NHS

Sheffield Clinical Commissioning Group

# Risk Management Strategy

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**Governing Body meeting**

**4 April 2013**

| Author(s)/Presenter and title | David Barker, Risk and Health and Safety Advisor |
|---|---|
| Sponsor | Linda Tully, Head of Governance and Company Secretary |
| Key messages | |
| • The Strategy is informed and builds on good practice<br>• Senior Managers will remain responsible for identifying and managing risk.<br>• The Governance Sub-Committee will keep an overview of risk reporting to the Audit and Integrated Governance Committee and the Governing Body | |
| Assurance Framework (AF) | |
| ***Risk Reference Number***: 898<br><br>This paper provides assurance that risks will be identified and managed to help ensure the achievement of the CCG's objectives.<br><br>***Is this an existing or additional control***:<br>Existing control. | |
| Equality/Diversity Impact | |
| ***Has an equality impact assessment been undertaken?*** YES<br><br>***Which of the 9 Protected Characteristics does it have an impact on?***<br>Robust risk management should positively impact on the 9 Projected Characteristics. | |
| Recommendations | |
| The Governing Body is asked to approve the Risk Management Strategy and Action Plan for 2013/14 | |

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## 1. Introduction

1.1. In order to achieve its objectives the organisation will need a process to identify the risks it faces and ensure effective action is taken to mitigate these.

1.2. The attached strategy details the proposed way of working to ensure risk is effectively managed, monitored and reported on. It also details at appendix 4 the suggested key actions required to manage risk during the year.

## 2. Proposed Way of Working

2.1. It is proposed, building on the legacy of successful arrangements from the previous commissioning organisation and recognised good practice, that Senior Managers within the CCG are responsible for identifying and managing risks within their areas of responsibility. They will be required to keep accountable officers updated and seek appropriate additional support as necessary.

2.2. The Commissioning Support Unit (CSU) will maintain, on behalf of the CCG, a full Corporate Risk Register which captures all identified risks and actions to address these. The CSU will generate reports to appropriate Committees, Groups and individuals from the risk register.

2.3. The Governance Sub-Committee will consider risk at every meeting to seek assurance that appropriate action is being taken, instigate further actions as necessary and agree which risks (due to their strategic implications or high level) should be added to the Assurance Framework. The Governance Sub-Committee will provide assurance to the Audit and Integrated Governance Committee and Board at regular intervals on the risk management arrangements.

2.4. The Governance Sub-Committee will oversee progress against the Risk Management Action Plan.

## 3. Recommendation:

The Governing Body is asked to approve the Risk Management Strategy and Action Plan for 2013/14

Paper prepared by David Barker, Risk and Health and Safety Advisor

On behalf of: Linda Tully, Company Secretary

20 March 2013

Sheffield Clinical Commissioning Group

# NHS Sheffield Clinical Commissioning Group

# Risk Management Strategy

| Version: | 4 |
|---|---|
| Ratified by: | |
| Date ratified: | |
| Name/Department of originator/author: | David Barker |
| Name/Title of responsible committee/individual: | Risk and Health and Safety Advisor |
| Date issued: | |
| Review date: | March 2014 |
| Target audience: | All staff |

This strategy / service has been reviewed in accordance with Equalities Legislation on race, disability, age, gender, sexual orientation and gender identity, faith and belief.

