Risk Management Strategy

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Owner	Justin Dix
Approving Committee	Governing Body
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Version History

V.	Date	Status and/ or amendments
4.1	Sep 2016	Audit Committee approved

Improving care together
across Surrey Downs

Equality statement

Surrey Downs Clinical Commissioning Group (Surrey Downs CCG) aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability. Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

Surrey Downs CCG embraces the six staff pledges in the NHS Constitution. This policy is consistent with these pledges.

Equality analysis

This policy has been subject to an Equality Analysis, the outcome of which is recorded below.

		Yes, No or N/A	Comments
1.	Does the document/guidance affect one group less or more favourably than another on the basis of:		
	Age Where this is referred to, it refers to a person belonging to a particular age (e.g. 32 year olds) or range of ages (e.g. 18 - 30 year olds).	No	
	Disability A person has a disability if s/he 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.	No	
	Gender reassignment The process of transitioning from one gender to another.	No	

	Marriage and civil partnership In England and Wales marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples (except where permitted by the Equality Act).	No	
	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. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.	No	
	Race Refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins	No	
	Religion and belief Religion has the meaning usually given to it 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	No	
	Sexual orientation	No	

	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes		
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the document/guidance likely to be negative?	No	
5.	If so, can the impact be avoided?	N/A	
6.	What alternative is there to achieving the document/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

For advice in respect of answering the above questions, please contact the Corporate Office, Surrey Downs CCG. If you have identified a potential discriminatory impact of this procedural document, please contact as above.

Names and Organisation of Individuals who carried out the Assessment	Date of the Assessment
Justin Dix	September 2016
Haneef Khalid	

Contents

Appendices

1. Statement of Intent

1.1. Surrey Downs Clinical Commissioning Group (SDCCG) is committed to a strategy which provides a robust framework underpinned by effective governance ensuring it has structures in place that will effectively identify and manage risks (both acceptable and unacceptable) which are in line with its key aims. Some of these risks will be internal and thus, controlled by internal systems and controls. Other risks are external and arise due to unpredictable changes in the following environments: business, economic, financial, political and technology.

1.2 SDCCG's Governing Body will ensure it has in place a risk management framework to best support the key aims which are to commission high quality, safe and cost effective services. In doing this SDCCG will use this framework to take reasonable and practicable steps in the management of risks associated with; commissioned services, staff & visitors, SDCCG's reputation and its assets.

1.3 The philosophy at SDCCG is centred on the quality of care provided to patients and the safety of patients and it is these elements which create the culture embodied in its leadership and staff.

1.4 It is paramount a culture of openness and transparency is promoted and upheld throughout SDCCG so that risks can be; identified, evaluated, recorded and effectively managed.

1.5 The CCG will implement the 'three lines of Defence Model' (see appendix 1). This will see contracted suppliers, primary care contractors, local authority partners and any other partner it works with form part of the overall risk management process.

1.6 No organisation will be innovative without taking risks. The risk management framework is centred on identifying risks and managing these risks in a controlled manner. Accepting a risk is not a failure to managing a risk

1.7 The Governing Body will seek assurance the risk management framework is working effectively through its own activities and of its sub committees.

1.8 The Board Assurance Framework will provide a simple and comprehensive method for the effective and focused management of the principle risks to meeting the functions & strategic objectives of SDCCG. It will also provide a structure for evidence to support the Governing Body and Annual Governance statement

2. Introduction

2.1 This strategy sets out SDCCG’s approach to strategic management of risk and the supporting infrastructure which enables informed management decisions in; identification, assessment, treatment and monitoring of risk.

2.2 The Governing Body is responsible for ensuring SDCCG consistently follows the principles of good governance and are applicable to NHS organisations through its Assurance Framework and other processes. This is to include development of systems and processes for; financial and organisational control, clinical and information governance and risk management.

2.3 SDCCG’s Governing Body expects staff to acknowledge risks can be identified and managed if everyone adopts a standardised approach and is thus, committed to an open, transparent and honest approach to all matters.

2.4 Risk management is the process by which an organisation identifies and assesses the risks and puts forward controls and agreed actions are taken. This strategy provides the scope of risk management at SDCCG.

2.5 Risk is inherited in everything SDCCG does from commissioning services to managing projects. Thus, effective risk management is essential for the organisation in meeting both its strategic and operational objectives.

2.6 The Board Assurance Framework encompasses the management of all types of risk which SDCCG may be exposed to both clinical and non-clinical.

2.7 The Board Assurance is the systematic method of; identifying, analysing, evaluating (treating and reviewing) and communicating risks to ensure SDCCG’s corporate objectives are being achieved.

2.8 In line with SDCCG achieving its objectives this strategy has been devised to support its overall assurance framework and to ensure risks (whether actual or potential) are identified and actions are taken to eliminate or mitigate the potential impact.

