Name of Policy: Risk Management Strategy - Draft	
Policy owned by: Justin Dix, Governing Body Secretary	**Review Date:**
Policy Approved by:	

1: INTRODUCTION

1.1. Surrey Downs Clinical Commissioning Group (SDCCG) is committed to ensuring that Risk Management is an integral component of the SDCCG's approach to:

- Ensuring the availability of health services
- Improving the health of the local population
- Managing change effectively
- Commissioning high standards of safe patient care
- Having good relationships with the local community
- Working collaboratively with other organisations
- Guaranteeing business continuity
- Ensuring the safety of employees

1.2. SDCCG seeks to bring together these key elements together within an integrated governance framework using best practice benchmarks appropriate to a CCG.

1.3. Integrated Governance is defined by Surrey Downs CCG as systems, processes and behaviours which the organisation uses to lead, direct and control its functions in order to achieve organisational and locality objectives

1.4. The CCG's approach to risk management is one of proactive identification of both broad strategic risks and operational risks with subsequent mitigation and learning.

1.5. This document sets out the direction and commitment of SDCCG by:

- Putting Risk Management in the context of SDCCG's strategic aims and objectives as set out in its annual planning arrangements; and
- By describing arrangements for ownership of risk at different levels of the organisation.
- Clarifying arrangements for the management of different types of risk, particularly strategic, financial and clinical risks
- Defining the method for identifying, evaluating and prioritising risks
- Providing stakeholders with an understanding of the organisation's intent
- Ensuring in particular that the risk strategy is actively incorporated into working with partner organisations

2. SCOPE OF THE RISK STRATEGY

2.1. SDCCG was formed on 1st April 2013, and is responsible for ensuring the supply of health services to the population of the Surrey Downs Area.

2.2. The priorities of this strategy are to:

- Establish clear lines of accountability and reporting so that an unambiguous profile of all Risk Management issues is identified
- Support a culture whereby all staff understand their personal responsibilities in relation to managing risk and are provided with the appropriate support and training to discharge these responsibilities.

3. OBJECTIVES OF THE RISK STRATEGY

3.1. The Risk Management Strategy is an essential component of the realisation of SDCCG's business objectives with the primary objective being that of identifying and managing risks, which may prevent achievement of these goals.

3.2. The key objectives of the Risk Management Strategy in relation to the organisation's risk system and processes have been identified as:

- The management of operations and the development of capacity to manage risk
- Maximising the delivery of high standard, cost effective, safe care for the local population of Surrey Downs through effective risk assessment within commissioning processes and ensuring a risk and governance assessment and review is included within the commissioning process.
- Delivering compliance with the regulatory components of the NHS as they apply to SDCCG.

4. ACCOUNTABILITY AND RESPONSIBILITIES IN RELATION TO RISK MANAGEMENT

4.1. The Chief Officer has overall responsibility for ensuring an effective risk management system is in place within SDCCG and for meeting all statutory requirements and adhering to guidance issued by NHS England in respect of governance.

4.2. The Chief Officer will receive committee minutes and regularly reviews current risk management issues at the Executive Committee.

4.3. The Chief Operating Officer has overall responsibility for the development and delivery of robust processes for Governing Body assurance, integrated governance, performance management, risk management, business continuity, corporate facilities management and corporate business management.

4.4. The Chief Operating Officer is also the nominated director responsible for Health and Safety and Security.

4.5. The Chief Operating Officer has responsibility for the Patient Advice & Liaison Service (PALS), public engagement, managing the complaints, claims, freedom of Information requests, corporate responses and for ensuring effective and responsive staff communication.

4.6. The Chief Finance Officer is the accounting officer for financial matters, is responsible for ensuring the Governing Body has appropriate financial information, including taking responsibility for and reporting proposals to resolve any financial overspend. He is responsible for managing the strategic development and implementation of financial risk management including financial governance, financial management and investment advice. He is also responsible for ensuring that SDCCG is fulfilling its statutory financial duties and legal obligations.

4.7. Risk Management forms an integral part of the normal management process for these Executive Leads within their areas of responsibility. Managers are responsible for ensuring appropriate and effective processes are in place within their areas of responsibility. They are also responsible for implementing the actions identified to reduce an identified risk and for advising their line manager if the risk is increasing to a level where escalation to the Corporate Risk Register needs to be considered.

4.8. All Staff – including agencies, contractors and employees of other statutory agencies working in SDCCG premises - have a responsibility to co-operate with managers in order to achieve the objectives set out in this strategy document.

Key Individuals

4.9. Risk Management processes are overseen on a day to day basis by the Head of Corporate Business and Governing Body Secretary who acts as a central reference point for all business risk issues within SDCCG.

