North Tyneside
Clinical Commissioning Group

Corporate	CCG CO14 Risk Management Policy

Version Number	Date Issued	Review Date
V6.3	25 January 2022	3 March 2023
V6.2	23 March 2021	3 March 2023
V6.1	2 June 2020	3 March 2023
V6	3 March 2020	3 March 2023
V5.2	January 2019	January 2022
V5.1	02/05/2017	02/05/2020
V5	28/3/2017	28/3/2019
V4.1	28/09/2016	28/09/2018
V3.	08/05/2015	01/05/2017
V2:	01/02/2014	28/02/2015

Prepared By:	Head of Governance North Tyneside CCG (V5)
Consultation Process:	Internal Audit, Audit Committee 18/1/19 and Quality and Safety Committee 5/2/19
Formally Approved:	Governing Body 26 February 2019

Policy Adopted From:	v5.2
Approval Given By:	Quality & Safety Committee 3 March 2020 Head of Governance 25/1/2022 (following Governing Body approval of Corporate Objectives 2022/23

Document History

Version	Date	Significant Changes
1	28/02/2013	First issue
2	31/10/2013	Revision
3	14/04/2014	Minor amendments
4	27/09/2016	Addition of target risk score. Review of committee responsibilities and cycle of updating the register
4.1	27/09/2016	Change of cycle to Audit Committee
5	28/3/2017	Amalgamation of Corporate Risk Register and Board Assurance Framework into one consolidated document (Risk Assurance Framework) and change

		of review and reporting cycle to quarterly
5.1	02/05/2017	Update to risk management training requirements
5.2	February 2019	Update of Governing Body Responsibilities (section 5.3). Corporate Objectives updated to 19/20.
6	March 2020	Update to include Project Risk Management and Clinical Risk Management
6.1	2/6/2020	Corporate Objectives updated (2020/21)
6.2	23/3/2021	Corporate Objectives updated (2021/22)
6.3	25/1/2022	Corporate Objectives updated (2022/23)

Equality Impact Assessment

Date	**Issues**
31 August 2016	See section 9 of this document

POLICY VALIDITY STATEMENT
This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Contents

1. Introduction

North Tyneside Clinical Commissioning Group (the CCG) vision is to 'work together to maximise the health and wellbeing of North Tyneside communities by making the best use of resources'. As part of the vision, the CCG aims for better integration of services across health and social care which will be underpinned by more effective clinical decision making. In order to achieve the vision, the CCG has a duty to limit the potential impact of any clinical and non-clinical risks.

This policy aims to set out the CCG's approach to risk and the management of risk in fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding within the organisation of an effective risk management policy and processes will ensure that the reputation of the CCG is maintained and enhanced, and its resources are used effectively to reform services through innovation, large-scale prevention, improved quality and greater productivity.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

The purpose of this policy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The policy will:

- Set out an organisation wide approach to managing risk, in a simple, straightforward and clear manner the intentions of the CCG for timely, efficient and cost-effective management of risk at all levels within the organisation.

The aims of the Policy are summarised as follows:

- to ensure that risks to the achievement of the CCG's objectives are understood and effectively managed;
- to ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed;
- to assure the public, patients, staff and partner organisations that the CCG is committed to managing risk appropriately;
- to protect the services, staff, reputation and finances of the CCG through the process of early identification of risk, risk assessment, risk control and mitigation.

To achieve these aims the CCG is committed to ensure that:

- risk management is embedded as an integral part of the management approach to the achievement of our objectives;
- the management of risk is seen as a collective and individual responsibility, managed through the agreed committee and management structure;
- through a supportive culture where staff are encouraged to report adverse incidents and 'near misses' with a view to individuals and the organisation learning the lessons;
- complaints, claims, patient and staff feedback are used as part of or approach to risk management in terms of feedback on the patient experience;
- appropriate training and development is provided to all staff in the application of this policy and the approach to risk management.

This policy applies to all employees and contractors of the CCG. All staff at every level of the organisation are required to recognise that risk management is their personal responsibility.

