NHS
Merton
Clinical Commissioning Group

Report to the Merton Clinical Commissioning Group Governing Body

Date of Meeting: 18th July 2013

Agenda No: 6.2 (i) **ATTACHMENT : 04**

Title of Document: Risk Management: Policy And Strategy	**Purpose of Report:** For Agreement
Report Author: Richard Moss (SL CSU on behalf of MCCG)	**Lead Director:** Eleanor Brown Chief Officer, Merton CCG
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Executive Summary:

This policy and strategy sets out the risk management approach of Merton Clinical Commissioning Group (MCCG), and applies to all staff employed by Merton CCG, whether on a permanent, part-time, agency or contractor basis.

Key sections for particular note (paragraph/page), areas of concern etc:

S.10 of the document outlines the role of the CSU in supporting the CCGs risk management arrangements. This section may require further discussion and agreement.

Recommendation(s):

The Merton Clinical Commissioning Group Governing Body is requested to:
1. Review s.10 and suggest any required changes
2. Approve the Policy and strategy, pending CSU agreement with any amendments to s.10

Committees which have previously discussed/agreed the report:

- Clinical Quality Committee June 2013
- Finance Committee June 2013
- Audit and Governance Committee June 2013

Financial Implications:

None identified

Other Implications: (including patient and public involvement/Legal/Governance/ Risk/ Diversity/ Staffing) None identified
Equality Analysis: See document information panel p.2
Information Privacy Issues: None identified
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) In preparation

Merton Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP

RISK MANAGEMENT: POLICY AND STRATEGY

DOCUMENT INFORMATION

Title /Version Number/(Date)	Risk Management Policy and Strategy
Document Status (for information/ action etc)and timescale	For implementation (**/**/201*)
Accountable Executive	Chief Officer
Responsible Post holder/Policy Owner	
Date Approved	
Approved By	CCG Governing Body
Publication Date	(**/**/201*)
Review Date	(**/**/201*)
Author	**Richard Moss, Interim Corporate Governance Manager**
Stakeholders engaged in development or review	**[CCG to decide and progress locally]**
Equality Analysis	**EQUALITY ANALYSIS** This document has been assessed for equality impact on the protected groups, as set out in the Equality Act 2010. This Policy is applicable to the Governing Body, every member of staff within the CCG irrespective of their age, disability, sex, gender reassignment, pregnancy, maternity, race (which includes colour, nationality and ethnic or national origins), sexual orientation, religion or belief, marriage or civil partnership, and those who work on behalf of the CCG The policy will go through the South London CSU internal review process. If changes are recommended as a result of that review, the CCG will be made aware so they can refresh their policy.
Contact details for further information	

Amendment History

Version	Date	Reviewer Name(s)	Comments
1.3	01-03-2013	Ben Vinter	
1.4	02-03-2013	Jenny Kay, Director of Quality	Amendment to s.7.5 to include risk summits
1.5	02-03-2013	Eleanor Brown, CO	• Addition of ISO 3100 flow chart s.7 • Addition of role designations to Appendix 2, Committee Structure; addition of Joint Charity Funds Committee
1.6	09-04-2013	Jenny Kay	Amendments to:

			• Ss 5.1; • 7.2.5; • 7.2.6; • 8 • 8.7 • Appendix1 • Appendix 4
1.7	11-04-2013	Jenny Kay	Addition of Appendix 7 – risk
1.8	07.06.13	Jackie Moody	Amendments following review by MCQC in May
1.9	18.06/2013	Jackie Moody	Amendments following Finance Committee and Audit and Governance Committee

This policy progresses the following Authorisation Domains and Equality Delivery System (tick all relevant boxes).

Clear and Credible Plan		Commissioning processes	
Collaborative Arrangements		Leadership Capacity and Capability	
Clinical Focus and Added Value		Equality Delivery System	
Engagement with Patients/Communities		NHS Constitution Ref:	

Associated Policy Documents

Reference	Title
	CCG Constitution V*.*

Glossary

Term	Definition
Accountable Executive	CCG Executive accountable for development, implementation and review of the policy
Policy Owner	Post holder responsible for the development, implementation and review of the policy
Document definitions	These are provided in Section 1

Contents

1. INTRODUCTION

1.1. This policy and strategy sets out the risk management approach of Merton Clinical Commissioning Group (MCCG).
1.2. MCCG is responsible for delivering health improvements and reducing health inequalities for the population of Merton through its commissioning processes.

2. SCOPE

2.1. This policy and strategy applies to all staff employed by Merton CCG, whether on a permanent, part-time, agency or contractor basis.

