Risk Management Strategy

Ratified	Final
Status	Approved
Issued	June 2015
Approved By	Governing Body <25/03/2015> Governance and Risk Committee
Consultation	Internal NECS review Internal CCG review
Equality Impact Assessment	Completed
Distribution	All Staff
Date Amended following initial ratification	NA
Implementation Date	March 2018
Planned Review Date	July 2018
Version	3.1
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Reference No	CO014

Strategy Validity Statement
This strategy is due for review on the latest date shown above. After this date, strategy and process documents may become invalid. Strategy users should ensure that they are consulting the currently valid version of the documentation.

Version Control

Version	Release Date	Author	Update comments
1	28/02/2013	CSU	First issue
2	04/12/2013	CSU	Safeguard Incident Risk Management System details added to strategy. Standard Operating Procedure included for reference.
3	30/01/2015	CSU	Review • Standard Operating Procedure SIRMS Risk register removed following review. • Risk management & SOP work plan removed following review. • Section 7 Training has been updated following review.
3.1	12/03/2018	CSU	Extension until July 2018. Equality Impact Assessment updated.

Approval

Role	Name	Date
Approval	Governance and Risk Committee	11/02/2015
Approval	Governing Body	27/03/2015
Approval	Head of Governance	12 Mach 2018.

Review

The strategy will remain valid, including during its period of review. However, the strategy must be reviewed at least once in every 3 year period.

1. Introduction

1.1 This strategy sets out the approach and arrangements for management within the South Tees Clinical Commissioning Group (CCG)

1.2 The principles are consistent with those within the NHS England's Risk Management Strategy and Risk Management Policy and Procedure issued in July 2013.

1.3 This strategy sets out the CCG approach to risk and the management of risk in fulfilment of its overall objectives. In addition, the adoption and embedding within the organisation of an effective risk management framework and processes will ensure that the reputation of the CCG is maintained and enhanced, and its resources are used effectively to ensure business success, continuing financial strength and to ensure continuous quality improvement in its operating model.

1.4 As part of this strategy it is also acknowledged that not all risks can be eliminated. Ultimately it is for the organisation to decide which risks it is prepared to accept based on the knowledge that an effective risk assessment has been carried out and the risk has been reduced to an acceptable level as a consequence of effective controls.

1.5 At its simplest, risk management is good management practice and risk assessment provides an effective management technique for managing the organisation (through the identification of risks and the development of mitigating action). Through this strategy the CCG is keen to ensure that risk management is not seen as an end in itself, but rather a part of an overall management approach that supports the organisation in developing achievable management action plans.

2. Definitions

The strategy is based on the following definitions:

- **Risk** is the chance that something will happen that will have an impact on the achievement of the CCG objectives. 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 Management** is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk.

- **Risk Assessment** is the process used to evaluate the risk and to determine whether precautions are adequate or more should be done. The risk is compared against predetermined acceptable levels of risk.

Further definitions of terms are set out in Annex 1.

3. Approach to Risk Management: Principles, Aims and Objectives

3.1 This strategy sets out the CCG's approach to the way in which, in general terms, risks are managed. This will be achieved by having a thorough process of risk assessment in place. This will provide a useful tool for the systematic and effective management of risk and will inform and guide staff as to the way in which all significant risks are to be controlled.

3.2 The aims of the strategy are summarised as follows:

- to ensure that risks to the achievement of CCG's objectives are understood and effectively managed;
- to maintain a risk management framework to assure the Governing Body that strategic and operational risks are being effectively managed;
- to ensure that risk management is a cohesive element of the internal control systems within the CCG's corporate governance framework;
- to ensure that risk management is an integral part of the CCG culture and its operating systems;
- to ensure that the CCG meets its statutory obligations including those relating to health and safety and data protection, and
- to assure all stakeholders, staff and partner organisations that the CCG is committed to managing risk appropriately.

3.3 In order to achieve these aims the CCG is committed to ensuring that:

- risk management is embedded as an integral part of the management approach to the achievement of objectives;
- themes and trends will be identified patch wide and on an individual CCG basis via SIRMS and this will inform the management of risk;
- the management of risk is seen as a collective and individual responsibility, managed through the agreed committee and management structures;
- patient feedback, complaints and staff feedback are used as an integral part of the approach to risk management;
- risk management support, training and development will be provided by the Commissioning Support Unit governance team;
- a training needs analysis will be undertaken to identify staff members affected by the roll out of the strategy. Based on the findings of the analysis a risk management training programme will be put in place; and

- risk management guidance will be provided to all staff.

