NHS Basildon and Brentwood Clinical Commissioning Group

NHS Mid Essex Clinical Commissioning Group

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Thurrock Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

Mid and South Essex CCGs

RISK MANAGEMENT POLICY

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1 INTRODUCTION

1.1 The five mid and south Essex (MSE) CCGs (NHS Basildon & Brentwood CCG, NHS Castle Point & Rochford CCG, NHS Mid Essex CCG, NHS Southend CCG and NHS Thurrock CCG (hereafter referred to as 'the CCGs')) work collaboratively across the Health and Care Partnership (HCP) footprint to manage their risks. The CCGs acknowledge that commissioning health services and tackling health inequalities in an innovative and effective way is inherently risky, but that it can bring positive advantages, benefits and opportunities where managed appropriately. The CCGs do not aim to create a risk-free environment, but rather one in which risk is considered as a matter of course and appropriately identified and managed.

1.2 The CCGs recognise that good risk management will provide a safer environment and better care for patients and will allow the CCGs to fulfil their strategic objectives. Risk Management is therefore a core organisational process, embedded within all structures and processes.

1.3 The CCG recognises the importance of involving local stakeholders in its risk management processes and of working in partnership to identify, prioritise and manage shared risks. Consequently, there is a much closer working relationship with partners to manage system wide risks as the introduction of the statutory Integrated Care System evolves.

1.4 This policy sets out how the CCGs are now managing MSE risks within one Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and describes that risk management process.

1.5 The CCGs have formed the Mid and South Essex CCGs Joint Committee (hereafter referred to as the 'Joint Committee) for the purpose of commissioning and managing contracts on behalf of the CCGs (where they are delegated to do so). Risks relating to services commissioned by the Joint Committee form part of the BAF and CRR process and are therefore managed under the one process described in this policy.

2 PURPOSE / POLICY STATEMENT

2.1 The purpose of this policy is to provide the overarching framework for the management of risks within the CCGs. It applies across all CCGs in all departmental areas, it includes all CCG staff, Board Members and Member Practices (where risks need to be reported to the CCG). It relates to all areas of the CCGs activities as commissioners of NHS services, and applies to all premises of the CCGs and persons engaged in business on behalf of the CCGs.

2.2 The aim of the policy is to establish and maintain a framework for risk management which:

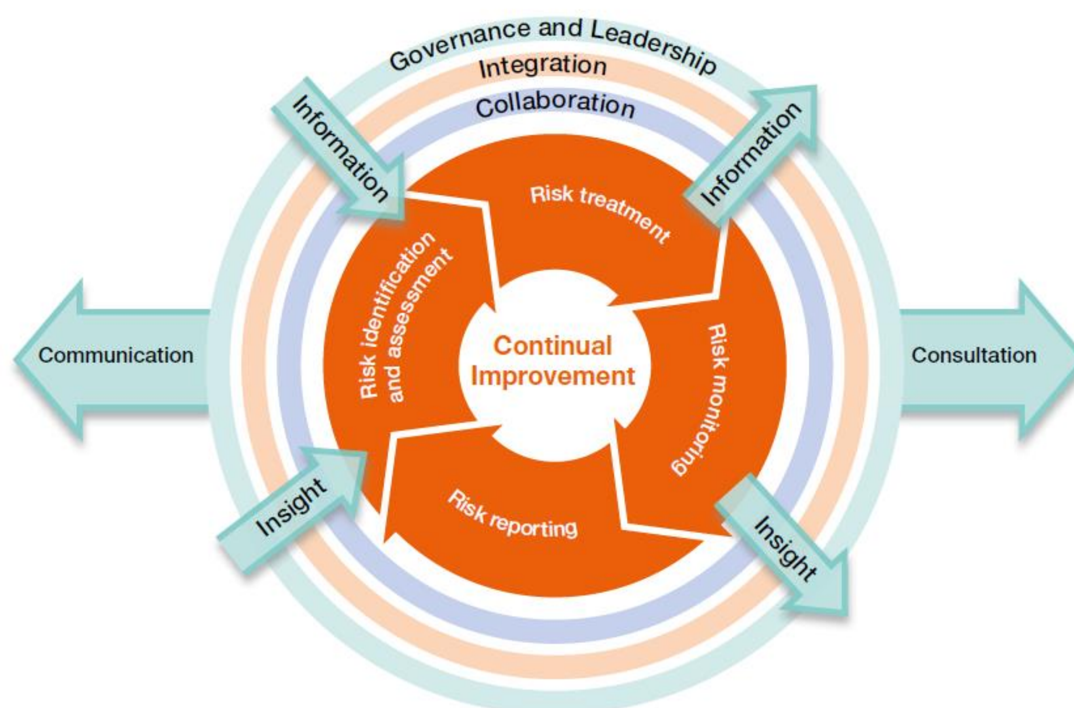
- Supports the CCGs in **achieving their strategic objectives** and realising the significant quality, financial and organisational benefits from minimising / managing risk;
- Ensure processes are based on **best practice and national guidance**;
- Promotes an approach to **integrated risk management** across all areas of corporate and clinical risk across the MSE area;
- Assists the CCG Boards in **agreeing the Governance Statement** for 2021/22;
- **Embeds risk management practices** in the day-to-day functions of the CCGs as well as their role within the HCP, across system working.

2.3 In the NHS risks are managed continuously, sometimes consciously and sometimes without realising. However, often risks are not managed systematically, which could expose the CCGs to extreme levels of risk threatening the way in which they operate and, in some cases, whether they operate at all. It is important to adopt a systematic and consistent approach to risk management, which encompasses all the CCGs functions and activities.

2.4 The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks, striking the balance between cost and benefit. Risk and risk taking is unavoidable and inherent in everything that the CCGs do, such as assessing levels of health need in the community, determining service priorities, managing a project, taking decisions about future strategies, or even deciding not to take any action at all. It is important therefore that CCGs take action to manage risk in a way which they can justify to a level which is tolerable. The amount of risk which is judged to be tolerable and justifiable is the 'risk appetite'.

