NHS
Redditch and Bromsgrove
Clinical Commissioning Group

NHS
South Worcestershire
Clinical Commissioning Group

NHS
Wyre Forest
Clinical Commissioning Group

Risk Management Strategy and Policy

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Version	Description of Change(s)	Reason for Change	Author	Date
V1	Original draft		Hana Taylor	July 2016
V2	Second draft	Amendments applied based on feedback from Audit Committee	Tony Ciriello	October 2016
V3	6 month Rollover	6 month rollover to allow time to explore any alignment and consistency that could be achieved with Herefordshire CCGs Risk Management Strategy, across the STP footprint	Tony Ciriello	October 2018

Contents Page

1. Executive Summary

The Risk Management Strategy and Policy is a shared document between the three CCGs (the CCGs) in Worcestershire:

NHS Redditch and Bromsgrove CCG
NHS South Worcestershire CCG
NHS Wyre Forest CCG

This strategy sets out the CCGs' overarching approach to the management of risk, both operational and strategic, across the three organisations. The Governing Bodies will be aware of all significant risks and have sufficient information to enable them to make decisions on the implementation of appropriate controls and the allocation of appropriate resources. In managing risks effectively, the CCGs will be able to discharge statutory functions, while supporting quality improvement encouraging innovation and managing risk.

The Governing Bodies will use this strategy to ensure it meets their statutory requirements to comply with National Standards for Risk Management. The strategy details the approach necessary to demonstrate sound risk management practices are embedded throughout the organisations and reflect the CCGs' Constitutions, values and visions.

The CCGs actively encourage a risk aware organisational culture that is open and supportive, while ensuring robust accountability. Organisational culture and the behaviours of leaders play a vital role in the development of good governance, as highlighted by the Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). It is important that we promote and embed a culture of transparency; openness and honesty throughout the CCGs to ensure risks are properly identified, evaluated, documented and managed. The CCGs are committed to an approach which minimises risks wherever possible, providing a robust framework that is underpinned by the concepts of effective governance and other systems of internal control; enabling the identification and management of both acceptable and unacceptable risks.

Every activity that the CCGs undertake, or commission others to undertake on their behalf, brings with it some element of risk that has the potential to undermine, threaten or prevent the organisations from achieving its vision and corporate objectives. The Risk Management Strategy enables the CCGs to have a clear view of the risks affecting each area of their activity, how those risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCGs' objectives. It sets out the policy for the identification and management of CCG specific risks and those which relate to all three CCGs.

2. Introduction

2.1 The Risk Management Strategy and Policy establishes a framework for the effective and systematic management of strategic and operational risks. It enables the CCGs to have a clear view of the risks affecting each area of their activity, how those risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of corporate objectives. When embedded throughout the organisations, it will make a real contribution to the achievement of the organisations' corporate objectives.

2.2 The strategy applies to all three CCGs' members and staff; and to those organisations providing support services who undertake functions on our behalf; it is not just the responsibility of one person or role within the organisations. Ensuring risks are managed effectively, consistently and systematically has become an integral part of everyday practice throughout the organisations.

2.3 In May 2016, the three CCGs implemented shared management structure arrangements with the view to introducing shared governance arrangements by April 2017. The CCGs developed shared countywide objectives and as a result, key organisational strategies and processes underpinning the successful delivery of these objectives, have been reviewed and aligned. The CCGs' risk management strategy outlines a joint approach towards managing risks and a single process underpinning the strategy.

2.4 While the Director of Corporate and Organisational Development is the countywide executive lead for risk management, the Head of Corporate Governance has been identified as being responsible for the day-to-day operational risk management process and to take the programme of work forward.

3. Purpose of the Strategy

3.1 The purpose of this Risk Management strategy is to:

- Promote a culture of honest reporting and transparency which is upheld throughout the CCGs to ensure risks are properly identified, documented, evaluated and managed;
- Define what risk management is about and what drives risk management within the CCGs;
- Ensure structures and processes are in place to support the assessment and management of both strategic and operational risks throughout the CCGs;
- Outline how the strategy will be implemented;
- Identify the relevant roles and responsibilities for risk management within the CCGs;
- Formalise the risk management process across the CCGs - making it part of "business as usual";
- Provide assurance to the public, patients, staff and partner organisations that the CCGs are committed to managing risk effectively.

4. Risk Definitions

4.1 Risk

4.1.1 Risk is defined as "the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events" (HM Treasury Orange Book 2004) and may be associated with people, buildings and estate, equipment and consumables or systems and management. Risk is the chance of something happening that will have an impact on the achievement of the organisations objectives and the delivery of high quality patient care. It can be any type of risk spanning corporate, clinical, financial, operational or reputational.