**Policy Audit Tool**

**Please give status of Policy: Reviewed**

| | | |
|---|---|---|
| **1.** | **Details of Policy** | |
| 1.1 | Title of Policy: | |
| 1.2 | Sponsor (Member of MEG): | Linda Tully, Company Secretary Head of Governance |
| 1.3 | Author: | David Barker, Risk and Health and Safety Advisor |
| 1.4 | Lead Governance Sub Committee: | Governance Sub Committee |
| 1.5 | Reason for Policy: | |
| 1.5 | Who does the Policy affect? | |
| 1.6 | Are the National Guidelines/Codes of Practices etc issued? | Yes |
| 1.7 | Has an Equality Impact Assessment been carried out? | Yes |
| **2.** | **Information Collation** | |
| 2.1 | Where was Policy information obtained from? | Best practice |
| **3.** | **Policy Management** | |
| 3.1 | Is there a requirement for a new or revised management structure for the implementation of the Policy? | No |
| 3.2 | If YES attach a copy to this form. | N/A |
| 3.3 | If NO explain why. | Structure already in place during shadow year required. |
| **4.** | Consultation Process | |
| 4.1 | Was there external/internal consultation? | Yes |
| 4.2 | **List groups/persons involved** | |
| 4.3 | **Have external/internal comments been included?** | Yes |
| 4.4 | If external/internal comments have not been included, state why. | N/A |
| **5.** | Implementation | |
| 5.1 | How and to whom will the policy be distributed? | It will be distributed to all staff via the intranet and internet. |
| 5.2 | If there are implementation requirements such as training please detail. | N/A |
| 5.3 | What is the cost of implementation and how will this be funded? | N/A |
| **6.** | Monitoring | |
| 6.1 | List the Key Performance Indicators | • Risk Management Action Plan<br>• Annual Risk Audit |
| 6.2 | How will this be monitored? | • Governance Committee |
| 6.3 | Frequency of Monitoring | • Quarterly |

## Risk Management Strategy

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## INTRODUCTION

1.1 All actions contain inherent risks. Risk management is central to the effective running of any organisation. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach. NHS Sheffield Clinical Commissioning Group (CCG) will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

## AIMS

2.1 The aims of this Risk Management Strategy are to ensure that the staff, patients, visitors, reputation, and finances of associated with NHS Sheffield Clinical Commissioning Group (CCG) are protected through the process of risk identification, assessment, control and elimination/reduction.

## 3. DEFINITIONS

3.1 Definitions of the terms used in this Risk Management Strategy are included in Appendix 1.

## 4. OBJECTIVES

4.1 The objective of the Risk Management Strategy is to create a framework to achieve a culture that encourages staff to:

- Identify and control risks which may adversely affect the operational ability of the CCG

- Compare risks using the grading system explained at Appendix 3;

- Where possible, eliminate or transfer risks or reduce them to an acceptable and cost effective level, otherwise ensure the organisation openly accepts the remaining risks.

4.2 To encourage this managers in the CCG will be judged on the quality of the decision making process to identify and address risk rather than the outcome of that process.

## 5. APPLICATION OF THE STRATEGY

5.1 This strategy is intended for use by all directly employed and agency staff and contractors engaged on CCG business in respect of any aspect of that work, including clinicians and others paid by the CCG, whether employed or otherwise funded, directly employed staff, and staff managed by the Commissioning Support Unit. Whilst all actions contain inherent risks, the key strategic risks are identified and monitored by the Assurance Framework. Operational risks should be managed on a day-to-day basis by staff throughout the CCG and progress of all risks is acknowledged through the CCG Risk Register as a comprehensive central record.

## 6. STRATEGIC RISKS

6.1 Strategic risks, and associated action plans, are recorded in more detail in the Assurance Framework and an up to date position is provided in quarterly reports to Governing Body.

In addition the Assurance Framework and Risk Report is presented to every meeting of the Governance Sub - Committee which reports to the Audit Committee.

## 7. THE WAY WE WORK

7.1 All members of staff have an important role to play in identifying, assessing and managing risk; detailed advice on the process is given at Appendix 3. To support staff in this role, the CCG provides a fair, consistent environment and encourages a culture of openness and willingness to admit mistakes. Staff are encouraged to report any situation where things have, or could have gone wrong. Balanced in this approach is the need for the organisation to provide information, counselling and support, and training for staff in response to any such situation.

7.2 At the heart of this strategy is the desire to learn from events and situations in order to continuously improve management processes. Where necessary, changes will be made to the CCG systems to enable this to happen.

7.3 In the interest of openness and the process of learning from mistakes, formal disciplinary action will not usually be taken as a result of a risk management investigation. However, a serious breach of health and safety regulations or serious negligence causing loss or injury are examples of gross misconduct and will be dealt with through the Disciplinary Procedure. Disciplinary action may, therefore, be appropriate where it is found that a member of staff has acted:

- Illegally - against the law; or
- Maliciously - intending to cause harm which s/he knew was likely to be the result; or
- Recklessly - deliberately taking an unjustifiable risk where s/he either knew of the risk or s/he deliberately closed his/her mind to its existence.

7.4 Should disciplinary action be appropriate, this will be made clear as soon as the possibility emerges. The investigation would then be modified taking into account human resources policies together with advice from Human Resources colleagues as appropriate.