2.5 A risk management framework operated in isolation can be ineffective and lack 'continual learning'. It is therefore important to ensuring that risks are adequately reported at all appropriate levels of the organisation and particularly to the ultimate accountable officers (i.e. the Board). This will enable monitoring of whether or not the risk profile of the CCGs are changing and provide assurance that risk management is effective, identifying if and when further action is necessary.

2.6 An effective risk management framework, strikes an appropriate balance in how those accountable for risk throughout the organisation engage with the risk management process, depicted in the diagram below adapted from HM Treasury: The Orange Book. Management of Risk – Principles and Concepts (2020), referred to hereafter as the 'Orange Book'.



2.7 The BAF and CRR enable that balance to be struck whereby the Board are concerned with strategic risks; those that may affect the overall delivery of CCG objectives, functions and duties and Directorates and Executives are concerned with the operational risks on a delivery level; with an escalation process that ensures

operational risks that can impact on strategy are escalated to the Board.

2.8 This policy has been established to achieve this and is therefore based on current best practice in the field of risk management.

2.9 In addition to ensuring that risk management is an on-going, continual process, the CCGs specific integrated risk management objectives for 2021/2022 are to:

- Revise and update the CCGs Risk Management Policy;
- Continue to develop wider ownership of risk processes collectively across MSE;
- Raise awareness of risk management;
- Maintain the BAF and CRR on a bi-monthly basis that profiles the CCGs risks managed by the Boards / MSE CCGs Joint Committee where they are considered extreme and managed by the Senior Management Teams/relevant Committees where they are considered high, medium or low risk;
- Support CCG Committees meeting in common to discharge their delegated risk management responsibilities and develop how the BAF and CRR process is embedded within wider system assurance functions;
- Consider how wider risks across the system, within Provider Trusts are reflected within the CCGs BAF and CRR, looking to the development of a system framework as part of the Integrated Care Partnership from 2022/2023.

3 DEFINITIONS

Board Assurance Framework (BAF)	The BAF provides the structure and process that enables the CCG to focus on those risks that might compromise achieving its most important (principle) strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has gained sufficient assurance about the effectiveness of these controls. This relates to the extreme documented risks of the CCG set out within the framework (rated 15 and above).
Corporate Risk Register	Represents the same process as that identified (in the BAF) above, but for the high, medium and low priority risks that could possibly escalate to become risks that threaten CCG Objectives.
Risk	The possibility that loss or harm will arise from a given situation / the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. In the context of this policy and strategy, this encompasses anything from the possibility of injury to an individual patient or member of staff to anything which impacts upon the ability of the CCGs to fulfil their aims and objectives.
▪ **Operational Risks**	A risk that may impact on the organisation's ability to carry out its functions daily in a safe and efficient manner, such as clinical (patient safety), staff safety, security, information, financial and litigation. Whilst they may have some external impact, they mostly impact on the internal functioning and services of the CCGs. Significant operational risks, which are not effectively managed, may impact on the delivery of strategic objectives. Those operational risks will therefore be escalated to strategic level if and when they are risk rated as red/extreme.
▪ **Project Risks**	Risks that are associated with a specific project and that are not intended to have an impact beyond the remit of that project.

	Consequently, project risks assessed as a high impact may not represent a 'corporate' high risk. Project risks assessed as 'Extreme' will be re-assessed as part of the Corporate Risk framework to determine whether they should be escalated to the Corporate Risk Register or Board Assurance Framework.
▪ **Reputational Risks**	Loss of loyalty or commitment from stakeholders following an event that harms the CCG's reputation.
▪ **Strategic Risks**	A risk that may impact upon the whole organisation and the achievement of the CCG's objectives, rather than having an impact on only one department. They have the highest potential for external impact including engagement with the wider HCP community and with external stakeholders. Strategic risks are reviewed and, where necessary modified, by the Boards on a bi-monthly basis and are to be managed as complex processes as opposed to discrete events. The Boards will ensure that strategic risks are properly identified and correctly managed, by review of the BAF and performance management.
Risk Appetite	The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.
Risk Management	A proactive approach to the: ▪ **Identification** of risks; ▪ **Analysis and assessment** of the likelihood and potential impact of risks; ▪ **Elimination of those risks** that can be reasonably and practicably eliminated; ▪ The **management** of risk through treatment (improvement in controls), transference (moving the risk to a third party for example through insurance), termination (ceasing the activity that gives rise to a risk) or toleration (accepting that the risk exists and cannot be treated). ▪ **Communication of risks**; and ▪ **Regular monitoring of risks** to ensure that controls are effective in reducing the level of risk. Risk management is an integral part of the systems of internal control and corporate assurance programme. Corporate assurance is a process designed to provide evidence that NHS organisation is doing its 'reasonable best' to meet objectives, protect patients, Board members, staff, member practices, the public and all stakeholders against risks of all kinds.
Inherent Risk	The exposure arising from a specific risk before any action has been taken to manage it.
Residual Risk	The exposure arising from a specific risk after action has been taken to manage it, making the assumption that the action is effective.
Risk Profile	The documented and prioritised overall assessment of the range of specific risks faced by the organisation.
Integrated Risk Management	Addresses the management of risk across the organisation at varying levels and directorates. Integrated risk management provides a more effective risk system than that available from a limited scope risk process.
Risk Materialisation	When the risk (circumstances) thought possible actually occur.

4 ROLES AND RESPONSIBILITIES

4.1 All CCG Employees and Board Members

4.1.1 All staff, committees, sub-committees and groups that support the CCGs business have responsibility for identifying, assessing and putting systems in place to mitigate any risks to the achievement of strategic objectives, and ensuring these are managed through the risk register system.

4.1.2 Specifically, all staff and Board Members (including contractors, agency or locum staff and third party (back office) providers) are responsible for:

- Reporting incidents/accidents and near misses using the CCGs' incident reporting procedures;
- Maintaining safe working practices;
- Being aware of their duty under legislation to take reasonable care of their own health and safety and that of others;
- Complying with all CCG policies, procedures and guidance for the protection of the health, safety and welfare of themselves and others;
- Familiarising themselves and complying with the Risk Management Policy of the CCGs and any relevant directorate/department risk management procedures;
- Being aware of any emergency procedures relevant to their role and place of work, e.g. evacuation/lockdown and fire safety procedures;
- Identifying risks within their area of work and taking appropriate action to assess and manage such risks and/or report them to their line manager;
- Attending training and development events to ensure a full understanding of their risk management responsibilities.

