Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Risk Management Strategy and Action Plan 2022-2023

March 2022

Version:	Version 8.0
Policy Number:	F005/10/2022
Date ratified:	17 March 2022
Name of originator/author:	Corporate Services Risk and Governance Manager
Name of Sponsor:	Associate Director of Corporate Services
Name of responsible committee	Audit and Integrated Governance Committee
Date issued:	March 2022
Review date:	October 2022
Target audience:	All staff working within or on behalf of NHS Sheffield CCG

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http://www.intranet.sheffieldccg.nhs.uk/policies-procedure-forms-templates.htm

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Policy Audit Tool

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Please give status of Policy:	**Revised**

1.	**Details of Policy**	
1.1	Policy Number:	F005/10/2022
1.2	Title of Policy:	Risk Management Strategy
1.3	Sponsor	Associate Director of Corporate Services
1.4	Author:	Corporate Services Risk and Governance Manager
1.5	Lead Committee	Audit and Integrated Governance Committee
1.5	Reason for policy:	To ensure risk is effectively managed throughout the organisation
1.6	Who does the policy affect?	All staff
1.7	Are the National Guidelines/Codes of Practices etc issued?	Yes
1.8	Has an Equality Impact Assessment been carried out?	Yes
2.	**Information Collation**	
2.1	Where was Policy information obtained from?	National 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.	
3.3	If NO explain why.	Can be operated under existing structures
4.	**Consultation Process**	
4.1	Was there external/internal consultation?	Yes
4.2	List groups/persons involved	Governance Sub-committee Audit and Integrated Governance Committee 360 Assurance Risk Management Audit
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?	Staff will be made aware of all new policies via the Weekly Bulletin and Team Briefings. All CCG policies are available on the intranet.
5.2	If there are implementation requirements such as training please detail.	Risk management training is mandatory for all staff
5.3	What is the cost of implementation and how will this be funded	N/A
6.	**Monitoring**	
6.2	How will this be monitored	Governance Sub-committee reports
6.3	Frequency of Monitoring	Quarterly

Version Control

Version	Date	Author	Comment
4.0	Mar 18	Sue Laing	General updates to include recommendations from the Risk Management – Risk Identification Process September 2017
			Definitions moved from Appendix to body of Strategy (4)
			Additional information with regard to each of the committees/sub-committees and groups who review the risk process
			Clarity on team risk logs and role of deputies group
			General update to training and implementation section
			Additional clarity regarding providing guidance on how risks should be reported through the CCGs risk structure so that the significance of them can be considered and risks managed appropriately
			Revised Escalation and Implementation chart
			Updates to Operational Responsibility for Risk Management (Appendix 2)
			Remove table 4 – Risk Rating following the addition of additional guidance on risk reporting
			Appendix 4 updated to show Action Plan for 2018/19
5.0	Mar 19	Sue Laing	Update to section PMO Risks
			Addition of section 11 – Partnership Risk Management
			Addition of section 12 – Commissioned Services
			Amendments to Appendix 1 with regard to Programme risks
			Amendments to Table 1: Measures of Consequence (now aligned to risk matrix and increase in reference to financial loss (£)
			Updated Table 2 to reflect risk matrix
			Revised Risk Management Action Plan
6.0	Mar 2020	Sue Laing	Aims – updated to provide additional clarity
			Para 7.0 Strategic Risks – additional clarity
			Para 9.8 Information Risk Management – new paragraph included
			Table 1 – Measure of Consequences – alignment to risk matrix
			Action Plan - updated
			General minor amendments throughout
7.0	March 2021	Sue Laing	Simplified and updated diagram – Risk management overview
			Minor updates throughout the Strategy
			Change of Policy Sponsorship
			Change of colour within Risk Matrix for critical risks to Dark Purple
8.0	March 2022	Carol Henderson	Minor updates throughout the Strategy

1 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.

The Governing Body is responsible for ensuring that the CCG consistently follows the principles of good governance applicable to NHS organisations through its Assurance Framework (AF) and other processes. This includes the development of systems and processes for financial and organisational control, clinical governance and risk management.

Risk management is the process by which an organisation identifies and assesses the risk, implements controls and ensures agreed actions are taken. This Strategy provides the vision through which risk management underpins the way the NHS Sheffield CCG undertakes its business.

