St Helens Clinical Commissioning Group

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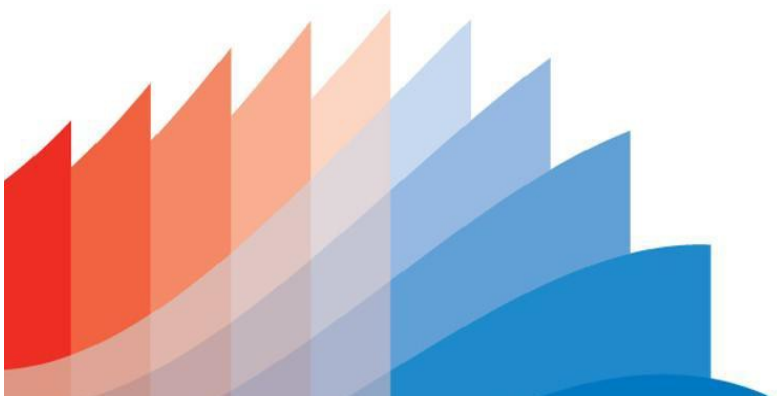
Risk Management Strategy 2016 - 2018

(Updated September 2016)



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1. Executive Summary

St Helens Clinical Commissioning Group (the CCG) is committed to its core aspiration of ensuring that the services that are commissioned on behalf of its population are safe, are of high quality and meet local health needs. This aspiration is underpinned and supplemented by the introduction of this Risk Management Strategy, the design of which is based upon a programme of internal control and risk management which looks to maximise available resources across the whole organisation and which is designed to enable the CCG to meet its objectives and statutory requirements and to maximise potential opportunities whilst minimising risks to patients, staff, the public and other stakeholders. The updated strategy aims to provide a continued systematic programme of risk management with a consistent approach to its implementation across all activities and commissioned services of the CCG to ensure delivery of our mission:

Our organisational Mission, Vision and Values, which have been developed through extensive engagement with our Governing Body, our constituent member practices, patient groups, and other stakeholders underpins this Risk Management Strategy.

Our Mission 'Making a Difference – Right care, Right place, Right time'

Our Vision: St Helens Clinical Commissioning Group will create and promote a culture that strives for inclusion and improvement. We will actively pursue partnerships and collaborative working across the health and social care landscape. We will always be receptive to patients needs and act in an open and honest manner to achieve the best results for our population.

Our Values

- **Efficient and Effective**; we will ensure delivery of the best care for our patients by making the most of our resources
- **Respectful and caring**; with courage and sensitivity, we will be balanced and inclusive with our respect and care
- **Leadership and Ambition**; Our vision is to commissioning world class healthcare for the local population through courageous leadership
- **Innovation and creativity**: Open to new ideas, use available evidence to embrace new technology and ensure change happens
- **Collaborative and Inclusive**: listening to each other, working together, delivering the best for our community
- **Honest and transparency**: we will conduct ourselves, reach decisions and communicate in an open and trustworthy manner.

Our Purpose:

- Our role is to commission safe, responsive and effective healthcare for the population of St Helens.

- We will improve the health and wellbeing of the population of St Helens and reduce health in-equalities.
- We will spend the healthcare budget in a fair and transparent manner to meet the needs of the population.

Our four aims:

- Improving Outcomes – We will focus on improving outcomes for patients and communities, developing a health economy where supply is tailored to meet the needs and priorities of the population.
- Empowering Patients – We will promote shared approaches to care, giving patients the power to shape their own healthcare and promote self-care and prevention.
- Using Evidenced Based Practice – We will use an evidenced based approach to assessing needs, designing services and monitoring outcomes.
- Sustainability – A commitment to the sustainable and effective use of resources.

Our strategic objectives are

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- To deliver financial sustainability
- To deliver improvements through system redesign and in priority areas
- To deliver improved outcomes for patients
- To develop primary care capacity and capability as system leaders

St Helens CCG acknowledges its primary responsibility for the provision of a high quality and safe healthcare service lies with the individuals and organisations providing the direct care. Within this context the CCG operates a proactive system for maintaining internal control, effective risk management and appropriate assurance by identifying the following key priorities:

- To employ and embed a robust, systematic and comprehensive programme of risk management across the local healthcare system ensuring the minimisation of corporate, clinical and organisational risk to patients, staff, the public and other stakeholders
- To ensure the system of risk management is fully integrated and operational to protect the interests of the CCG during collaborative working arrangements with the local stakeholders with the aim of maximising opportunities of current and future activities
- To promote safe working practices and procedures for all concerned as a paramount principle in the design, delivery and implementation of all the activities and business of the local healthcare system
- To encourage and incorporate any experiential learning, lessons learned and best practice from a local/national level and use this to inform service improvement and implementation

- To establish a programme of risk management that embraces innovation, reduces inefficiencies, increases effectiveness and informs continuous improvements in corporate, clinical and organisational implementation
- To intervene and take appropriate remedial action where risk requirements and or standards are not being met
- To ensure full compliance with all appropriate legislative requirements

These key risk management objectives are underpinned by the pledges made to patients by the NHS Constitution, which sets out rights to which patients, public, and staff are entitled based on the principles and values of the NHS in England. Patient rights in relation to the quality of care and environment are articulated including the right to expect NHS organisations to monitor and make efforts to improve the quality of healthcare they commission.

The risk management strategy is closely aligned to the delivery of the aims and objectives of the CCG's Strategic Objectives and the main regulatory bodies including: the Care Quality Commission, the NHS Improvement, the National Health Service Litigation Authority, the National Audit Office and the Health and Safety Executive. It introduces a risk-based assessment approach based and established on the principles of good practice in determining the control measures for maintaining assurance whilst minimising and managing risk.

2. Introduction

2.1 Effective risk management supports the CCG to deliver on its vision of making a difference: Right Care, Right Place, Right Time.

2.2 Risks are inherent in all of the functions that the CCG undertakes and in all of the services that it commissions others to undertake on its behalf. Unmanaged risk can impact upon patients and the wider population, the achievement of CCG objectives and its reputation.