4.2 MSE CCGs Boards

4.2.1 The CCG Boards are accountable and responsible for ensuring that the CCG has an effective programme for managing all types of risks, which is achieved via review of the BAF. In order to verify that risks are being managed appropriately and that the CCGs can deliver their objectives; the Boards receive and consider reports or minutes from all CCG committees (including the MSE CCGs Joint Committee).

4.3 Board Committees

Audit Committees

4.3.1 The CCG Audit Committees have over-arching responsibility for risk management within the CCG and will ensure organisation-wide coordination and prioritisation of risk management issues. The Audit Committees are responsible for the development, monitoring and review of the Board Assurance Framework and Corporate Risk Registers. The Committees will receive a report on the BAF at each meeting and will seek assurance via the minutes of other Board committees that risks are being appropriately managed and robust processes exist to provide assurance that risks are managed appropriately to enable achievement of CCG objectives.

4.3.2 The Audit Committees will review the Risk Management Policy on an annual basis and will be responsible for agreeing the annual audit plan to ensure the CCG receives

assurance that controls are adequate and effective and will obtain assurance sufficient to enable the Governance Statement to be signed-off by the Accountable Officer at the end of each financial year.

Patient Safety & Quality Committees

4.3.3 The Patient Safety & Quality Committees are the committees with overarching responsibility for the management of safety and quality related risks. The Committees will receive the extract of relevant risks at each meeting (bi-monthly) to review risks and seek assurance that actions are being taken to mitigate and manage risks to the target risk level. The Committees will be responsible for holding management to account for risk mitigation and recommending the escalation/de-escalation/closure of risks on the CRR and BAF.

Finance & Performance Committees

4.3.4 The Finance & Performance Committees are the committees with overarching responsibility for the management of finance and performance related risks. The Committees will receive the extract of relevant risks at each meeting (bi-monthly) to review risks and seek assurance that actions are being taken to mitigate and manage risks to the target risk level. The Committees will be responsible for holding management to account for risk mitigation and recommending the escalation/de-escalation/closure of risks on the CRR and BAF.

4.4 MSECCGs Joint Committee

4.4.1 The MSE CCGs Joint Committee is the committees with overarching responsibility for the management of risk associated with the matters delegated to the Committee by the CCGs. The Joint Committee will receive the extract of relevant risks associated with their delegated authority at each meeting (bi-monthly) to review risks and seek assurance that actions are being taken to mitigate and manage risks to the target risk level. The Committee will be responsible for holding management to account for risk mitigation and recommending the escalation/de-escalation/closure of risks on the CRR and BAF.

4.5 Accountable Officer

4.5.1 The Accountable Officer has overall responsibility for ensuring there is an effective risk management system in place within the CCG, for meeting statutory requirements and adhering to guidance issued by NHS England in respect of governance.

4.5.2 The Accountable Officer will report annually to the CCG Boards on the adequacy of internal control and risk management as part of the Board's overall responsibility to prepare a Governance Statement for inclusion in the CCGs' Annual Reports.

4.5.3 This will be delivered through the office of the Chief of Staff and via the Governance Leads of the MSE CCGs.

4.6 Chief Finance Officer

4.6.1 The Chief Finance Officer has delegated responsibility for financial risk management and will ensure:

- The effectiveness of the CCGs financial control systems.
- Significant financial risks faced by the CCG are identified and managed effectively.
- The Audit Committee and Internal Audit effectively perform their roles in assuring the CCGs system of internal control.

- Robust counter fraud arrangements are in place and comply with NHS standards in relation to counter fraud.

4.6.2 The Chief Finance Officer also acts as the Senior Information Risk Owner.

4.7 Executive Director of Nursing & Quality

4.7.1 The Executive Director of Nursing & Quality has lead officer responsibility and accountability for safeguarding children and adults for the CCGs and works in partnership with the Local Authority and other key agencies to ensure that the statutory duties of the CCGs in relation to safeguarding children and adults are met. The Executive Director of Nursing & Quality also acts as the Caldicott Guardian for the CCGs.

4.7.2 The Executive Director of Nursing & Quality provides assurance to the Boards regarding patient safety within commissioned services in line with local and national legislation and guidance and will therefore ensure that any associated risks are appropriately captured on the BAF and CRR along with actions taken to manage those risks.

4.8 NHS Alliance Directors and Executive Directors

4.8.1 The NHS Alliance Directors and Executive Directors are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility. They are also responsible for ensuring that all members of their staff area aware of the risks within their work environment and of their personal responsibilities, and that all their staff receive appropriate information, instruction and training to enable them to work safely. These responsibilities extend to anyone affected by the CCG's operations, including contractors, members of the public and visitors.

4.8.2 Responsibilities also include ensuring that all necessary risk assessments are carried out within their directorate/department in liaison with relevant advisors where necessary, e.g. in relation to Health & Safety and Information Governance and ensuring the identification and mitigation of risk within all investment plans, business cases, and new projects initiated by the CCG or Joint Committee.

4.8.3 NHS Alliance Directors and Executive Directors are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated areas and scope of responsibility. In situations where red/extreme operational risks have been identified and where local control measures are considered inadequate, they are responsible for escalating those risks for the attention of the relevant Committee. Furthermore, where risks remain static over three iterations of the BAF/CRR the Directors will be called to account by the relevant Committee to explain the circumstances surrounding the risks and how and when they will be managed to their target level.

4.8.4 Directors may delegate the delivery of some of the operational risk processes to an appropriate senior manager, who will be named as the 'System/Place Lead' on the BAF and will be responsible for providing regular updates on risks.