3. DEFINITIONS

3.1. For the purposes of this document, the following definitions are adopted:

3.2. Risk

3.2.1. Risk is defined as '...uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of likelihood and impact, including perceived importance.'[1]

3.3. Risk assessment

3.3.1. 'Risk assessment is a systematic process for identifying and evaluating events (i.e. possible risks and opportunities) that could affect the achievement of objectives, positively or negatively.'[2]

3.4. Risk management

3.4.1. '... all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.'[3]

3.5. Risk taking

3.5.1. Delivering health improvements and embracing positive change may involve taking risks. Risk taking which is appropriately identified and controlled is sometimes necessary in order to achieve greater benefits.

3.6. Risk appetite

3.6.1. The degree of risk which MCCG is willing to accept to achieve its corporate objectives.

[1] http://www.hm-treasury.gov.uk/psr_governance_risk_definitions.htm
[2] http://www.pwc.com/en_us/us/issues/enterprise-risk-management/assets/risk_assessment_guide.pdf
[3] http://www.hm-treasury.gov.uk/psr_governance_risk_definitions.htm

3.7. Risk tolerance

3.7.1. The acceptable level of variation relative to achievement of an individual objective. It is the amount of risk to which a programme or an activity is prepared to be exposed to or that its resources allow it to be exposed to, before actions become necessary.

3.8. Governance

3.8.1. 'The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives and by which they relate to their partners and wider community.[4]

3.9. Principal objectives

3.9.1. The principal organisational objectives are those that are critical to the success of the organisation and which are the key focus of Governing Body deliberation.[5] (See Appendix 1)

3.10. Principal risks

3.10.1. The principal or key risks are those that directly threaten the achievement of the organisation's objectives.[6]

3.11. Key controls

3.11.1. The systems, measures and management actions that are in place to manage or mitigate the effects of the principle risks.[7]

3.12. Assurance

3.12.1. Evidence that shows [that MCCG is] reasonably managing [its] risks and [its] objectives are being delivered.[8]

4. POLICY STATEMENT

5. MCCG is committed to implementing the principles of risk management and good governance. In order to commission high quality care, MCCG will ensure that all reasonably foreseeable risks arising from its activities and plans, which threaten the achievement of its strategic objectives or the health, safety and welfare of patients, staff and all those who might be affected by its activities are effectively and efficiently managed. A systematic and consistent approach to managing risk will support creativity and innovation and be able to respond to new threats and opportunities.

[4] Audit Commission 2002
[5] Integrated Governance Handbook
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129615.pdf
[6] ibid
[7] ibid
[8] NHS Integrated Governance Handbook 2006 p.24

6. PURPOSE

6.1. The purpose of this policy and strategy is to:

- ensure robust governance and risk arrangements to support the delivery of the organisation's strategic and operational objectives
- ensure commissioning of high quality and safe patient care and maximise the resources available for patient services.
- develop a proactive approach to identification and understanding of risks inherent in and external to the organisation
- minimise MCCG's financial liability
- maintain a system of internal control across the organisation
- reduce risks to the health, safety and welfare of patients, staff and all those who might be affected by its activities, to the lowest level it is reasonably practicable to achieve (see also Appendix 5)
- identify the risk owner, who will identify the resources required to identify, manage, control and evaluate risk in the most cost effective manner