4. Roles and Responsibility for Implementation of the Risk Management Strategy.

The following staff have specific responsibilities with regards to risk management:

4.1 The Chief Officer has overall responsibility for ensuring the effective implementation of this strategy.

4.2 The Chief Finance Officer is the nominated lead for co-ordination of governance and risk management throughout the CCG.

4.3 Officers (including commissioning support staff) will:

- be familiar with the main risks in their area of activity, leading the management of risks where required;
- ensure the processes for managing risk within services/teams are clearly understood by managers, appropriately delegated and effective. and
- ask for feedback from managers about risk assessments relevant to their portfolio and work stream; carry out further risk assessment to determine if the risk is common across the service/CCG work stream; in conjunction with the wider team, determine the level of risk and required actions to eliminate or control the level of risk and report back to the team any progress and outcome in relation to action agreed.

4.4 All staff – risk management is everyone's responsibility and all staff must be familiar with the main risks in their area of activity. All staff must work within the guidance of the Safe Guarding Incident Risk Management System (SIRMS) Standard Operating Procedure for Risk Registers which is available via internal CCG communications.

4.5 The Commissioning Support Unit, working with and on behalf of the CCG, will:

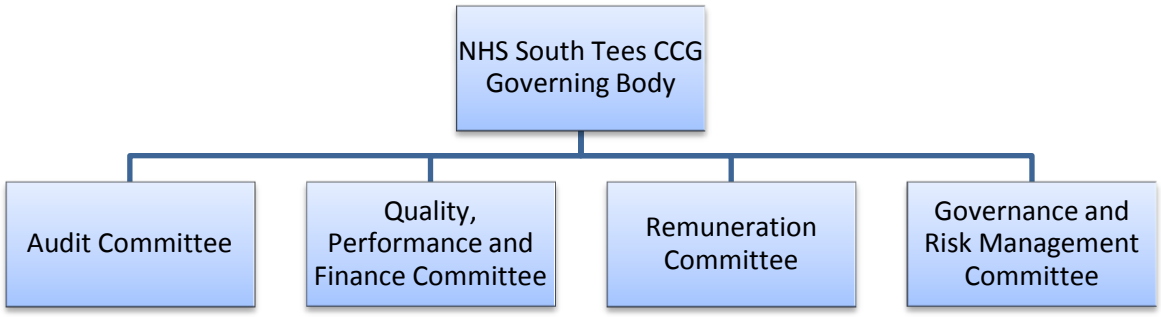
- provide advice to ensure consistency in grading risks to identify the level of priority required in addressing risks;
- support staff throughout the risk assessment process as outlined in the SOP;
- support and monitor the implementation of CCG risk registers.
- collate and analyse data showing trends and patterns and generate appropriate reports as agreed within the CCG risk management portfolio;
- support the development and reporting of the Governing Body Assurance Framework and Annual Governance Statement working closely with the Chair, lay members and other Governing Body members to ensure strategic risk is accurately reflected and managed.

- Whilst working on behalf of the CCG, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the CCG, however they will continue to be governed by all policies and procedures

4.6 The CCG has developed clear lines of accountability with defined responsibilities and objectives, the risk management reporting committees are outlined below:

- The Governance and Risk Management Committee is responsible for reviewing and providing verification on the systems in place across the CCG for governance and risk management including internal control.
- The Quality, Performance and Finance Committee is responsible for ensuring that risks to the delivery of the principles of patient safety, quality, safeguarding, performance and finance are identified, addressed and reported to the Governing Body as appropriate.
- The Audit Committee is responsible for ensuring that organisational risk management systems and processes are in place.
- The Remuneration Committee advises the Governing Body regarding appropriate remuneration and terms of service for the Accountable Officer and other senior employees.
- The Governing Body monitors high level, principal risks relating to the achievement of the strategic objectives through the Governing Body Assurance Framework.

Governance infrastructure enabling effective risk management:



Supporting working groups as required

4.7 The Governance and Risk Management Committee is chaired by the Chief Finance Officer and has overall responsibility for overseeing the implementation of this strategy. The committee will also:

- review all risks on the risk register and monitor progression of stated action each meeting;
- review trend analysis for all risks;

- ensure the established processes to manage risk by each team is in place and provide support for action where necessary;
- ensure the processes for managing risk within the CCG are clearly understood, appropriately delegated and effective, and
- escalate issues to the Governing Body as appropriate, in particular the identification of new significant risks or areas of concern of risks graded high or extreme.