4.9 Governance Leads - Policy Authors

4.9.1 The Governance Leads of each CCG have operational responsibility for the development and implementation and review of the CCG's Risk Management Policy,

Board Assurance Framework and ensuring that comprehensive registers of all significant risks that might impact upon achievement of the CCG's strategic objectives are maintained, updated and reported regularly to the relevant Committees/Sub-Committees, the CCG Boards and the Joint Committee. This will include:

- Ensuring risk management systems are in place throughout the CCGs.
- Ensuring the BAF and CRR is regularly reviewed by the senior managers designated as risk holders, updated and reported to the CCG Boards and committees.
- Ensuring that there is appropriate external review of the CCGs' risk management processes (for example as part of the internal audit programme) and that the outcome is reported to the Audit Committees.
- Ensuring that identified risk mitigation and actions are put in place, regularly monitored and implemented.
- Ensuring that risks are reviewed in line with the CCGs reporting arrangements.
- Providing advice on the risk management process.
- Working collaboratively with Internal and External Audit.
- Ensuring that the Risk Management Policy is updated on an annual basis and approved by the CCG Boards.
- Ensuring that the CCGs comply with relevant legislation and guidance.
- Ensuring that the CCGs move towards closer management of risks across the mid and south Essex system by review and (where appropriate) incorporation of system risks into the BAF and CRR.

4.9.2 The Head of Corporate Governance from Mid Essex CCG has responsibility for co-ordinating and leading the working in relation to the BAF and CRR on behalf of all CCGs.

4.10 Partnership Working

4.10.1 It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks are most difficult to ascertain. Only by working closely and collaboratively with a wide range of partner organisations can these risks be identified and properly managed.

4.10.2 The CCG will endeavour to involve partner organisations in all aspects of risk management as appropriate. Key partners include GP Practices, providers of shared services to the CCGs, Provider Trusts, Local Authorities, the Police, statutory and voluntary bodies and patient representative groups.

4.10.3 Although the CCG currently works closely with key stakeholders around areas of identified risk (such as child protection, discharge arrangements, workforce planning) and there are a number of joint structures that exist between agencies (e.g. Partnership Boards), more explicit systems need to be developed to ensure that risk management is fully integrated in joint working arrangements.

4.10.4 With the establishment of the Joint Committee, the CCGs are developing governance arrangements for risks where accountability remains with the CCG, but responsibility for the management of associated risks sits with system partners and is overseen by groups such as the System Finance Leaders Group, System Leaders Executive Group and System Oversight and Assurance Group.

5 POLICY DETAIL

5.1 Overview

5.1.1 The CCG has adopted the Australia/New Zealand risk management model, advocated within the Orange Book. This provides a generic model for identifying, prioritising and dealing with risks in any situation, whether at local or corporate level. There are 7 stages to managing risk in this model:

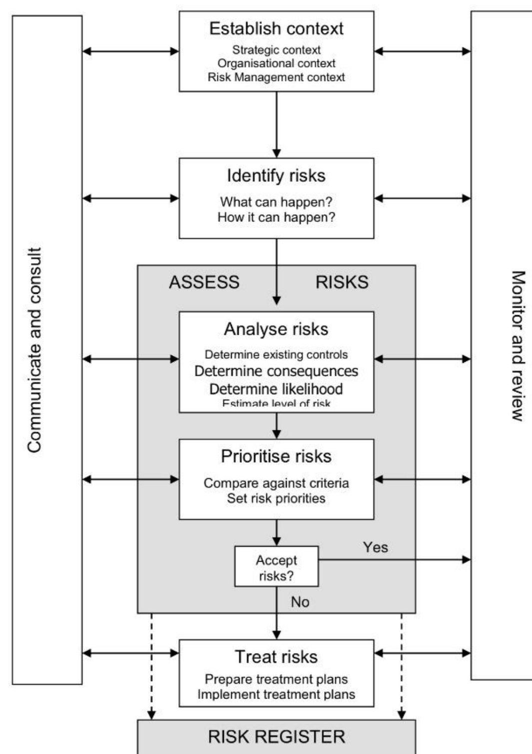
1. Establish the context
2. Identify hazards
3. Analyse risk
4. Prioritise risk
5. Treat risk
6. Monitor and review
7. Communicate and consult

5.1.2 Each stage of the risk management process should be documented in order to:

- Demonstrate the process is conducted properly.
- Provide evidence of systematic approach.
- Provide a record of risk and to develop the CCGs knowledge of risk.
- Provide relevant decision makers with a risk management plan for approval etc.
- Provide an accountability mechanism and tool.
- Facilitate review and monitoring.
- Provide an audit trail.
- Share and communicate information.

5.2 Risk Management Process Model

5.2.1 The diagram below summarises the risk management process model:



5.3 Defining Strategic Objectives / Identifying Functions & Duties

5.3.1 The risk management programme is the primary system by which the CCG Boards can gain assurance that the CCGs are achieving their objectives, functions and duties. It provides the system by which senior management can manage the risks that threaten the delivery of those objectives.

5.3.2 Strategic objectives must be well defined and cover the statutory duties of the CCG and the objectives it must meet. At the outset of the year the CCGs set out their Operational Plan defining their vision and operational objectives for the year ahead as reflected in the overall objectives of the Mid and South Essex Health & Care Partnership (HCP) Plan and locally within the Alliance 'Place Plans'.

5.3.3 For 2021/22 the CCG Strategic Objectives have been defined as:

Strategic Objective 1	Restore access to services to achieve performance against NHS Constitutional standards, quality improvement priorities and deliver ongoing COVID-19 requirements.
Strategic Objective 2	Work with partner organisations and our population to address health inequalities, including those derived from Covid-19, and achieve social value.
Strategic Objective 3	Support system transformation and organisational change to ensure the ICS is successfully established and can fulfil its aims and duties.
Strategic Objective 4	Develop and support the creation and wellbeing of a diverse and highly skilled workforce and ensure the safe transition of staff to the new organisation.
Strategic Objective 5	Achieve key statutory financial duties including delivery of the system financial control total, value for money and reduction of the underlying system deficit.
Strategic Objective 6	Build effective Alliances at place to transform and strengthen the ability of Primary and Community Care Services to focus upon prevention and early intervention and improve outcomes in the most appropriate settings.
Strategic Objective 7	Promote digitally delivered services whilst considering the requirements of those who need to access services in other ways.