## 8. ACCOUNTABILITIES, RESPONSIBILITIES AND ORGANISATIONAL FRAMEWORK

### 8.1 Accountabilities and Responsibilities

The Accountable Officer has overall accountability and responsibility for risk management. A detailed list of operational responsibilities for risk management in the CCG is included at Appendix 2

### 8.2 Organisational structure

Organisational structures to manage delegated responsibility for implementing risk management systems are illustrated and explained in Appendix 2.

### 8.3 Assurance Framework

The CCG is supported in the assurance and governance process by the Assurance Framework (AF). Through this framework the CCG gains assurance from key accountable officers that risks are being appropriately managed throughout the organisation. The framework is built around the organisation's strategic objectives and principal risks and aligned to the Risk Register and Business Plan.

8.4 **Risk Register**

The organisation maintains a central corporate risk register which captures all risks and enables these to be analysed against the organisational objectives to ensure appropriate action is being taken to address risk and that lessons are being learned. This is maintained on behalf of the CCG by the Commissioning Support Unit.

## 9. SYSTEMS FOR MONITORING THE EFFECTIVENESS OF THE STRATEGY

9.1 An annual report on risk management within the CCG will be produced by the CSU in the first quarter following the end of the financial year. This report will be reviewed by the Governance Sub-Committee, Audit and Integrated Governance Committee and the Governing Body.

9.2 In addition a risk report is presented to each meeting of the Governance Sub-Committee which outlines progress against all high risks, lists all new risks identified and raises any additional significant risk issues. Specific reports on appropriate risks are provided to other groups within the governance structure.

9.3 The Governance Sub-Committee will annually review risk management arrangements to ensure compliance with the strategy and that risk is being effectively managed.

## 10. ACTION PLAN/KEY PERFORMANCE INDICATORS

10.1 An annual risk management action plan will be agreed and monitored by the Governance Sub-Committee. The Action Plan for 2012/13 is attached as Appendix 4 as an example. An Action Plan for 2013/14 will be developed. Progress in the achievement of these actions will act as the key performance indicator for Risk Management and will be reported to the Governance Sub Committee and the Governing Body annually through the Annual Risk Report. The risk management action plan will be developed in consultation with key stakeholders and through consultation on the strategy.

## 11. IMPLEMENTATION, TRAINING AND SUPPORT

11.1 The successful implementation of this Risk Management Strategy will underpin the effective commissioning organisation and the delivery of a quality service and this will be used alongside staff training and support and will provide an improved awareness of the measures needed to prevent, control and contain risk.

11.2 The CCG will:

- ensure all staff and stakeholders have access to a copy of this Risk Management Strategy by publishing on the intranet;

- commission the CSU to produce a register of risk across the CCG which will be subject to regular review
- communicate to staff any action to be taken in respect of risk issues;
- develop policies, procedures and guidelines based on the results of assessments and all identified risks to assist in the implementation of this strategy;
- ensure that training programmes raise and sustain awareness throughout the organization of the importance of identifying and managing risk;
- monitor and review the performance of the organisation in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk through the audit arrangements outlined above.

## 12. OTHER RELEVANT POLICIES

This strategy should be read in conjunction with the following policies:

- Health and Safety Policy
- Incident Reporting Policy
- Compliments and Complaints Policy
- Whistleblowing Policy
- Disciplinary Policy, Procedure and Rules
- Claims Management Policy