2 AIMS

2.1 Managing risk is part of every decision made and as such is the responsibility of all managers at all levels and therefore ultimately all staff. The aim of this strategy is to:

- ensure that the staff, patients and visitors, reputation and finances of the CCG are protected through the process of risk identification, assessment, control and elimination/reduction. This process supports delivery of the CCG's objectives.

- Ensure that risk is managed more effectively throughout the organisation; however it does not mean that its implementation will result in the avoidance of all risks, only that risk is managed to the best of our ability.

3 OBJECTIVES

3.1 NHS Sheffield CCG recognises the need, and its responsibility, to reduce all identifiable negative risk to the lowest practicable level and to embrace and develop any opportunities identified. This will be achieved through adopting a holistic approach to risk management across the organisation, which embraces corporate, quality, safety, regulatory, reputational, financial, innovation and partnership risks.

The objectives of risk management within NHS Sheffield CCG are 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**

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

- provide the Governing Body with assurance that risk is being effectively managed through appropriate risk management escalation mechanisms for the purposes of decision making

- establish systems to ensure proportionate monitoring and compliance with agreed processes

4 DEFINITIONS

Assurance	Provides confidence or guarantee that a risk is being managed appropriately
Control	Measures which prevent or reduce the risk. Once actions on risk assessments are completed these will become controls.
Risk	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).
Operational Risk	A key risk, which impacts on a programme's operational achievement or may impact on people, premises or equipment.
Strategic Risk	A significant risk that may impact the organisation's ability to achieve its strategic objectives. A strategic risk will be placed on the Governing Body Assurance Framework. (See Governing Body Assurance Framework)
Risk Appetite	The amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time and is intended to guide employees in their actions and ability to accept and manage risks. It is defined by the organisation's willingness to accept and manage risk in pursuit of its objectives.
Risk Management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk. See Fig 1 below
Risk Maturity	The relative measure of the systems and process in place for managing risk
Risk Register	A central repository which captures information such as risk likelihood, consequence, actions to mitigate and manage the risk for all identified risks. Risk registers will be maintained and reported at team, scheme and corporate levels
Governing Body Assurance Framework (GBAF)	An integral part of the system of internal control which records the significant principal risks that could impact on the CCG achieving its strategic objectives. It summarises the sources of control that are in place, or are planned to mitigate against them. Gaps are identified where key controls and assurances are not robust and actions to address these are implemented. The GBAF is a tool for providing assurance to the Governing Body.

Risk Management Overview

5 RISK MANAGMENT STRATEGY

The Governing Body has two principal roles in respect of risk management:

i) Within the Governing Body itself, an informed consideration of risk should underpin its organisational strategy, decision making and allocation of resources.

ii) Responsibility for ensuring that the organisation has appropriate risk management processes in place to deliver the operational plan and comply with regulators' requirements. This includes the need to systematically assess and manage risks including clinical, financial, reputational and corporate risks.

5.1 The work of the Governing Body is supported in this respect by the Audit and Integrated Governance Committee (AIGC), which has the responsibility to monitor, scrutinise and challenge the work and conduct of the CCG, its Governing Body and Committees which in turn monitor, scrutinise and challenge the work and conduct of their respective disciplines.

5.2 Risk management by the Governing Body is therefore underpinned by six interlocking systems of internal control:

i) Governing Body Assurance Framework (GBAF)

ii) Corporate Risk Register (informed by team, directorate, PMO, committee / group risk)

iii) Local team risk logs

iv) Audit and Integrated Governance Committee

v) Governance Sub-committee

vi) Annual Governance Statement

6 APPLICATION OF THE STRATEGY

6.1 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. The strategy applies to clinicians and others engaged by the CCG, whether employed or otherwise funded, directly employed staff.

Whilst all actions contain inherent risks, the key strategic risks are identified and monitored by the Governing Body Assurance Framework (GBAF). Operational risks will be managed on a day-to-day basis by staff throughout the CCG which are acknowledged through the CCG Corporate Risk Register as a comprehensive central record.

Teams/directorates are encouraged to capture risks on team risk logs with escalation to the corporate risk register which is overseen by the Deputy Directors' group. See Identification and Escalation of Risk at **Appendix 1**.

7 STRATEGIC RISKS

7.1 Strategic risks which threaten the objectives of the organisation, and associated action plans, are recorded in more detail in the GBAF. An up-to-date position is provided in quarterly reports to both AIGC and Governing Body.