5.3.4 A workstream structure has been developed across MSE, as well as four 'Places'; Basildon & Brentwood, Mid Essex, South East Essex and Thurrock; to deliver the objectives across the system and place and is shown in the table below. To ensure a comprehensive risk profile is established, each of the workstreams feature within the BAF and CRR against which a detailed risk assessment is carried out, identifying the risks associated with the delivery of the workstreams and ultimately the overarching objectives of the CCGs.

System Priorities & Programmes	
Planned Care	Urgent Emergency Care
Cancer & End of Life	Vaccination
Community	Health Inequalities
Mental Health & LD	CYP / Maternity
Estates	Digital & BI
People	Population Health
Medicines Optimisation	Stewardship
Primary Care	Integrated Care System
Maternity	Finance

5.4 Identifying Risks

5.4.1 The CCGs must know what risks they face in order to actively manage them and therefore identifying risks is the first step in building the CCGs risk profile. To truly embed a culture of risk management throughout the CCG, it has been decided to take a combined 'top down' and 'bottom up' approach to the identification of risk.

5.4.2 It is important to have both a pro-active and re-active approach to identifying risk and so once both strategic objectives have been identified the risk assessment must use prior experience and knowledge of existing risks (re-active) as well as horizon scanning (pro-active) to identify risks. Horizon scanning expands the risk management framework to identify 'potential' risks to the achievement of objectives to foresee and react to risks before they are realised.

5.4.3 To capture a full profile of risks across MSE, each workstream lead is asked to identify the work they need to undertake to achieve their overarching objectives and asses what significant risks exist that could impact on the achievement of their workstream objectives. This is mapped within the BAF and CRR.

5.5 Rating of Risks (assessing the impact and likelihood of risks)

5.5.1 Once risks have been identified, they need to be assessed to determine the severity of the impact of the risk and how likely it is to occur. There are three important principles for assessing risk:

- Ensure that there is a clearly structured process in which both likelihood and impact are considered for each risk;
- Record the assessment of risk in a way which facilitates monitoring and the identification of risk priorities;
- Be clear about the difference between, inherent and residual risk.

5.5.2 The CCG uses a 5 x 5 matrix to assess the impact and likelihood of risks.

5.5.3 The rating of risks is useful as a guide for prioritising mitigation of risks and ensuring that risks are brought to the attention of the most appropriate staff, i.e. the highest risks are notified to the most senior management level.

5.5.4 Risk is measured in two dimensions: the *impact* **(Appendix B)** (what the outcome would be should the risk materialise) and the *likelihood* **(Appendix C)** (how probable it is that the risk will materialise). The overarching risk rating will result in risks being rated in one of the following three categories **(Appendix D)**:

- Extreme risk (red), those rated 15 or above
- Medium risk (amber), those rated between 8 and 12
- Low risk (green), those rated between 1 and 6.

5.5.5 In many cases, there will be existing controls already in place to reduce the impact and likelihood of risks, e.g. policies and procedure, monitoring and reporting mechanisms, audits and training. The effectiveness of these controls will be mapped against identified risks in the bi-monthly update description and the residual risk assessed as described below.

Assessing the Impact of Risks

5.5.6 Risks manifest themselves in varying ways. In some cases, a numerical value can be assigned allowing for a very structured approach to the assessment, but in other cases this is not possible because the risk is more subjective. A framework is therefore required to ensure that all risks are assessed consistently. Appendix B provides the framework for assessing the potential impact of a risk by guiding the assessor as to what constitutes a 1 to 5 score in several example areas.

5.5.7 Risks identified within the BAF and CRR are selected from a drop-down list of the following categories:

- Acute Hospital Demand
- Claims & Complaints
- Finance
- Health Inequality
- Patient Experience
- Patient Safety & Harm
- Primary Care Demand
- Regulator Penalties
- Reputational Damage
- Safeguarding
- Service Delivery

5.5.8 Each of the categories selected will identify the potential negative outcomes of not achieving the associated workstream objective for example a failure to deliver the objectives of Continuing HealthCare could result in reputational damage, acute hospital demand and patient experience. Management will have the opportunity to filter risks to identify those risks that could impact on patient experience for example, providing a dynamic approach to reviewing and prioritising the management of risks.

5.5.9 The impact of risks (both inherent and residual) is recorded in the BAF/CRR on a scale of 1 to 5 and is based on the most likely impact/outcome; where there is more than one potential outcome the highest score of the scores is recorded.

Assessing the likelihood: design of key controls

5.5.10 To understand what action needs to be taken to address risk, the assessor will need to determine how likely it is that the risk may be realised. The likelihood assessment provides the context for how systems of internal control have already been established to manage the risk.

5.5.11 Firstly, an assessment needs to be made of the inherent likelihood of the risk being realised. This is how likely it is the risk may be realised if there are no control measures in place and allows the CCG to understand what exposure there will be should the controls in place fail. The assessor should consult the description element of the likelihood assessment matrix at Appendix C.

5.5.12 Once the inherent risk score (impact score x inherent likelihood score) has been determined, the assessor can then identify the measures of internal control and resources that have been established to manage the risk, which will inform the current likelihood score. The assessor should consult the 'controls' and 'resources' section of the likelihood assessment matrix in Appendix C to determine the current likelihood score.

5.5.13 As a moderating process to ensure consistency of approach the Head of Corporate Governance co-ordinating the BAF/CRR will review all risks with risk owners and ensure that the scoring of impact and likelihood conforms to the corporate approach and methodology set out within this policy, taking account of most recent data/intelligence/circumstances.