2.3 This Risk Management Strategy sets out the CCG's intentions and arrangements for the effective evaluation and management of its risks. It provides a comprehensive framework for the continuous identification, assessment, management and monitoring of all risks, reflecting legislative requirements and current best practice.

2.4 To effectively manage the risks that are inherent in a health care setting requires a management culture that engages all staff, as everyone is both a risk taker and a risk manager. Risk management is therefore not an addition to our everyday work, but must be an integral part of all activity of the organisation.

2.5 Every member of staff has an individual responsibility for risk management as described in this strategy. The organisation recognises that for this to be achieved it requires a commitment from all staff to ensure risks are managed efficiently and effectively and to ensure that continuing

development of a management culture which is seen to be just and places a high value on honesty and openness at all levels of the organisation.

2.6 When unexpected or unintended events occur, risk management is about understanding what went wrong and why, and taking action to minimise the possibility of similar incidents happening again.

3. Statement of Intent

3.1 The CCG is committed to establishing an organisational culture that ensures risk management is an integral part of everything it does. Risk management will be embedded into all management systems and corporate planning as well as the setting of strategy and objectives. The CCG is committed to working in partnership to manage risk at the boundaries between organisations.

3.2 The CCG regards the Risk Management Strategy as an important tool in helping to ensure it achieves its objectives of delivering financial sustainability, delivering improvements through system redesign in priority areas, delivering improved outcomes for patients and developing primary care capacity and capability as system leaders.

3.3 The CCG recognises that a robust risk management system is a key component of the organisation's system of internal control and serves to provide assurance to key stakeholders of its capability to deliver its objectives.

3.4 The management of risk is the responsibility of all staff. The organisation will aim to support the identification of risks, incidents and 'near misses' quickly through an open, supportive and just culture and will use the management of risk as an opportunity fro learning and improvement. It will encourage the reporting of risks, incidents and hazards and will consider disciplinary action only in cases where there is evidence of a breach of law, professional misconduct or malpractice, repetitious incidents, deliberate non-reporting of incidents or collusion with the non-reporting of incidents.

4. Definitions

4.1 **Hazard** is the potential to cause harm; **Risk** is the likelihood of harm (in defined circumstances, and usually qualified by some statement of the severity of the harm).

4.2 **Risk Assessment** is the process where:

4.2.1 Hazards are identified
4.2.2 Risks associated with each hazard are analysed / evaluated
4.2.3 Appropriate ways to eliminate or control the hazard are identified

4.3 The **Risk Management System** is the culture, processes and structure that are directed towards effective management of potential opportunities and threats to the organisation achieving its objectives.

4.4 The **Risk Register** is a record of all of the organisation's identified risks, with details of their assessment (risk score) and how the risk is being managed.

4.5 The **Governing Body Assurance Framework** identifies the risks to the strategic objectives of the organisation and provides assurance that those risks are being managed effectively.

5. Strategic Objectives for Risk Management

5.1 Embed key risk management systems and processes

5.1.1 Establish clearly defined responsibilities for risk management and lines of accountability throughout the organisation
5.1.2 Develop, implement and maintain a robust Governing Body Assurance Framework
5.1.3 Develop, implement and maintain a Corporate Risk Register
5.1.4 Embed operational and project risk registers across all areas of the organisation
5.1.5 Embed a systematic process for the identification, analysis, evaluation, treatment and monitoring of risks across all areas of the organisation
5.1.6 Initiate a systematic and consistent approach to learning lessons and promoting continuous improvement
5.1.7 As far as reasonably practicable, minimise costs associated with risk
5.1.8 To ensure compliance with all appropriate legislative and statutory requirements, including Care Quality Commission, NHS Improvement, the National Health Service Litigation Authority, the National Audit Office and the Health and Safety Executive.
5.1.9 To create and support an organisational culture which recognises that human errors may occur as a result of system failures, and to work to ensure that 'lessons learned' are used to bring about improvements.
5.1.10 To ensure that staff are trained and competent in their role and that they take account of the hazards and risks likely to be encountered in the work place.

5.2 Embed risk management into commissioning process

5.2.1 Ensure that all risks associated with the way the organisation commissions and procures services are identified, assessed, minimised and wherever practicable, eliminated
5.2.2 Ensure that the design and specification of new services and service re-design actively considers potential risks, including clinical, safeguarding and financial risks and seek to minimise or eliminate them
5.2.3 Embed systematic processes for considering incidents in commissioned services, which compromise the safety and welfare of patients, children and vulnerable adults,

4.2.4 Promote active stakeholder involvement in risk management with particular reference to key partnerships

5.3 Ensure that the CCG is 'risk aware' and the members of the governing body and staff are appropriately trained and skilled in risk management (see appendix 1 for risk maturity definitions)

5.3.1 Raise awareness of risks and their management through a programme of communication and training
5.3.2 Foster an environment whereby all governing body members and staff understand that risk management is their responsibility

5.4 Ensure statutory and regulatory compliance

5.4.1 Satisfy all mandatory and statutory duties and undertakings
5.4.2 Satisfy the requirements of the Annual Governance Statement
5.4.3 Achieving and improving performance against all internally and externally regulated risk management activities
5.4.4 Ensure the health and safety of all those who work for or visit the CCG offices

5.5 Equality and Diversity

5.1. The risk management strategy applies to the whole population and no protected groups are adversely affected by its application.

6. Accountability and Organisational Structure

6.1 Organisational Structure

6.1.1 The CCG Membership, Governing Body, Committees and senior team are committed to ensure that risk management is integral to the CCG's strategic and operational planning, processes and systems.

6.1.2 The CCG has effective governance arrangements capable of taking responsibility and accountability for quality, finance and performance and:

a) will enable maximum probity transparency and accountability within proportionate and defensible processes
b) is robust enough to withstand challenge whilst being flexible enough to enable local ownership from the clinical community
c) is not overly bureaucratic but sufficient to safeguard those involved in the processes
d) has been developed on existing sound practices and aligned to NHS approaches and guidance on good governance

6.1.3 The CCG Governing Body is responsible for ensuring delivery of the organisation's aims and objectives and that structures are in place to reflect the organisation's roles and responsibilities. The Governing

Body, including Governing Body committees, will consider each individual aspect of governance at an adequate level of detail but also bring them all together to give the organisation appropriate assurance. The CCG governance structure is attached at Appendix 2.