**APPENDIX 1**

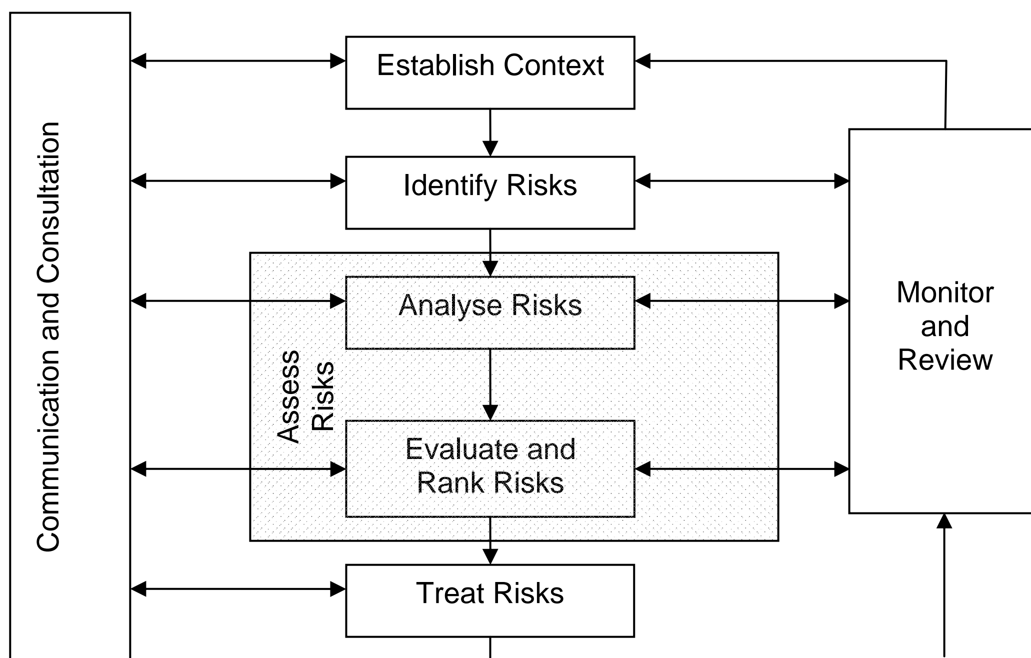
## DEFINITIONS

(Adapted from the Australian/New Zealand standard AS/NZS 4360:1999.)

*Risk* is the chance that something will happen that will have an impact on achievement of the CCG's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

*Risk Management* is "the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects".

*The risk management process* is "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk". It is described in the following diagram:




Risk Management Overview from AS/NZS 4360:1999

*Significant Risks* are those which, when measured according to the risk grading tool at Appendix 3, are assessed to be 'High'. The Governing Body will take an active interest in the management of significant risks.

**APPENDIX 2**

## NHS SHEFFIELD CCG OPERATIONAL RESPONSIBILITY FOR RISK MANAGEMENT

### 1. Accountable Officer

The Accountable Officer has overall responsibility for the management of risk within the CCG.

### 2. Chief Financial Officer

The Chief Financial Officer will keep an overview of the risks within finance and ensure that these are appropriately actioned.

### 3. Commissioning Executive Team

Members of the Commissioning Executive Team will keep an overview of risks within their area of responsibility ensuring these are being appropriately actioned. They will also ensure that there is a nominated risk lead for each service area and who is notified to the Risk and Health and Safety Advisor.

### 4. Company Secretary

The Company Secretary is designated as the accountable officer for implementing the system of internal control, including the Risk Management Strategy.

### 5. Commissioning Support Unit

The Commissioning Support Unit will maintain a corporate risk register, generate reports on risks and provide specialist advice and support on risk management.

### 6. Clinicians and Managers

All clinicians and managers within the CCG are accountable for the day-to-day management of risks of all types within their area of responsibility. They are charged with ensuring that risk assessments are undertaken on a pro-active basis and that preventive action is carried out where necessary. They are also responsible for seeking advice about implementation of risk reduction plans from the Risk and Health and Safety Advisor. Managers are responsible for setting objectives, relevant to corporate objectives, for their own staff, and monitoring staff achievement against them.

Individuals are empowered to manage risk. If resources or expertise are identified as insufficient to manage risk the matter should be escalated to the appropriate Senior Officer. Similarly if identified local risks have wider implications for the organisation they must be notified to the Accountable Officer.

### 8. Employees

Management of risks is a fundamental duty of all staff whatever their grade, role or status. All staff must comply with NHS Sheffield CCG policies and procedures which explain how this duty is to be undertaken. In particular, staff must ensure that identified risks and incidents are dealt with swiftly and effectively and reported to their immediate line manager in order that further action may be taken where necessary. Staff are accountable for

achievement against agreed personal objectives which contribute to organisational objectives and must ensure that risks to the achievement of objectives are raised through the risk management process.

**APPENDIX 3**

# GUIDELINES TO IDENTIFY, ASSESS, ACTION AND MONITOR RISKS

## 1 INTRODUCTION

Risk Management covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them and monitoring and reviewing progress.

In order for the CCG to manage and control the risks it faces, it needs to identify and assess them. This document provides a step-by-step guide to help staff undertake risk management systematically and will ensure consistency of approach across the organisation.

## 2 IDENTIFYING A RISK

There is no unique method for identifying risks. Risks may be identified in a number of ways and from a variety of sources, for example:

- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment
- Clinical risk assessments
- Environmental / workplace risk assessments
- Risk assessment as part of CCG business – at all levels of the organisation
- Annual planning cycle
- Performance management of key performance indicators
- Internal risk assessment processes e.g. requirements to assess risks as part of development and approval of policies, procedures, strategies and plans
- Claims, incidents (including Serious Untoward Incidents) complaints and enquiries
- Organisational learning e.g. assurance reviews
- External reviews, visits, inspections and accreditation e.g. health and safety inspections, fire inspections, external consultant reports, Information Governance Toolkit
- Staff and patient surveys
- National recommendations including Confidential Inquiries, safety alerts, NICE guidance etc
- Internal and External Audit
- Clinical audits
- Information from partner organisations
- Environment scanning of future risks (both opportunities and threats)

This list is not exhaustive. In general, the more methods that are used the more likely that all relevant risks will be identified.

There are two distinct phases to risk identification:

a) Initial Risk identification - relevant to new services, new techniques, projects

b) Continuous Risk Identification – relevant to existing services and should include new risks or changes in existing risks e.g. external changes such as new guidance, legislation etc.

## 3 DESCRIBING THE RISK

Failure to properly describe risk is a recognised problem in risk management. Common pitfalls include describing the *impact* of the risk and not the risk itself, defining the risk as a statement which is simply the converse of the objective, defining the risk as an absence of controls etc.

A simple tip is to consider describing the risk in terms of cause and consequence. The example below provides a useful everyday example to help staff define the risk accurately and precisely:

| Objective: To travel to a meeting at a certain time | | |
|---|---|---|
| Risk description | | Comment |
| Failure to attend meeting at a certain time | ✖ | This is simply the converse of the objective |
| Being late and missing the meeting | ✖ | This is a statement of the **impact** of the risk and not the risk itself |
| Missing the train causes me to be late and miss the meeting | √ | This is a risk that can be controlled by ensuring I allow enough time to get to the train station |
| Severe weather prevents the train from running and me getting to the meeting | √ | This is a risk that I cannot control but against which I can make a contingency plan |

## 4 ASSESSING THE RISK

Having identified and described the risk, the next step is to assess the risk. This allows for the risk to be assigned a standard rating which determines what actions (if any) need to be taken.

Ideally, risk assessment is an objective process and wherever possible should draw on independent evidence and valid quantitative data. However such evidence and data may not be available and assessor(s) will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

The risk assessment should be undertaken by someone competent in the risk assessment process and should involve staff familiar with the activity being assessed. Trade union representatives, external assessors or experts should be involved or consulted, as appropriate.

Risks are assigned a score based on a combination of the **likelihood** of a risk being realised and the **consequences** if the risk is realised.

The CCG uses three risk scores:

- Initial Risk Score: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.
- Current Risk Score: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.

- Target Risk Score: This is the score that is expected after the action plan has been fully implemented.

**a) Scoring the consequences**

Use *Table 1 Measures of Consequence*, to score the consequence, with existing controls in place:

Choose the most appropriate domain(s) from the left hand column of the table. Then work along the columns in the same row and, using the descriptors as a guide, assess the severity of the consequence on the scale 1 = Insignificant, 2 = Minor, 3 = Moderate, 4 = Major and 5 = Catastrophic.

## Table 1: Measures of Consequence

| Domain | Consequence Score and Descriptor | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| | **Insignificant** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| Injury or Harm Physical or Psychological | No / minimal injury requiring no / minimal intervention or treatment<br><br>No time off work required | Minor injury or illness, requiring intervention<br><br>Requiring time off work for < 4 days<br><br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring intervention<br><br>Requiring time off work for 4 -14 days<br><br>Increase in length of hospital stay by 4 -14 days<br><br>RIDDOR / agency reportable incident | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >14 days | Incident leading to death<br><br>Multiple permanent injuries or irreversible health effects |
| Quality of the Patient Experience / Outcome | Unsatisfactory patient experience not directly related to the delivery of clinical care | Unsatisfactory patient experience directly related to clinical care – readily resolvable | Mismanagement of patient care, short term effects < 7 days | Mismanagement of patient care, long term effects >7 days | Totally unsatisfactory patient outcome or experience |
| Statutory | Coroners verdict of natural causes, accidental death, open<br><br>No or minimal impact of statutory guidance | Coroners verdict of misadventure<br><br>Breech of statutory legislation | Police investigation.<br><br>Prosecution resulting in fine >£50k<br><br>Issue of a statutory notice | Coroners verdict of neglect/system neglect<br><br>Prosecution resulting in fine >£500k | Coroners verdict of unlawful killing<br><br>Criminal prosecution (incl Corporate manslaughter) > imprisonment of Director/ Executive |
| Business/ Finance & Service Continuity | Minor loss of non-critical service<br><br>Financial loss <£10K | Service loss in a number of non-critical areas <2 hours or 1 area or <6 hours<br><br>Financial loss £10 - 50k | Loss of services in any critical area<br><br>Financial loss £50 - 500k | Extended loss of essential service in more than one critical area<br><br>Financial loss £500k to £1m | Loss of multiple essential services in critical areas<br><br>Financial loss > £1 m |
| Potential for Complaint or Litigation / Claims | Unlikely to cause complaint or litigation | Complaint possible<br><br>Litigation unlikely<br><br>Claim(s) < £10k | Complaint expected<br><br>Litigation possible but not certain<br><br>Claim(s) £10-100k | Multiple complaints / Ombudsmen inquiry<br><br>Litigation expected<br><br>Claim(s) £100k - £1m | High profile complaint(s) with national interest<br><br>Multiple claims or high value single claim >£1m |
| Staffing and Competence | Short-term low staffing level that temporarily reduces patient care / service quality (<1 day)<br><br>Concerns about competency / skill mix | Ongoing low staffing level that reduces patient care / service quality<br><br>Minor error(s) due to levels of competency (individual / team) | Ongoing problems with levels of staffing that results in late delivery of key objective/service<br><br>Moderate error(s) due to levels of competency (individual / team) | Uncertain delivery of key objective/service due to lack of staff.<br><br>Major error(s) due to levels of competency (individual / team) | Non-delivery of key objective/service due to lack of staff / loss of key staff.<br><br>Critical error(s) due to levels of competency (individual / team) |
| Reputation or Adverse Publicity[1] | Within the CCG<br><br>Local media 1 day e.g. inside pages, limited report | Local media <7 day coverage e.g. front page, headline<br><br>Regulator concern | National media <3 day coverage<br><br>Regulator action | National media >3 day coverage. Local MP concern. Questions in the House | Full public enquiry<br><br>Public investigation by regulator |
| Compliance Inspection / Audit | Non-significant / temporary lapses in compliance / targets. | Minor non-compliance with standards / targets. Minor recommendations from report | Significant non-compliance with standards / targets. Challenging report | Low rating. Enforcement action. Critical report | Loss of accreditation / registration. Prosecution. Severely critical report |

## b) Scoring the likelihood

Use *Table 2 Likelihood*, to score the likelihood of the consequence(s) occurring with existing controls in place , using the frequency scale of Rare = 1, Unlikely = 2, Possible = 3, Likely = 4 and Certain = 5.

Likelihood can be scored by considering

- Frequency i.e. how many times the consequence(s) being assessed will actually be realised

or

- Probability i.e. what is the chance the consequence(s) being assessed will occur in a given period

Table 2: Likelihood

| Descriptor | Score | Frequency | Probability |
|---|---|---|---|
| Rare | 1 | This will probably never happen / recur | > 1 in 100 000 |
| Unlikely | 2 | Do not expect it to happen / recur but it is possible | > 1 in 10 000 |
| Possible | 3 | Might happen / recur occasionally | > 1 in 1 000 |
| Likely | 4 | Will probably happen / recur but it is not a persistent issue | > 1 in 100 |
| Almost Certain | 5 | Will undoubtedly happen / recur, possibly frequently | > 1 in 10 |

## c) Scoring the risk

Calculate the risk score by multiplying the consequence score by the likelihood score. See *Table 3 Risk Score*

IMPORTANT: It may be appropriate to assess more than one domain of consequence. This may result in generating different scores. Use your judgement to decide on the **overall** score.