5.6 Prioritisation of Risks

5.6.1 Risk prioritisation involves agreeing the order in which risks need to be addressed. Generally, risks will be prioritised according to their rating, i.e. the higher the rating, the higher the priority afforded to mitigating the risk. However, some minor risks may be easy to address and tackled sooner rather than later for that reason. Some extreme risks may be part of the nature of care provided and difficult, impractical and even inappropriate to reduce. Reducing a risk may have an adverse impact on another aspect of the business of the CCGs, prevent the taking up of an important opportunity or stifle innovation. Risk prioritisation must consider these broader considerations. For this reason, the Committees will have responsibility for prioritising within their remit risks, except those relating to the system of financial controls which will be prioritised by the Audit Committee.

5.6.2 Risk owners will be accountable to their relevant Committee for risks that remain unchanged over three iterations of the BAF and consider whether to categorise the risk as 'long burning', where the nature of the risk will take time to mitigate or whether 'innovative' or 'radical' actions can be taken to make more immediate progress to address the risk.

5.7 Risk Appetite

5.7.1 It is the amount of risk that any organisation is prepared to accept, tolerate or be exposed to at any one point in time. The Board will discuss and agree the risk appetite of the CCGs annually, a summary of which has been included in **Appendix E**.

5.7.2 The CCGs will express their risk appetite target score by using the 5 x 5 matrix used for assessing risk and will agree the target risk rating for each risk based on the relevant category it falls within (i.e. Finance, Clinical Quality & Patient Safety, Statutory & Regulatory Compliance, Reputation, Innovation, Partnerships/Clinical Engagement **(Appendix E**).

5.8 Treatment of Risks

5.8.1 Once the risk priority has been set in the context of the CCGs' risk appetite, a decision must be made about the action to be taken to address the risk. The purpose of addressing risk is to turn uncertainty to the CCGs' benefit by constraining threats and taking advantage of opportunities. There are four broad categories of how risks are managed as follows:

- Tolerate

This is where the Boards take a decision to accept the risk involved. This may be because it is within the CCGs' risk appetite, the ability to do anything about the risk is very limited or the cost of acting is disproportionate to the potential benefit gained. Any risk area 'accepted' must be accompanied by contingency plans for handling the impact that might arise if the risk is realised.

- Transfer
  It might be necessary to transfer some risks. This can be achieved by conventional insurance or by contracting the service to another provider / third party. In most cases the risks will not be 'fully' transferrable and consequently the CCGs may retain some element of risk such as those relating to reputational damage. The CCGs must be mindful of risks that are transferred where they still hold some accountability. The relationship with the body to whom the risk has transferred should be managed effectively to successfully transfer the risk.

- Terminate
  Depending on the risk appetite and the risk involved, the only sensible option may be to terminate the risk. For example, by closing a service / terminating activity. This is a fairly limited option in the NHS and must therefore be fully considered in terms of the potential impact and 'side effects' of doing so before any decision is made.

- Treat
  Most risks will be addressed in this way. This is where measures of internal control are introduced or strengthened to constrain the risk to an appropriate level.

5.8.2 Once the above options have been considered and the most appropriate way forward identified, a risk action plan will be drawn up and implemented. The rating and prioritisation of the risk will determine the speed at which the risk action plan should be implemented and the level of the organisation to which the risk must be reported.

- **Extreme (Red) risk** – immediate action required. The appropriate Director must be informed, who will take responsibility for development and implementation of an appropriate risk action plan. Risk and proposed action plan to be reported to the relevant Committee and Board level. Risks rated 'extreme' will constitute the Board Assurance Framework as key risks that may impact on the delivery of strategic objectives.
- **High (Amber) risk** – urgent senior management attention required. Within one month an appropriate action plan must be agreed, usually with a deadline for completion of no more than 6 months. Risk and proposed action plan to be reported to the relevant Committee.
- **Low (Green) risk** – acceptable risk. Periodic monitoring and review may be undertaken at Directorate/Departmental level to ensure that risk has not escalated, and controls are still effective.

5.9 Assurance

5.9.1 The primary function of the Board Assurance Framework is to provide assurance to the Boards that the CCGs are managing the risks to the achievement of their strategic objectives. This is achieved through discussion at the Boards/Joint Committee of the

extreme risk areas and the steps that are being taken to better manage the risk (thereby reducing the overall risk rating).

5.9.2 Assurance is a process whereby the control measures established to address risks are tested to confirm if they are working. Assurance can be received from 'internal' sources i.e. departmental reports, committee minutes, key performance metrics, or they can be from 'external' sources i.e. from a body that is independent of the CCG such as the internal or external auditors, CQC, Consultants or NHS England.

5.9.3 Assurance can be in the form of a verbal update, written report, minutes of meetings, statistics or actual document such as policies or procedures. Furthermore, the assurance themselves can be either positive or negative. Positive assurance confirms that the controls are operating as expected, negative assurance confirms that controls are not working in practice or are not effective.

5.9.4 The Board Assurance Framework and Corporate Risk Register records the potential sources of assurance available against key risks as well as documenting the actual assurances received and the outcome of that assurance.

5.9.5 It is important to ensure that 'assurance' is read in full before being applied to the framework so that it is clear whether the report is commenting on the whole system of control or just individual elements, in the latter case this would require further assurance to be attained.

5.9.6 Assurances are documented within the BAF/CRR using the 'three lines of defence'. The 'description/controls' column within the framework outlines the first line of defence whereby risk owners explain the control measures in place to manage the risk and provide an update as to the status of the risk. 'Success measures' document the second line of defence by measuring how successful the workstream risks are being managed. Finally, the third line of defence documents where independent assurance has been received in relation to the control measures in place to manage the risk.

5.10 Action Planning

5.10.1 Action plans must be established to address any gaps in the systems of internal control as well as any gaps in the assurance process. High level actions are documented on the Board Assurance Framework and Corporate Risk Register along with a deadline for completion.

5.10.2 Action plans are not required for risks that meet the CCG risk appetite.

5.11 Monitoring & Review of the BAF

5.11.1 The Board Assurance Framework is an on-going continual process based on the 'Plan, Do Check, Act' model. Therefore, risks are updated bi-monthly (as well as ad hoc) and are revisited annually. The rationale for this is continual improvement in the risk management process.

5.11.2 Committees will consider whether a detailed review should be undertaken of any strategic risk where the rating has increased or has not decreased for three consecutive iterations of the BAF.

5.12 Risk Registers

5.12.1 The CCGs operate a combined risk register and Board Assurance Framework whereby risks rated as extreme constitute the Board Assurance Framework and those rated

less than extreme constitute the CCGs Corporate Risk Register.

5.12.2 Risk registers are therefore documented within the framework for all areas of the CCGs operations as set out in 5.3.4.

5.12.3 The requirement for all NHS Accountable Officers to sign a Governance Statement as part of the statutory accounts and annual report heightens the need for Boards to be able to demonstrate that they have been properly informed about the totality of their risks, both clinical and non-clinical. To do this they need to be able to provide evidence that they have systematically identified their objectives and managed the principal risks to achieving them.

5.12.4 The Audit Committee will be responsible for preparing a summary report to the Boards about the effectiveness of the organisation's system of internal control; the Board Assurance Framework.

5.12.5 The Board Assurance Framework will identify which of the organisation's strategic objectives are at risk because of inadequacies in the operation of the organisational controls or areas where the organisation has insufficient assurance about the effectiveness of the controls in place. At the same time the Board Assurance Framework will provide structured assurances where key risks are being managed effectively and which strategic objectives are being delivered.

5.12.6 The Board Assurance Framework will form the key document for the Boards in ensuring all principal risks are controlled, that the effectiveness of these key controls has been assured, and that there is sufficient evidence to support the Governance Statement.

6 MONITORING COMPLIANCE

6.1 The Governance Leads are responsible for monitoring the ongoing compliance with this policy and ensuring that an appropriate risk management culture is embedded within the CCGs.

6.2 The Audit Committees of the CCGs are accountable to the Boards for ensuring that the risk management process delivers as expected and so will scrutinise the BAF and seek assurance from the Governance Leads that the process remains robust and operates effectively.

6.3 The Audit Committee will ensure that the Annual Internal Audit Plan incorporates periodic assurance to the Board on the robustness of the CCGs risk management arrangements to support completion of the Governance Statement.

7 STAFF TRAINING

7.1 All staff will be made aware of the CCGs Risk Management Policy, what their role is and the forms of support available to them. Line Managers will be responsible for ensuring that employees' risk management training needs are assessed via local induction and reviewed annually via the CCGs individual performance review procedure.

7.2 The Governance Leads will provide ongoing risk management support to relevant staff and will offer one-to-one meetings with all Risk Owners, or attendance at team meetings, to assist in the review of their risks prior to each Committee, Board or Joint Committee meeting. The Governance Leads will also offer risk awareness training to supplement that provided via the e-learning portal were appropriate.

8 ARRANGEMENTS FOR REVIEW

8.1 This policy will be reviewed annually. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance.

8.2 If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the CCG Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the CCG Board.

9 ASSOCIATED DOCUMENTATION / POLICIES

- Board Assurance Framework and Corporate Risk Register
- Risk Management Training

Associated Policies

- Health & Safety Policy
- Conflicts of Interest Policy
- Information Governance Policy
- Anti-Fraud, Bribery and Corruption Policy
- Whistleblowing Policy
- Standards of Business Conduct Policy

10 REFERENCES

- The Orange Book: Management of Risk – Principles and Concepts; HM Treasury, October 2004.
- Risk Management Assessment Framework: a tool for departments: HM Treasury, July 2009
- NHS England: Risk Management Policy and Process Guide
- National Patient Safety Agency: Risk Assessment Programme Overview
- Department of Finance and Personnel: Policy and Framework for Risk Management
- HM Treasury: Managing Risks with Delivery Partners
- HM Treasury: Thinking about Risk (Managing your risk appetite: A Practitioner's Guide)
- COSO: Enterprise Risk Management – Integrated Framework
- COSO: ERM Risk Assessment in Practice
- COSO: Enterprise Risk Management – Understanding and Communicating Risk Appetite
- COSO: Internal Control – Integrated Framework.

11 LIST OF STAKEHOLDERS CONSULTED

Date Policy Circulated	Name of Individual or Group	Were Comments Received?	Were Comments incorporated into Policy?	If no, why not?
12/10/2021	Governance Leads	Yes	Yes	
15/10/2021	Audit Committee			

12 Equality Impact Assessment

12.1 The policy has been assessed for equality impact. The Risk Management Policy is applicable at varying levels to every member of staff within the CCGs irrespective of their race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability. The EIA has identified no equality issues with this policy.

12.2 The EIA has been included as Appendix A.

13 Change History:

Date	Version	Author	Description
11/10/2021	0.1	Nicola Adams, Associate Director of Corporate Governance	1st draft of combined MSE policy.
12/10/2021	0.2		Updated draft submitted to audit committee.

APPENDIX A

Equality Impact Assessment

To be completed and attached to any policy/procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	▪ Race	No	
	▪ Ethnic origins (including gypsies and travellers)	No	
	▪ Nationality	No	
	▪ Gender	No	
	▪ Culture	No	
	▪ Religion or belief	No	
	▪ Sexual orientation including lesbian, gay and bisexual people	No	
	▪ Age	No	
	▪ Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	N/A	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