6.1.4 Specific accountabilities, roles and responsibilities for risk management are set out below and provide a structure that supports the integrated approach to risk and governance.

6.2 The CCG Governing Body

6.2.1 The Governing Body is committed to providing the resources and support systems necessary to support the Risk Management Strategy. It has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

6.2.2 The Governing Body discharges this duty as follows:

a) Identifies risks which inhibit the achievement of its strategic goals
b) Monitors risks via the CCG Governing Body Assurance Framework and Corporate Risk Register
c) Ensures that there is a structure in place for the effective management of risk throughout the CCG
d) Receives regular updates and reports from the CCG Sub-Committees identifying significant risks and progress on mitigating actions
e) Demonstrates leadership, active involvement and support for risk management

6.3 The CCG Audit Committee

6.3.1 The Audit Committee is a statutory sub-committee of the CCG Governing Body responsible for establishing and maintaining effective systems of integrated governance, risk management and internal control that support the CCG's overall objectives. The Audit Committee has delegated authority from the CCG Governing Body to approve the CCG's risk management arrangements.

6.3.2 The Audit Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities which support the achievement of the CCG's objectives.

6.3.3 In particular the Audit Committee will review the adequacy and effectiveness of:

a) all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG Governing Body.

b) the underlying assurance processes that indicate the degree of achievement of the Clinical Commissioning Group objectives,

c) the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

d) the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

e) in carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from officers and Governing Body members as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

f) this will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

g) the Committee will approve the Detailed Financial Policies of the CCG and its arrangements for discharging the financial duties.

6.3.4 The terms of reference of the CCG Audit Committee are attached at Appendix 3.

6.4 Responsibility of other CCG Committees and Sub-Committees

6.4.1 All committees and sub-committees of the CCG are responsible for:

a) providing assurance on key controls where this is identified as a requirement within the Governing Body Assurance Framework
b) ensuring that risks associated within their areas of responsibility are identified, reflected on the corporate risk register and effectively managed

6.4.2 In addition committees and sub-committees have responsibilities for specific areas of risk managements as follows:

6.4.3 Finance, Governance and Risk Committee

The Finance, Governance and Risk Committee will meet monthly to discuss general items of business however, the Committee will hold bi-monthly monthly meetings for the purpose of reviewing and developing the, Governing Body Assurance Framework and Corporate Risks Registers. Formal minutes will be produced and reported to the Governing Body. The Corporate Risk Register will be reviewed and populated by the Senior Management Team prior to its submission to the FGR Committee.

The committee is responsible for coordinating the Governing Body Assurance Framework which allows integration of the governance activities that focus on continually improving the patient experience and ensure safe practice, efficiency and effectiveness through risk management. The committee oversees the development and embedding of CCG systems and process in relation to internal control and risk management. The committee also oversees the continuing development of the GBAF and management of the Corporate Risk Register ensuring that risk co-ordinators, managers and staff within the CCG are provided with appropriate training.

The Finance, Governance and Risk Committee will also advise the CCG Governing Body on all financial matters and provide assurance in relation to the discharge of statutory functions in line with the Standing Financial Instructions (SFIs).

6.4.5 Quality and Performance Committee

The Quality and Performance Committee is responsible for the quality and safety processes across all CCG commissioned services, and for assuring the Governing Body that quality and patient safety activity is coordinated and transparent, ensuring a coherent and systematic review of the system. This includes the approval of quality and safety aspects of new service specifications for implementation.

The committee will also be responsible for ensuring an open and transparent relationship with the National Commissioning Board (NHS England) is established and maintained on issues relating to the quality of primary care.

The Quality and Performance Committee will have the responsibility of reviewing and monitoring the Governing Body Assurance Framework aspects it has direct responsibility to oversee and to ensure that any identified risks allocated to the Committee are actioned appropriately and that assurances are sought.

The committee will ensure that the performance of commissioned services is monitored. The committee will also be responsible to

monitor the performance of CCG key performance indicators, for example as outlined in the NHS Operating Framework.

6.4.6 HR and Remuneration Committee

The HR and Remuneration Committee has delegated authority to approve determinations about pay and remuneration of senior CCG staff. The Committee will have the responsibility of reviewing and monitoring the Governing Body Assurance Framework and to ensure that any identified risks allocated to the Committee are actioned appropriately and that assurances are sought. The Committee is also responsible for providing assurance to the Governing Body that all corporate duties in relation to this agenda are compliant. It will make recommendations to the Governing Body on determinations about HR, OD & Workforce and Equality & Diversity matters

6.4.7 Medicines Management.

The Medicines Management Group will;

a) make recommendations to the CCG on the management of the prescribing budget and advise on the deployment of resources effectively and efficiently to meet the needs of patients in St Helens, in line with best evidence, national guidance and local priorities
b) oversee the quality of prescribing with the aim to reduce the variance in prescribing performance across member practices contributing to the reduction in health inequalities across St Helens.
c) ensure that policies and procedures promote the safe and secure handling of medicines in line with the Care Quality Commission Standards and legal and ethical requirements

6.5 The Clinical Chief Executive

6.5.1 The Clinical Chief Executive has overall accountability for the management of risk and discharges this duty as follows:

a) continually promotes risk management and demonstrates leadership, involvement and support
b) ensures an appropriate committee structure is in place, with regular reports to the Governing Body
c) ensures that senior officers of the CCG are appointed with managerial responsibility for risk management
d) ensures the development of appropriate Policies, Procedures and Guidelines for the CCG in relation to risk management
e) identifies risks to the achievement of the CCG's strategic goals
f) monitors these via the CCG Governing Body Assurance Framework and Corporate Risk Register

6.6 Lay Member – Audit and Governance Lead

6.6.1 The lay member for Governance and Audit on the CCG Governing Body has responsibility for oversight of the risk management strategy and systems and discharges this duty as follows:

a) Chairs the CCG Audit Committee
b) is accountable to the CCG Governing Body for the work of the CCG Audit Committee
c) through the work of the Audit Committee, confirms that appropriate and effective risk management systems are in place