2. Definitions

The following terms are used in this document:

- **Risk** refers to the chance that something will happen that will have an impact on the achievement of CCGs Corporate 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);
- **Strategic Risk** is a risk that undermines the CCG's ability to meet its statutory duties. These are identified as 'strategic risks' on the Risk Assurance Framework. They will remain on the Risk Assurance Framework permanently to provide assurance that the risks are effectively managed;
- **Corporate Risk** refers to a risk that is transient in nature and once managed to an acceptable level will be closed. These are identified as 'corporate risks' on the Risk Assurance Framework;
- **Risk Assurance Framework** is a document which consolidates the Corporate Risk Register (see corporate risks) and Assurance Framework (see strategic risks) into one document;
- **Risk Appetite** the organisation's unique attitude towards risk taking that in turn dictates the amount of risk that it considers is acceptable;
- **Risk Management** is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects;
- **Risk Assessment** is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk; and
- **Residual Risk** the risk remaining after the risk response has been applied.

Examples of the types of risk that the CCGs might encounter and need to mitigate against include:

- **Governance risks** – operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues;
- **Clinical risks** – associated with our commissioning responsibilities and including service standards, competencies, complications, equipment, medicines, staffing, patient information;
- **Clinical risks in the application & deployment & use of health IT Systems** - ensuring that health organisations deploying & using new or modified health IT systems have a structure to manage clinical risks associated with that deployment;
- **Project risk** – the management of risk throughout the project life cycle;
- **Reputational risks** – associated with quality of services, communication with public and staff, patient experience;
- **Financial** – associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the QIPP programme; and
- **Environmental including health and safety** – ensuring the well-being of staff and visitors whilst using our premises.

3. Risk Management Framework

3.1 Whenever a risk to the achievement of the CCG's objectives has been identified, it is important to assess the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk matrix is used, details of which are provided at Appendix 1. The matrix is based on current national guidance provided by the National Patient Safety Agency.

3.2 Use of this standardised tool will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

3.3 Risks are assessed initially using the risk matrix to assess the likelihood of occurrence/re-occurrence and the consequences of it happening. A target risk score is assigned to each risk taking into account the risk appetite of the CCG. Controls are then identified to reduce the likelihood of the risk occurring. An assessment is then made as to the strength of the controls i.e. whether they are considered to be satisfactory, have some weaknesses or to be weak to arrive at the rating of the residual risk. Once the residual risk rating is determined an action plan identifying further mitigating action to achieve the target risk score is put in place. The four levels of risk:

- **Extreme** – the consequence of these risks could seriously impact upon the achievement of the organisation's objectives, its financial stability and its reputation. Examples include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability;
- **High** – these risks require being brought to the attention of the Responsible Director and the responsible committee to ensure robust mitigating action is initiated as soon as the risks are identified. With a concerted effort and a challenging action plan, the risks could be reduced within a realistic timescale;
- **Moderate** – these risks can be reduced through practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements; and
- **Low** – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department.

3.4 Once the level of risk has been identified, this then needs to be entered onto the Risk Assurance Framework. Please refer to section 3.7 below for further guidance on the Risk Assurance Framework.

3.5 Any risk that is identified through the risk assessment process or the incident reporting system and which the CCG is required legally to report will be reported accordingly to the appropriate statutory body, e.g. Health and Safety Executive or Information Commissioner.

3.6 **Risk Appetite**

3.6.1 The CCG endeavours to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However an understanding of the organisation's 'risk appetite' will ensure the CCG supports a varied and diverse approach to commissioning, to work proactively to improve efficiency and value.

3.6.2 Risk appetite is the organisation's unique attitude towards risk taking that in turn dictates the amount of risk it considers acceptable. It is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time. It can be influenced by personal experience, political factors and external events. Risks need to be considered in terms of both **opportunities and threats** and should not be confined to money. They will also invariably impact on the capability of the CCG, its performance and its reputation.

3.6.3 The Governing Body will set boundaries to guide staff on the limits of risk they are able accept in the pursuit of achieving its organisational objectives. The Governing Body will set these limits bi-annually or at other intervals determined by Governing Body.

3.6.3 The Governing Body will set these limits based on whether the risk is:

- A threat: the level of exposure which is considered acceptable; or
- An opportunity: what the Governing Body is prepared to put 'at risk' in order to encourage innovation in creating changes.