2.9 SDCCG will take a proactive approach to risk management through effective organisational governance arrangements.

3. Principles of Strategy

3.1 The Governing Body, Executive Management Team (EMT), Heads of Service and Senior management are committed to risk management and provide risk management leadership.

3.2 Not all risks can be eliminated and it is therefore the Governing Body's responsibility to ensure systems and controls are in place to manage some risks at an acceptable level.

3.3 Risk appetite is the amount of risk an organisation is prepared to take whilst pursuing its objectives and risk tolerance is the amount of uncertainty it is prepared to accept. Ultimate ownership of defining SDCCG's risk appetite falls with the Governing Body (see appendix 2).

3.4 Clearly defined responsibility and ownership of risks and associated action plans.

3.5 Effective staff participation and consultation, where appropriate in the risk management process.

3.6 All Risks, Incidents, Complaints and FOIs to be recorded on SDCCG'S DatixWeb system.

3.7 Resources within each department/team to implement and support the risk management process will be provided.

4. Risk Management Strategy

4.1 There are to be three tiers of risk:

a. Risk to the organisation's functions – these are high level and usually strategic and are managed through the Governing Body assurance framework. The Governing Body takes corporate responsibility for ensuring that it directs the Executive where necessary on the scale of mitigation and willingness to accept risk
b. Significant risks that the Governing Body should be sighted on but which should be managed by the executive.
c. Project risks or service area risks which are the subject of local risk registers which the executive should be sighted on.
(see appendix 3).

4.2 The Governing Body should:

a. Within itself should have an informed consideration of risk which underpins SDCCG's organisational strategy, decision making and allocation of resources;

b. Be responsible for ensuring SDCCG has the appropriate risk management process in place, is effective and regularly reviewed. It is also the Governing Body's responsibility to ensure there is adequate risk management capacity i.e. systems in place and staff training and development.

4.3 The SDCCG Governing Body is underpinned by the following internal controls:

1. Board Assurance Framework (BAF)
2. Corporate risk register (including strategic & operational risks)
3. Audit Committee (responsible for review of internal controls system and risk management system through review of work of sub committees)
4. Annual Governance statement

4.4 The Governing Body will receive the Board Assurance Framework at all 6 meetings held in the public domain. It is expected the Governing Body will:

a. Consider the risks on the BAF and assess how they have been identified, evaluated and managed;
b. Assess the effectiveness of the related system of internal control in managing the risks, having regard, in particular, to any significant failings or weakness in internal control that have been reported
c. Consider whether necessary actions are being taken promptly to remedy any significant failings or weaknesses.
d. Consider whether the findings indicate a need for more extensive monitoring of the system of internal control.

4.5 The Audit committee sends the Governing Body a report outlining the effectiveness of the internal control, risk management systems and assurances that it has received from sub committees, senior managers and internal auditors.

4.6. Risk appetite

4.6.1 SDCCG has no appetite for fraud/financial risk and zero tolerance for regulatory breaches. The CCG supports well managed risk taking and will ensure that the skills, ability and knowledge are there to support innovation and maximise opportunities to further improve services. The Governing Body secretary and Audit committee will review the appetite on annual basis and propose any changes to the Governing Body (see appendix 2).

4.6.2 The Four T's are to; Treat, terminate, tolerate or transfer a risk. They are the four fundamental choices in relation to an individual risk. These are reflected with the Risk database on DatixWeb (see appendix 4).

5. Accountability, duties & responsibilities

5.1 A key component of an effective Board Assurance Framework is a clearly defined structure that makes explicit the scheme of delegation and clearly identifies the line of reporting.

5.2 The Governing Body will demonstrate commitment to board assurance through its endorsements and implementation of the BAF and associated policies and reports, receiving regular updates as and when appropriate.

The diagram below (fig.1) shows the relationship with risks and the organisational structure of the SDCCG Governing Body:

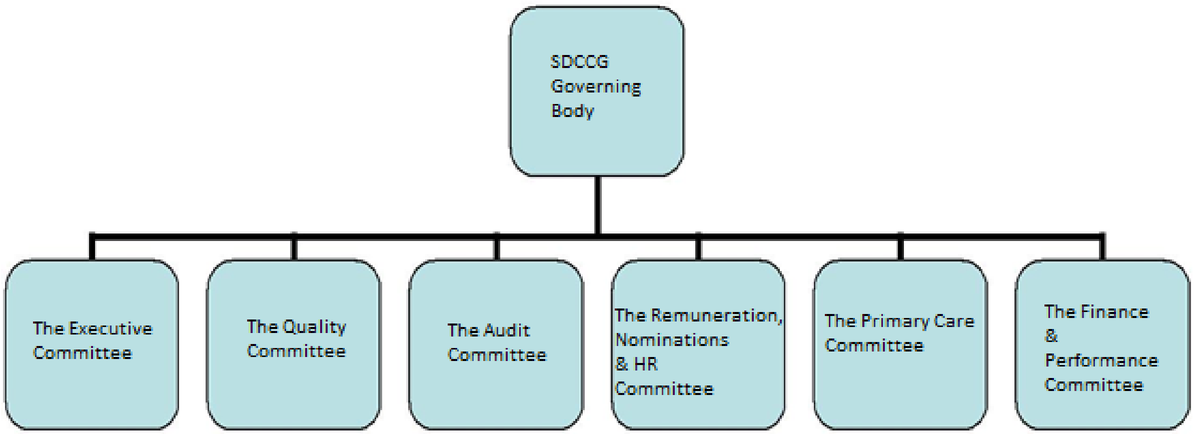

SDCCG Governing Body
The Executive Committee
The Quality Committee
The Audit Committee
The Remuneration, Nominations & HR Committee
The Primary Care Committee
The Finance & Performance Committee

Fig.1

5.3 The terms of reference for the established committees and the Governing Body are available through the Governing Body secretary. All committees should have in their terms of reference the requirement to consider risk and their mitigation and escalate as appropriate.

5.4 The Executive Committee

5.4.1 The Executive committee discharges the responsibilities for day-to-day operational management of SDCCG.

5.4.2 The Executive committee will review the Corporate Risk register and BAF quarterly.

5.5 The Quality Committee

5.5.1 The Quality Committee will review risks associated with the quality of commissioned services, financial duties and delivery of the operational plan and performance.

5.5.2 Risks will be populated through identification from team/department and project risk registers to include (but not limit to) safeguarding risks.

5.6 The Audit Committee

5.6.1 The Audit committee is responsible for the review of the internal control system and risk management system for the identification, control and monitoring of all risks both internal and external through its review of the work of the Governing Body sub committees.

5.6.2 The Audit committee will use the BAF to guide its work.

5.6.3 The Audit committee will review the BAF entries at each meeting and will make recommendations to the Governing Body relating to its finding on the management of the risks associates with the entries and the assurance it has received.

5.7 The Finance and Performance Committee

5.7.1 This committee has responsibility for reviewing and commenting upon finance and performance risks.

5.7.2 These risks will be populated from all the finance and performance risks including risks to the delivery of QIPP which are identified on the project risks registers.

5.8 The Remuneration, Nominations & Human Resources Committee

5.8.1 This committee reviews and agrees pay and performance of directors and clinical leads as well as setting the strategy to senior management for the Governing Body.

5.8.2 The committee has overall responsibility for reviewing SDCCG’s HR strategy, work force risks and talent management.

5.9 Primary Care Committee

5.9.1 This committee is tasked with ensuring effective primary care development and signs off independently on decisions where clinical members of SDCCG are conflicted due to their roles as primary care contractors.

5.10 All Senior managers

5.10.1 Head of Service are operationally responsible for ensuring effective structures and systems for managing risks exist within their teams/departments (taking into consideration this policy). This is to include ensuring adequate opportunities for staff attendance at risk management training programmes e.g. DatixWeb risk register training.

5.10.2 Risk management, ultimately, is a line management responsibility and all managers are responsible for implementing and monitoring and identified and appropriate risks management control measures within their teams/departments and scope of responsibility

5.11 All Staff

5.11.1 All staff members are accountable for their own working practice and behaviour and this is implicit in contracts of employment. All employees have an individual responsibility including; contractors, voluntary and agency staff who have a responsibility to co-operate with managers in order to achieve the objectives of SDCCG.

5.12 The Chair

5.12.1 The Chair is responsible for leading the Governing Body ensuring its effectiveness on all aspects of its role and setting the agenda.

5.13 The Chief Officer

5.13.1 The Chief Officer has overall accountability and responsibility within SDCCG.

5.14 The Governing Body Secretary

5.14.1 The Governing Body Secretary is responsible for the day-to-day co-ordination of the Assurance Framework and Corporate risk register. He/she is also responsible for liaising with Head of Services who manage local risk registers.

5.15 The Chief Finance Officer

5.15.1 The Chief Finance Officer will ensure that there are arrangements in place to identify corporate risks associated with finance and performance, the mitigation measures necessary to control the risk and to monitor these measures.

5.16 Head of Quality/Chief Nurse

5.16.1 The Head of Quality will ensure that there are arrangements in place to identify, mitigate and monitor risks associated with clinical care and treatment within SDCCG commissioned services.

5.17 Commissioning support for hosted services

5.17.1 SDCCG hosts the following services on behalf of other organisations; Individual Funding Requests (IFR), Continuing Health Care (CHC) and Medicines Management.

5.17.2 The CCG is also responsible of Referral Support Services (RSS) to local GP practices.

5.17.3 SDCCG will use disputes procedures if there are issues with agreeing the level or impact of risk in any given situation with services provided to include on its risk register which is mutually acceptable.

6. Approach to Risk Management

6.1 The following information sets out the process to be followed in identifying risks. All definitions for risk and risk management are set out in the appendices (see appendix 5 & 6).

6.2 The risk management process is built on identification, analysis, control and review of risks and potential risks as per fig.2.

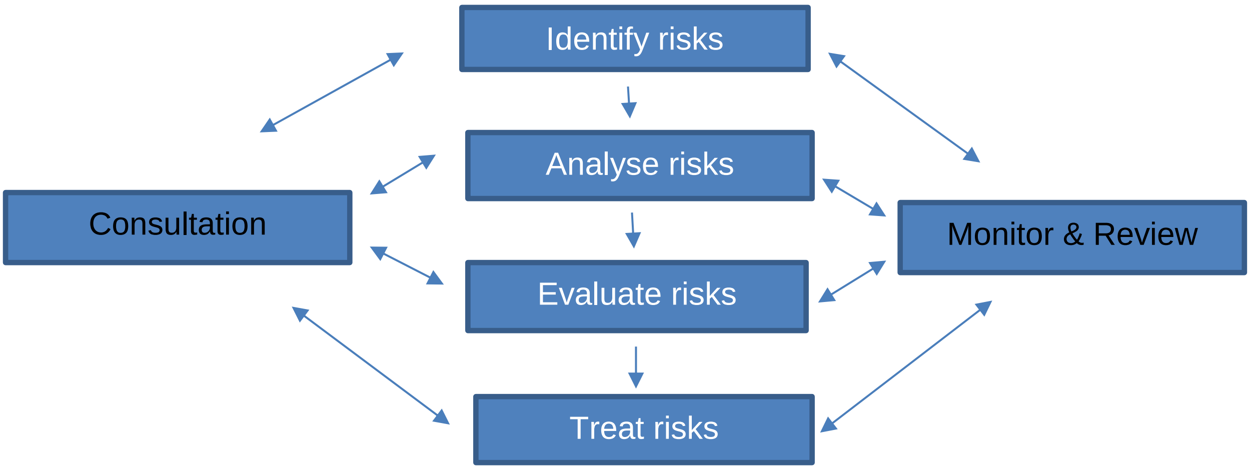


Fig.2

6.4 **Identify the Risks**: Risk identification sets out to identify the exposure to uncertainty and should be approached in a methodical way to ensure that all significant activities within SDCCG have been identified and the risks flowing from these activities defined. The identification process can be both proactive and retrospective. Many lessons can be learnt from examining why an adverse incident occurred and the taking appropriate action to avoid a re-occurrence. The risk should be described so that anyone reading the description can understand the issue.

6.5 **Analyse and Evaluate the Risks**. Once risks have been identified each one will be analysed by assessing both what the consequence/impact and the likelihood would be of it occurring. In the first instance risks are measured with no controls in place, existing controls should then be considered and finally what controls need to be put in place to reduce the risk to an acceptable level. The subsequent risk rating should then be recorded on DatixWeb in the appropriate module. This process creates a manageable programme of risk management.

6.6 SDCCG uses the NPSA (National Patient Safety Agency) 5 x 5 risk grading matrix giving equal weighting to both the impact and the likelihood of the risk. This risk tool provides both a qualitative and quantitative analysis of the risk and is used to assess the severity of the risk for all events e.g. incidents, complaints, risk assessments and risk registers (see appendix 7).

6.7 Risk mitigation is the process of selecting and implementing appropriate actions and controls to modify the risk (see appendix 4).

6.8 An acceptable risk is one which has been accepted after proper evaluation and is one where appropriate controls have been implemented. For a risk to be deemed acceptable it will be:

1. Identified and entered on a risk register
2. Analysed in the context of the current controls in place
3. Analysed using the risk grading matrix (impact & likelihood)
4. Escalated to the appropriate level of management for action
5. Action taken to reduce the risk and then kept under review.

6.9 **Monitoring & Reviewing Risks.** Monitoring at Committee level is undertaken by the Governing Body secretary or department head supported by senior managers. At local level monitoring is by the appropriate manager in close liaison with their team (see appendix 3).

6.10 Strategic Risk Register

6.10.1 The strategic risks are raised by the Executives or Senior managers and drafts presented to the Executive committee. The Governing Body secretary will facilitate adding of risk onto the DatixWeb risk register to ensure that mitigation is described fully and in a consistent format. It is down to the risk lead (manager) named against the risk to ensure the record is kept up-to-date on DatixWeb.

6.10.2 The risks on the Strategic risk register can only be closed with the approval of the Governing Body and approval by the Executive committee.

6.11 Operational Risk Register

6.11.1 Operational risks are raised by; Heads of Service, Team managers and Project leads. All risks will be added by the user onto DatixWeb directly. It is down to the risk lead (manager) named against the risk to ensure the record is kept up-to-date on DatixWeb.

6.11.2 Risks can be closed subsequent to local meetings.

6.13 Risk Register linking

6.13.1 The Strategic and Operational risk registers may contain risks which are related. In such instance the risk will be cross-referenced on the controls of both risks.

6.14. Escalation and De-escalation of Risks

6.14.1 Any movement between the operational and strategic risks registers will be proposed by the Executive committee and therefore subject to the approval of the Governing Body.

7. Risk Management tools

7.1 Risk assessment

7.2 All risks will be entered onto DatixWeb risk module. Staff will put in risks via the RISK1 form by logging into DatixWe. The RISK1 is to be submitted to the Head of service/department who will check the entry, identify if it is a risk and not an issue and review in accordance with this policy (see appendix 3).

7.3 The risk assessment on DatixWeb (RISK1) is for all types of risks. This tool enables a suitable, trained, competent member of staff from each department to identify and quantify risks in their respective areas.

7.4 It is down to the Head of service to authorize a RISK1 form.

7.5 Board Assurance Framework (BAF)

7.5.1 The BAF is a tool for the Governing Body to satisfy itself that risks are being managed and objectives are being achieved. The Governing Body has established a clear BAF so that it can confidently sign the Annual Governance statement.

7.6 Risk Registers

7.6.1 A Risk Register is a management tool that enables an organisation to understand its comprehensive risk profile. It is a repository for all risk information and can be used as a communication tool. It records dependencies between risks and links between the BAF, Project and Committee Risk Registers.

7.7.1 Corporate Risk Register

7.7.2 The Corporate Risk Register is a vehicle for high risks to be captured and reported in the context of strategic & operational objectives. Risks are captured in the context of causes and consequences with actions mitigating the causes. These are based on documented (DatixWeb) risk assessments and may be linked to incidents, audits, external assessments or other qualitative information. Each risk added to the Register is supported by risk mitigation and progress on identified actions is monitored at an appropriate level.

7.8 Each department will have a ‘Risk/Datix’ champion and produce a ‘team’ risk register that is reviewed at relevant meetings of the team.

7.9 Project risk registers will be maintained by the Programme Management Office and contain all identified risks below 15 which impact on SDCCG’s objectives.

7.10 **Incident reporting**

7.10.1 Incident reporting is a fundamental element for identification of risk and a key component of governance. All staff are actively encouraged to report incident and near misses onto DatixWeb.

7.10.2 The main aim is to record and analyse the overall profile of incidents and near misses and identify hotspots and prioritise action in order to learn from such events. Patient safety incidents will be reported in line with SDCCG's policy on the Reporting of Serious Incidents and Never Events.

8 Communication & Training

8.1 This Strategy will be available to all staff, the public and other stakeholders on SDCCG's website and will be communicated to all staff via management channels.

8.2 Effective implementation of the Strategy requires staff to be both aware of SDCCG's approach to risk management, and to be clear about their roles and responsibilities within the process.

8.3 All staff will have access to training tools.

APPENDIX 1: **The Three Lines of Defence**

The risk strategy identifies three tiers of risk:

1. Risks to the organisation’s functions - these are high level and usually strategic and are managed through the Governing Body Assurance Framework. The Governing Body should take corporate responsibility for ensuring that it directs the Executive, where necessary, on the scale of mitigation and the willingness to accept risk (see appendix 4).
2. Significant risks that the Governing Body should be sighted on but which should be managed by the Executive.
3. Project risks or service area risks which are the subject of local risk registers which the Executive should be sighted on.

APPENDIX 2: **RISK APPETITE STATEMENT**

STATEMENT OF RISK APPETITE

1) What are risk appetite and risk tolerance?

1.1 Risk appetite is the amount of risk that an organisation is prepared to take when pursing its aims. No two organisations will have exactly the same objectives and therefore all organisations need to define their risk appetite accordingly, and ensure this is agreed at Board level. The rest of the organisation – Executives, Heads of Service and individual staff - can then work with the confidence of knowing the parameters that constrain and enable them.

1.2 Risk tolerance is the amount of uncertainty an organization is prepared to accept in total or more narrowly within a certain business unit, a particular risk category or for a specific initiative.

2) Why do we need to define risk appetite at Governing Body level?

3.1 Policy in the UK has developed partly in response to international failings in corporate governance, for instance Barings Bank and Exon, where small groups of managers and in some cases individuals can cause significant losses in complex organisations.

3.2 The UK corporate governance code clearly states that the board of any enterprise is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives, and should maintain sound risk management and internal control systems. Risk management can therefore only be effective if (in the CCG's case) the Governing Body has set out its expectations.

3) Parameters of risk appetite

3.3 The risk appetite statement drives both the organisation's strategic objectives and its operational responses in given situations. It gives the Executive and senior management clear expectations on how the Governing Body feel risks should be managed and contributes to a clear culture for the continuous management of risk across the organisation.

3.4 However, whilst the statement of risk appetite enables the rapid development of ideas and proposals it does not give individuals or teams the right to act unilaterally. Whether innovation, development or response to an incident, the usual internal controls still apply and in setting out a proposal or framing a risk, senior managers should scope specific risks and benefits using the statement of risk appetite for context.

4) Outcomes – controlled and developed

4.1 In setting its risk appetite the CCG is mindful of the need to distinguish between what it has a duty to control and what it has a duty to develop. For instance, the CCG is expected to control Health Care Associated Infections (HCAIs) and its risk appetite in this area will be low. However, an innovative project to improve outcomes and quality of life for sufferers of dementia may be worth pursuing even if there is a risk of a financial loss, since without testing innovative new approaches the possibility of health gain does not exist.

5) Risk appetite as a subjective function of leadership

5.1 Following the changes to the NHS in April 2013, new leadership structures have been put in place and are continuing to evolve. More than ever risk management is operating in a fast moving environment in which leaders are expected to define risk appetite, and sometimes redefine it on a regular basis, based on their individual and collective experience. Political factors and responding to external events will form part of this but it is important for leaders to avoid becoming risk averse.

5.2 Risks need to be considered in terms of their broader impact and not the dominance of a single factor such as finance. The overall capability of the CCG – which has statutory duties relating to money, quality, the NHS constitution and its own staff – needs to be factored in. It is therefore acknowledged that the statement of risk appetite is a broad one which enables better internal control and does not offer definitive answers to any specific risk management issue.

6) Risk appetite within the overall approach to internal controls

6.1 Risk appetite operates within the overall system of controls. The process model for this is as follows.

i. All the CCGs activities should be subject to risk management as set out in the risk strategy. These fall into three broad categories:

1. Risk managing the organisations functions (via the assurance framework).
2. Risk managing specific projects or service areas
3. Risk managing the response to external events in-year

ii. In all three cases the lead manager should frame the risk using the accepted methodology in the risk strategy and the template for the corporate risk register. When determining the risk tolerance (target score) and setting out the mitigating actions the manager should review the statement on risk appetite below.

6.2 The risk score should be moderated by the appropriate Committee and agreed by the Executive before submission to the Governing Body for approval.

7) Risk appetite, risk tolerance and exceptions

7.1 It should be noted that in defining a broad area as zero tolerance, this does not mean that the target score for risk tolerance purposes is automatically a 1 as it can still fall into a range of scores between 2 and 5.

7.2 The expected score ranges are set out in the statement on risk appetite below.

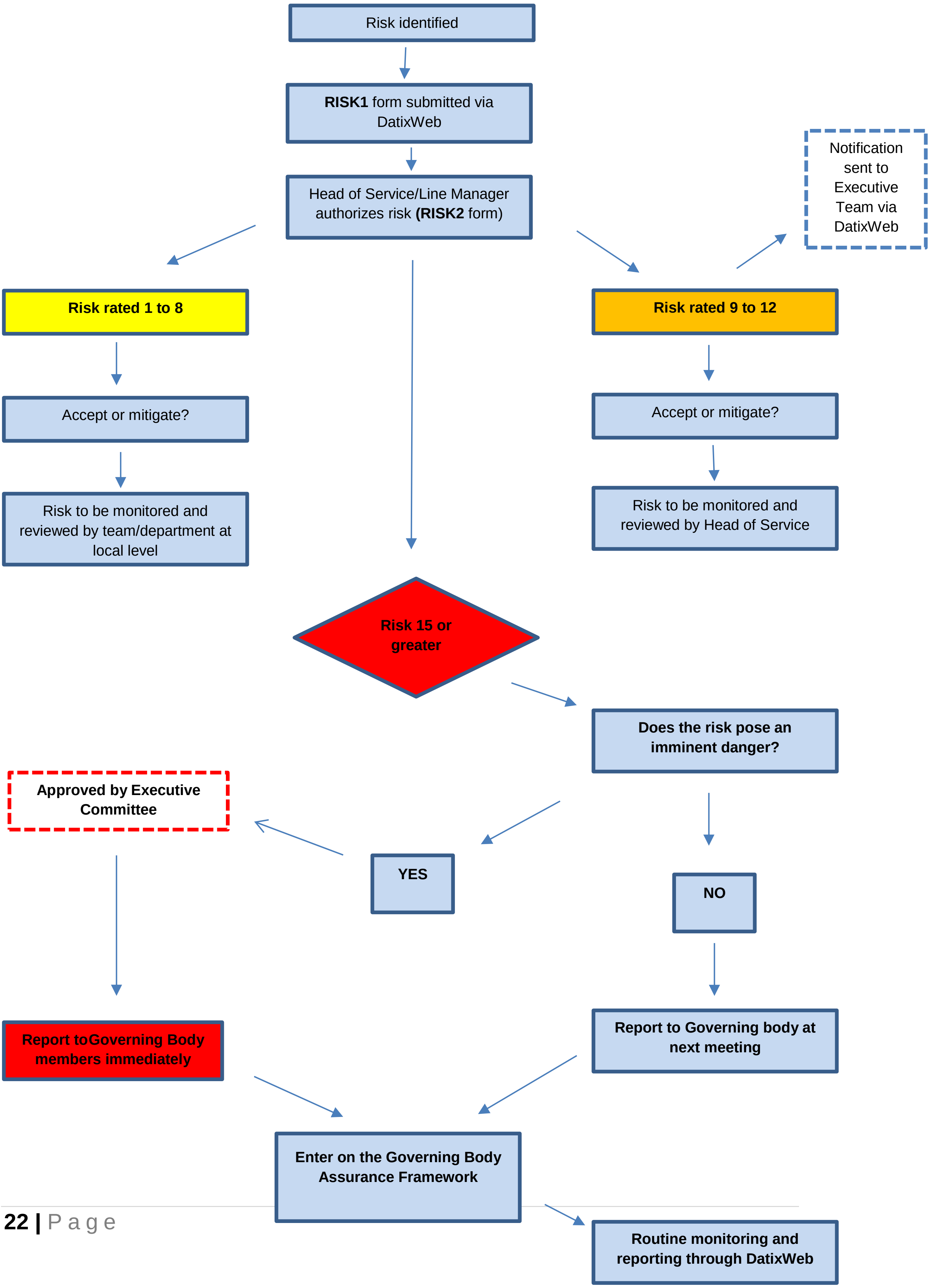
7.3 No statement of risk appetite can encompass every eventuality and there may be exceptions which mean that the CCG has valid reasons for setting a level of tolerance outside of the scope of the statement of risk appetite.

7.4 In this case the rationale will be formally documented and lessons learnt for a revised statement of risk appetite will be put in place.

8) Surrey Downs CCG statement of risk appetite.

RISK LEVEL	SUPPORTING WHAT OUTCOMES?	SCORES
Minimal risk appetite	• Safe patient care • Disaster avoidance • Financial sustainability • Nationally defined expectations • Continued confidence of the public in the CCG	Expected target score range for specific risks: 1-5
Low risk appetite	• Mitigation of unsafe services • Stakeholder collaboration • In-year financial balance • Maintenance of critical systems • Regulatory compliance • Health and Safety	Expected target score range for specific risks: 6-8
Medium risk appetite	• Integrity of specific budgets and service areas • Patient safety awaiting national direction • Maintenance of non-critical systems • Decision making processes that may require reputation management • Good workforce strategy and organisational change • Effective management of delegated functions	Expected target score range for specific risks: 9-12
High risk appetite	• Taking carefully described financial and clinical risks for long term benefit • Management action to avoid a service becoming a high risk clinically or financially	Expected target score range for specific risks: 15-20

APPENDIX 3: **SDCCG RISK IDENTIFICATION FLOW-CHART**


Risk identified
RISK1 form submitted via DatixWeb
Head of Service/Line Manager authorizes risk **(RISK2** form)
Notification sent to Executive Team via DatixWeb
Risk rated 1 to 8
Risk rated 9 to 12
Accept or mitigate?
Accept or mitigate?
Risk to be monitored and reviewed by team/department at local level
Risk to be monitored and reviewed by Head of Service
Risk 15 or greater
Does the risk pose an imminent danger?
Approved by Executive Committee
YES
NO
Report toGoverning Body members immediately
Report to Governing body at next meeting
Enter on the Governing Body Assurance Framework
Routine monitoring and reporting through DatixWeb

APPENDIX 4: **THE FOUR T's METHODOLOGY**

The CCG articulates the principles of risk appetite through the use of the "Four Ts" methodology as follows.

Treat - treat or mitigate is in practice the most common response, achieved by taking action to reduce the probability of the risk occurring or by reducing the impact. This enables the organisation to continue with the activity/objective but with controls and actions in place to maintain the risk at an acceptable level.

Tolerate - it may be appropriate to tolerate the risk without any further action for example due to either a limited ability to mitigate the risk or the cost of mitigation may be disproportionate to the benefit gained. The decision to tolerate would ideally be supported by a contingency plan in the event that the risk escalated. The risk may reach a "tolerate" level having been "treated" through an action plan that identifies a target risk score. If the risk cannot be tolerated, the risk owner must identify a target risk score and set out the actions that will be taken to achieve the agreed level of tolerance.

Transfer - this option is normally taken to transfer a financial risk or pass the risk to an insurer. However, there is also the opportunity to agree to transfer risks to a partner organisation in a joint project, but it is important that all parties are clear to the exact extent of each partner's liability and responsibility for the risk.

Terminate - some risks can only be managed by terminating the activity. The capacity to address risks in the NHS in this way is limited, although it may apply to some projects that are no longer considered viable due to the resources required to manage the risks being disproportionate to the potential outcomes or benefits. The decision to terminate may mean that other more manageable or strategically acceptable risks have to then be described. An example would be terminating a contract that is unsafe or unsustainable. Terminating it may eliminate the risk but may mean that other risks have to be described and managed in the short term.