6.7 Associate Director - Corporate Governance

6.7.1 The Associate Director - Corporate Governance is a member of the Executive Senior Management Team and has managerial leadership for risk management and will discharge this duty as follows:

a) prepare the risk management strategy for review and approval by the CCG Audit Committee
b) lead the preparation and regular updating of the Governing Body Assurance Framework and Corporate Risk Register for review by the Finance, Governance and Risk Committee
c) ensure the development of the policy, procedures and guidelines to support the delivery of the CCG risk management strategy for review and approval by the CCG Audit Committee
d) supports the Chair of the CCG Audit Committee in forward planning and programming in respect of risk management and ensuring that committee members are aware of best practice, national guidance and other relevant documents and have access to independent advice as appropriate
e) responds to requests from the CCG Audit Committee for reports and positive assurance on risk management arrangements
f) identifies the training needs of CCG governing body, committee and sub-committee members and staff and ensures these are met
g) ensures that the CCG's risk management requirements from its Commissioning Support provider are clearly specified, communicated and agreed
h) contract manage the delivery of required Commissioning Support Services in relation to risk management.
i)

6.8 Executive Leadership Team

6.8.1 Senior Managers should incorporate risk management within all aspects of their work and are responsible for directing the implementation of the CCG Risk Management Strategy by:

a) contributing to the preparation and updating of the Governing Body Assurance Framework and Corporate Risk Register

b) demonstrating personal involvement and support for the promotion of risk management
c) ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility.
d) ensuring staff are aware of the strategy and implement the systems included within their areas of responsibility.
e) setting personal objectives for risk management and monitoring their achievement
f) ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable.
g) ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis.
h) ensuring a risk register is established and maintained that relates to their area of responsibility and to involve staff in this process to promote ownership of the risks identified.
i) ensuring risks are escalated where they are of a strategic nature.

6.8.2 All governing body members and senior managers are responsible for compliance with the Risk Management Strategy and must ensure that:

a) staff undertake mandatory and statutory training
b) risk assessments are undertaken and recommended actions are implemented
c) the reporting of adverse incidents within their work area is undertaken, together with action to prevent or minimise reoccurrence
d) they take action to protect themselves and others from risks

6.9 All Staff

6.9.1 All CCG staff are responsible for being aware of and complying with the Risk Management Strategy and will assist the risk management process by:

a) being aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by the CCG's business and to comply with appropriate organisational procedures and guidance
b) identifying and reporting risks and incidents to their line manager using the correct processes and documentation
c) communicating all dangerous situations to anyone who could be at risk
d) attending mandatory and statutory training as identified for their role
e) following CCG policies, strategies and guidance when developed

6.10 Ensure Robust Partnership Risk Management

6.10.1 It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks can sometimes be difficult. St Helens CCG recognises that there are risks as well as opportunities in partnership working and that failing to actively engage with partners also carries risks. St Helens CCG endeavours to work closely and collaboratively with a wide range of partner organisations 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 agreements the CCG Governing Body will seek assurance that risks to strategic objectives have been identified from both St Helens CCG perspective and by the partner organisation and that adequate risk controls have been put in place. A section 75 partnership agreement has been developed with St Helens Local Authority and both organisations will work within the agreed governance arrangements for risk management relating to integrated commissioning priorities and pooled budget arrangements.

A risk register detailing any partnership risks and mitigations shall be reviewed by the Integrated Commissioning Steering Group.

6.11 Minimising Partnership Risks within Commissioned Services

6.11.1 St Helens CCG is working closely with partner organisations to achieve a shared ownership of risks facing the St Helens health economy and the solutions that are implemented. The CCG expects risk management to be a priority for those from whom it commissions services, and will require evidence of robust risk management systems, policies and procedures within service level agreements and contracts issued. St Helens CCG commissions healthcare services through a variety of local providers on and behalf of the residents of St Helens and via independent contractors. The potentially complex system can mean that in order to safeguard the interest of patients and staff alike, the CCG needs to actively engage with independent contractors to support good practice in risk management e.g. offer support and help them to develop their own risk management processes.

6.11.2 the organisation will employ a variety of methods to share its risk management strategy and risk management plans both internally and externally.

6.12 Responsibilities of Independent Contractors and Commissioned Services in the provision of NHS funded care

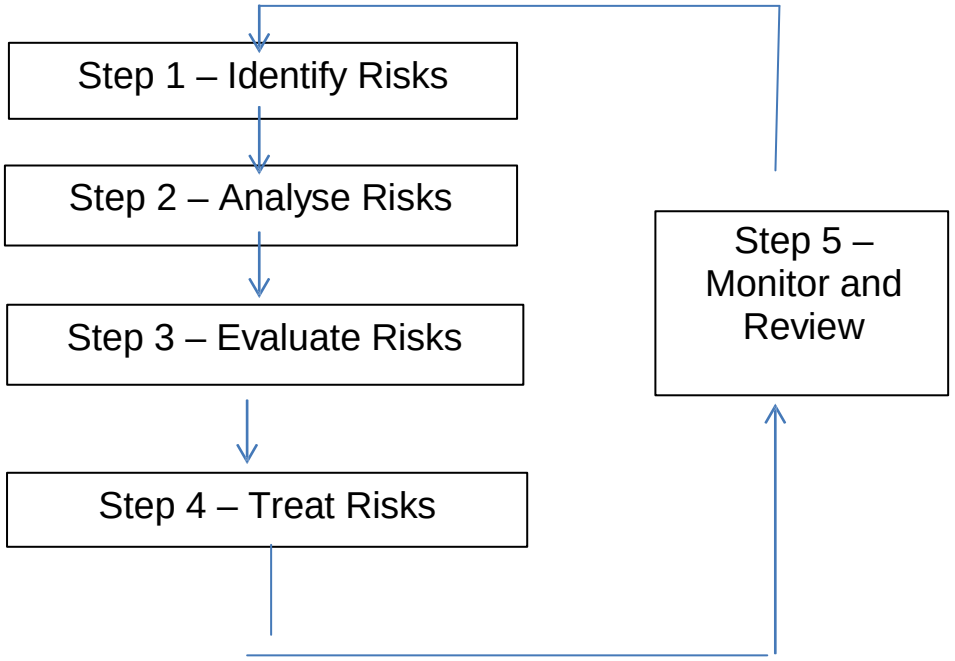
6.12.1 Although Independent Contractors and services commissioned by the CCG are not bound by this strategy, they are required to comply with statutory obligations in the same way as St Helens CCG (e.g. Health and Safety at Work Act, Environment Act, COSHH regulations). In addition, clinicians are responsible to their

professional bodies for their clinical practice. As part of the commissioning process services commissioned by the CCG (including Independent Contractor Services) will need to demonstrate compliance with the key requirements of this strategy to demonstrate that they have both the capacity and capability to manage clinical and non-clinical risks appropriately.

