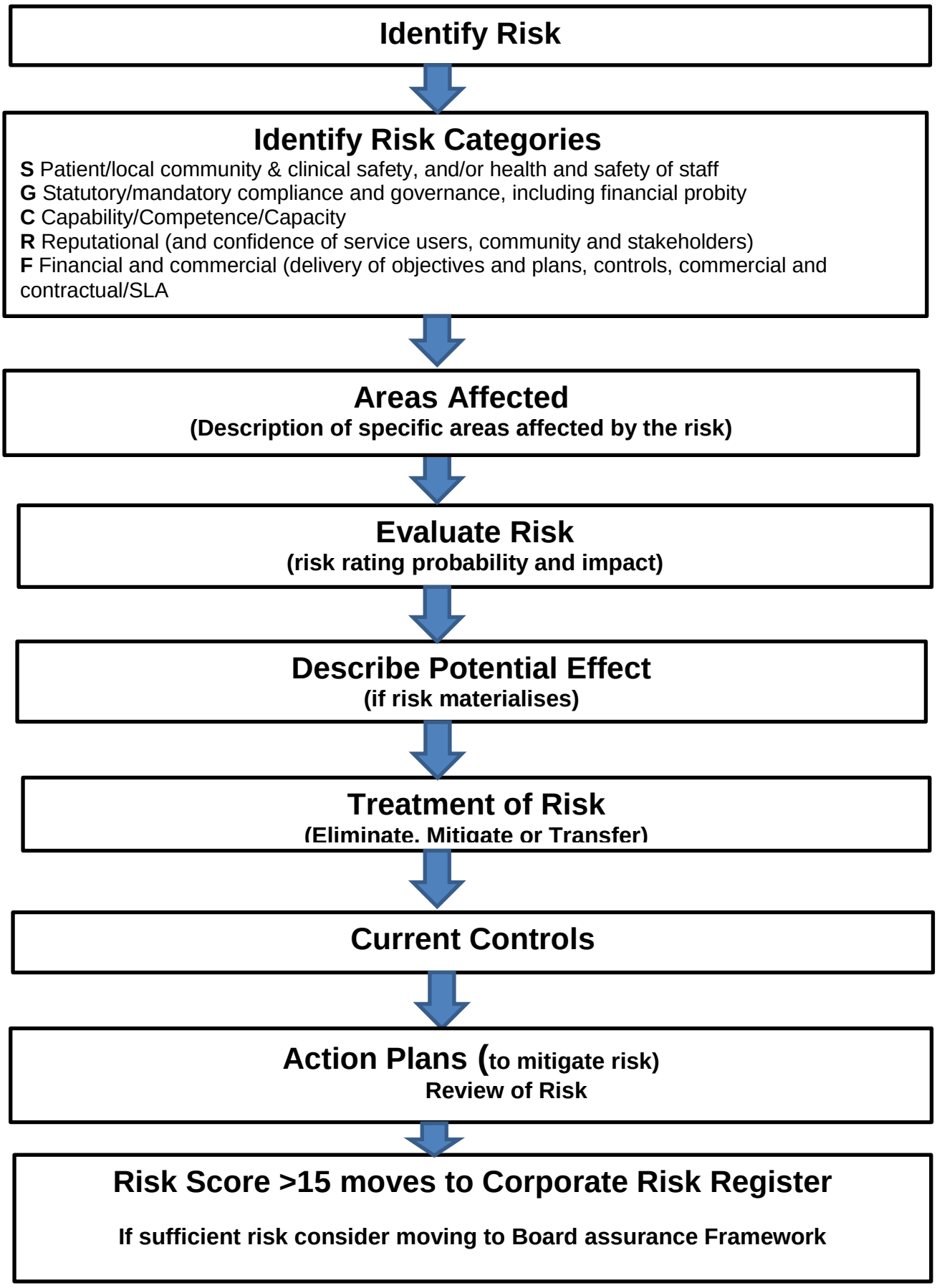
6.7.2 The details will be recorded on the risk register with a low level risk rating for CCG.