7. RISK MANAGEMENT STRATEGY

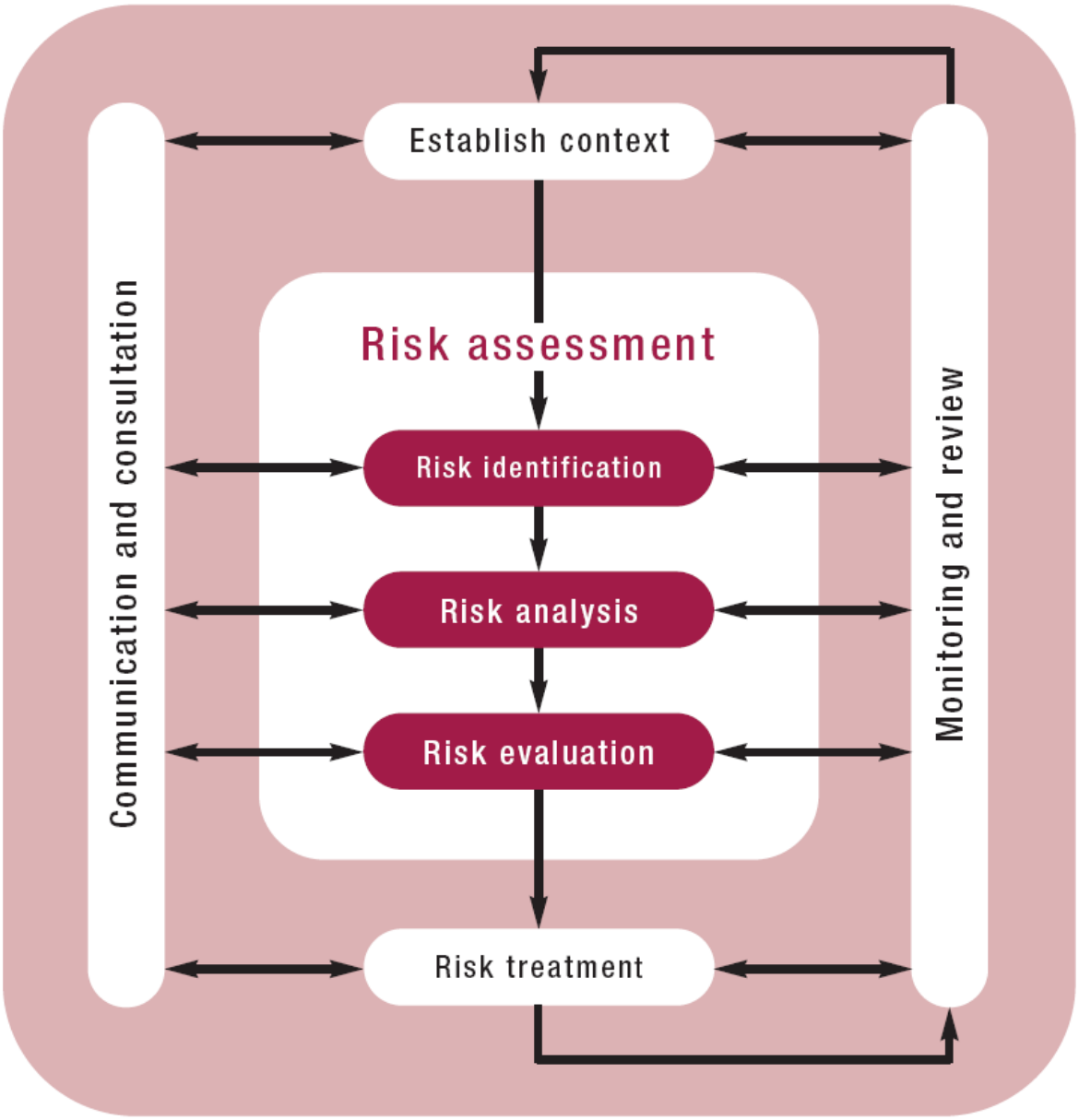
AIM **To ensure that the intentions of the Policy statement in s4 above are met**	
OBJECTIVE	**INDICATORS/ ASSURANCES**
1. To ensure that all reasonably foreseeable risks are identified and assessed in a proactive manner	• Local and organisational risk registers regularly updated as risks emerge • Review of risk registers at Directorate and Corporate level • No surprises • Review of GBAF at Corporate level • Internal and External Audit
2. To ensure that the Risk Register and the Governing Body Assurance Framework are regularly updated and presented to the relevant committees for scrutiny	• Committee minutes • Review of risk registers at Directorate and Corporate level • Review of GBAF at Corporate level • Internal and External Audit
3. To ensure that risks are escalated to the right level in the organisation in a timely fashion	• MCCG audit and review of Risk Register

AIM To ensure that the intentions of the Policy statement in s4 above are met	
OBJECTIVE	**INDICATORS/ ASSURANCES**
(see Appendix 4)	• Internal and External Audit
4. To ensure that decisions on risk treatment plans are timely and appropriate to the level of risk (see Appendix 5)	• MCCG audit and review of Risk Register and action plans
5. To ensure that risk treatment plans are implemented	• Risk register shows reduction in levels of risk • Individual workstreams achieve desired outcome

8. RISK MANAGEMENT PROCESS

8.1. The risk management process is described in the chart below, based on ISO 3100[9].

[9] Available to download at http://www.iso.org/iso/catalogue_detail?csnumber=43170



8.2. Duties

8.2.1. Chief Officer: Accountable Officer[10]

- Has overall responsibility for risk management
- understand corporate governance as a key element of integrated governance
- understand the CCG's risk environment including knowledge and understanding of the strategies that have been adopted by the CCG, and the inherent risks

[10] All duties of governing body members in this document adapted with reference to 'Clinical commissioning group governing body: Roles outlines, attributes and skills http://www.england.nhs.uk/wp-content/uploads/2012/04/ccg-mem-roles.pdf

8.2.2. Governing Body Chair

- ensure that the CCG has proper constitutional and governance arrangements in place
- assess and confirm that appropriate systems of internal control are in place for all aspects of governance, including financial and risk management

8.2.3. Lay members of the Governing Body

- assess and confirm that appropriate systems of internal control and assurance are in place for all aspects of governance, including financial and risk management
- Chair (s) of Audit and Governance Committee and Clinical Quality Committee

8.2.4. Chief Finance Officer

- oversee robust audit and governance arrangements leading to propriety in the use of CCG resources
- demonstrate a working understanding of integrated governance and assurance

8.2.5. Clinical leads and clinical members of the Governing Body

- assess and advise on matters of clinical risk and patient care
- advise on quality, safety and clinical governance, having regard to any statutory or regulatory requirements

8.2.6. Senior managers/risk owners

- take responsibility for the management of risk in their departments and for local risk registers, in accordance with the requirements of this policy and strategy by:
    - assessing risk
    - identify and implement mitigating actions in a timely fashion
    - ensure that risks are escalated to the appropriate level in the organisation

8.2.7. All staff

- Will:
    - ensure that any significant risks they identify are reported to their line manager
    - attend any safety, risk and governance training which has been identified by a process of training needs analysis as necessary for the performance of their role
    - be aware of risks associated with their acts or omissions
    - undertake appropriate risk assessments
    - minimise risks wherever possible, in a managed way

- ensure that they are fully aware of all appropriate MCCG policies and procedures that impact on their work

8.3. Risk management: committee structure

8.3.1. Audit and Governance Committee

The Committee shall provide the Governing Body with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the CCG's activities (clinical and non-clinical).

8.3.2. Clinical Quality Committee

The Committee will report annually to the Governing Body in respect of the fulfilment of its functions with its terms of reference. Such report shall include, but not be limited to, functions undertaken in relation to the effectiveness of risk management within the CCG; the managements of serious quality and safety incidents and any pertinent matters in respect of which the Committee has been engaged.

8.3.3. Finance Committee

The Finance Committee shall consider and review the financial report to be presented to the Governing Body, incorporating financial performance against budget, financial risk analysis, forecasts and robustness of underlying assumptions.

8.4. Risk identification

8.4.1. Risks will be identified from a number of sources, including but not limited to:

- incident reports and trends (internal, and by monitoring incidents in commissioned services)
- complaints monitoring in commissioned services
- patient and staff surveys
- inspections, such as Care Quality Commission and Royal Colleges
- Key Performance Indicators
- risk assessments
- local risk registers
- internal/ external feedback and recommendations

8.5. Identifying and managing risks arising in commissioned services

8.5.1. Commissioning is the process of putting in place healthcare services that effectively meet the needs of the population[11].

8.5.2. The CCG has a duty to act with a view to securing continuous improvement to the quality of services[12] and to assist and support the NHS England in relation to the Governing Body's duty to improve the quality of primary medical services.[13]

8.5.3. The CCG is responsible for monitoring the safety and quality of the services it commissions and for taking action where there is significant concern, alongside, as necessary in the circumstances at the time, the appropriate regulatory body. The CCG, through the Director of Quality, will maintain oversight of the following:

- The processes in place in commissioned services to provide assurance with regard to clinical risk management, including (but not necessarily limited to):
- Safeguarding of adults and children
- Clinical Governance and Information Governance
- Confidentiality (including Caldicott Guardian)
- Health & Safety
- Infection Prevention and Control
- Managing and overseeing the performance management of serious incidents reported by the providers of health services commissioned by the CCG.

8.5.4. Clinical and quality risk will be monitored through Clinical Quality Review Groups and Clinical Quality Committee. In South London, monthly quality surveillance groups will meet to ensure all partners share information about quality of commissioned services.

8.5.5. Risk Summits may be arranged when any commissioner has a serious concern about quality. Further guidance will follow following new guidance from the NHS England.[14,15]

8.6. Risk assessment

8.6.1. Risks should be assessed using the matrix shown at Appendix 3.

8.7. Risk assessment consistency

8.7.1. The risk assessment process is qualitative and therefore prone to subjectivity. To ensure consistency all risks entered on the Risk

[11] http://www.england.nhs.uk/wp-content/uploads/2012/09/procure-brief-1.pdf
[12] See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
[13] See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/126820/How-to-Organise-and-Run-a-Risk-Summit.pdf.pdf
[15] http://www.england.nhs.uk/wp-content/uploads/2012/11/board-7-main-qual.pdf NHS England Board paper

Register and Governing Body Assurance framework will be moderated by the Corporate Affairs Manager and reported to the CCG SMT prior to presentation at the relevant Committee.

8.8. Risk register

8.8.1. The risk register will include as a minimum:

- source of the risk (including, but not limited to, incident reports, risk assessments, local risk registers, and external recommendations)
- description of the risk
- risk score
- summary risk treatment plan
- date of review
- residual risk rating

8.8.2. The risk register and GBAF will be monitored at each meeting of the Executive Management Team.

8.8.3. High and extreme risks will be transferred to the Governing Body Assurance Framework for review at each meeting of the Governing body, which will monitor the progress of Risk Action Plans.