6.12.2 St Helens CCG will work in partnership to disseminate good practice, sharing its risk management policies, procedures and tools and assuring risk management processes through contract and quality monitoring processes as outlined in St Helens CCG Quality and Safety Strategy.

7. Systems and Processes for Managing Risk

7.1 The CCG's risk management process is illustrated below:



7.2 Identifying Risk

7.2.1 The CCG is exposed to a wide range of potential strategic and operational risks.

7.2.2 Strategic risks can be categorised as:

a) **Patient / Public:** those associated with the failure to meet the current and changing needs and expectations of patients and citizens
b) **Political:** those associated with the failure to deliver government or local membership policy
c) **Economic:** those affecting the ability of the CCG to meet its financial targets
d) **Market:** those affecting the ability of the CCG to secure appropriate cost and quality of provision to deliver its commissioning priorities
e) **Legislative:** those associated with current or potential changes in national or European law
f) **Social:** those relating to the effects of changes in demographic, residential or socio-economic trends
g) **Technological:** those associated with the capacity of the CCG to deal with the pace or scale of technological change or effectively harness technology to deliver its objectives
h) **Environmental:** those relating to the environmental consequences of progressing the CCG's strategic objectives

7.2.3 Operational risks can be categorised as:

a) **Clinical:** those related to the delivery of effective care and treatment
b) **Contractual:** those related to the failure of providers to deliver services
c) **Business:** those affecting the delivery of the CCG's operational business plans
d) **Health and Safety:** those related to accident prevention and securing the safety and welfare of patients, staff and visitors
e) **Financial:** those associated with financial management
f) **Workforce and recruitment:** those related to the ability to attract, develop and retain required capacity and skills
g) **Legal liability:** those related to possible breaches of legislation
h) **Estate and technological:** those related to reliance on buildings and operational equipment

7.2.4 The CCG identifies risks from a range of external and internal sources.

7.2.5 External identification of risks occurs via various agencies, including external assessments and inspections:

a) NHS Commissioning Board (NHS England)
b) National reports and guidance
c) NHS litigation authority
d) Health and Safety Executive
e) External audit

f) Mersey Internal Audit Agency
g) Care Quality Commission inspections
h) Ombudsman reports
i) Partner agencies
j) Commissioned providers
k) Coroner reports
l) Media and publications
m) Medicines and Healthcare products Regulatory Agency
n) Central Alerting System (CAS) from Department of Health

7.2.6 Internal identification of risks occurs via various internal processes and monitoring arrangements including:

a) Strategic and operational planning
b) Programme and project management
c) Risk assessment
d) CCG Committees and sub committees
e) CCG Membership
f) Staff members
g) Staff survey
h) Patient Participation Groups
i) Patient satisfaction surveys
j) Serious untoward incidents
k) Incidents and complaints monitoring
l) Claims
m) Health and Safety, Fire and Environmental audits
n) Training needs analysis

7.2.7 The identification of risks is the responsibility of all CCG members and staff and will be done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints.

7.3 Analysing Risk

7.3.1 Once a risk is identified it will be analysed to determine how the risk may occur, and the sort of effects it may have. The major controls will be identified, formal and informal, which help to prevent or mitigate the risk and their effectiveness (adequate, inadequate, or uncertain) will be assessed.

7.3.2 Risks will be analysed to determine their cause, their impact on patients and staff safety, the achievement of local objectives and strategic objectives, the likelihood of them occurring and how they may be managed. Such analysis will be undertaken by the most appropriate level of management.

7.4 Assess / Evaluate Risk

7.4.1 The risk assessment will reflect both the likelihood and any consequences of the risk and its potential to:

a) Cause death, injury or ill health to individuals or groups
b) Result in civil claims / litigation against the CCG, a governing body member, or member of staff
c) Result in enforcement action to the CCG
d) Cause damage to the environment
e) Cause property damage / loss
f) Impact on the day to day operational issues of the CCG
g) Result in the loss of reputation for the CCG

7.4.2 Risks will be graded using the CCG's risk matrix attached at Appendix 4. The level of risk is assessed by judging the ***likelihood*** of the residual risk occurring and ***consequences*** for the CCG should the event occur. This assessment results in an overall score ranging from 1 to 25 and a risk level of low, moderate, high, or extreme.

7.4.3 In assessing risk it is important to match the consequence to the likelihood. Scoring this risk should be based on the most common consequence from a fall not the extreme worse case which might occur.

7.5 Treat Risk

7.5.1 Controls should be sufficient to ensure that risks to the delivery of strategic objectives of the organisation are not compromised. Where controls are insufficient and could impact on the ability to deliver key objectives then escalation of the risk should take place. The risk identification and escalation process is illustrated in Appendix 5.