The GBAF is presented to the Senior Management Team (SMT) for review and challenge prior to presentation to AIGC and corporate risk reports presented to each meeting of the Governance Sub-committee which, in turn, provides assurance to AIGC of the adequacy and effectiveness of the CCG's assurance processes including risk management.

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8 THE WAY WE WORK

8.1 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** and reiterated as part of the Risk Management training programme. 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.

8.2 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 CCG systems to enable this to happen.

8.3 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.

8.4 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 HR colleagues as appropriate.

9 ACCOUNTABILITIES, RESPONSIBILITIES AND ORGANISATIONAL FRAMEWORK

9.1 Accountabilities and Responsibilities

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

9.2 Organisational structure

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

9.3 Governing Body Assurance Framework

The CCG is supported in the assurance and governance process by the Governing Body Assurance Framework (GBAF). Through this framework the CCG gains assurance from key accountable officers that strategic risks are being appropriately managed throughout the organisation. The framework is built around the organisation's strategic objectives, and principal risks aligned to the Risk Register. The GBAF should also be read in conjunction with the CCG's Commissioning Intentions and Operational Plan. SMT receives quarterly reports on the high level risks prior to review and challenge by the AIGC and ultimately, Governing Body.

9.4 Corporate Risk Register

The organisation maintains a web-based central Corporate Risk Register, which is hosted by NHS Wakefield CCG and managed by The Health Informatics Service (THIS). Access to the system is online via the HSCN network. The Register captures all operational risks and enables analysis against organisational objectives, ensuring appropriate action is being taken to address risk and that lessons are being learned. The corporate risk register is reviewed on a 13 week cycle where all risks are reviewed by risk owners, senior risk owners and ultimately by the final reviewer (Director level). Corporate risks are reported to the Governance Sub-committee and via Governance Sub-committee reports to AIGC on a quarterly basis. The Corporate Risk Register allows for risks to be linked to the GBAF and strategic objectives.

9.5 Local/team Risk Logs

Each directorate, team or specific work stream should have its own risk log where all assessed risks are reported and held. It is for each team to own and ensure the maintenance of these registers by assigning a designated person within the directorate to manage and coordinate. The register will provide a local record of all potential or actual risks facing the team. Actions to mitigate these risks will be managed by the respective team with the appropriate senior lead. Where appropriate individual risks may be escalated to the Corporate Risk Register following discussion by Deputy Directors. Team risks should be an integral part of team meetings where risks and actions identified to mitigate the level of risk may be shared.

9.6 Programme Risks

The CCG has adopted a Programme Management Office (PMO) approach and the management of risk is embedded in this process. Project risk management enables the systematic identification, clarification and management of risk through the lifespan of a project. Project risk management helps to control both the probability of an adverse event materialising and mitigate the impact of an adverse risk event. Where projects are managed as a programme then there may be a need for risk assessment at both project and programme level as projects may be interdependent.

The process for reporting and managing programme risks is as follows:

- Programmes manage their own risks and maintain a risk log
- Programme risks are reported in the programme highlight report each month which is presented at various meetings and is submitted to the Programme Management Office (PMO) via Aspyre
- Risks are highlighted at the Integrated QIPP Working Group where it is decided whether or not the risk should be added to the Corporate Risk Register or escalated to Governing Body through the QIPP update report

9.7 Partnership Risk Management

It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks can often be difficult. The CCG recognises that there are risks as well as opportunities in partnership working and that failing to actively engage with partners also carries risk. The CCG is committed to the continued development of partnership working and will work closely with all partner organisations including health and social care to ensure these risks are identified and appropriately managed and that risk management is fully integrated into all joint working arrangements.

In all partnership working arrangements, the Governing Body will seek assurance that risks to its strategic objectives have been identified both from NHS Sheffield CCG perspective and by the partner organisations and that adequate risk controls have been put into place. A Section 75 partnership agreement is in place with Sheffield Local Authority and both organisations will work within the agreed governance arrangements for risk management relating to integrated commissioning priorities and pooled budget arrangements.

9.8 Information Risk Management

Information risk is inherent in all administrative and business activities and everyone working for or on behalf of the CCG continuously manages information risk. The Governing Body recognises that the aim of information risk management is not to eliminate risk, but rather to provide the structural means to identify, prioritise and manage the risks involved in all activities. It requires a balance between the cost of managing and treating information risks with the anticipated benefits that will be derived. The Governing Body acknowledges that information risk management is an essential element of broader information governance and is an integral part of good management practice. The intent is to embed information risk management in a practical way into business processes and functions. This is achieved through key approval and review process / controls and not imposing risk management as an additional requirement.

The Senior Information Risk Owner (SIRO) is responsible for coordinating the development and maintenance of information risk management policies, procedures and standards for the CCG.

CCG Information Asset Owners (IAOs) will ensure that information risk assessments are completed at least annually on all information assets where they have been assigned 'ownership'. Assessments are completed as part of the Information Asset Register.

9.9 Commissioned Services

The CCG is working closely with partner organisations to achieve a shared ownership of risks facing the Sheffield health economy and the solutions that are implemented. The CCG expects risk management to be a priority for those organisations from whom the CCG commissions services and will require evidence of robust risk management systems, policies and procedures within service level agreements and contracts issued.

The Governing Body should be informed of and where necessary, consulted on all significant risks that arise from the commissioning of services. Risks associated with commissioned services must be systematically identified, assessed and analysed in the same way as other risks to the organisation.

10 SYSTEMS FOR MONITORING THE EFFECTIVENESS OF THE STRATEGY

10.1 An annual report on risk management within the CCG will be produced in the first quarter following the end of the financial year. This report will be reviewed by the Governance Sub-committee and AIGC.

10.2 Additionally, a risk report is presented to each meeting of the Governance Sub-committee which outlines progress against all high level risks, lists all new risks identified and risks marked for closure, and raises any additional significant risk issues. A summary report is presented to AIGC via the quarterly Governance Sub-committee report.

The corporate risk register allows each directorate to review its own risks and those of the wider organisation which may, for example, be discussed at team briefings or

senior manager meetings. Specific reports on appropriate risks may be provided to other groups within the governance structure.

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

11 ACTION PLAN/KEY PERFORMANCE INDICATORS

11.1 An annual risk management action plan will be agreed and monitored by the Governance Sub-committee. The Action Plan for 2022/23 is attached at **Appendix 4**. Progress in the achievement of these actions will act as the key performance indicator for risk management and will be reported annually to the Governance Sub-committee and AIGC through the Annual Risk Report. The risk management action plan will be developed in consultation with key stakeholders and through consultation on the strategy.

12 IMPLEMENTATION, TRAINING AND SUPPORT

12.1 This strategy describes risk management as the responsibility of everyone in the organisation. The training and development of managers and staff is an integral part of the CCG's approach to risk management. An effective implementation strategy requires managers and staff to be both aware of the CCG's approach to risk, and to be clear about their roles and responsibilities within the risk management process. Risk management training is mandatory for all staff. Training on request is available with regard to the risk management software offered according to the level of responsibility within their respective roles. This will include identifying risks, assessing risk ratings, describing key controls and action plans, the risk escalation process, monitoring and review process.

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

12.2 The CCG will:

- ensure all staff and stakeholders have access to a copy of this Risk Management Strategy through publication on the intranet as well as through Team Briefings
- be actively engaged in the cross CCG Risk Register User Group which meets quarterly and hosted by THIS/NHS Wakefield CCG to review, develop and enhance the Corporate Risk Register and to ensure it continues to meet the needs of the organisation
- 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 organisation 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.

13 LINKS TO OTHER GUIDANCE AND CCG POLICY

The Risk Management Strategy should be read in conjunction with the CCG's other related documents and guidance and in particular the GBAF, the Corporate Risk Register and both GBAF and Risk Register Protocols.

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

- Health and Safety
- Policy for the Management of Serious Incidents (SIs)
- Disciplinary
- Freedom of Information and Environmental Information Regulation
- Incident Reporting
- Feedback and Complaints
- Claims Management
- Fraud, Bribery and Corruption
- Freedom to Speak Up, Raising Concerns (Whistleblowing)

14 MONITORING AND REVIEW

This strategy will be reviewed and updated (if required) annually and not later than 31 March 2023. The revised policy will be presented to the AIGC for formal approval.

15 RETENTION, DISPOSAL AND ARCHIVING

The disposal of withdrawn or archived documents is the responsibility of the Corporate Governance Manager and will be managed in accordance with the Records Management Policy. At least one copy of the previous strategy will be archived and all other paper copies of the document destroyed. Documents published on the intranet will be removed when a policy has been formally approved and the revised version put in its place.

16 DISSEMINATION

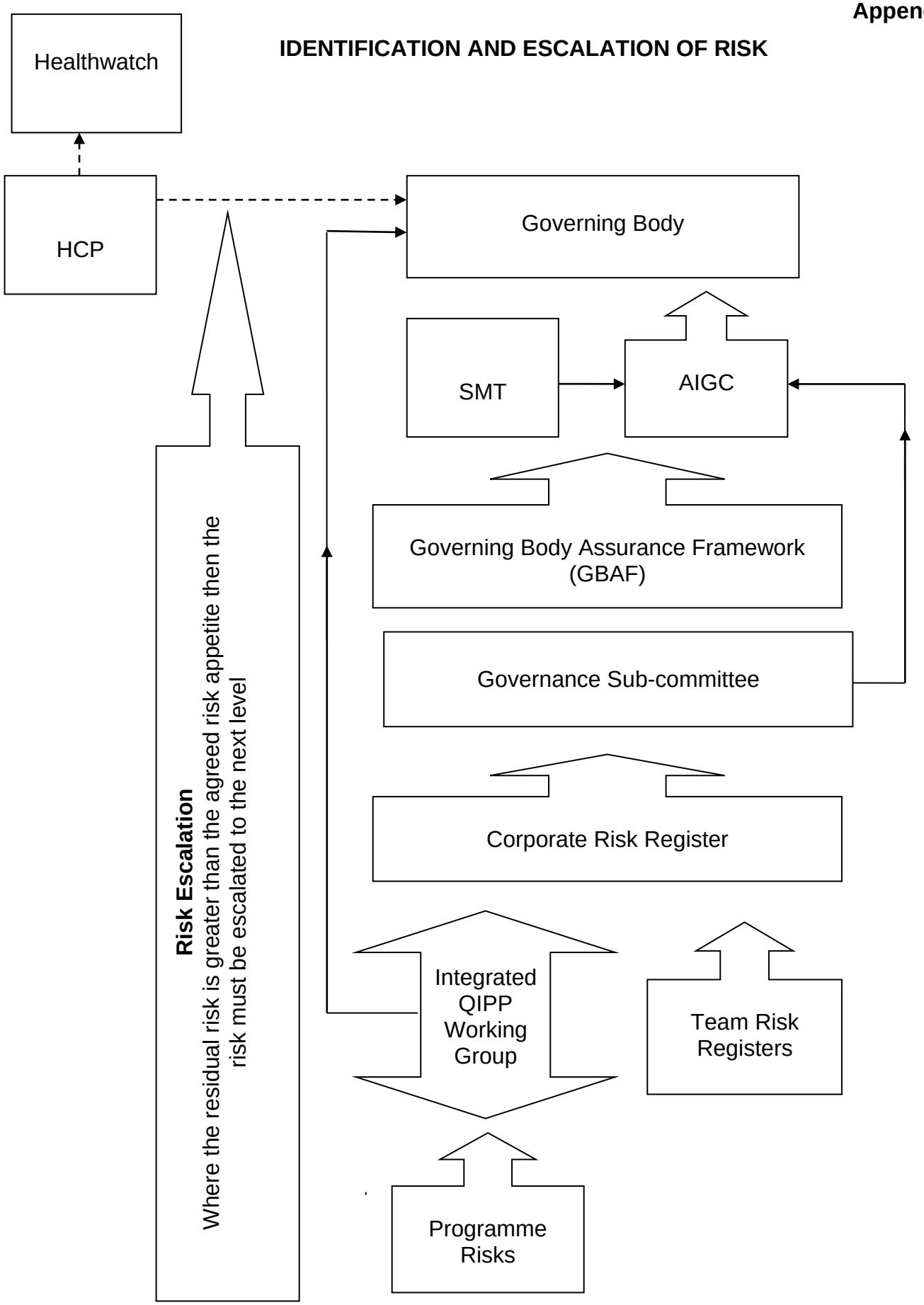
The policy will be available to staff through the CCG's communications channels, i.e. Team Brief, Weekly Round-Up and the policies section of the intranet.

17 EQUALITY AND DIVERSITY STATEMENT

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

Appendix 1

IDENTIFICATION AND ESCALATION OF RISK



Appendix 2

OPERATIONAL RESPONSIBILITY FOR RISK MANAGEMENT

1 Accountable Officer

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

2 Director of Finance

The Director of Finance will keep an overview of financial risks, ensuring that these are appropriately actioned.

3 Corporate Governance Manager

The Corporate Governance Manager holds responsibility for ensuring that there are effective systems and processes for the management of risk, including a robust governance framework, GBAF and Corporate Risk Register. S/he will:

- ensure that the GBAF is developed, reviewed and reported to SMT, AIGC and Governing Body as appropriate
- Prepare the Annual Governance Statement, setting out the CCG's arrangements for managing risk
- Work with the Governance lead in Barnsley CCG to ensure delivery of risk management training and providing support to staff with regard to all aspects of risk management

4 Governing Body

The Governing Body has overall responsibility for ensuring strong governance arrangements are in place within the CCG. The Governing Body also holds responsibility for ensuring implementation of the Risk Management Strategy and confirm and challenge of the GBAF.

5 Audit and Integrated Governance Committee

AIGC will be responsible for:

- Providing assurance to the Governing Body on the effectiveness and adequacy of the processes for managing principal risks and the risk management framework
- Challenging the way in which risk is managed, particularly where there is uncertainty or concerns over the effectiveness of existing arrangements.
- Ensuring that arrangements for risk management are regularly included in the cycle of internal audits.

6 Governance Sub-committee

The Governance Sub-committee has responsibility for:

- Promoting a culture of sound governance

- Providing the AIGC with assurance that the CCG has robust internal controls in place to achieve its objectives as an employer and a statutory body by identifying, monitoring and reporting risks.
- Quarterly detailed review and challenge of the Corporate Risk Register

7 Quality Assurance Committee

This Committee has overarching responsibility for clinical risk management and provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. Its work programme addresses safeguarding, infection control, quality in contracts, incidents and medicines management.

8 Senior Management Team

The Senior Management Team will review the GBAF on a quarterly basis, providing scrutiny and challenge and working with AIGC providing assurance to the Governing Body that the high level principal risks facing delivery of the organisation's objectives are being appropriately managed.

9 Deputy Directors

Deputy Directors meet bi-monthly and will offer leadership and guidance on mitigating the level of risk and ensuring that risks are appropriately managed. Deputy Directors will also consider potential escalation from team risk logs to the Corporate Risk Register where this is appropriate.

10 Clinicians and Managers

Clinicians and managers should be familiar with the Risk Management Strategy and guidance, including the maintenance of risk registers, and methodologies around risk assessment and risk rating. They should ensure that their staff are sufficiently aware of general risk issues, and the need to raise matters of risk encountered in the course of their work. They are also responsible for seeking advice about implementation of risk reduction plans.

Managers are responsible for setting objectives, relevant to the organisation's objectives for their own staff, and monitoring staff achievement against them. In support of this, managers are responsible for ensuring that staff receive training in line with their requirements and that all mandatory training is completed.

Individuals are empowered to manage risk. If resources or expertise are identified as insufficient 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.

11 Employees

Management of risk 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. All staff should ensure they are fully up-to-date with mandatory training requirements.

Appendix 3

GUIDELINES TO IDENTIFY, ASSESS, ACTION AND MONITOR RISKS

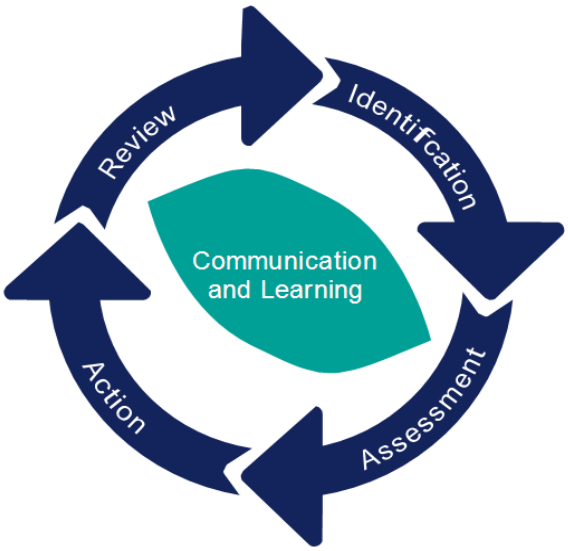
1 Introduction

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 Risk Management Plan

Risk Management Process



Risk management is the process of identifying risk referred to as inherent risk. Assessing the inherent risks and agreeing the most appropriate measures to control the risk to an acceptable level is referred to as residual risk.

Once this has been implemented the residual risk must be reviewed to ensure that the actions taken have had the desired effect in controlling or mitigating the risk

3 Identifying a Risk

There is no unique method of 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
- 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 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, Data Security and Protection 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.

4 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 ie

"There is a risk of slipping **due to** spilt coffee in the kitchen **resulting in** injury to staff or visitors to the organisation"

The example below provides a useful everyday illustration to help 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

5 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 may 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 = Negligible, 2 = Minor, 3 = Moderate, 4 = Major and 5 = Extreme.

Table 1: Measures of Consequence

Domain	Consequence Score and Descriptor				
	1	2	3	4	5
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Injury or Harm Physical or Psychological	No / minimal injury requiring no / minimal intervention or treatment No time off work required	Minor injury or illness, requiring intervention Requiring time off work for < 4 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring intervention Requiring time off work for 4 -14 days Increase in length of hospital stay by 4 -14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >14 days	Incident leading to death 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 No or minimal impact of statutory guidance	Coroners verdict of misadventure Breech of statutory legislation	Police investigation. Prosecution resulting in fine >£50k Issue of a statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in fine >£500k	Coroners verdict of unlawful killing Criminal prosecution (incl Corporate manslaughter) > imprisonment of Director/ Executive
Business/ Finance & Service Continuity	Minor loss of non-critical service Financial loss <£100K	Service loss in a number of non-critical areas <2 hours or 1 area or <6 hours Financial loss £100k - £1m	Loss of services in any critical area Financial loss £1m - £2m	Extended loss of essential service in more than one critical area Financial loss £ 2m to £4.5m	Loss of multiple essential services in critical areas Financial loss > £4.5m
Potential for Complaint or Litigation / Claims	Unlikely to cause complaint or litigation	Complaint possible Litigation unlikely Claim(s) < £10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100k - £1m	High profile complaint(s) with national interest 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) Concerns about competency / skill mix	Ongoing low staffing level that reduces patient care / service quality 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 Moderate error(s) due to levels of competency (individual / team)	Uncertain delivery of key objective/service due to lack of staff. 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. Critical error(s) due to levels of competency (individual / team)
Reputation or Adverse Publicity	Within the CCG Local media 1 day e.g. inside pages, limited report	Local media <7 day coverage e.g. front page, headline Regulator concern	National media <3 day coverage Regulator action	National media >3 day coverage. Local MP concern. Questions in the House	Full public enquiry 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 of Occurrence

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	0 – 5%
Unlikely	2	Do not expect it to happen / recur but it is possible	6 – 20%
Possible	3	Might happen / recur occasionally	21 – 50%
Likely	4	Will probably happen / recur but it is not a persistent issue	51 – 80%
Almost Certain	5	Will undoubtedly happen / recur, possibly frequently	81 – 100%

b) Scoring the risk

Calculate the risk score by multiplying the ***likelihood*** *by the* ***consequence*** score (L x C). 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.

Risks are also RAG rated and graded as set out in table 3 below:

Table 3: Risk Score

Risk Stratification Risk Matrix		Likelihood				
		-1 Rare	-2 Unlikely	-3 Possible	-4 Likely	-5 Almost certain
Consequence	-1 Negligible	1	2	3	4	5
	-2 Minor	2	4	6	8	10
	-3 Moderate	3	6	9	12	15
	-4 Major	4	8	12	16	20
	-5 Extreme	5	10	15	20	25

1 to 3	Low
4 to 9	Medium
10 to 14	High
15 to 19	Very High (Serious)
20 to 25	Critical

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.

6 Documenting the Risk

It is important that identified risks are appropriately documented and included on the Risk Register

7 Addressing Risks

7.1 Internal Control

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.

The response initiated by the organisation to risk is called internal control and can take one of the following forms:

- 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 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 April - June 2022

Target	Date	Key Performance Indicator/Assurance
Review principal risks currently included on GBAF, ensuring progress with regard to identified Gaps in Control and/or Assurance are managed and recorded and where appropriate included within the SY ICB AGS	Quarterly	GBAF
Actively participate in the review and refinement of the CCG Corporate Risk Register through the West Yorkshire User Group	Ongoing	Updates to Governance Sub-committee and Audit and Integrated Governance Committee
Delivery of risk management training module, ensuring all staff appropriately trained in risk management.	Ongoing	Training records – Mandatory 3 yearly attendance Reports to Governance Sub-committee and People Plans to Directors Evaluation forms
Improved Health and Safety of staff	Ongoing	Risk Assessments Number of Health and Safety incidents Health and Safety audits Minutes of Health and Safety Group Reports to Governance Sub-committee Annual Health, Safety and Security Report Annual Premises, Fire and Security Risk Assessment
Embed a risk awareness culture within the CCG.	Ongoing	Increased Incident reporting Further refine Risk Register Availability of information for staff on risk Mandatory training Establish Team Risk Logs Head of Internal Audit Opinion Statement Minutes of Information Governance Group
Compliance with external assessments of risk	Ongoing	Audit/Inspection reports ICB Annual Governance Statement
Implementation and staff awareness of Datix Incident Reporting system	Ongoing	Incident reporting system in place which is accessible to all staff Increase in incident reporting Incident Reporting Policy

Target	Date	Key Performance Indicator/Assurance
Implementation of Local/team risk logs	Ongoing	Risk logs in place at local level
Regular review of Corporate Risk Register by Deputy Directors to ensure consistency across organisation	Ongoing	Deputy Director meetings Consistency of approach to risk management Increased number of risks reviewed ICB Annual Risk Report
Work with South Yorkshire governance colleagues to agree the approach to risk management in the SY ICB	June 2022	Approval of Proposal Paper to Change and Transition Board Effective risk management process across SY ICB.

NHS Sheffield CCG Equality Impact Assessment 2020

Title of policy or service	RISK MANAGEMENT STRATEGY	
Name and role of officers completing the assessment	SUE LAING, CORPORATE SERVICES RISK AND GOVERNANCE MANAGER	
Date assessment started/completed	15 February 2021	15 February 20201

1. Outline	
Give a brief summary of your policy or service • Aims	The aims of this Risk Management Strategy are to ensure that the staff, patients, visitors, reputation, and finances associated with NHS Sheffield Clinical Commissioning Group (CCG) are protected through the process of risk identification, assessment, control and elimination/reduction.
• Objectives	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; • Eliminate or transfer risks or reduce them to an acceptable and cost effective level wherever possible, otherwise ensure the organisation openly accepts the remaining risks. • Provide the Governing Body with assurance that risk is being effectively managed through appropriate risk management escalation mechanisms for the purposes of decision making. • Established systems to ensure proportionate monitoring and compliance with agreed processes.

• Links to other policies, including partners, national or regional	The Risk Management Strategy should be read in conjunction with the CCG's other related documents and guidance and in particular the Governing Body's Board Assurance Framework (GBAF). The strategy should be read in conjunction with the following policies: • Health and Safety Policy • Incident Reporting Policy • Policy for the Management of Serious Incidents • Feedbackand Complaints Policy • Freedom to Speak Up, Raising Concerns (Whistleblowing) Policy • Disciplinary Policy, Procedure and Rules • Claims Management Policy and Procedure • Freedom of Information and Environmental Information Regulations • Fraud, Bribery and Corruption

2. Gathering of Information

This is the core of the analysis; what information do you have that indicates the policy or service might *impact on protected groups, with consideration of the General Equality Duty*.

	What key impact have you identified?			**What action do you need to take to address these issues?**	**What difference will this make?**
	Positive Impact	**Neutral impact**	**Negative impact**		
Human rights		✓		No action required	
Age		✓			
Carers		✓			
Disability		✓			
Sex		✓			
Race		✓			
Religion or belief		✓			
Sexual orientation		✓			
Gender reassignment		✓			
Pregnancy and maternity		✓			
Marriage and civil partnership (only eliminating discrimination)		✓			

Other relevant group		✓			

Please provide details on the actions you need to take below.

3. Action plan				
Issues identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication			
When will the proposal be reviewed and by whom?			
Lead Officer	SUE LAING	**Review date:**	February 2021