8.9. 4Risk system and updating the Risk Register

8.9.1. 4Risk is the software system used by MCCG to manage its risk register and GBAF. The effectiveness of the system depends on those responsible for entering and updating the information held on the system.

8.9.2. See Appendix 6 for detail of risk register and GBAF maintenance.

8.9.3. Any person with responsibility for updating the information on 4Risk will be:

- Trained in the use of the 4Risk system
- Familiar with the concepts and language of risk management

9. RISK TAKING, RISK ACCEPTANCE, RISK APPETITE AND RISK TOLERANCE

9.1. MCCG has set its risk tolerance threshold at score 15. At this level or below risks are monitored and evaluated on an ongoing basis to confirm or reassess that rating.

9.2. All risks above this threshold (at any level of the organisation) are actively managed and mitigating actions taken to bring the risks back to within tolerance.

9.3. Each risk identified at every level of the organisation is aligned with a corporate objective or sub objective. Where mitigating actions do not reduce the risk, the issue will be escalated to the Director responsible for

the objective or sub objective which the risk threatens and entered in the GBAF.

9.4. All risks with an impact score of 5 (catastrophic) must have a contingency plan developed by the responsible manager, irrespective of the likelihood of occurrence.

9.5. Authority levels for managing different levels of risk and risk escalation

9.5.1. All risks with a score of more than 15 will be managed by a Director. See also Appendix 4 for more detail

9.6. Risk treatment types

9.6.1. See Appendix 5

9.7. Compliance monitoring

9.7.1. Compliance with the requirements of this Policy will be conducted by the following means:

- Monitoring via MCCG committees (see Appendix 7)
- Internal and external audit

9.8. Audit and Governance Committee

9.8.1. The Governing Body Assurance Framework will be reviewed by the Audit and Governance Committee in accordance with s6.6.4 of the Audit and Governance Committee Terms of Reference.[16]

9.9. Process for monitoring external recommendations

- external recommendations specific to the organisation will be monitored by the responsible CCG officer
- external recommendations specific to the organisation will be assessed on the following criteria:
    - statutory requirement: recommendations will be implemented as soon as is reasonably practicable
    - extreme or high risk: recommendations will be implemented as soon as is reasonably practicable
    - moderate or low risk: recommendations will be implemented in order of priority when assessed alongside other CCG priorities
- written action plans to implement external recommendations will be developed by the responsible CCG officer, and, where required by the degree of risk, entered on the risk register and/or Assurance Framework

[16] Draft v8, undated, author not identified

- action plans will be followed up by the relevant CCG officer and the relevant monitoring committee, according to the degree of risk
- compliance with the above will be monitored by the relevant CCG officer and the relevant monitoring committee

10. ROLE OF THE COMMISSIONING SUPPORT UNIT (CSU)

10.1. The CSU will:

- Provide expert advice on governance and risk management
- Support the administration of a locally owned and accountable risk management framework including the risk register and Governing Body Assurance Framework
- Provide day to day assistance with Governing Body and Committee organisation including:
  - Organising venues
  - Preparation and distribution of agendas and meeting papers
  - Note taking and the production and distribution of meeting notes

11. GOVERNING BODY ASSURANCE FRAMEWORK[17,18,19]

11.1. In order to complete an annual Governance Statement, the Governing Body is required to have in place a Governing Body Assurance Framework (GBAF). The GBAF is a document that sets out the risks for each organisational objective, along with the controls in place and assurances available on their operation.

11.2. The purpose of the GBAF is to provide the Governing Body with 'reasonable assurance' that systems are in place to identify and control risks that may arise.

11.3. Responsibilities for updating and maintaining the RR and GBAF are shown in Appendix 6.

The Governing Body Assurance Framework will be developed and maintained by the CSU, ensuring that:

- The principal objectives at strategic level set out with involvement of members of the Governing Bodies and the MCCG Executive Management Team. These objectives should be reviewed at least annually.

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[17] Building the Assurance Framework: A practical Guide for NHS Boards March 2003. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4093993.pdf

[18] Integrated Governance Handbook http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129615.pdf

[19] www.**foresight-partnership.co.uk**/downloads/doc_download/5

- Risks to the achievement of these objectives are identified and recorded on the Governing Body Assurance Framework
- Risks are evaluated and any gaps identified
- Key controls intended to manage these risks are identified
- Assurances available to support achievement of these objectives are recorded
- Action plans will be put in place to address any gaps that have been identified, with clear accountability, timescales and monitoring.