7.5.2 The treatment of risks and responsibility for their management will depend upon the risk level assessed:

a) **EXTREME RISKS** (Scoring 15-25) are unacceptable and require immediate intervention. They should be managed by a Senior Officer and sub-Committee. They should be escalated immediately to the Clinical Chief Executive who will support Senior Management Team Lead and sub-Committee to determine the appropriate response required, potentially including suspending activities unless the suspension could trigger an even higher risk to the CCG. Following this, all such risks should be reported immediately to the Associate Director - Corporate Governance for inclusion in the Corporate Risk Register for reporting via the CCG Governing Body.

b) **HIGH RISKS** (Scoring 8-12) should be managed appropriately by the relevant Senior Manager and sub-Committee and reported to the Associate Director - Corporate Governance for reporting via the CCG Finance, Governance and Risk Committee and included on the Corporate Risk Register.

c) **MODERATE RISKS** (Scoring 4-6) should be managed appropriately by the relevant Senior manager and reported to the Associate Director - Corporate Governance.
d) **LOW RISKS** (Scoring 1-3) are low priority and will be managed appropriately by the relevant service and included on the service or project risk register.

7.5.3 Possible responses to risks are:

a) **Transfer** – commonly through insuring against the risk
b) **Avoid** – requiring a review of the objectives threatened by the risk and may require the suspension or abandonment of certain services or activities at least until risk reduction measures are taken
c) **Reduce** – taking action to reduce the likelihood or consequence of the event thereby reducing the level of risk to an acceptable level
d) **Accept** – do nothing but keep it under review for any changes and if resources permit consider actions to reduce it

7.5.4 Responsibility for determining the most appropriate options will depend upon the risk level, as indicated above. Expert advice will be sought as required from within the organisation, and from external sources such as the CCG legal advisors, Care Quality Commission, Health & Safety Executive, NHS Litigation Authority, Counter Fraud & Security Management Service, Internal or External Auditors or by sharing best practice and learning from other organisations.

7.6 Monitoring and Review

7.6.1 In order to ensure risks are identified and quantified at all levels two key risk documents have been developed. The Governing Body Assurance Framework and Corporate Risk Register will provide assurance that the principal risks to the strategic objectives of the organisation have been identified and are being managed effectively. The Audit Committee has delegated responsibility on behalf of the Governing Body to monitor and scrutinise these documents before presenting them to the Governing Body. The Finance, Governance and Risk Committee will ensure regular review and oversight in line with the constitution and Committee Terms of Reference.

7.6.2 **Governing Body Assurance Framework**

a) The Governing Body Assurance Framework identifies and quantifies strategic risks within the organisation. The Framework is the means by which the Governing Body monitors and controls the risks which may impact on the organisation's capacity to achieve its objectives.

b) Each principal risk is scored based on the likelihood and consequence of the risk resulting in failure to achieve the strategic target. The Governing Body, through the Finance, Governance and Risk Committee, will review the Governing Body Assurance Framework.

c) The responsibility for managing, monitoring and reviewing strategic risks is delegated as follows:

i. a risk owner, who will be a member of the senior management team, assigned to each strategic risk has overall responsibility for the risk and for ensuring actions are implemented
ii. a responsible Governing Body member will be assigned to each sub-committee and will be responsible for the relevant group of risks and with the risk owner to ensure the appropriate level of assurance and that actions are implemented as agreed by the sub-Committee
iii. the Finance, Governance and Risk Committee will review the strategic risks quarterly and may amend scores and assurance ratings as a result of completed actions.
iv. the CCG Audit Committee will review assurance ratings and progress and hold risk owners accountable for delivering identified corrective action

7.6.3 **Corporate Risk Register**

a) The purpose of the Corporate Risk Register is to provide the Governing Body with a summary of the principal risks facing the organisation, with a summary of the actions needed and being taken to reduce these risks to an acceptable level. The information contained in the Corporate Risk Register should be sufficient to allow the Governing Body to be involved in prioritising and managing major risks.

b) The Corporate Risk Register supports the Governing Body Assurance Framework by providing a means of identifying operational risks which impact on the CCG's ability to provide assurance against strategic risks.

c) The Governing Body, through the Finance, Governance and Risk Committee, will review the Corporate Risk Register.

d) The Finance, Governance and Risk Committee will identify those risks which require escalation to the Governing Body due to insufficient controls or where the risk threatens the strategic objectives of the organisation.

e) The corporate risk register will be reviewed monthly; bi-monthly by the Finance, Governance and Risk Committee and bi-monthly by the CCG Senior Management Team and Clinical Chief Executive. The register will be reported as requested to the CCG Audit Committee.

f) Operational and project risk registers will be reviewed monthly by the relevant service or project management team.

g) Individual risk owners are responsible for compliance with the risk management strategy in order to ensure that remedial action is taken where key risks are identified within their area of responsibility. This will include monitoring risks, ensuring that actions are taken to manage and reduce risks as required, and updating the relevant risk register.

8. Risk Management Training

8.1 Training and development, including regular updates, will be required to support the successful and ongoing implementation of the risk management strategy. This will be reflected in the CCG Organisational Development Plan and in individual learning and development plans for all Staff.

9. Monitoring Effectiveness of the Strategy

9.1 The Audit Committee will monitor compliance with the Risk Management Strategy through regular reports received throughout the year. The Committee may commission internal audits or seek further assurance and action from officers in areas where there may be a lack of compliance.

10. Communication

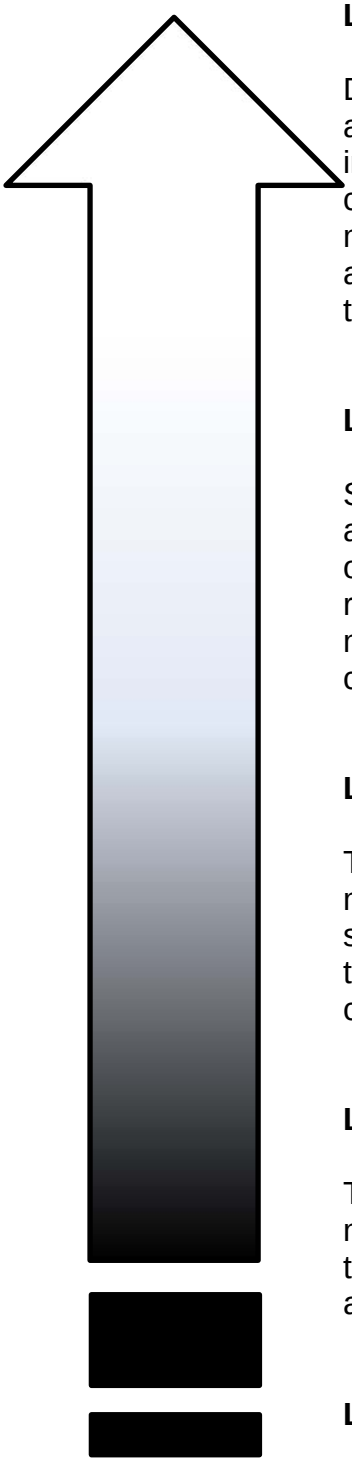
10.1 This document will be made available to all employees via the CCG intranet and external website. A programme of risk management training for all levels of staff will be developed to support implementation and communication.

11. Strategy Review Arrangements

11.1 This strategy will be reviewed on an annual basis by the Audit Committee. The Strategy is next due for review in September 2018, unless determined otherwise by the CCG Governing Body.

- This third iteration of the CCG Risk Management Strategy was presented to the CCG Audit Committee on 16th September 2016.

Appendix 1 **Risk Maturity Definitions**



Level 5 - Risk enabled

Driven by the Governing Body, staff at all levels actively consider issues of risk in all areas of activity and develop control and assurance processes to manage those risks/ Risk management and internal controls fully embedded into the operations.

Level 4 – Risk managed

Staff throughout the organisation are aware of the importance and the organisations response to risk/Enterprise approach to risk management developed and communicated.

Level 3 – Risk defined

The organisation has considered risk management, and put in place strategies led from a risk management team/ Strategy and policies in place and communicated. Risk appetite defined.

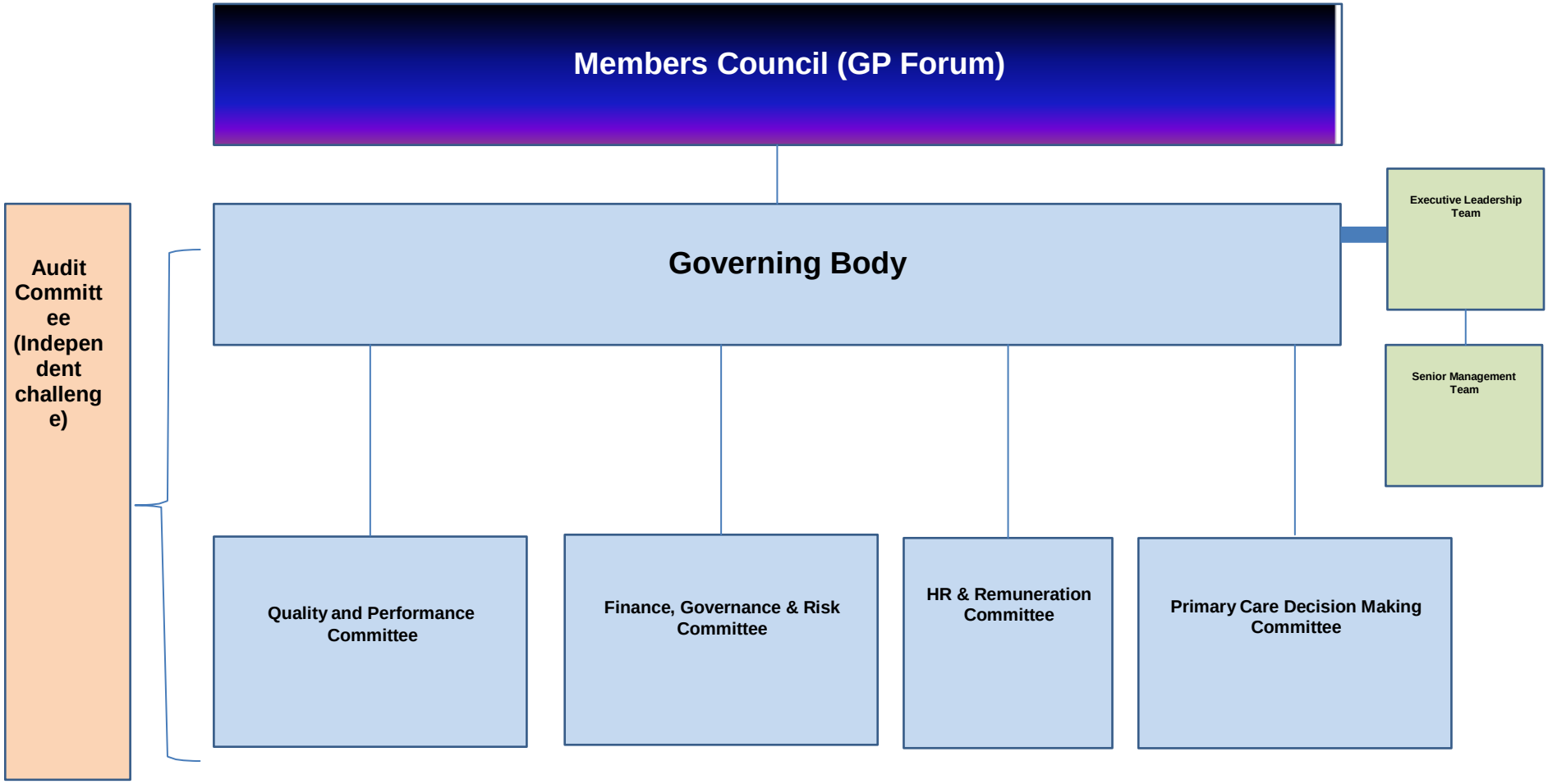
Level 2 – Risk aware

The organisation is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management.

Level 1 – Risk naïve

The organisation has little or no awareness of the importance of risk management/ No formal approach developed for risk management.

Appendix 2 – CCG Committee Structure



Appendix 3;

Audit Committee

Terms of Reference

The Audit Committee (the Committee) is established in accordance with St Helens Clinical Commissioning Group's (the CCG) Constitution. These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

1. Membership

- Chair of the Committee (who shall be a Lay Member of the Governing Body with significant financial experience)
- Lay Member of the Governing Body (who will be the vice chair)
- 3 Clinical Members of the Governing Body

In attendance

- Internal Audit Representative
- External Audit Representative
- Counter Fraud Representative
- The Chief Finance Officer

Other senior staff may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that officer. Representatives from NHS Protect may be invited to attend meetings.