3.7 Risk Assurance Framework

3.7.1 Current and potential risks are captured in the Risk Assurance Framework and include actions and timescales identified to minimise such risks. The Risk Assurance Framework is a log of risks that threaten the organisation's success in achieving its aims and objectives and is populated through the risk assessment and evaluation process.

3.7.2 The Risk Assurance Framework contains a record of corporate and strategic risks. The Risk Assurance Framework is updated on a quarterly basis by the Head of Governance in conjunction with the risk owner and/or the Lead Director. In addition it is updated immediately new risks arise, or for existing risks, where residual risk scores increase to high or extreme. Risks may be escalated to the RAF from projects, clinical risk assessments etc. where they are material and likely to impact the wider organisation. Risks are reviewed on a regular basis by the relevant committee (see Appendix 1 - Assurance flows).

3.8 Clinical Risk Management

3.81 *Standard SCCI 0160, Clinical Risks in the Application & Deployment & Use of Health IT Systems*, requires health organisations deploying & using new or modified health IT systems to have a structure to manage clinical risks associated with that deployment.

The CCG follows the Clinical Risk Management System (CRMS) which provides a framework that promotes the effective risk management of potential health IT hazards and operational incidents. Its process for CRMS is here S:\Corporate\Organisation\Clinical Risk Management

Any residual risk which scores 5* on the CRMS Hazard Log must be escalated to the Project Sponsor who will determine whether the risk requires escalation to the Risk Assurance Framework (RAF). Where escalation is required, the Project Sponsor will notify the CCG Head of Governance who will arrange for the entry to be made on the RAF.

*The CRMS Hazard Log uses a different 'Heat Map' to the RAF and 5 is a 'red risk' at CRMS level.

3.9 Project Risk Management

3.9.1 Project risk management applies to the management of risk in the design and delivery of projects and throughout the project lifecycle.

The CCG manages its projects through CQI (project management tool). CQI requires projects to assess risks and record mitigations and to manage risks throughout the project lifecycle. Exceptionally, where a residual project risk is extreme the Project Sponsor may decide it is appropriate to escalate the risk to the RAF. In these circumstances the Project Sponsor will notify the CCG Head of Governance who will arrange for the entry to be made on the RAF.

4. Duties and Responsibilities

4.1 Council of Practices

The council of practices has delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.

4.2 Chief Officer

As the Accountable Officer the Chief Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements

4.3 Medical Director, Executive Director of Nursing & Chief Operating Officer and Clinical Directors

The Medical Director, Executive Director of Nursing & Chief Operating Officer and the Clinical Directors will promote risk management processes with all the CCG's member practices. This ensures that the CCG is aware of all risks to the achievement of the Corporate Objectives and able to assess and mitigate as appropriate

4.4 Chief Finance Officer

The Chief Finance Officer has a responsibility to:

- provide professional advice to the CCG Governing Body on the effective, efficient and economic use of the CCG's allocation to remain within the allocation and identify risks to the delivery of required financial targets and duties;
- ensure robust risk management and audit arrangements are in place to make appropriate use of the CCGs financial resources;
- ensure appropriate arrangements are in place to identify risks and mitigating actions to the delivery of QIPP and resource releasing Initiatives; and
- incorporating risk management as a management technique within the financial performance management arrangements for the organisation.

4.5 Head of Governance

The Head of Governance is the CCG's lead for risk management and has a responsibility for;

- ensuring risk management systems are in place throughout the CCG, co-ordinating risk management in accordance with this Policy;
- ensuring the Risk Assurance Framework is regularly reviewed and updated;
- ensuring that an external review of the CCG's risk management systems takes place and that the results of this are reported to the Governing Body;
- overseeing the management of risks, ensuring risks actions plans are in place, regularly monitored and implemented;
- incorporating risk management as a management technique within the performance management arrangements for the organisation;
- ensuring that quality systems are in place for assuring high quality and safe services, and the on-going monitoring of the same;
- ensuring incidents, claims and complaints are managed via the appropriate procedures.