APPENDIX 1: MCCG Strategic Objectives (as at 01-04-2013)

1: DELIVERY:

To commission high quality and cost effective health services ensuring positive patient outcomes and health improvement, financial balance and delivery of QIPP

2: STRATEGY:

To take ownership and leadership of the strategy programme, including Better Services Better Value (BSBV), Better Healthcare Closer to Home (BHCH), promoting healthy living and a preventative approach to commissioning and service improvement

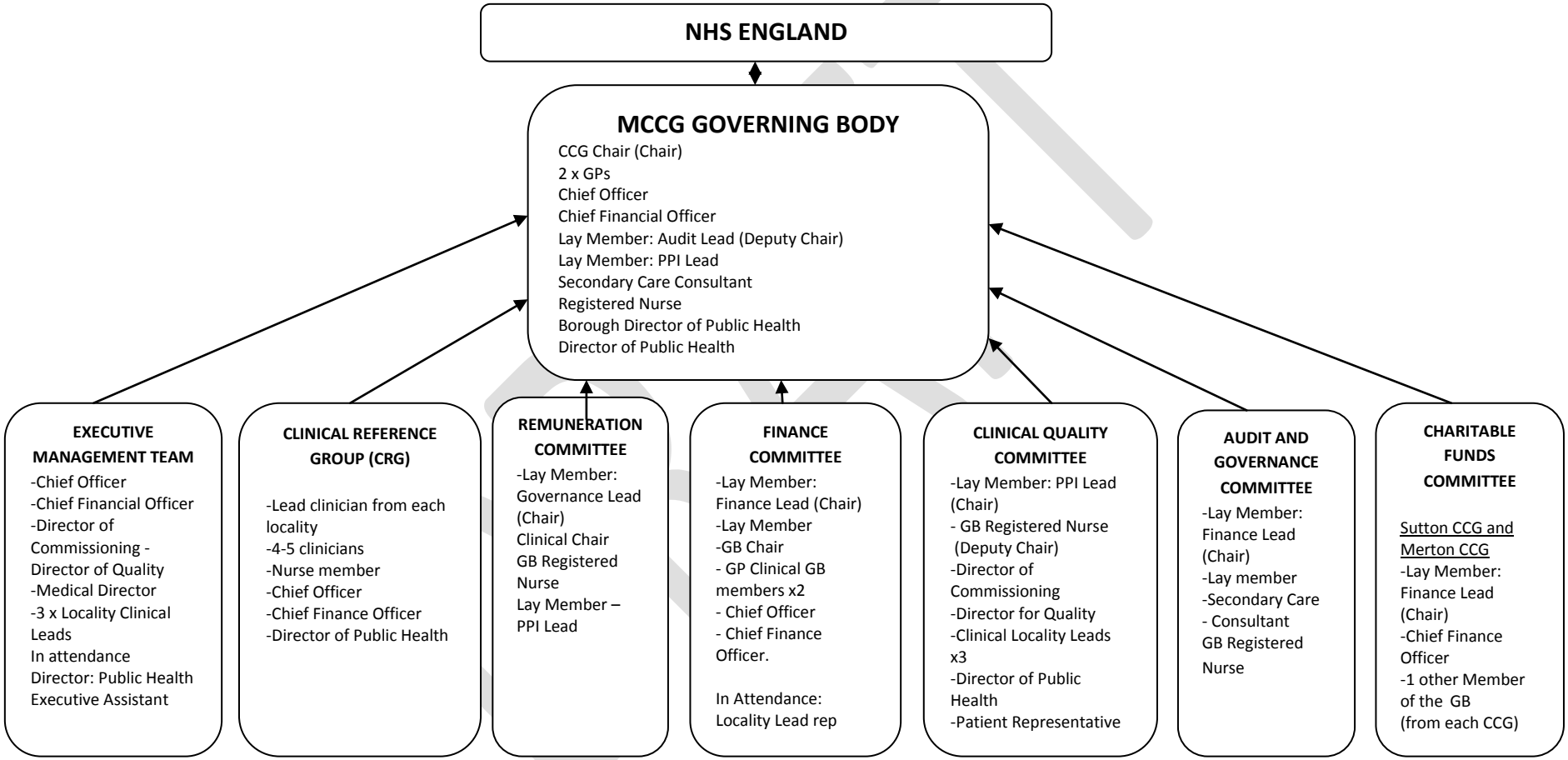
3: PEOPLE:

To ensure staff are able to make the transition to the new system effectively and are prepared for new ways of working to support commissioning. To ensure Merton CCG is a good partner, working with all key stakeholders to achieve and communicate its vision for health.