4.10. The Head of Corporate Business and Governing Body Secretary receives and collates information on risks, monitors new developments in risk management, develops knowledge and expertise and acts as liaison point for risk management issues, both within SDCCG and with external bodies. The role includes monitoring of proposed developments and initiatives and checking that they are likely to be compliant with good risk management processes.

5. RISK MANAGEMENT ORGANISATIONAL STRUCTURE

5.1. SDCCG's overall Risk Management system will be continuously reviewed as the organisation's structure is developed. Individual Executive Leads are expected to maintain control of risks at an operational level.

5.2. The Corporate Risk Register will be reviewed by the Executive Committee and the Audit, Corporate Governance and Risk Committee. The Corporate Risk Register will be reviewed by the Governing Body at each Governing Body meeting.

5.3. Responsibility for managing risk is vested at various levels throughout the organisation as set out in the Scheme of Reservation and Delegation.

The Governing Body

5.4. The Governing Body has overall responsibility for Risk Management.

The Executive Committee

5.5. The Executive Committee is a committee of the Governing Body that discharges the responsibilities for day to day operational management through the four localities of SDCCG.

Clinical Governance, Clinical Quality and Safety Committee

5.6. This Committee is a key committee, reviewing all aspects of patient safety and quality including safeguarding, infection control and early warning systems.

5.7. The committee also monitors collaborative work on quality with other CCGs and partner bodies.

Audit, Corporate Governance and Risk Committee

5.8. The Committee's primary role is to provide assurance regarding the adequacy and effective operation of the organisation's overall internal control system.

5.9. The Committee's work predominantly focuses upon the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives (the Assurance Framework).

5.10. The Committee has a pivotal role to play in reviewing the disclosure statements that flow from the organisation's assurance processes. In particular these cover the Annual Governance Statement, included in the Annual Report and Accounts, and the authorisation standards are met.

5.11. The Audit, Corporate Governance and Risk Committee is in a position to focus proactively on the high risk areas for the organisation, either where the inherent risk is high and the level of dependency upon the operation of controls is critical, or where the residual risk is high and the situation needs monitoring. Part of this responsibility is discharged by commissioning programmes of audit that help to identify risks before they become critical and thus support the organisation in the achievement of its objectives.

Remuneration and Nominations Committee

5.12. This is the committee of the Governing Body that reviews and agrees pay and performance of directors and clinical leads and sets the strategy for the Governing Body in relation to very senior managers.

Collaborative arrangements and Commissioning Support

5.13. SDCCG is responsible for ensuring there is a robust system of governance within its contractual arrangements with the following outsourced services:

- Commissioning Support South
- Services provided under collaborative arrangements with other CCGs

6. TYPES OF ORGANISATIONAL RISKS

Strategic Risk

6.1. A strategy is a long term plan of action designed to achieve a particular goal, most often success in achieving corporate objectives. SDCCG is charged with delivering a number of strategies within the overall NHS planning framework; these include:

- Key targets such as improved access to healthcare
- Better quality of healthcare
- Protection of the public from infectious diseases
- Long term and sustainable improvements in the nation's health
- Capacity changes or innovative ways of working that require system reform
- Business continuity planning as a Category 2 responder under civil contingencies

Financial and Resource Management Risk

6.2. Financial and Resource Management risks are those which may affect the ability of the organisation to achieve its business objectives whilst at the same time ensuring financial probity, public accountability and compliance with budgetary constraints.

6.3. The following key areas are considered when managing financial risks:

- Clarity of financial objectives
- Financial accountability
- Responsibilities for financial management
- Auditing
- Governance of financial and resource management arrangements
- Standing Financial Instructions
- Training
- Monitoring the effectiveness of the Risk Management process
- Leadership
- Resources

Clinical Risk

6.4. Clinical Risks are those which may directly affect patients in the care of the organisation. The Clinical Governance agenda directs the focus on these risks but the following key areas are considered when managing clinical risks:

- Patient safety
- Clinical effectiveness and best practice
- Clinical Audit
- Records management
- Integrated Care
- Managing and learning from incidents
- Monitoring the effectiveness of Risk Management process
- Staff Training and Development

Organisational Risk

6.5. Organisational Risks are those which relate to the functioning and management of the Trust's operational areas.

6.6. The following key areas are considered when managing organisational risks:

- Organisational structure
- Human Resources / recruitment and retention of staff
- Use of technology and information

- Change Management
- Equality and Diversity

7. RISK IDENTIFICATION

7.1. SDCCG will take all reasonable steps to manage risk by a process of risk identification and risk assessment. Guidance is available for all staff within the Risk Assessment Policy and Procedure Document (RM2)

7.2. Risks are either identified as part of a structured assessment process, through performance monitoring or incidents. Typically, incidents relate to where risks have materialised or there has been a near miss.

7.3. Performance reporting also tends to highlight the materialisation of risks. Programmed assessments are more likely to identify risks before they have materialised.

7.4. Risk identification processes seek to determine the precise nature of risks and their underlying causes. Assessments also seek to gauge the severity of the impact to the organisation in the event the risk materialises. The likelihood of the risk materialising is also assessed and is determined from an assessment of the internal controls in place.

Internal Sources of Risk Identification and General Inspection Programmes

7.5. These include:

Risks identified through business processes

- Commissioning Decisions
- Research and Development
- Performance Management
- Provider led initiatives

Risks identified through horizon scanning:

- NHS News
- Legal intelligence

Risks identified through clinical processes:

- Clinical Audit
- Serious Incidents
- Incident Reporting
-

Risks identified through patient and public engagement:

- Complaints
- PALS

Risks identified through regulatory process:

- Care Quality Commission inspections
- Meetings with NHS England
- Compliance notices

Risks identified through proactive processes:

- Internal audit work programmes
- External audit work programmes
- Environmental Inspections

Directorate risks:

- CSU HR
- CSU IG
- Finance
- Service redesign
- Performance
- Corporate
- Continuing Health Care

Risks identified through the CCG's governance structures:

- Council of Members
- Governing Body
- Executive Committee
- Clinical Quality Committee
- Audit, Corporate Governance and Risk Committee

8. RISK ANALYSIS

8.1. The Risk Management system in place conforms to the principles that a risk factor is established by multiplying the probability of harm occurring (Likelihood) by the likely consequences to person(s) or Trust (Impact). SDCCG has adopted the NPSA's risk scoring matrix. A copy of the Risk Scoring Matrix is attached in appendix 3.

8.2. Directors, service and departmental managers will assess risks and devise action plans using the generic risk assessment form, risk scoring matrix, local risk registers (see methodology set out in Risk Assessment Policy and Procedures). Directors and service / local managers will regularly review and monitor their local risk register.

Acceptable Risk

8.3. It is not possible to eliminate all risk and it is the responsibility of the Governing Body to ensure that there are systems and controls in place to manage some risks at an acceptable level. Acceptability could be defined as those risks that have a score of 4 or less, although this may be dependent on the specific risk. SDCCG may tolerate some instance where a risk may be deemed unacceptable, e.g. a risk may be tolerated as its removal may prove detrimental to service provision. Similarly a risk may be untreatable or the cost of treatment or control may be prohibitive. Where the decision is taken to accept a risk action needs to be put in place to minimise as far as possible the effects of risk exposure.

8.4. The Governing Body must ensure that staff assess risks, score them using the risk scoring matrix and escalate any risks that cannot be managed using the escalation process outlined in section11

Risk Action Plans

8.5. Action plans which may include investment decisions will be developed for each risk on the Corporate Risk Register. The risk rating obtained by using the risk scoring matrix will determine the response and the level within the organisation at which effective treatment may be delivered.

Risk Control

8.6. Following identification and analysis of risk, a decision will need to be made as to whether SDCCG can avoid, reduce, eliminate, accept or retain or transfer the risk.

8.7. Avoid whether a task can be undertaken in a different way so that the risk does not occur

8.8. Reduce: whether action can be taken to reduce, as far as possible, the probability or impact of the risk exposure and change in behaviour. •

8.9. Eliminate: whether definitive action can be taken to eliminate the risk exposure.

8.10. Transfer: the most common form of risk transfer is insurance. (As part of its approach to minimising financial risk and liabilities, SDCCG is part of NHSLA's risk pooling scheme).

9. SDCCG RISK REGISTER

9.1. The Risk Register is a tool to enable the Trust to manage its risks and improve its performance. It provides a mechanism for the prioritisation of the Trust's risks and associated action plans so that control measures can be implemented most effectively.

9.2. The Risk Register is a record of all forms of risks. It describes the risk in enough detail for it to be understood and assesses the impact and likelihood of realisation of the risk as well as the action necessary to treat / remove / transfer the risk. Details of the responsible officer for implementing the action and the expected completion date are also included in the Risk Register.

9.3. The Executive Committee will review the Corporate Risk Register on a regular basis. It will be responsible for approving any additions, changes and closures on the Risk Register.

9.4. In situations where significant risks (those scoring 15 and over using the risk scoring matrix) have been identified within the Risk Register and where local control measures are considered to be potentially inadequate, departmental and service managers are responsible for bringing these to the attention of their Executive Lead. Risks are mapped to the Assurance Framework, and the principal objectives of the organisation.

9.5. The Risk Register will be used within the business planning process to inform the allocation of resources to the highest risks.