4.6 Senior Leads

All Senior Leads have a responsibility to incorporate risk management within all aspects of their work and are responsible for ensuring the implementation of this policy by:

- Demonstrating personal involvement and support for the promotion of risk management;
- Ensuring staff under their management are aware of their risk management responsibilities in relation to this policy;
- Setting personal objectives for risk management and monitoring their achievement;
- Ensuring risks are identified, managed and mitigating actions are implemented in functions for which they are accountable, and ensuring risks are escalated to the responsible director where they are of a strategic nature.

4.7 All Staff

All staff, including temporary and agency staff, are responsible for:

- Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken;
- Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities;
- Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly;
- Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager;
- Attending training/awareness sessions when provided.

4.8 Risk Management Process as a Commissioner

As the CCG focuses on its role as a commissioner of safe and high quality services, it seeks to embed the principles and practice of risk management into its commissioning function. As a commissioner, the CCG seeks to ensure that all services commissioned meet nationally identified standards which are managed through the contracting process. Risk management within commissioning is regularly reported through the quality processes on behalf of the CCG Governing Body.

4.9 **Partnership working**

The CCG has a duty to work with partners to improve the health of the local population. It will ensure that any work carried out across the health and social care economy adheres to the CCG's principles of robust risk management. Partnerships can involve high levels of risk because of their complexity and potential lack of clarity in the roles and responsibilities of those involved (See CCG CO12 Policy and Framework for Partnership Governance). Sources of assurance from partner organisations will appear in the Risk Assurance Framework.

5. Implementation

5.1 This policy will be available to all staff for use and be available through the intranet and public websites for the CCG. It will also be available from the Governance lead.

5.2 The CCG has adopted a standardised framework for the assessment and analysis of all risks encountered in the organisation and which is set out in this policy. The implementation of this policy is achieved through the completion of the risk register. It is also supported by a detailed reporting structure through its various committees and which are described in the policy (Appendix 1). Directors and senior leads will be responsible for ensuring the policy is implemented in their areas of responsibility and compliance with this policy may be monitored through a process of auditing as set out by the Governing Body.

5.3 The Governing Body has overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:

- Demonstrates leadership, active involvement and supports risk management
- Approves the Risk Management Policy (at its review date or earlier) as recommended by Quality & Safety Committee
- Approves the CCG's risk appetite annually or at intervals determined by the Governing Body
- Each NHS organisation is required to produce and maintain an Assurance Framework. The Governing Body discharges this responsibility by having in place a Risk Assurance Framework (RAF)
- Receives assurance from Audit Committee that the RAF identifies risks to achievement of its corporate objectives
- Receives assurance from the Audit Committee that the actions controls and assurances shown on the RAF are appropriate for the effective management of risk

6. Training Implications

The training required to comply with this policy is key to the successful implementation of this policy and embedding a culture of risk management in the organisation. Staff and members will receive practical advice on the implementation of this policy from the Head of Governance. Risk management training will be included in in the corporate staff induction programme.

7. Documentation

7.1 Other related policy documents.

- Incident Reporting and Management Policy

7.2 Legislation and statutory requirements

This Risk Management policy is developed with reference to Department of Health publications and publications of expert bodies on governance and risk management:

- Data Protection Act 2018
- Principles and framework contained in the legislation including: Health and Safety at Work Act 1974
- Principles contained within the Information Governance toolkit
- Risk Management Matrix for Risk Managers National Patient Safety Agency, (NPSA) (2008) ISO 31000 -2009

7.3 Best practice recommendations

- NHS Audit Committee Handbook (2011)
- Building the Assurance Framework: A practical Guide for NHS Boards March 2003. Gate log Reference1054
- Integrated Governance Handbook 2006
- Intelligent Commissioning Board (2006 & 2009)
- Making a Difference – Review of Controls Assurance Gateway Ref. No. 4222
- NHS Litigation Authority – CNST Risk Management Standards Governing the NHS: A guide for NHS Boards (2003)
- Taking it on Trust – Audit Commission (2009) Institute of Risk Management
- The Healthy NHS Board: Principles for Good Governance (2010)

8. Monitoring, Review and Archiving

8.1 Monitoring

The Governing Body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

8.2 Review

8.2.1 The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

8.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

8.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

8.3 Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

9. Equality Analysis

Risk Policy - Equality Impact Assessment -

Appendix 1

CCG Risk Management System

1. Introduction

It is recommended that the CCG uses the guidance provided by ISO 31000:2009 (formerly AZ/NZ Standard 4360:2004) and the NPSA in developing its approach to risk management and particularly in carrying out risk assessments.