4.1.2 For a public body such as the Clinical Commissioning Group, risk can be further defined as anything that poses a threat to the achievement of corporate objectives, programmes and service delivery. This may include damage to the reputation of the Governing Body, which could undermine public confidence.

4.2 Strategic Risk

4.2.1 Strategic risks are directly linked to the achievement of the CCGs' corporate objectives and are captured within each CCG's Governing Body Assurance Framework.

4.3 Operational Risk

4.3.1 Operational risks are risks which are largely linked to team objectives and which, in their own right, don't represent a threat to the achievement of corporate objectives. However they may have the potential to do so if not adequately managed. These risks will be captured on the Worcestershire CCGs' risk register.

4.4 Risk Management

4.4.1 Risk management is a proactive approach which aims to identify, assess and prioritise risk so as to minimise its negative consequences. Risk management is a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process in the way that will enable organisations to minimise losses and maximise opportunities.

5. Risk Management and Governing Body Assurance Process

5.1 Implementation of this strategy and policy is essential to achieving a robust risk management system throughout the organisation on which the commissioning of health care services for the population ultimately depends. All CCG staff should be aware of their responsibility with regards to risk management and take proactive steps to manage and mitigate any strategic or operational risks which threaten the achievement of the CCGs' corporate objectives, or may have the potential to do so if not adequately managed.

5.2 The three CCGs operate a shared risk management process. Although a number of both operational and strategic risks may be specific to individual organisations and are managed as such, there are a

significant number of strategic and operational risks linked to countywide objectives. These are managed through the following mechanisms:

- Countywide risk management strategy
- Same format of Governing Body Assurance Framework with countywide objectives and risks
- Shared operational risk register which is reported at CCG level

5.3 Partnership working is key to the CCGs' achievement of corporate objectives. Examples of the CCGs' key partners include the Local Authority, voluntary organisations, non-statutory health service providers, patients, carer and user groups, as well as other local CCGs, the Commissioning Support Unit and NHS England. It is therefore important that these organisations are sighted on CCGs' key strategic and operational risks and that risk owners involve the appropriate organisations and their representatives in delivery of the appropriate mitigating actions. Conversely, the CCGs should ensure that they are sighted on risks that partner organisations may have identified, particularly where such risks may impact upon commissioning activities.

6 Key Principles of the Risk Management Process

6.1 The risk management process observes the following principles:

- A culture where risk management is considered an essential and positive element in the provision of healthcare;
- Risk reduction and quality improvement should be seen as integral and part of routine activities;
- Risk management often works within a statutory framework which cannot be ignored;
- A risk management approach should provide a supportive structure for those involved in adverse incidents or errors by enabling a no-blame culture;
- Managing risk is both a collective and an individual responsibility;
- Every organisation should strive to understand the causes of risk, and the importance of addressing issues;
- Where organisations commission services on the CCGs' behalf, for example the Worcestershire County Council's Integrated Commissioning Unit, the CCGs must be sighted on any risks connected to the commissioning activity and record them as appropriate in line with this strategy.

7 Identifying Risk

7.1 Strategic and operational risks can be identified by anybody, anywhere and risk identification and management should be an integral part of CCGs' everyday activities. Some specific ways of identifying risks include:

- Horizon scanning
- Formal risks assessment exercise (for example health & safety)
- Lessons learnt following an incident or a complaint
- Discussion at a Governing Body/ Committee Level
- Completing/reviewing a Project Business Case

- Performance discussions with providers

7.2 All strategic and operational risks should have a link to corporate objectives. The achievement of objectives ultimately depends on the identification and successful management of associated risks.

8 Risk Assessment

8.1 The risk assessment programme allows the CCGs to:

- establish which hazards and risks are most serious and to whom or which function
- assess whether existing controls are adequate
- devise mitigating actions to further control the risk
- review the impact of mitigating actions and assurances

8.2 Once a strategic or operational risk is identified, it is important to establish the likelihood of a risk happening and the potential impact if it did occur. This is measured by using the following criteria:

8.3 Likelihood Scoring Criteria

- Rare (1) – This will probably never happen/recur
- Unlikely (2) – Do not expect it to happen/recur but it is possible it may do so
- Possible (3) – Might happen or recur occasionally
- Likely (4) – Will probably happen/recur but it is not a persisting issue
- Almost certain (5) - Will undoubtedly happen/recur, possibly frequently

8.4 Impact Scoring Criteria

8.4.1 In order to assist the assessment and scoring of risks and ensure consistency of approach across all three CCGs, suggested risk impact scoring criteria is included within *Appendix Two.*

8.4.2 Once the likelihood and the impact score have been established, a total risk score can be determined in line with the scoring matrix below:

	IMPACT				
Likelihood	**1 Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 – Rare	1	2	3	4	5
2 - Unlikely	2	4	6	8	10
3 - Possible	3	6	9	12	15
4 – Likely	4	8	12	16	20
5 - Almost Certain	5	10	15	20	25

Risk Priority Key: Red – High Risk; Amber – Medium Risk; Green – Low Risk

9 Governing Body Assurance Framework

9.1 The Governing Body Assurance Framework (GBAF) provides a structured approach to management of principal strategic risks threatening the achievement of corporate objectives. These risks are assigned to Executive Leads and are proactively managed by individual committees. The Audit Committee takes a lead role in reviewing the adequacy of the Assurance Framework and scrutinising controls and assurances in place to mitigate strategic risks. The Governing Bodies has an overarching responsibility for monitoring risks contained within the GBAF.

9.2 Countywide, corporate objectives are identified and agreed by the Governing Bodies at the start of each financial year. These are underpinned by both countywide and local (CCG specific) deliverables. Executive leads are then supported in scoping potential and actual risks to the delivery of the objectives.

9.3 The draft Assurance Framework is presented to committees in May and June for comment and approval. Executive leads and Committees focus their attention on ensuring that controls and assurances are in place and that mitigating action plans with clear timescales and outcomes are identified.

9.4 Through the course of the year, any strategic risks which are in line with the target risk score can be closed. Any residual strategic risks which clearly map to specific objectives and associated priorities will be transferred to the following years' Assurance Framework. Those residual, strategic risks falling outside the scope of corporate objectives will be transferred to the CCGs' risk register as an operational risk. There is an expectation that action plans for mitigating residual, strategic risks will be developed no later than April each year.

9.5 The GBAF is a key document for ensuring that the Audit Committees and CCG Governing Bodies are:

- Updated on progress against the organisations' corporate objectives and the mitigation of the associated strategic risks;
- Assured that the controls, actions and assurances in place are sufficient to manage and mitigate risks;
- Aware of areas of concern for which they may request additional assurances. Please see section 14.3.2 for further detail on how such concerns may be identified

9.6 Individual Committees and Executive Leads are responsible for assessing and reviewing risks for which they are responsible on at least a bi-monthly basis.

9.7 The GBAF is continually reviewed and updated and is informed by and interlinked with the Risk Register.

10 Risk Register

10.1 Staff should report any operational risks or potential risks to their line manager.

10.2 Risks should be discussed within teams, and the likelihood and potential impact of the risk should be established using the risk assessment matrix (see section 8.4 above).

10.3 Each operational risk needs to be recorded on the risk register as a countywide or CCG specific risk together with existing controls, mitigating actions and assurances and must include a timescale for expected completion of mitigating actions. Each risk is assigned to a senior manager who is responsible for updating the risk register. A responsible director as well as a committee or a sub-committee overseeing the risk is also allocated to the risk. Each committee or sub-committee will periodically review those risks for which they are responsible, ensuring that appropriate controls are in place and mitigating actions have been agreed. Any new risks will be considered as part of this process. Once actions are complete and the risk has been mitigated, which would be reflected by the risk score falling in line with the target score, it should be closed or resolved on the risk register; not deleted. The risk can then be subsequently reopened, should it re-materialise. Please see *Appendix Three* – Risk Management Flow Chart.

10.4 Although each operational risk is reviewed and managed by the appropriate risk owner, team and committee/subcommittee, it is essential that the same process is followed across the three organisations and all operational risks are captured on the countywide risk management database. Tailored reports for each team/ committee will be extracted from the central database and this process will be managed by the countywide corporate team. To ensure that no risks are missed out or duplicated, it is crucial that a single risk register is used at all times.

11 Project risks

11.1 Effective risk management significantly contributes towards successful completion of projects which in turn support the delivery of CCGs' corporate objectives. The CCGs operate a large number of projects at any one time and these can vary significantly in importance, duration and organisational impact. By their nature, projects often carry a large number of detailed risks which impact upon project delivery. Where a risk is deemed to exceed the life of the project or has an organisation-wide impact, it should be captured on the risk register.

12 Serious Incidents

12.1 The CCGs maintain a risk management database which allows reporting of clinical and non-clinical incidents and near misses.

12.2 The CCGs will provide information on patient safety incidents through the National Learning System (NRLS) and to the National Patient Safety Agency. The Executive Nurse will be responsible for ensuring patient safety incidents are reported accordingly.

12.3 The CCGs will ensure the implementation and embedding of good practice by:

- Promoting the use of guidelines and protocols;

- Ensuring that staff undertake continuing professional development activity and awareness training.

13 Risk Mitigation

13.1 The CCGs will ensure appropriate mitigating actions along with timescales for delivery and leads for each action are identified by the relevant senior manager and approved. Delivery of these actions will be regularly monitored to ensure they are positively impacting upon risks and supporting a reduction in risk score.

13.2 In addition to identifying mitigating actions, the CCGs will identify robust controls to minimise the reoccurrence of risks. The effectiveness of controls will be tested and challenged by the Audit Committee. Where mitigating actions have been successfully undertaken and have produced a clear, consequential impact in reducing the risk, they will be documented as controls.

13.3 The CCGs will ensure that commissioned services and their staff learn from knowledge they have obtained through clinical and non-clinical risks and all staff will be engaged in the continuing professional development process.

14 Accountabilities, Roles and Responsibilities

14.1 Managing clinical and non-clinical risk is accepted as a key organisational responsibility and is an integral part of management systems and processes. The following section defines the roles, responsibilities and lines of accountability of committees and key individuals relating to risk management. *Appendix One* sets out the CCGs' Committee Structure.

14.2 Governing Bodies

14.2.1 Each CCG through their Accountable Officer is ultimately responsible and accountable for the comprehensive management of risks.

14.2.2 Each CCG Governing Body has a duty to assure itself that there are adequate processes and controls in place to mitigate risks and the impact they have on the organisations and its stakeholders. The Governing Bodies will:

- Agree the CCG's key objectives and review these on an annual basis;
- Determine the risk appetite for the CCG;
- Support the identification of principal risks which may prevent the achievement of corporate objectives;
- Receive and consider risk management reports from Localities and Committees responsible for identifying significant risks and progress on mitigating actions in relation to key strategic programmes;
- Monitor strategic risks identified within the Governing Body Assurance Framework (GBAF); noting actions taken by committees and reviewing any areas of concern raised by Audit Committee
- Put in place a structure for the effective management of risk throughout the CCG.

14.3 Audit Committee

14.3.1 The Audit Committee, which meets as a committee in common across all three CCGs, will focus on the adequacy of the risk management systems and processes as part of an effective system of integrated governance. It is responsible for assessing the effectiveness of the Governing Body Assurance Framework and in particular the adequacy of the implementation of this Risk Management Strategy, and of effective risk management across the organisation.

14.3.2 The Audit Committee will:

- Review the establishment and maintenance of an effective system of risk management across the whole of the CCGs' activities and support the achievement of its objectives;

- Review the Governing Body Assurance Framework on a bi-monthly basis; with specific focus upon reviewing the actions taken by individual committees and identifying any gaps/areas of concern where further investigation may be required. This may be evidenced in various forms including:

    - Increases in risk score
    - Risk score is 100% greater than the target score for a period of 3 months or longer
    - Outstanding mitigating actions or actions not positively impacting upon risk score
    - Notable and sustained gaps in controls and assurances
    - Failure to meet quarterly deliverables

- Though the committee's primary role is centred upon reviewing the adequacy and robustness of the overarching risk management framework, should Audit Committee identify any concerns on the basis of the parameters outlined above, individual risks may be examined in greater detail and assurances requested.

- Receive a summary risk register report in order to gain assurance that the process for the management of operational risks is robust. Similar to the Board Assurance Framework, specific focus will be placed upon actions taken by individual committees and any areas of concern identified will be explored further.

- Receive reports from the executive lead for risk management, the Director of Corporate and Organisational Development, who will be responsible for ensuring that the CCGs comply with the policies and practices laid down;

- Cite any particular areas of concern within the Audit Committee summary report that is submitted to Governing Body

- Review internal and external sources to provide adequate assurance that risks are being appropriately controlled;

- Ratify the Risk Management Strategy and Policy;

- Ensure that risk management processes are embedded throughout the organisation;

- Satisfy itself that the CCGs have adequate arrangements in place for countering fraud including an appropriate suite of policies.

14.4 Internal Audit

14.4.1 Internal audit will agree (jointly with the Audit Committee) a programme of audits which assess the adequacy of existing controls in place to counteract the risks affecting the organisation. This programme should be reflective of the risk evaluation contained within the GBAF and the risk register.

14.5 Committees

14.5.1 Whilst the Governing Bodies will review the GBAF in its entirety and Audit Committee will focus on the effectiveness of risk management systems and processes, individual committees will be required to review the assurance framework and risk register risks which fall within their respective remits. Review of some operational risks may be delegated to individual sub-committees, as detailed within the committees' terms of reference. The corporate team will produce tailored reports to enable individual committees to:

- Review those risks which fall within the remit of the committee, including associated controls and assurances;
- Consider and comment on the CCGs current performance in relevant areas;
- Consider the impact of mitigating actions, controls and assurances on the current risk score;
- Review whether the management of risks is having a positive impact upon the achievement of corporate objectives and deliverables
- Report back to the Audit Committee as appropriate.

14.6 Accountable Officer

14.6.1 The Accountable Officer for each CCG has overall accountability for the management of risk and is responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support;
- Ensuring an appropriate committee structure is in place, with regular reports going to the Governing Body;
- Ensuring that directors and senior managers are appointed with managerial responsibility for risk management;
- Ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG.

14.7 Director of Corporate and Organisational Development

14.7.1 The Director of Corporate and Organisational Development is the countywide executive lead for risk management and is responsible for:

- Ensuring risk management systems are in place across the CCGs;
- Ensuring that there is appropriate external review of the CCGs' risk management systems, and that these are reported to the Governing Body;

14.8 Head of Corporate Governance

14.8.1 The Head of Corporate Governance has been identified as being responsible for the day-to-day operational risk management process and to take the programme of work forward, specifically:

- Implementation of the Risk Management strategy;
- Ensuring the Governing Body Assurance Framework is regularly reviewed and updated;
- Overseeing the management of risks as determined by the Audit Committee;
- Ensuring risk action plans are put in place and are regularly monitored and implemented;
- Providing training and advice on managing risks as appropriate.

14.9 Executive Nurse and Deputy Executive Nurse

14.9.1 The Executive Nurse and Deputy Executive Nurse are responsible for overseeing patient safety and clinical governance within each CCG, including:

- Providing clinical leadership for the development and implementation of the quality assurance plan and the quality strategy;
- Ensuring the effective delivery of clinical care, including clinical audit, evidence based medicine and national and local guidelines in commissioned services;
- Reporting to the Governing Bodies on patient safety and clinical governance matters.

14.10 Chief Finance Officers

14.10.1 The Chief Finance Officers are responsible for progressing financial risk management and for ensuring that effective risk management and risk sharing arrangements are in place.

14.11 Senior Managers

14.11.1 Senior Managers should incorporate risk management within all aspects of their work. They are accountable for the effective management of risks in their related areas. Senior Managers should direct the implementation of the CCG Risk Management Policy by:

- Demonstrating personal involvement and support for the promotion of risk management;
- Ensuring that staff accountable to them are aware of and understand risk management in their areas of responsibility;
- Ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable;
- Ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis;
- Ensuring risks are escalated where they are of a strategic nature;
- Ensuring that learning from events and risk assessments is disseminated throughout the organisation.

14.12 Managers and staff

14.12.1 Managers need to familiarise themselves with the risk management guidance and the risk register. They should understand how the risk register is maintained and how the risks are rated. Managers must ensure that all staff are made aware of risk issues and the need to identify and raise risks that they encounter in their work.

14.12.2 Where staff are involved in management of projects and where these risks have wider implications or exceed the duration of the project, they must be also entered on the organisations' risk register as an operational risk.

14.12.3 All staff have a duty under legislation to take reasonable care of their own safety and the safety of others and to comply with appropriate CCG regulations, policies, procedures, guidelines and statutory and mandatory training requirements.

14.13 Commissioning Support, Collaborative Commissioners, Contractors, Agency and Locum Staff

14.13.1 Managers must ensure that where they are outsourcing, employing or contracting agencies and locum staff, these are made aware of and adhere to all relevant policies, procedures and guidance of the CCG.

14.13.2 They should also:

- Take action to protect themselves and others from risks;
- Bring to the attention of others the nature of risks which they are facing in order to ensure that they are taking appropriate protective action.

15 Monitoring the Effectiveness of the Strategy and Policy

15.1 Regular reports are received by the CCGs' Governing Bodies as well as individual committees. The Director of Corporate & Organisational Development assumes overarching, executive responsibility for ensuring that the organisations adopt sound risk management practices; which is consistent with the principles outlined within this policy.

15.2 The Audit Committee will regularly review the effectiveness of the strategy and report back to the three Governing Bodies.

15.3 Committee effectiveness reviews are undertaken annually for all key committees. The effectiveness of and compliance with the risk management strategy is tested as part of this exercise.

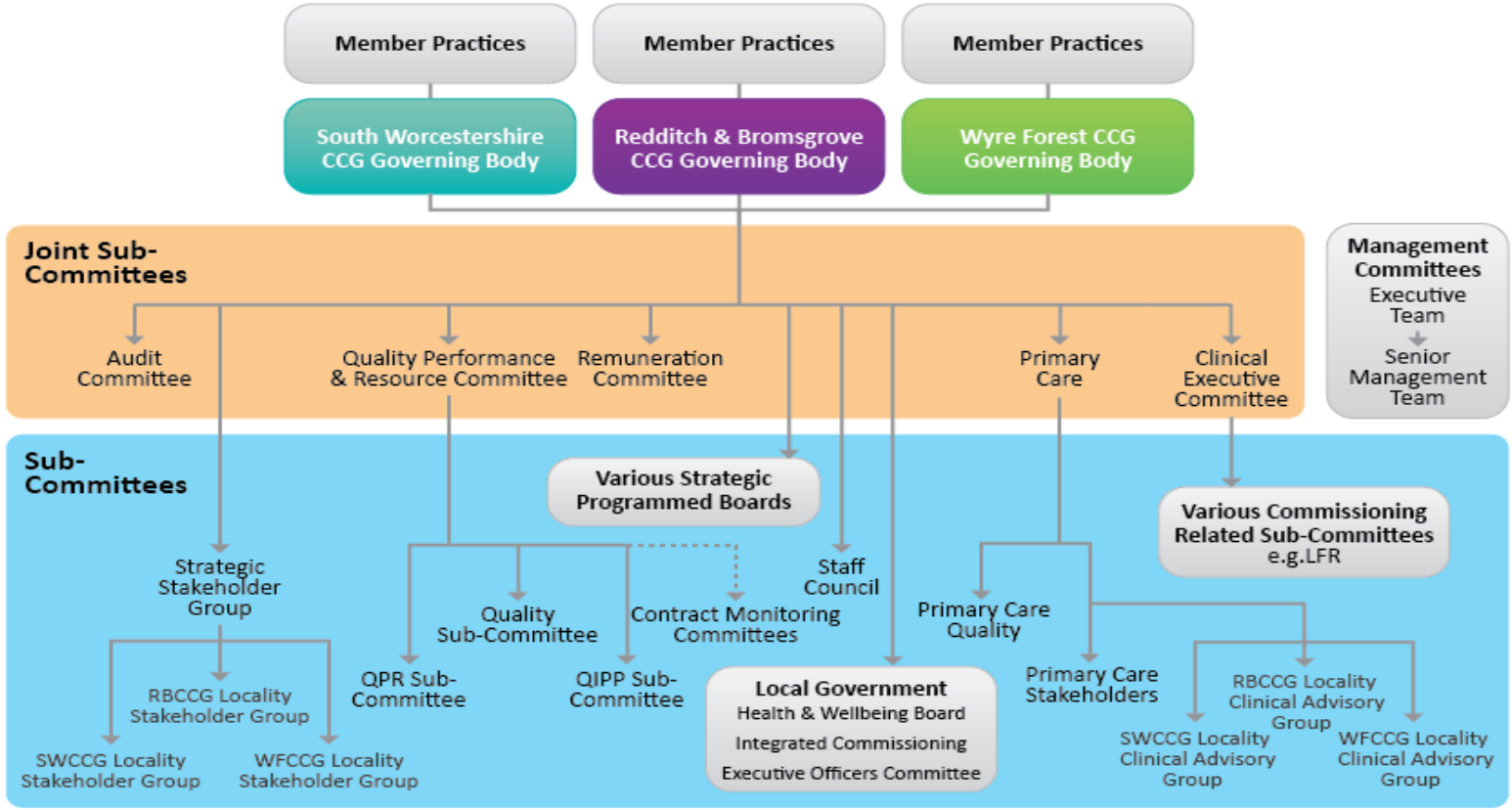
15.4 The Strategy & Policy Implementation plan is attached as *Appendix Four*. This will be monitored by the Head of Corporate Governance and submitted to Audit Committee on a bi-monthly basis.

16 Equality and Diversity

16.1 In applying this strategy and policy, the CCGs will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to discriminating on the basis of background, trade union membership, or any other personal characteristic.