At least once a year the Committee should meet privately with the external and internal auditors. Regardless of attendance, external audit, internal audit, local counter fraud and security management (NHS Protect) providers will have full and unrestricted rights of access to the Audit Committee

The Clinical Commissioning Group Chair will be invited to attend one meeting each year in order to form a view on, and understanding of, the committee's operations.

2. Remit and responsibilities

The duties of the Committee will be driven by the priorities of the Clinical Commissioning Group, as identified by the CCG, and the associated risks. It will support the Governing Bodies main functions of overseeing efficiency, effectiveness, economy and governance.

Integrated governance, risk management and internal control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the CCG's objectives.

Its work will align to that of the Clinical Quality Committee which the CCG is establishing to seek assurance that robust clinical quality is in place and that other risks are mitigated.

The Committee will have the responsibility of reviewing and monitoring the Board Assurance Framework and to ensure that any identified risks allocated to the Committee are actioned appropriately and that assurances are sought.

In particular the Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG.
- The underlying assurance processes that indicate the degree of achievement of Clinical Commissioning Group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- In carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from officers and Governing Body members as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- This above will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will approve the Detailed Financial Policies of the CCG and its arrangements for discharging the financial duties.

Internal audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and CCG. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Clinical Commissioning Group
- An annual review of the effectiveness of internal audit.
- Approving the appointment of the internal auditors.

External audit

The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Clinical Commissioning Group and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Selection of external auditors once freedom to appoint is given to the CCG.

Other assurance functions

- The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group,
- These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and

professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

- The Audit Committee will also review the circumstance and reason behind any suspension of the Constitution.

Counter fraud

The Audit Committee shall satisfy itself that the Clinical Commissioning Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the arrangements for counter fraud and the associated work programme.

Management

- The Audit Committee shall request and review reports and positive assurances from senior staff on the overall arrangements for governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the Clinical Commissioning Group as they may be appropriate to the overall arrangements.

Financial reporting

- The Audit Committee shall monitor the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Group's financial performance.
- The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG.
- The Audit Committee shall adopt on behalf of the Governing Body the annual report and financial statements, focusing particularly on:
    - The wording in the Governance Statement and other disclosures relevant to the terms of reference of the committee;
    - Changes in, and compliance with, accounting policies, practices and estimation techniques;
    - Unadjusted mis-statements in the financial statements;
    - Significant judgements in preparing of the financial statements;
    - Significant adjustments resulting from the audit;
    - Letter of representation; and
    - Qualitative aspects of financial reporting.

3. Administration

The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business. The Secretary will take minutes and produce action plans as required.

4. Quorum

The Audit Committee Chair (or Vice Chair) and 1 Clinical Member.

5. Frequency and notice of meetings.

The Audit Committee shall meet on at least 4 occasions during the financial year. Internal Audit and External Audit may request a meeting if they consider one necessary. Members shall be notified at least 10 days in advance that a meeting is due to take place. Agendas and reports shall be distributed to members 7 working days in advance of the meeting date.

6. Reporting

The ratified minutes of Audit Committee will be submitted to the Governing Body. An annual report will be submitted by the Audit Committee Exception reports will also be submitted at the request of the Governing Body. An annual report will be produced by the Audit Committee for the Governing Body which will include a work plan for the year ahead.

7. Conduct

All members are required to make open and honest declarations of the interest at the commencement of each meeting or to notify the Committee Chair of any actual, potential or perceived conflict in advance of the meeting. All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

Appendix 4

Risk Scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence 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	Extreme Risk

Consequence Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	**Negligible**	• None or very minor injury. • No financial loss or very minor loss up to £100,000. • Minimal or no service disruption. • No impact but current systems could be improved. • So close to achieving target that no impact or loss of external reputation.
2	**Minor**	• Minor injury or illness requiring first aid treatment e.g. cuts,bruises due to fault of CCG. • A financial pressure of £100,001 to £500,000. • Some delay in provision of services. • Some possibility of complaint or litigation. • CCG criticised, but minimum impact on organisation.
3	**Moderate**	• Moderate injury or illness, requiring medical treatment (e.g. fractures) due to CCG's fault. • Moderate financial pressure of £500,001 to £1m. • Some delay in provision of services. • Could result in legal action or prosecution. • Event leads to adverse local external attention e.g. HSE, media.
4	**Major**	• Individual death / permanent injury/disability due to fault of CCG. • Major financial pressure of £1m to £2m. • Major service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £100,000 not covered by NHSLA. • Risk to CCG reputation in the short term with key stakeholders, public & media.
5	**Catastrophic**	• Multiple deaths due to fault of CCG. • Significant financial pressure of above £2m. • Extended service disruption/closure in commissioned healthcare services CCG accountable for. • Potential litigation or negligence costs over £1,000,000 not covered by NHSLA. • Long term serious risk to CCG's reputation with key stakeholders, public & media. • Fail key target(s) so that continuing CCG authorisation may be put at risk.

Likelihood Score for the CCG if the event happens		
Level	**Descriptor**	**Description**
1	**Rare**	• The event could occur only in exceptional circumstances. • No likelihood of missing target. • Project is on track.
2	**Unlikely**	• The event could occur at some time. • Small probability of missing target. • Key projects are on track but benefits delivery still uncertain. • Less important projects are significantly delayed by over 6 months or are expected to deliver only 50% of expected benefits.
3	**Possible**	• The event may occur at some time. • 40-60% chance of missing target. • Key project is behind schedule by between 3-6 months. • Less important projects fail to be delivered or fail to deliver expected benefits by significant degree.
4	**Likely**	• The event is more likely to occur in the next 12 months than not. • High probability of missing target. • Key project is significantly delayed in excess of 6 months or is only expected to deliver only 50% of expected benefits.
5	**Almost Certain**	• The event is expected to occur in most circumstances. • Missing the target is almost a certainty. • Key project will fail to be delivered or fail to deliver expected benefits by significant degree.

Appendix 5

Identification of Risk & Escalation Process