APPENDIX 5: **RISK DEFINITIONS**

A Risk
A risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives of a programme area. It is measured in terms of impact and likelihood. It consists of a combination of the probability of a perceived threat or opportunity occurring, and the magnitude of its impact on the objectives, where:

1. Threat is an uncertain event that could have a negative impact on objectives
2. Opportunity is an uncertain event that could have a favourable impact on objectives

Risk Management
Risk management is a corporate and systematic process for identifying risks of any severity or scale, evaluating their potential consequences, determining the most cost-effective means of risk control and acting on this information.

Risk Assessment
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.

Corporate Risk
These are the combination of Strategic Risks & Operational Risks where the impact will threaten the overall purpose of SD CCG.

Strategic Risk
A risk that threatens the Strategic Objectives of SDCCG.

Operational Risk
A risk threatens a function of SDCCG.

Project Risk
A project risk is limited to and managed within a team and does not appear on any report to Governing Body or its sub committees. It is expected that such risks will be actively managed at project level with a clear process for escalation if the threat covers a wider area than the project.

Control
A control is a measure which is already in place and functioning to mitigate a risk.

Assurance
Assurance is evidence either of the scale of the problem, or that a control is or is not working.

Assurance Framework
The Assurance Framework is a tool which the Committee/Board uses to gain assurance that suitable controls are in place to assist the organisation in meeting the strategic objectives and that identified risks are being managed appropriately.

APPENDIX 6: **RISK GLOSSARY**

Term	Explanation
Action	A specific process once completed that will bring the risk to a desired measured state in terms of likelihood and impact, to within the risk appetite of SDCCG
Appetite (of Risk)	A measurement usually in terms of likelihood and impact by which the Governing Body require categories of risk to be managed Within (see appendix 2)
Assessment (of Risk)	The process by which risk is analysed through identification, description, estimation and evaluation.
Board Assurance Framework (BAF)	The BAF provides evidence that SDCCG has systematically identified its objectives both strategically and operationally, and manages its risks to achieving them. The framework systematically provides a vehicle for the identification of assurances and controls to risks and their effectiveness.
Cause	The reason for the risk to potentially occur.
Consequence	The results should the risk materialise.
Control	A measure put in place to mitigate a risk from occurring i.e. to prevent. Different types of control can be preventative, detective, directive and corrective.
Datix Risk Champion	Person identified in each department/team to be individual to maintain system and input and extraction of information.
Description	The way of explaining risk to allow consistent understanding across SDCCG in a single sentence where possible to put the risk in context.
Impact	A measurement of the effect the risk will have if it will materialise.
Inherent Risk	The measurement in terms of likelihood and impact on a risk before controls are considered to mitigate the risk.
Likelihood	A measurement of the chance that a risk will materialise.
Mitigation	An action that will control a risk. Different types include tolerate, transfer, terminate and treat (see appendix 4).
Net Risk	The measurement in terms of likelihood and impact on a risk after controls are considered to mitigate the risk. Used on the Board Assurance Framework.

Objective	The context in which risks are assessed i.e. Group Aims/Objectives, Directorate Aims/Objectives.
Risk Owner	Either the owner of the risk (i.e. Governing Body member, Director) or owner of an action (action owner i.e. the completer on the assigned action by the risk owner).
Risk Lead	Person responsible for consulting with teams to identify and assess risks and determined mitigating actions; The on-going maintenance of a risk register for their area of the business; Ensuring risk registers undergo regular review and quality assurance
Profile	Collectively the analysis of all risk across SDCCG, or Project, whichever is the context.
Register	A tool to capture and report on the risks identified at either Project, Committee or Corporate level.
Risk	The chance of something happening that will have an impact upon objectives. It is measured in terms of likelihood and impact. A risk can be a threat or an opportunity.
Risk Management	The culture, processes and structures that are directed towards effective management of potential opportunities and adverse effects.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	The tool used to as accurately as possible identify the measurement of likelihood and impact of the risk identified.
Residual Risk	Another term for net risk.
Severity	Another term for impact.

APPENDIX 7: **RISK MATRIX & SCORING METHODOLGY**

The risk evaluation matrix is a simple approach to quantifying risk by defining qualitative measures of consequence (severity) and likelihood (frequency or probability) using a simple 1-5 rating system. This allows the construction of a risk matrix, which can be used as the basis of identifying risk. The risk score is calculated by Consequence x Likelihood.

Consequence (Severity)

	Consequence score (severity levels) and examples of descriptors				
Domains	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating	Multiple breeches in statutory duty Prosecution Complete systems change required

				Critical report	Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service / business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood (frequency or probability)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it / does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1–10 per cent	10–50 per cent	>50 per cent

Risk Score (Consequence x Likelihood)

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