Countywide Operating Model

Appendix One



Appendix Two

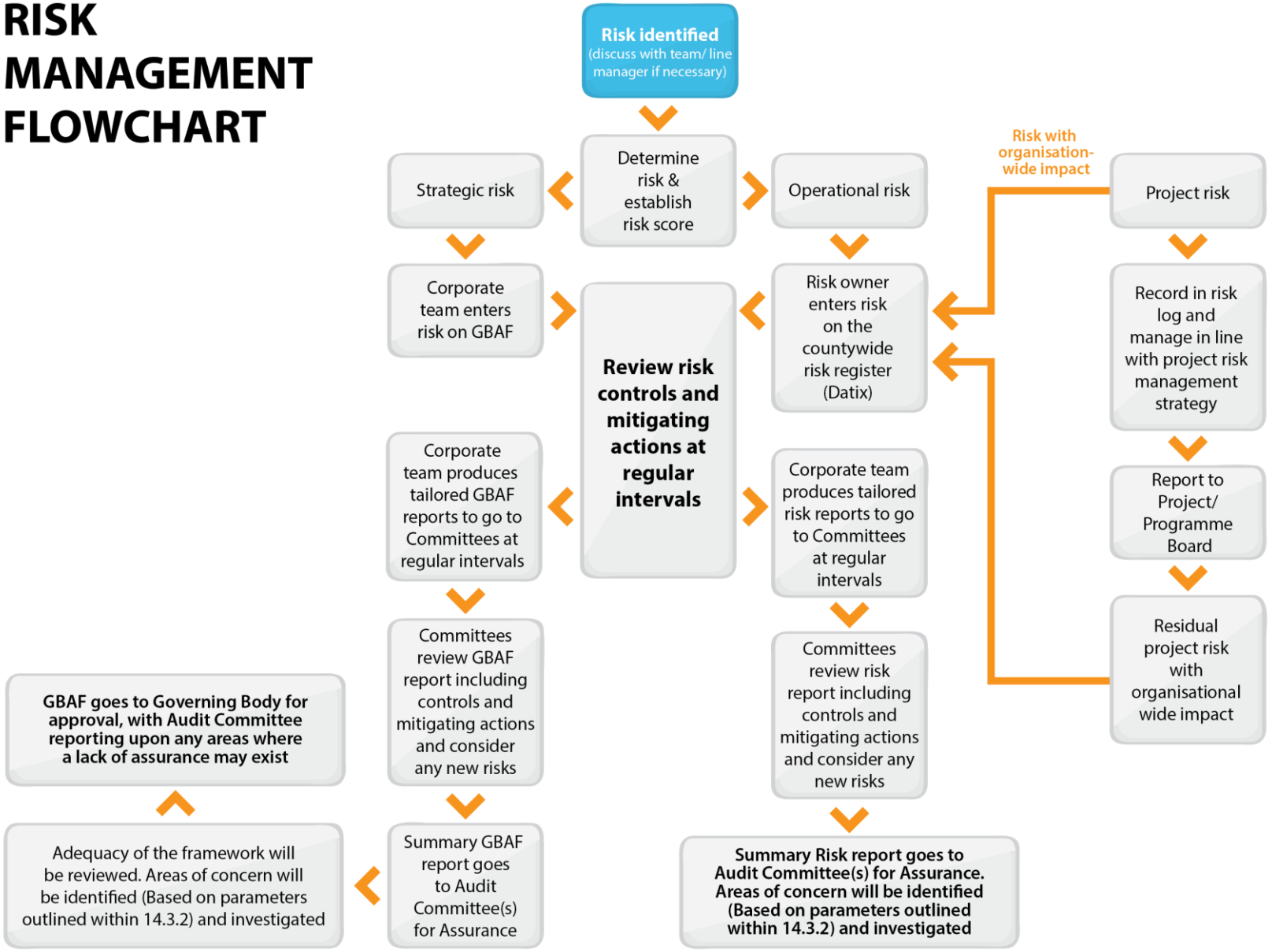
Risk impact Scoring Table

	Negligible	Minor	Moderate	Major	Catastrophic
Financial	Overspend of < £17,000	Overspend of £17 – 170k Loss of 0.1 – 0.25% of budget	Overspend of £170k - £1.7m Loss of 0.25 – 0.5% of budget	Overspend of £1.7m - £8.5m Loss of 0.5 – 1% of budget	Overspend of > £8.5m Loss of > 1% of budget
Service redesign	Insignificant cost increase. Minimal project timescale slippage.	< 5% over project budget. Minor project timescale slippage.	5-10% over project budget. Moderate project timescale slippage.	1—25% over project budget. Major project timescale slippage. A key objective not met.	>25% over project budget. Catastrophic project timescale slippage. Multiple key objectives not met.
Commissioning (including PC commissioning)	Some minor impact to the quality and cost effectiveness of commissioning. Manageable within project/team/work stream.	Minor impact on quality and cost effectiveness of commissioning activities. Less than 2 week delay to milestones/plans.	Short term impacts to quality and cost effectiveness of commissioning. Resources used from other parts of the organisation.	Significant delays or quality reduction in provision of effective commissioning across multiple work streams (<1 month delay to work stream).	Realisation of risk would prevent the Group from delivering significant services through its contracts with providers to the public.
Staffing/Human Resources	Short-term low staffing level that temporarily reduces services quality (<1 day).	Low staffing level that reduces the service quality (>1 day).	Late delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (1-5 days). 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. On-going unsafe staffing levels or Competence. Loss of several key staff. No staff attending mandatory/key training on an on-going basis.

	Negligible	Minor	Moderate	Major	Catastrophic
Patient Safety/Safeguarding	Minimal injury requiring no/minimal intervention. Mortality rates or serious incidents which require routine monitoring.	Major injury or illness, requiring minor intervention. Mortality rates within normal limits or individual serious incidents that require monitoring.	Moderate injury requiring professional intervention. An increasing mortality rate or serious incident/never event trend requiring monitoring with action plan to mitigate risk.	Major injury leading to long-term incapacity/disability. Increased mortality rates or serious incident/never event trend indicating urgent interventions e.g. improvement plan/contractual action.	Incident leading to death. Increased mortality rates or serious incidents/never event trend indicating failure of the service to deliver patient safety requiring immediate intervention such as suspension of service or escalation.
Quality/Patient experience	Peripheral element of treatment or service suboptimal. Unsatisfactory patient experience not directly related to patient care.	Overall treatment or service suboptimal. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved. Unsatisfactory patient experience – readily resolvable.	Treatment or service has significantly reduced effectiveness. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on. Mismanagement of patient care – short term effects.	Non-compliance with national standards with significant risk to patients if unresolved. Low performance rating. Critical report. Mismanagement of patient care – long term effects.	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. Totally unsatisfactory patient outcome or experience.
Reputation	Rumours. Potential for public concern.	Local media coverage – short term reduction in public confidence.	Local media coverage – moderate loss of public confidence in the CCG.	National media coverage with < 3 days service well below reasonable public expectation. Long term reduction in public confidence.	National media coverage with > 3 days service well below reasonable public expectations. MP concerned (questions in House). Total loss of public confidence in the organisation.

Appendix Three

Risk Management Flowchart



Appendix Four - Implementation Plan July 2016

	Action	Action Lead	Sign off/ approval by	Status & Completion date
Risk Management Strategy	Risk Management strategy drafted & reviewed by Executive Team	Head of Corporate Governance	Executive Team	Complete
	Risk Management strategy & new approach to managing risks to be approved by Audit Committee	Head of Corporate Governance	Audit Committee	To be approved at Audit Committee on 3rd November 2016
	Strategy disseminated to all staff and members	Head of Corporate Governance	n/a	Post Audit Committee on 3rd November 2016
	Risk Management training for CCG teams	Head of Corporate Governance	n/a	By March 2017
Governing Body assurance Framework	Countywide objectives agreed	Director of Corporate & Organisational Development	Governing Bodies	Complete
	Countywide & Local Deliverables agreed	Head of Corporate Governance	Governing Bodies	Complete
	Format of 2016/17 Countywide GBAF agreed and strategic risks identified	Head of Corporate Governance	Audit Committee	Complete
	GBAF to be reviewed and taken to Committees at least bi-monthly	Head of Corporate Governance/ Corporate Services Officer	Individual Committees	On-going
	GBAF process to be reviewed by audit Committee bi-monthly	Head of Corporate Governance	Audit Committee	On-going
	Governing Bodies to review the GBAF in its entirety at each public meeting	Director of Corporate & Organisational Development/ Head of Corporate Governance	Governing Bodies	On-going
Risk Register (Operational Risk Management)	All risks migrated into DATIX	Corporate Services Officer	n/a	Complete
	All risks to be reviewed and validated with risk leads	Corporate Services Officer	n/a	Complete
	Risk reports designed and tailored to individual committees	Corporate Services Officer	n/a	Complete
	Risk reports to go to Committees' meetings for review	Corporate Services Officer	Individual Committees	On-going
	Risk register assurance report to go to Audit Committee bi-monthly	Head of Corporate Governance	Audit Committee	On-going

Appendix Five - Equality Impact Assessment

Department **Corporate** Name of person completing EIA **Tony Ciriello**

Date of EIA July 2016 Accountable CCG Lead **Lucy Noon/ Hana Taylor** work

~~CCG Sign off and date~~ ~~Audit Committee – 11 August 2016~~

Other partners/stakeholders involved

Who will be affected by this piece of work? **Redditch and Bromsgrove CCG staff, South Worcestershire CCG staff, Wyre Forest CCG staff**

Single Equality Scheme Strand	**Baseline data and research on the population that this piece of work will affect.** What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**	**Is there likely to be a differential impact?** Yes, no, unknown.
Gender	There is no evidence to suggest that gender will have any differential impact upon the application of this policy.	No
Race	There is no evidence to suggest that race will have any differential impact upon the application of this policy.	No
Disability	There is no evidence to suggest that disability will have any differential impact upon the application of this policy.	No
Religion/ belief	There is no evidence to suggest that religious beliefs will have any differential impact upon the application of this policy.	No
Sexual orientation	There is no evidence to suggest that sexual orientation will have any differential impact upon the application of this policy.	No
Age	There is no evidence to suggest that age will have any differential impact upon the application of this policy.	No
Social deprivation	There is no evidence to suggest that social deprivation will have any differential impact upon the application of this policy.	No

Carers	There is no evidence to suggest that being a carer will have any differential impact upon the application of this policy.	No
Human rights	There is no evidence to suggest that human rights will be differentially impacted upon through the application of this policy.	No