4: GOVERNANCE AND COMPLIANCE:

To ensure the CCG is compliant with statutory (and non statutory) duties and obligations, has good governance systems in place and promotes the reputation of the organisation at every opportunity in terms of behaviour and performance.

APPENDIX 2: Risk management: MCCG governance structure



APPENDIX 3: Risk assessment matrix[20]

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

[20] Adopted from the National Patient Safety Agency (now part of the NHS ENGLAND) Risk Management Framework
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59833&q=0%c2%acrisk%c2%ac&p=1

Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Projects/ Objectives	Insignificant cost increase/ schedule slippage Key 'political' target is being achieved and impact prevents improvement	<5 per cent over project budget Schedule slippage Key 'political' target is being achieved but impact reduces performance marginally below target in the near future or Performance currently on target, but there is no agreed plan to meet the target	5–10 per cent over project budget Schedule slippage Key 'political' goal is marginally below target or is soon projected to deteriorate beyond acceptable limits or There is an agreed plan but it does not yet meet the rising target	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key 'political' target not being achieved and impact prevents improvement, or substantial decline in performance trend	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met Key 'political' target is not being achieved and the impact further deteriorates the position

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

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

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	**Low risk**
4 - 6	**Moderate risk**
8 - 12	**High risk**
15 - 25	**Significant risk**

APPENDIX 4: Authority levels for managing different levels of risk and risk escalation

All action plans required must use the template shown as Appendix 5: Risk Action Plan and Assurance Report

Key Levels of Risk	Risk Category	Management Actions	Action Plan Requirements
1-3	Low Risk	To be brought to the attention of the department/ team leader. Manage by routine procedures	Formal action plan not required
4-6	Moderate Risk	Line Manager - immediate control measures in place - review risk assessment - inform Heads of Department. Specific responsibility for risk assessment and action planning must be allocated to a named person. Deadline for completion will usually be within 6 to 12 months and will depend on the availability of resources.	Head of Department to decide whether to Accept the Risk. If Accepted no formal action plan is required. If risk requires Mitigation a formal action plan must be produced. The Risk will be managed at Departmental Level.
8-9	High Risk	Urgent attention required. To be brought to the attention of the responsible Director, Heads of Department, Line Manager - immediate control measures put in place - review risk assessment - action plan devised. Within one month of identification appropriate action must be agreed. The deadline for implementation and reassessment will normally be no later than 6 months from identification.	Director to decide whether to Accept the Risk. If Accepted no formal action plan is required. If risk requires Mitigation a formal action plan must be produced. The Risk will be managed at Directorate level.
10-12	High Risk	Urgent attention required. To be brought to the attention of the responsible Director, Heads of Department, Line Manager - immediate control measures in place - review risk assessment - action plan devised. Within one month of identification appropriate action must be agreed. The deadline for implementation and reassessment will normally be no later than 6 months from identification.	An action plan should be produced. The risks must be added to the Corporate Risk Register or the Directorate Risk Register. The Director must also decide whether to recommend that the risk be escalated to the Governing Body Assurance Framework. This may be agreed in exceptional circumstances even though the risk is scored below 15. Otherwise management and oversight of the risk will be at Directorate level.
15-25	Significant Risk	**ALL RISKS IN THIS CATEGORY TO BE MANAGED BY A DIRECTOR** Immediate action required by Executive Director and Head of Department. To be brought to the attention of the Governing Body and Risk Committee/Clinical Governance Committee. Carry out root cause analysis - review risk assessment. A Director must be informed and he/she will take responsibility for immediately planning action	Formal Action Plan required mitigating the level of risk. The Action Plan Template must be used. Must be added to the Corporate Risk Register and Governing Body Assurance Framework. Action Plan must be sent to Governing Body and Audit and Governance Committee. Risk managed at Director level with oversight by Governing body and Audit and Governance Committee.

APPENDIX 5: Risk Action Plan and Assurance Report

Date of This Report			
Name of Risk Work Stream			
Description of Risk			
Risk Owner	Name of Director		
Original Risk Score		**Date Added:**	
Current Risk Score		**Date Last Updated:**	
Target Risk Score		**Achievement Date:**	

Current Controls	Gaps in Controls / Assurance
1. Detail 2. Detail 3. Detail 4. Detail 5. Detail 6. Detail	1. Detail 2. Detail 3. Detail 4. Detail 5. Detail 6. Detail

Action Plan Milestones (See attached for Full Action Plans)		
Milestones in Order of Achievement Date	**Owner (Job Title)**	**Achievement Date**
Last Milestone must be achievement of Target Risk Score	Name of Director	Date Target Risk will be achieved