6.8 Risk Reporting

6.9 The following table sets out the Assurance Framework and risk reporting structure which is in place at a corporate level. The management of local risks are the responsibility of the senior leads and are managed locally, although those risks that are extreme and threaten the achievement of organisational objectives will be included on the Assurance Framework and, if necessary, the raising of a risk on the Corporate Risk Register.

Monthly	Risk Register	Detail
	Senior Management Team Business Committee	All risks 15 and over, along with controls and review dates
Quarterly	**Assurance Framework**	**Detail**
	Governing Body	Proposed that all corporate risks linked to objectives of the organisation with associated action plan, assurance, controls and any gaps

6.11 Risk Management Flow Chart



7 ASSURANCE FRAMEWORK

7.1 The CCG is mandated to have an Assurance Framework in place, and is it required to submit an Annual Governance Statement (under current guidance). However, it is recognised that an Assurance Framework is good governance and risk management practice. It is therefore intended to implement an Assurance Framework and the risk register database has already been set up to produce this document. As a minimum this framework will identify:

- The organisation's principal objectives linked to the business plan
- Principle risks facing the organisation (those risks classified as extreme)
- Independent or positive assurances, which includes reports received that include action plans and exceptions not directly taken from risk registers
- Gaps in assurances and controls
- Action plans and dates for completion to address gaps

7.2 The Assurance Framework is set up and informed by the strategic and corporate objectives which are refreshed and reviewed on an annual basis. Once these have been agreed the risks to achieving these objectives are identified, the controls and gaps are reviewed and recorded, the level of risk is assessed, action planned, review dates are agreed and a robust mechanism for the regular review and management of the risks are developed.

7.3 Any risk on the Corporate Risk Register scoring 15 or over can if deemed sufficient risk to the organisation to be moved to the Board Assurance Framework; this demonstrates that the CCG is sufficiently concerned that this could affect the strategic direction of the organisation itself.

8 ROLES, RESPONSIBILITIES AND DUTIES

8.1 The Governing Body, Accountable Officer and Directors.

8.1.1 All these persons are ultimately directly responsible for the monitoring, reviewing, mitigating and accepting the Corporate Risk Register is true and accurate record of all risks which have been identified as 15 and above. They have the final responsibility for all risks ensuring the necessary framework and resources are available to manage and if possible mitigate such risks.

8.1.2 The Governing Body will regularly review the Corporate Risk Register (rated at 15 and above) and the Assurance Framework and provide challenge along with additional assurance to the risk management and assurance process. They wil also;

- Approve Strategies and plans
- Ensure the high quality aspects of the CCG strategic aims and objectives
- Provide scrutiny and challenge to ensure financial effectiveness.
- Oversee the risk management strategy and implementation.

- Develop and maintain governance systems including risk management.
- Ensure the conduct of business and decisions made uphold the values of the Equality Act 2010 and consistent with good practice.
- Receive regular updates from the committees directly.

8.2 Directors or Committee Chairs

8.2.1 Directors and Committee Chairs may nominate individuals to take the lead on risk management and the maintenance of that register in line with this policy on their behalf, and ensure the process of escalating new and increasing risk to the Corporate Risk Register.

8.2.2 Each chair of a committee with responsibility for a risk register will be responsible for:

- Ensuring the implementation of the Risk Management Framework within their area of responsibility.
- Systematically assessing and prioritising all risks.
- Taking appropriate risk controls measures within resources available Highlighting risks for their risk register which are not manageable within their resources to the relevant director as soon as practicable and appropriately as possible

8.3 The Chief Finance Officer

8.3.1 The Chief Finance Officer has delegated responsibility for the delivery of specific strategic objectives, for assessing risks associated with the delivery of those objectives. For ensuring plans are in place to reduce and contain such risks and for monitoring and reporting on the outcomes of this on a regular basis or when statutory requirements affect the content, having overall responsibility for ensuring the information held on the Corporate Risk Register is up to date and accurately reflects the current status of each risk: reports will be taken from the register and submitted by the Business Committee and Governing Body.

8.3.2 The Chief Finance Officer is the Senior Information Risk Owner (SIRO), who will be responsible for all information risks within the CCG.

8.3.3 The Chief Finance Officer is also responsible for reporting on issues relating to Health and Safety and Information Governance, reported to them by the Head of Corporate Services.

8.4 Senior Risk Owner (SRO)

8.4.1 The Senior Risk Owner is a director who can monitor and affect change with any risk under their control. In the case of Scarborough and Ryedale CCG this will either be the Chief Finance Officer or Executive Nurse. They in turn can appoint a suitable manager to manage each risk on their behalf but reporting to them and onwards at the frequencies indicated.

8.5 Head of Corporate Services

8.5.1 The Head of Corporate Services is responsible for ensuring the governance and risk management frameworks are in place and the risk registers are reported to the relevant groups and committees, directors and the Governing Body. The Head of Corporate Services is also responsible for ensuring the risk management policy and assurance strategy is reviewed and updated on an annual basis or as when statutory requirements affect the content. In addition they will be responsible for collating all risk and issues which are deems necessary to record on issues around Health and Safety, Information Governance and Equality and Inclusion. The Corporate Risk Register with be held, complied and maintained by the Corporate Services team

8.5.2 All recorded risks need to be mapped to the organisations strategic objectives.

8.6 Managers and Staff

8.6.1 All managers and staff should be familiar with risk management framework and guidance, including the maintenance of risk registers, and methodologies around risk assessment and risk rating.

8.6.2 They should ensure that their staff are sufficiently aware of general risk issues, and the need to raise matters of risk encountered in the course of their work. Individual staff are responsible for:

- Reporting to their line manager any perceived risk in the work area which requires assessment and management.
- Engage in risk assessment when necessary
- Actively participating in the CCG risk management process in particular adverse incident and near miss reporting.
- Actively participating in the management and control of risks where actions have arisen as a result of incident reports.
- Actively participating in the implementation of the CCG Policies and Procedures.
- Maintain safe effective and up to date practice and knowledge of the risk management process and procedures.

8.7 Corporate Service Manager

8.7.1 The Corporate Service manager is responsible for receiving all new risks and managing existing risks to ensure that the Board Assurance Framework/ Corporate Risk Register is maintained. This manager will also ensure that all risk updates are provided within the described timeframes and that the risks are adequately scored with the necessary supporting evidence before transferring all risks greater than 15 (rated for the whole organisation), are added to the appropriate framework.

9 EDUCATION AND TRAINING

9.1 An effective implementation strategy requires managers and staff to be both aware of the CCG's approach to risk, and to be clear about their roles and responsibilities within the

risk management process. Training on the system and process for incident reporting and risk management/assessment will be given to staff as part of general risk management training. The Governing Body will receive relevant updates in respect of Risk Management as and when significant legislative changes occur, which impact on the overall Governance Agenda and as part of a regular review of this Framework.

9.2 Training will be offered to all personnel according to the level of responsibility in their respective roles. This will include identifying risks, assessing risks, describing key controls and action plans, the risk escalation process, monitoring and review process.

10 MONITORING AND REVIEWING OF STRATEGY

10.1 This document will be subject to review by the Corporate Service Team on a 2-yearly cycle or as national guidance requires, prior to submission to the Audit and Governance Committee for revaluation.

10.2 In order that there is an audit trail at each committee an Exception Report will be presented giving an overview of the remaining risks (below15) indicating any substantial changes and trends, this will be accompanied with a list of risks appertaining to the relevant committee which have been closed by the SRO for the committee to approve this action. The closed risks will then be transferred to the Closed Risk Register.

11 LISTENING, LEARNING AND RESPONDING ORGANISATION

11.1 The CCG has a lead role in supporting to improve the health and welfare of its local community and the effective identification and management of risk is integral to this role.

11.2 The CCG cannot do this in isolation. All partners need to be aware of the CCGs approach to risk management, if a common and mutual approach to shared risks and agendas is to be supported. This is reflected in the Audit and Governance Committee which meets regularly and includes both Governing Body members CCG staff and Internal Audit representation

11.3 Developing such a culture is a prerequisite of successful risk management.

11.4 The CCG will:

- Be open and fair
- Approach all incidents, complaints and issues fairly and equally
- Ensure transparency in the review of incidents, complaints and other issues and transfer the learning both internally and externally
- Ensure all staff are aware of this Strategy and process and all other associated policies that compliment delivery of robust internal control
- Support and advise staff
- Provide relevant training, information and resources
- Acknowledge reports received and feedback on actions and decisions taken to demonstrate it has listened

- Ensure there is a framework by which staff can raise concerns of malpractice and impropriety in a supportive, fair blame manner
- Ensure the physical environment for staff and service users is safe and a holistic approach to risk is taken
- Respond to gaps in strategy, policy and process to improve outcomes, experience and the overall management of risk.

12 IMPLEMENTATION

12.1 This policy will be published on the CCG website and all staff will be made aware of its publication through communications and team meetings.

13 TRAINING AND AWARENESS

13.1 The Senior Management Team and line managers are responsible for ensuring that all staff are aware of the policy which will be available on the CCG intranet.

13.2 Training will be provided for individuals named in this policy. Any further training needs will be identified via the appraisal process and training needs analysis.

14 MONITORING AND AUDIT

14.1 State how implementation and compliance will be measured in line with the policy objectives. Identify any key performance indicators.

15 POLICY REVIEW

15.1 The policy and procedure will be reviewed at least every two years by the CCG in conjunction with managers, and Trade Union representatives if appropriate, with changes made as required and the outcome published. Where review is necessary due to legislative change, this will happen immediately.

15.2 The Audit and Governance Committee has delegated responsibility for monitoring and reviewing the policy and will report any concerns to the Governing Body.

16 REFERENCES AND ASSOCIATED DOCUMENTATION

16.1 List any relevant national legislation, guidance, publications and related policies.

17 APPROVAL

18 APPENDIX 1: DEFINITIONS

Risk

The threat that an event or action will adversely affect an organisations ability to maximise stakeholder value and to achieve its business objectives

Risk Management
A logical and systematic method of identifying, analysing, assessing, treating, monitoring and communicating risks in a way that will enable organisations to minimise losses and maximise opportunities

Strategic Risk
Those risks which affect the organisation at a strategic level and which may be the irks arising from the overall business strategy

Operational Risk
The risks associated with all of the on-going day to day management of the business. It will also include the risk around the business processes employed to meet the business

Quality/Patient Safety Risk
Any risk that compromises direct patient care or the quality of that care

Information Risk
Risks arising from the organisation making decisions based on information which is in some way flawed, or where information governance or security is breached

People Risk
Risks arising from the fact that people make both deliberated and inadvertent errors in carrying out their day to day tasks

Financial Risk
Risks related specifically to the financial aspects of the business and the underlying financial processes

Risk Appetite
The tolerance that the organisation has for risk in its day to day and strategic business activities

Risk Maturity
Identifies the level of organisational competence in the area of risk management. For example, from a novice or naïve approach through to an expert and exemplary approach

External Risk
Forces that could either put an organisation out of business or significantly change the assumptions that drive its overall objectives and strategies

Control
Those elements of an organisation (resources, systems, processes, culture, structure and tasks) that taken together, support people in the achievement of the organisations objectives

Risk Identification
The process of determining what can happen, why and how

Risk Assessment
The process used to determine risk management priorities by evaluation and comparing the level of risk against predetermined standards, target risk levels or other criteria

Risk Analysis
A systematic use of available information to determine how often specified events may occur and the magnitude of their likely consequences

Risk Treatment
The selection and implementation of appropriate options for dealing with risks. These may include

Risk Acceptance – An informed decision to accept the likelihood and consequences of a particular risk

Risk Transfer – Shifting the responsibility or burden for loss to another part, e.g. through insurance

Risk Reduction – A selective application of techniques to reduce likelihood of occurrence or the impact or both

Risk Avoidance – An informed decision not to become involved in a risk situation or to cease activities in a particular area because the risk is too high

Residual Risk
The remaining level of risk after risk treatment measures have been taken

Clinical Risk
The application of risk management principles to direct patient care. This includes all aspects relating to standards of clinical care, communication and record keeping.

Non-Clinical Risk
The application of the risk management principles other than those relating to direct patient care including the environment, health and safety, fire, security, personal security of staff, waste management, CCG leased property.

19 APPENDIX 2: RISK PROCESS and SCORING

Step 1	**Consequence Scoring**				
	1. Negligible	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
Staff/Patient Safety (physical/ psychological)	Minimal injury/ Nominal intervention - no time off work	Minor injury or illness Time off work > 3 days Increase in hospital say by 1-3 days	Injury requiring professional intervention Time off work 1-4 days RIDDOR reportable Increase hospital stay 4-15days	Major injury leading to long term disability Time off work >14days Increase hospital stay >15days Management of patient care	Incident leading to death Multiple permanent injuries or irreversible health effects Impact on large number of patients
Complaints	Informal complaint/enquiry	Formal complaint	Formal complaint – ombudsman Intervention / investigation	Non-compliance of National Standards	Unacceptable level o/ treatment
Human Resources Organisational Development	Short term staffing levels that temporarily reduces service quality (<1 day)	Low staffing levels that reduces service quality	Unsafe staffing levels. Late delivery of key services due to lack of staff	Unsafe staffing level (>5 days) Loss of key staff Uncertain delivery of key services	Ongoing safe staffing levels. Loss of several key staff. Non delivery of key services
Statutory duty/ inspections	No minimal impact on breach of guidance	Breach of statutory legislation Reduced performance	Single breach of statutory duty	Multiple breaches of statutory duty, critical report, low performance	Multiple breaches of statutory duty Prosecution Zero performance rating
Financial claims	Small loss- risk of claim remote	Loss of 0.1-0.25% of budget Claim less than £10,000	Loss of 0.25-0.5% of budget. Claim between £10,000 and £100,000	Loss of 0.5-1% of budget. Claim between £100,000 and £1,000,000	Loss of > £1,000,000 Claim > £1,000,000 Loss of contract
Service interruption	Loss/interruption < 1hour Minimal or no impact on the Environment	Loss/interruption of < 8 hours Minor impact on environment	Loss/interruption of > 1day Moderate impact on the environment	Loss/interruption > 1week Major impact on environment	Permanent loss of service Catastrophic impact on the environment
Reputational	Event, incident, or CCG change which could lead dot a one-off negative media report, limited to a single entity (either media organisation or group)	Event, incident, or CCG change which could lead to one-off negative media interest pursued by multiple media entities and communities	Event, incident, or CCG change with the potential to lead to negative media coverage and adverse community reaction over the course of a number of weeks	Event, incident, or CCG change with the potential to lead to negative media coverage, adverse community reaction and parliamentary interest over a prolonged period of time which restrains the ability of the CCG to carry out its functions and/or results in disciplinary action for senior staff	Event, incident, or CCG change with the potential to destroy the reputation of the CCG and undermine all future actions, such as incident leading to death, multiple permanent injuries or irreversible health effects impacting on a large number of patients

Step 2

Likelihood Scoring

How likely is it to happen given the controls you have in place

Frequency	Likelihood	Score
Not expected for years	< 1% will only occur under exceptional circumstances	**1. RARE**
Occur at least annually	< 1.5% unlikely to occur	**2. Unlikely**
Occur at least monthly	6-20% - reasonable chance of occurring	**3. Possible**
Occur at least weekly	21-50% - Likely to occur	**4. Likely**
Occur at least daily	>50% almost certain to occur	**5. Almost certain**

Step 3

Establish Overall Score and rating

Using the appropriate scores for consequence and the appropriate scores for Likelihood, follow the table below to obtain the overall incident/risk severity rating

Consequence	Likelihood				
	1. Rare	**2 Unlikely**	**3. Possible**	**4. Likely**	**5. Almost certain**
5. Catastrophic	**5** (Moderate)	**10** (High)	**15** (Extreme)	**20** (Exterme)	**25** (Extreme)
4. Major	**4** (Moderate)	**8** (High)	**12** (High)	**16** (Extreme)	**20** (Extreme)
3. Moderate	**3** (Low)	**6** (Moderate)	**9** (High)	**12** (High)	**15** (Extreme)
2. Minor	**2** (Low)	**4** (Moderate)	**6** (Moderate)	**8** (high)	**10** (High)
1. Negligible	**1** (Low)	**2** (Low)	**3** (Low)	**4** (Moderate)	**5** (Moderate)

Step 4

Risk Appetite: Risk Responsibility Level/ Remedial Action/ Acceptance

	Level of acceptance / action required	Timescale – Immediate : Action Plan	Minimum time for review/ report
Extreme 25-15	CCG Senior Management team (SMT) agree action plan. Next available Governing Body to review Consider convening meeting if 25	Immediate - Implementation	1 month and monthly there after
High 8-12	SMT action /service plan. Director to review and agree. Report to next SMT	Immediate action. Implementation within 3 months	2 Months
Moderate 4 -6	Team/Service Action Plan Acceptance – head of Service	Routine review at team meeting with local action plan – report to relevant committee on progress	6 months
Low 1-3	Local team meetings acceptable	Manage by routine procedures – no additional costs. Report to relevant committee within 6 months if not closed.	6 months

20 APPENDIX 3: GENERAL RISK ASSESMENT FORM

Department or Team		**Assessors Name**	
Assessment number		**Contact Email**	

Brief description/ background *(e.g. risk of non-achievement of standard, with relevant history/circumstances leading to recognition of risk*			
Persons affected (i.e. Staff, patients/ general public			
Risk description – *accurate description of risk limit to 250 words***.**			
Initial Risk Rating – *Rating at the time of the assessment Risk Rating = Likelihood X Consequence*	**Likelihood score**	**Consequence score**	**Current Risk Score**
Controls in place at the time of risk assessment			
Gaps/weakness in controls *Any area where controls have not been completely implemented or failing to mitigate the risk*			

Current risk rating *Rating taking into account the current controls in place. Rating Likelihood X Consequence*	**Likelihood Score**	**Consequence Score**	**Current Risk Rating**
Action Plan *List of actions which need to be taken to mitigate or control the risk*			
Target Risk Rating *Predict ratings once all planned actions have been taken*	**Likelihood Score**	**Consequence Score**	**Current Risk Rating**
Target Completion date for actions to be implemented			
Responsible Person *Person who is responsible for ensuring that the planned actions are taken*	**Name**		
	Job Title		
	Contact number		
Risk Owner *(Senior Manager)*			
Director			
Committee who will monitor this risk			
Gaps in assurance			
Resourcing Requirements (staffing /financial)			
Review Date *>15 must be reviewed and reported on every month*			

Please return completed Risk Assessment form (both pages) to scrccg.corporateservices@nhs.net

For completion by Corporate Service Manager					
Date Risk Assessment Received		**Agreed for Assurance Framework**	**YES/ NO**	**Date Input**	
		Agreed for Corporate Risk Register	**YES/NO**		
Risk reference Number		**Date next input is required**			

21 APPENDIX 4 – RISK MONITORING PROCESS