Table 3: Risk Score

| **Likelihood** | **Consequence** | | | | |
|---|---|---|---|---|---|
| | Insignificant (1) | Minor (2) | Moderate (3) | Major (4) | Catastrophic (5) |
| Rare (1) | 1 | 2 | 3 | 4 | 5 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Almost certain (5) | 5 | 10 | 15 | 20 | 25 |

## 5 RATING THE RISK

Risk rating makes it easier to understand the risk profile. It provides a systematic framework to identify the level at which risks will be managed and overseen in the organisation; prioritise remedial action and availability of resources to address risks; and, direct which risks should be included on the risk register.

Having assessed and scored the risk, use *Table 4 Risk Rating* to rate the risk. The table provides guidance on the documentation/registration of the risk, the urgency of actions to mitigate the risk and clarifies reporting and oversight arrangements.

Table 4: Risk Rating

| Scores | Risk grade | Responsibilities and Accountability |
|---|---|---|
| 1 – 4 | Low | ▪ Risk Assessment Form completed. Registering on to DATIX at<br>▪ Directorate to monitor via local governance arrangements<br>▪ Risk Reported to Governance Committee to check grading and action |
| 6 – 10 | Moderate | ▪ Risk Assessment Form completed and risk registered on DATIX<br>▪ Directorate(s) to monitor via local governance arrangements.<br>▪ Risk Reported to Governance Committee to check grading and action |
| 12-25 | High | ▪ Risk Assessment Form completed and risk registered on DATIX<br><br>▪ Wherever possible, the action plan should include urgent action to reduce risk<br>▪ Directorate(s) to monitor via local governance arrangements.<br>▪ Risk Reported to Governance Committee to check grading and<br>▪ Included on High Level Risk Table and progress reported to Governance Committee |

## 6 DOCUMENTING THE RISK

It is important that identified risks are appropriately documented risk assessment forms are available on the intranet site.

## 7 ADDRESSING RISKS

Having identified, assessed, scored and rated the risk, the next stage is to decide and document an appropriate response to the risk. The response should describe how the Target Risk Score will be achieved.

In general, there are four potential responses to address a risk once it has been identified and assessed – commonly known as the four Ts:

- Tolerate
- Treat
- Transfer
- Terminate

a) Tolerate the risk

The risk may be considered tolerable without the need for further mitigating action, for example if the risk is rated LOW or if the CCG's ability to mitigate the risk is constrained or if taking action is disproportionately costly.

If the decision is to tolerate the risk, consideration should be given to develop and agree contingency arrangements for managing the consequences if the risk is realised.

b) Treating the Risk

This is the most common response to managing a risk. It allows the organisation to continue with the activity giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it.

It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance to the CCG that the risk will be reduced to an acceptable level.

Action plans must be documented, have a nominated owner and progress monitored by the appropriate risk forum.

c) Transfer the risk

Risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets.

It is important to note that reputational risk cannot be fully transferred.

d) Terminate the risk

The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently.

However, this option is limited in the NHS (compared to the private sector) where many activities with significant associated risks are deemed necessary for the public benefit.

**APPENDIX 4**

## SHEFFIELD CCG RISK MANAGEMENT ACTION PLAN 2013/14

| Target | Lead | Date | Key Performance Indicator/Assurance |
|---|---|---|---|
| Approve and implement a Risk Management Strategy | | April 2013 | Approved and published strategy |
| Produce an updated Assurance Framework and agree system for management of this | | May 2013 | Assurance Framework<br>Statement of Internal Control |
| Develop a comprehensive and updated CCG Risk Register | | May 2013 and ongoing | April 2013 |
| Staff appropriately trained in risk and health and safety | | October 2013 | Training records |
| Improved Health and Safety of Staff | | February 2014 | Risk Assessments<br>Number of Health and Safety Incidents<br>Health and Safety Audits |
| Embed a risk awareness culture within the CCG. | | March 2014 | Increased Incident reporting<br>More fully developed Risk Register resulting in demonstrable reduction in risk<br>Availability of information for staff on risk |
| Overall reduction in risk level over the year | | March 2014 | Datix Risk Management System/Governance Committee Reports |
| Compliance with all external assessments of risk | | March 2014 | Audit/Inspection reports<br>Statement of Internal Control |