1. Action Plan to Address Gaps in Control/ Assurance

No	Action (A) / Milestone (MS)	A / MS	Owner	Priority	End Date	Resources	Contingency /Dependency
1	Actions must comply with SMART criteria i.e. be Specific, Measurable, Achievable, Realistic and Time Limited	A or MS	Job Title	High Medium Low	Date by which action will be achieved	What is needed to achieve the action	What other actions/ departments/ individuals etc does this action rely on
2							
3							

1a. Progress Reports for all Actions and Milestones

No	Progress	Evidence	RAG	Factors Preventing Green RAG Rating	Remedial Action Being Taken To Ensure Action End Date is Achieved	End Date For Remedial Action
1	Progress made to date on achieving the action	Evidence available to support the progress made and the RAG rating.	R	If the action is on track to achieve its End Date it should have a Green RAG Rating. If not explain why.	Please explain what is being done to get the action back on track.	When will the remedial action be complete
2			A			
3			G			

2. Action Plan to Achieve Target Risk Score

No	Action (A) / Milestone (MS)	A / MS	Owner	Priority	End Date	Resources	Contingency /Dependency
1	Actions must comply with SMART criteria i.e. be Specific, Measurable, Achievable, Realistic and Time Limited	A or MS	Job Title	High Medium Low	Date by which action will be achieved	What is needed to achieve the action	What other actions/ departments/ individuals etc does this action rely on
2							
3							

2a. Progress Reports for all Actions and Milestones

No	Progress	Evidence	RAG	Factors Preventing Green RAG Rating	Remedial Action Being Taken To Ensure Action End Date is Achieved	End Date For Remedial Action
1	Progress made to date on achieving the action	Evidence available to support the progress made and the RAG rating.	R	If the action is on track to achieve its End Date it should have a Green RAG Rating. If not explain why.	Please explain what is being done to get the action back on track.	When the remedial action be complete
2			A			
3			G			

APPENDIX 6: Maintenance of the MCCG Risk Registers and Assurance Framework

MCCG Risk Register	
Maintenance	CSU
Review and updating	Lead managers
Signed off by	Directors
Monitoring	• Clinical Executive Team • Audit and Governance Committee • Internal Audit • External Audit
Directorate Risk Registers	
Maintenance	Designated person in each Directorate
Review and updating	Risk owners identified in the register
Signed off by	Directors
Monitoring	CSU

APPENDIX 7: Monitoring Committees

Risk Category	Monitoring Committee
Change	
These concern risks that programmes and projects do not deliver agreed benefits on time and within agreed budget and or/introduce new or changed risks that are not effectively identified and managed.	• Governing Body • Executive Team
Financial	
These concern the effective management and control of the finances of the CCG. The risk events can range from insufficient funding, poor budget management, mismanage assets and liabilities and failure to collect due revenue	• Governing body • Audit and Governance Committee • Finance committee
Governance	
These concern the establishment of an effective organisational structure with clear lines of authorities and accountabilities. The risk events can include inappropriate decision making and delegation of authorities, lack of appropriate tone set by leader	• Governing Body • Executive Team • Audit and Governance Committee
Legal & Compliance	
These concern issues such as health & safety, consumer protection, data protection, employment practices, claims against any of the services you commission	• Governing Body • Executive Team • Quality committee will monitor legal claims against providers from a quality perspective.

Risk Category	Monitoring Committee
Operations	
These concern the day to day concerns MCCG is confronted with as it strives to deliver its strategic objectives. They can be anything from loss of key staff to process failure It covers risk events such as breakdown in process to deliver service	• Governing Body • Executive Team
People	
These concern the insufficient capacity and capability of 'human capital', as well as inappropriate staff behaviour, failing to comply with employment legislation or industrial action.	• Executive Team • Quality Committee (workforce assurance of providers in terms of impact on quality, staff survey etc.)
Strategic	
These concern external factors such as the economy, changes in the political environment, technological changes, changes in customer behaviour/needs, socio-economic, legal and regulatory changes, and environmental factors.	• Governing Body • Executive Team
Information Management and Technology	
These concern the day to day issues MCCG is confronted with as it strives to deliver its strategic objectives. They can be anything from loss of data to failure of a critical IT system. It covers risk events such as technological breakdown or loss of hard or soft copy data.	• Governing Body • Executive Team
Clinical	

Risk Category	Monitoring Committee
These concern risks that arise directly from the provision and delivery of healthcare to patients. This includes clinical errors and negligence, healthcare associated infection and failure to obtain consent.	• Governing body • Executive Team • Clinical Quality Committee
Partnerships/Contractual	
These concern risks associated with failure of contractors and partnership arrangements to deliver services or products to the agreed cost and specification. Contractor fails to deliver, partner agencies do not have common goals.	• Governing Body • Executive Team • Clinical Quality Committee (for risks associated with partners/contractors providing clinical and/or care services