4.8 The members of the Executive Group will:

- maintain awareness of the main risks facing the organisation;
- take ownership where relevant of principal (strategic) risks that pose a threat to the achievement of strategic objectives and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates to the Governing Body through contributing to the Assurance Framework;
- review all Extreme and High risks on a quarterly basis;
- take or delegate ownership, where relevant, of risks that pose a threat to the achievement of objectives or the business of the CCG and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates are added to the risk register;
- ensure the processes for managing risk within the CCG are clearly understood, appropriately delegated and effective.

4.9 Significant CCG projects/work streams require project / programme leads to ensure there are arrangements in place to develop, maintain and regularly review a project risk register to ensure effective management of risk. Red risks (graded as extreme or high) should be escalated to the CCG risk register if they are likely to impact on the CCG strategic objectives.

4.10 Assurance Framework

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 Accountable Officer in the Annual Governance Statement. It will be prepared at the start of each financial year when the CCG's strategic objectives are known. It should be prepared with the involvement of senior leaders, reviewed by the committee with oversight for it (e.g. the Governance and Risk Management Committee) on a regular basis and the Audit Committee. It will also be approved and reviewed by the Governing Body at least six monthly.

5. Approach to Risk Management and Assessment

5.1 Types of risks to be managed

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

- corporate risks – operating within powers, fulfilling statutory responsibilities and ensuring accountability;
- reputational risks – associated with quality of services, communication with customers, staff and stakeholders;
- financial risks – associated with achievement of planned surpluses, reduction in costs and revenue growth;
- environmental risks including health and safety – ensuring the well-being of staff and visitors whilst using CCG premises;
- strategic risk - a significant risk that will impact organisation wide and not just upon a function or team, and
- operational risk - a key risk, which impacts on a team's operational achievement.

5.2 Assessment of Risk

5.2.1 Whenever risks have been identified it is important to assess and record the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this a CCG risk register has been developed with an aligned SIRMS risk register SOP. The SOP has been developed based on current national guidance

5.2.2 By all staff using the CCG SIRMS risk register SOP it will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. Additionally, 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.

5.2.3 Risks are assessed in terms of the likelihood of 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.

5.2.4 For each risk that is not adequately controlled, an action plan to reduce or eliminate the risk is required. The implementation of the action plan and residual risk assessment must be kept under review, to assess whether planned actions have reduced or eliminated the risk as expected.

5.2.5 Any risk that is identified through the risk assessment process 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.

5.3 Risk Appetite

South Tees CCG endeavours to reduce risks to the lowest possible level that is reasonably practicable. All risks can be avoided, transferred or retained.

Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk.

5.4 **Risk Tolerance**

The threshold level of risk exposure which, when exceeded, will trigger an escalation to bring the situation to the attention of a senior manager. Any risks scored as 12 or above should be escalated to a senior manager and the Governance and Risk Management Committee for review and monitoring and reported to the Governing Body. Low, moderate & high risks will be managed and monitored at team level, any risks of concern even if not scoring as an extreme risk can be highlighted to the Governance and Risk Management Committee for escalation to the Governing Body.

6. Distribution and Implementation

6.1 This strategy will be made available to all staff via CCG internal communications.

6.2 Notifications of strategy changes will be shared via internal CCG communications.

6.3 Any further guidance will be provided via the CSU governance team.

7. Training Plan

7.1 SIRMS training embedded across the CCG, additional refresher training to be provided as required via the CSU governance team.

7.2 Risk management support, advise and development sessions (either 1-1 or as teams) to be provided as required via the CSU governance team tailored to CCG requirements.

7.3 Future training and development requirements to be discussed with CCG to ensure a robust approach to risk reporting and management are maintained across the CCG. Future developments such as risk management E-learning resources to be explored.

8. Monitoring

8.1 The Governance and Risk Management Committee will review the strategy annually. The Governing Body Assurance Framework and the full risk registers will be reviewed at each meeting.

8.2 Progress against the Risk Management Strategy Work Plan will be reported to each meeting of the Governance and Risk Committee via the Governance and Assurance Report.

8.3 Senior leads will ensure that teams review their risk registers on a monthly basis (or within individually agreed review times).

8.3 The Governing Body will ensure that archived copies of superseded strategy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

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 strategy must always follow the original approval process.