10. MONITORING AND REVIEW OF RISK

10.1. The effectiveness of the Risk Management process will be monitored by:

- A programme of audits of systems and controls by internal audit
- A programme of clinical audit facilitated by the Clinical Governance, Clinical Quality and Safety Committee
- Monitoring of the process by the Audit, Corporate Governance and Risk Committee
- Regular reports will be made to the SDCCG Governing Body by key managers. Their roles and responsibilities call for in-depth knowledge of the organisations Risk Management process, particularly the methodology used in quantifying risks, using the risk matrix and balancing decisions against financial consequences
- There will be a review of committee minutes against the terms of reference of the committees to assess if the committee has effectively executed its duties.

11. THE GOVERNING BODY ASSURANCE FRAMEWORK

11.1. The Governing Body's Assurance Framework process has two main purposes:

- It correlates directly to SDCCG's operational plan and is a high level management assessment process and record of the primary risks relating to the delivery of key objectives. It demonstrates clearly the strength of internal controls to minimise the likelihood of these risks occurring and it identifies sources of assurance and evaluates them for suitability. It then receives and reviews actual assurances (i.e. published reports) and uses the findings to confirm or modify management's opinion of the adequacy of internal control.

- In order for the Assurance Framework to be able to assess the ability of internal controls to ensure the delivery of key objectives it must record details of high level risk and control. It therefore cannot be an exception report relating to residual risks. In addition, it must be complete so as to allow assurance sources to confirm the accuracy of management assessments of risk and controls.

11.2. The high level risk identification process driving the Assurance Framework will take into account the need to manage potential risks rather than react to the consequences of risk exposure. Any gaps in control and assurance with regard to these potential risks need to be assessed by the Governing Body in terms of the impact they may have on objectives and performance.

11.3. The Assurance Framework for the CCG refers to: •

- Principal business objectives of the organisation
- Highest Rated Risks on the Risk Register that impact on the achievement of those objectives

11.4. The internal and external controls that have been put in place to provide assurance to the Governing Body :

- Of the adequacy of those controls
- Of further work that needs to be undertaken

12. RELATIONSHIP BETWEEN THE ASSURANCE FRAMEWORK AND RISK REGISTER

12.1. To enable the Governing Body to make informed judgements about the Assurance Framework and Risk Register it is important that the relationship between them is understood.

12.2. The purpose of the Risk Register is to list all the material risks that exist within the organisation. The risk register in seeking to identify all risks that give rise to doubt about the achievement of the organisation's objectives seeks to ensure the following:

- To guard against the possibility of that some areas of risk might be neglected.
- To provide a disciplined way of ensuring that all directorates anticipate problems that may come to be significant if not treated.
- To provide a framework that has meaning and relevance to all objectives even if not seen as critical to achieving SDCCG's strategic objectives. •
- To enable the Clinical Governance, Clinical Quality and Safety Committee to ensure that even minor or temporary issues are properly reviewed against the Assurance Framework so as to identify matters that ought to be brought to the attention of the Governing Body.

12.3. It is vital that the Governing Body monitor both the Governing Body Assurance Framework and Risk Register processes on a regular basis for the following reasons:

- Although all risks on the Assurance Framework will also appear in the Risk Register, not all risks on the Risk Register will necessarily appear in the Assurance Framework.
- The Assurance Framework contains important information about the Strategic / Principal Objectives that is not recorded as part of the wider-ranging Risk Register.
- The Risk Register will contain material risks for the organisation that may not otherwise be brought to the attention of the Governing Body.
- Maintenance of the Assurance Framework and Risk Register will be monitored and facilitated by the Risk Management Team. This includes ensuring consistency between the documents and providing the Governing Body with regular position reports.

13. LEARNING AND DEVELOPMENT

13.1. Staff education and training will be addressed through a systems approach by ensuring all new staff receive induction training in Risk Management and relevant

existing staff receive regular update training in line with requirements outlined within SDCCG's Statutory and Mandatory Training Guidance, which outlines the type of risk management training required, relevant staff groups and frequency of training.

13.2. Risk management training for managers provides them with an outline of their responsibilities in relation to the management of risk within their areas of responsibility. Specific Risk Management training seminars will be provided for the Governing Body, Commissioning Executive and Associate Directors on an annual basis. All risk management training is provided through the Learning and Development programme.

13.3. SDCCG will take positive action where there is identified low uptake of Learning & Development opportunities, in any staff groups.

14. MONITORING AND REVIEW OF THE STRATEGY

14.1. The Risk Strategy will be reviewed on an annual basis and its effectiveness assessed by reviewing its implementation and application across the organisation. The Quality and Performance Committee terms of reference will be reviewed annually to ensure they are updated and member's attendance monitored as specified and membership is appropriate to the purpose of the Committee.