APPENDIX B

Severity of Impact Framework

Level	Objectives / Projects	Clinical / Injury	Patient Experience	Complaints / Claims	Service / Business Interruption	Staffing and Competence / HR / OD	Financial / Materiality	Adverse Publicity / Reputation
1 Low	Insignificant cost increase / schedule slippage Barely noticeable reduction in scope or quality.	Minor Injury not requiring first aid.	Unsatisfactory patient experience not directly related to patient care.	Locally resolved complaint.	Loss / interruption > 1 hour.	Short term low staffing level temporarily reduces service quality (<1 day)	< £50k	Rumours
2 Medium	Less than 5% over budget / schedule slippage. Minor reduction in quality / scope.	Minor injury or illness, first aid treatment needed.	Unsatisfactory patient experience partly related to patient care – readily resolvable.	Justified complaint peripheral to clinical care.	Loss / interruption > 8 hours.	On-going low staffing level reduces service quality.	£50k – < £100K	Local media – Short-term. Minor effect on staff morale / service.
3 High	5-10% over budget / schedule slippage. Reduction in quality or scope.	Moderate injury or illness, requiring first aid or medical treatment i.e. fractures. RIDDOR / Agency Reportable.	Mismanagement of patient care.	Below excess claim. Justified complaint involving lack of appropriate care.	Loss / interruption > 1 day.	Late delivery of key objective / service due to lack of staff. Minor error due to poor training. On-going unsafe staffing level.	£100K – < £500K	Local media – Long-term. Significant effect on staff morale / Service.
4 Major	10-25% over budget / schedule slippage. Doesn’t meet secondary objectives.	Major injuries, or long-term incapacity / disability (loss of limb)	Serious mismanagement of patient care.	Claim above excess level. Multiple justified complaints.	Loss / interruption > 1 week.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to poor training.	£500K - < £1m	National Media - < 3 days.
5 Critical	>25% over budget / schedule slippage. Doesn’t meet primary objectives.	Death or major permanent incapacity.	Totally unsatisfactory patient outcome or experience.	Multiple claims or singe major claim.	Permanent loss of service or facility.	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training.	>£1m	National media - > 3 days. MP Concern (questions in House)

APPENDIX C

Likelihood Assessment Framework

Level	Description	Controls	Resources	KPIs/Output
1 Rare	The event **may** only happen in **exceptional circumstances**. < 20% chance or occurrence Could occur within 5 to 10 years	System controls are **sound** and **working effectively.** Policies and procedures established and followed.	**Stable** staff environment. **Good** training & development (T&D). **Positive** staff morale. **Suitable** premises / working environment	KPIs established and met. Full reporting to mgt & board. Accurate / valid mgt info
2 Unlikely	The event **could** occur (recur) at **some time**. 20% - 40% chance of occurrence Could occur within 1 to 5 years	System controls are **essentially sound** but minor weaknesses may still exist. Policies and procedures in place, but may not always by followed.	**Fairly stable** staff environment. **Some** T&D issues. **Generally positive** staff morale. Premises suitable, but a **little restrictive**.	KPIs generally established / met. Reporting to mgt / board generally good. Mgt info generally accurate / valid, may be some errors.
3 Possible	The event **may well** occur (recur) at some time, **but may not**. 40% - 60% chance of occurrence Could occur within 1 year	Some systems control **may be missing** or **applied inconsistently.** Policies and procedures generally exist, some may be missing or they may not be followed in a number of cases.	**Some** staff turnover / sickness. T&D **could be improved**. Staff morale **indifferent.** Premises in need of **some repair** / larger premises required	KPIs established, but not always met / monitored. Mgt info available, not always reported to mgt / board, sometimes unreliable.
4 Likely	The event **will occur** (recur) in **most circumstances**. (Could probably happen) 60% - 80% chance of occurrence Could occur within 6 months	A number of key controls **are missing** or controls are **not followed.** Policies and procedures generally lacking.	**Medium** staff turnover / sickness. **Lack** of T&D. **Low** staff morale. Premises requires **high level of repair** or is highly inappropriate (i.e. size)	Lack of appropriate KPIs or clear fall in performance. Lack of reports to mgt / Board. Data generally unreliable in most cases.
5 Almost Certain	The event is **expected to occur** (recur) in **all circumstances**. (Will happen, just a matter of when) 80% - 100% chance of occurrence Could occur within 1 month	Serious **lack of controls.** No policies / procedures established.	**Unstable** staff environment (i.e. high turnover / sickness). High use of agency staff. **Poor** T&D. **Negative** staff morale. **Unsuitable** premises / working environment.	KPIs not established / met. Lack of reporting to mgt / board. Unreliable management information.

APPENDIX D

Risk Assessment Matrix

Likelihood of Occurrence		Severity of Impact				
		Negligible (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Critical (5)**
	Rare (1)	1	2	3	4	5
	Unlikely (2)	2	4	6	8	10
	Possible (3)	3	6	9	12	15
	Likely (4)	4	8	12	16	20
	Almost certain (5)	5	10	15	20	25

APPENDIX E

Summary Risk Appetite and Acceptable Risk Score

Risk Category	Appetite	Acceptable Risk Score	Rationale
Finance	Moderate	10	The CCGs will seek to reduce risk levels to moderate and will seek to avoid risks above this level. However, this should not underestimate the challenges that CCGs will have in maintaining expenditure within allocated resources limits.
Fraud and negligent financial loss	Low	5	The CCGs will not tolerate financial losses from fraud and negligent conduct as this represents corporate failure to safeguard public resources.
Clinical Quality and Patient Safety	Low	5	The CCGs hold patient and staff safety in the highest regard and will not accept any risks that threaten this. The CCGs will commission high quality services for our patients. We will only rarely accept risks which threaten that goal.
Statutory and Regulatory Compliance	Moderate	10	The CCGs will comply with all applicable legislation and will not accept any risk which (if realised) would result in non-compliance.
Reputation	Moderate	10	The CCGs will maintain high standards of conduct and will not accept risks that may cause reputational harm because it could undermine public and stakeholder confidence.
Partnerships, Engagement and Collaborative Working	High	12	The CCGs will work with their member practices and other organisations (including but not restricted to other CCGs and Local Authorities) to ensure the best outcome for patients and communities. The CCGs are willing to accept the risks associated with a collaborative approach.
Innovation and Transformation	High	12	The CCGs encourage a culture of innovation and are willing to accept risks associated with this approach where they do not threaten risk areas that the CCG are not prepared to accept (as defined above e.g. quality patient care / safety).
Provider Performance	Moderate	8	The CCGs accept that Provider performance is challenged and there are underlying workforce deficits which mean that changes of performance can take some time to realise.
Commissioning	Moderate	8	Innovative approaches for commissioning incorporate an inherently high level of risk, which can impact on the delivery of outcomes.
National Policy	Low	5	The CCGs will follow national policy.
Clinical Engagement	Low	5	The CCGs place importance on the positive effects of clinical engagement and will endeavour to manage issues that risk this.