9. Equality Impact Assessment

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Introduction - Equality Impact Assessment

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:	**Debra Elliott**
Title of service/policy/process:	**Corporate Policy** **Risk Reporting & Management**
Existing: x **New/proposed:** ☐ **Changed:** ☐	
What are the intended outcomes of this policy	
This policy provides information and guidance to staff working within the CCG to report and manage risk.	
Who will be affected by this policy	
x Staff members **x Other**	
If other please state:	
Patients, Staff from other organisations, Public.	
What is your source of feedback/existing evidence?	
☐ **National Reports x Staff Profiles** ☐ **Staff Surveys x Complaints/Incidents** ☐ **Focus Groups** ☐ **Previous EIAs** **NECS & CCG joint working**	
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 incidents
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, an incident can be reported should it occur
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, an incident can be reported should it occur
Sex/Gender A man or a woman.
Positive impact, an incident can be reported should it occur
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
Positive impact, an incident can be reported should it occur
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
Positive impact, an incident can be reported should it occur

 **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?
x Verbal – through focus groups and/or meetings **X Verbal - Telephone** **☐ Written – Letter** **x Written – Leaflets/guidance booklets** **X Email x Internet** **☐ Other**
If other please state: **Via SIRMS**

 **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	**DE**	**Ongoing**
NA		**All**	**E-learning tool developed for risk awareness.**	Positive - increased by in and awareness of process	**DE**	**Ongoing**
NA		**All**	**E- learning tool to be developed for incident managers**	Positive - increased by in and awareness of process	**DE**	**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 & Head of Governance and Operational Lead	Evaluation of training

 **SIGN OFF**

Completed by:	**Debra Elliott**
Date:	**14/06/2017**
Signed:	**Debra Elliott**
Presented to:	**Head of Governance**
Publication date:	**12 March 2018**

10. Associated documentation

10.1 CCG CO14 Risk Management Strategy

10.3 CCG CO07 Health & Safety: Policy & Corporate Procedures

10.4 CCG CO08 Incident and CCG Incident Reporting and Management Policy

10.5 Business Continuity Plan

Appendix 1 – Definitions

Action plan	How the identified gap is to be addressed and how the risk is to be diminished.
Assurance Framework (AF)	The AF is an integral part of the system of internal control and defines the significant potential risks which may impact on delivery of the organisation priorities. It also summarises the controls and assurances that are in place, or are planned, to mitigate against them. Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the governing body to develop and subsequently monitor an assurance action plan for closing the gaps.
Consequence	This is a numerical value from one to five (five = catastrophic) for the impact that a risk may have on the organisation or individual, and may be physical, financial, reputational etc.
Control	The control of risk involves taking steps to reduce the risk from occurring such as application of policies or procedures.
Directorate risk register	The directorate risk register is a summary of the risks identified through internal processes.
External assurance	External evidence that risks are being effectively managed (e.g. planned or received audit reviews).
Gaps in controls or assurances	Where an additional system or process is needed, or evidence of effective management of the risk is lacking.
Impact	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.
Issue	A relevant event that has happened was not planned and requires action. It can be any concern, query and request for change.
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur. This is a numerical value from one to five (five = almost certain) for the potential of the risk to be realised.
Management assurance/actions	What are we doing to manage the risk and how this is evidenced? Sources of information used to ascertain whether controls are working or not. Examples include minutes of meetings, internal or external audit reports, survey results and reports

	to the Executive Group
Operational risks	A key risk that impacts on individual directorate operational achievement. Operational risks are managed locally within the directorate and are the responsibility of the appropriate Director /Senior Manager.
Risk appetite	The organisation's unique attitude towards risk taking that, in turn, dictates the amount of risk that it considers is acceptable.
Residual risk	The risk remaining after the risk response has been applied.
Risk	An uncertain event or set of events that, should it occur, would have an effect on the delivery of objectives. It is measured in terms of consequence and likelihood.
Risk assessment	The process used to evaluate the risk and to determine whether precautions are adequate or more should be done to mitigate the risk. The risk is compared against predetermined acceptable levels of risk.
Risk management	The systematic application of management policies, procedures and practices to the task of identifying, analysing, assessing, treating and monitoring risk.
Risk owner	A named individual who is responsible for the management, monitoring and control of all aspects of a particular risk assigned to them.
Risk tolerance	The threshold level of risk exposure which, when exceeded, will trigger an escalation to bring the situation to the attention of a senior manager. Any risks scored as 12 or above should be escalated to a senior manager for review at Executive Group for review and monitoring.
Strategic risks	A significant risk that has the potential to impact across the organisation. These risks have been mapped to the business plan objectives and will be presented to the Governing Body in the AF.