2. Risk Matrix: Carrying out a Risk Assessment

Step 1: Determine the Consequence Score

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Note impacts will either be negligible, minor, moderate, major or catastrophic. This is offered as guidance when completing a risk assessment, either when an incident has occurred or if the impacts of potential risks are being considered.

Table 1: Impact scores	**Consequence score (severity levels) and examples of descriptors**				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	Severe	**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	Overall treatment or service suboptimal	Treatment or service has significantly reduced	Non-compliance with national standards with	Totally unacceptable level or quality of

Table 1: Impact scores	**Consequence score (severity levels) and examples of descriptors**				
	service suboptimal Informal complaint/inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	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	significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
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 objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Table 1: Impact scores	**Consequence score (severity levels) and examples of descriptors**				
				met	
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

Step 2 Determine the likelihood

Now determine what is the likelihood of the impact 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. The frequency-based score will either be classed as rare, unlikely, possible, likely or almost certain.

Table 2 Likelihood score (L)

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

Step 3 Assigning a Risk Rating

Now apply the consequence and likelihood ratings to give you a risk rating for each of the risks you have identified. Calculate the risk score by risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

Table 3 Risk scoring = impact x likelihood (I x L)

	Impact score				
Likelihood	1	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	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	Medium risk
8 - 12	High risk
15 - 25	Extreme risk

Step 4 Determine Risk Target

Determine the target risk score by reference to the CCG's risk appetite.

Step 5 Assessing the effectiveness of the control(s)

For each of the risks (and especially high risks) identify the controls that are in place. For example, in an operational setting and where an incident may have occurred the controls may take the form of a policy, guideline, procedure or process, etc. For risks that have been identified as preventing achievement of organisational objectives then the control is likely to be a management action plan.

Review the control(s) for each of the risks and apply the following criteria;

Satisfactory:	Controls are strong and operating properly, providing a reasonable level of assurance that objectives are being delivered.
Some Weaknesses:	Some control weaknesses/inefficiencies have been identified. Although these are not considered to present a serious risk exposure, improvements are required to provide reasonable assurance that objectives will be delivered.
Weak:	Controls do not meet any acceptable standard, as many weaknesses/inefficiencies exist. Controls do not provide reasonable assurance that objectives will be achieved.

Step 6 Determining the residual risk

Reassess the risk using steps one to 3 taking into account the robustness of the controls.

Step 7 Developing an action plan

Once the residual risk is known then a detailed action plan of improved controls should be developed. This plan should include a description of risk, actions to be taken, responsible person and appropriate timescales.

Step 8 Risk Prioritisation and Action

Where risks have been identified and scored, more likely as a consequence of an incident, then the following management / escalation arrangements should be used.

3. Risk Management

Extreme	Proactive review by Governing Body and active management by Executive Team
High	Proactive review and management by Executive Team and oversight by Governing Body
Medium	Proactive review and management by the Directorate/ senior teams
Low	Ongoing review and management at operational level

4. Assurance Flows

All risks are grouped on the Risk Assurance Framework (RAF) by corporate objective.

On a quarterly basis (or the next available committee where a quarterly review is out of cycle) each nominated committee of the Governing Body reviews the risks relevant to their assigned corporate objective, as follows:

Quality and Safety Committee	Corporate objective 1
Clinical Commissioning and Contracts Committee	Corporate objectives 3 and 4
Finance Committee	Corporate objective 2

The Audit Committee will receive the full Risk Assurance Framework each quarter to enable it to provide assurance to the Governing Body.

The Risk Assurance Framework is reported to the Governing Body quarterly provide assurance to them that risks are being managed effectively. The Governing Body will have a particular focus on strategic risks and sources of assurance and corporate risks rated extreme and high.

Corporate Objectives 2021/22

1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution

2. Meet the CCG's statutory duties

3. Work collaboratively with partners and stakeholders to develop sustainable health and social care in North Tyneside and the wider Cumbria & North East system

4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture