NHS
North Yorkshire
Clinical Commissioning Group

Title of Meeting:	**Governing Body**	**Agenda Item: 7.2**
Date of Meeting:	**25 June 2020**	
Paper Title:	**Risk Management Strategy**	

Session (Tick)	
Public	X
Private	
Development Session	

Responsible Governing Body Member Lead Julie Warren, Director of Corporate Services, Governance and Performance	**Report Author and Job Title** Sasha Sencier, Senior Governance Manager and Board Secretary to the Governing Body

Purpose (this paper if for)

Decision	Discussion	Assurance	Information
X			

Has the report (or variation of it) been presented to another Committee / Meeting?

If yes, state the Committee / Meeting: Yes. The Audit Committee members and Executive Directors have reviewed this strategy and are making a recommendation for the Governing Body to approve.

Executive Summary

NHS North Yorkshire Clinical Commissioning Group (NY CCG) has a statutory and regulatory obligation to ensure that systems of control are in place to minimise the impact of all types of risk, which could affect patients, staff, public resources, and the function of the CCG. This includes both the risk to the organisation and the risk to those individuals to whom the CCG owes a duty of care.

The CCGs risk management system is designed to support the delivery of safe and effective health services for service users, staff and wider stakeholders. Risk Management is not about risk elimination; it is about encouraging appropriate risk-taking, ie those risks that have been evaluated and which are understood as well as is possible with currently available information. It is recognised that only through appropriate risk-taking will NY CCG be able to ensure high quality healthcare services are commissioned. Successful organisations are by their nature successful risk takers and aware of their risk appetite.

It is also recognised that inadequately managed risks within commissioned services have the potential to prevent NHS NY CCG from achieving its objectives and may directly or indirectly cause harm to those it cares for, employs or otherwise affects as well as incurring loss relating to assets, finance, reputation, goodwill, partnership working or public confidence.

In accordance with the guidance contained in Department of Health Building the Assurance Framework (2003), NY CCG intends to implement a system of internal controls which will encompass financial controls, organisational controls and clinical governance. This system of internal controls is designed to manage risk within defined levels of tolerance rather than to eliminate all risk completely. This framework of controls can therefore, only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on a continuous process of monitoring and review.

Audit Committee Members and Executive Directors have reviewed and commented on the Risk Management Strategy and amendments have been agreed. The Audit Committee recommends that the Governing Body approve the Risk Management Strategy.

Recommendations **The Governing Body is being asking to:** Approve the Risk Management Strategy	
Monitoring The policy This policy will be reviewed in three years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation / guidance, as instructed by the senior manager responsible for this policy. The Governing Body, Executive Directors, Committees and all CCG employees have responsibility to ensure the effective implementation of the Risk Management Strategy.	
Any statutory / regulatory / legal / NHS Constitution implications	The CCG is required to manage risk. The Risk Management Strategy and processes detailed within will be audited and will provide assurance that the CCG is meeting all statutory requirements.
Management of Conflicts of Interest	No conflicts of interest have been identified prior to the meeting.
Communication / Public & Patient Engagement	The policy will be circulated to the target audience identified within the policy.
Financial / resource implications	No resource implications have been identified.
Significant Risks to Consider	No significant risks to consider.
Outcome of Impact Assessments completed	As a result of performing an Equality Impact Assessment, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage.

Sasha Sencier, Senior Governance Manager / Board Secretary to the Governing Body

North Yorkshire
Clinical Commissioning Group

RISK MANAGEMENT STRATEGY

June 2020

Authorship:	Senior Governance Manager
Committee Approved:	NY CCG Governing Body
Approved date:	June 2020
Review Date:	June 2023 (three years from approval)
Equality Impact Assessment:	Completed – Neutral Impact
Target Audience:	Council of Members, Governing Body and its Committees and Sub-Committees, CCG Staff, agency and temporary staff & third parties under contract
Policy Number:	NY-201
Version Number:	1.0

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

STRATEGY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by and Date	Date on Intranet
0.1	Senior Governance Manager	New Strategy Development	Reviewed by Audit Committee Members by Email – May 2020	
1.0	Senior Governance Manager	New Strategy	Approved by Governing Body – June 2020	

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1.0 Introduction and Purpose

1.1 NHS North Yorkshire Clinical Commissioning Group (NY CCG) has a statutory and regulatory obligation to ensure that systems of control are in place to minimise the impact of all types of risk, which could affect patients, staff, public resources, and the function of the CCG. This includes both the risk to the organisation and the risk to those individuals to whom the CCG owes a duty of care.

Risk Management is integral to the CCG's decision making and management processes and will be embedded at all levels across the organisation.

The Risk Management Strategy demonstrates the approach to risk management and ensures there is a system for monitoring the application of risk management within the CCG and that actions are taken in accordance with the risk matrix guidance.

1.2 This framework offers guidance on what may be regarded as "acceptable risk" by the CCG and a statement of the CCG's "Risk Appetite.

1.3 The CCGs risk management system is designed to support the delivery of safe and effective health services for service users, staff and wider stakeholders. Risk Management is not about risk elimination; it is about encouraging appropriate risk-taking, ie those risks that have been evaluated and which are understood as well as is possible with currently available information. It is recognised that only through appropriate risk-taking will NY CCG be able to ensure high quality healthcare services are commissioned. Successful organisations are by their nature successful risk takers and aware of their risk appetite.

1.4 It is also recognised that inadequately managed risks within commissioned services have the potential to prevent North Yorkshire CCG from achieving its objectives and may directly or indirectly cause harm to those it cares for, employs or otherwise affects as well as incurring loss relating to assets, finance, reputation, goodwill, partnership working or public confidence.

2.0 Impact Analysis

2.1 **Equality**
As a result of performing the screening analysis, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. The results of the screening are attached.

2.2 **Sustainability**
A Sustainability Impact Assessment has been undertaken. No positive or negative impacts were identified against the twelve sustainability themes. The results of the assessment are attached.

3.0 Scope

3.1 This strategy is applicable to all risks that the CCG is exposed to, including Information Governance, programme, project and clinical risks and those arising from the commissioning of NHS services.

3.2 This strategy applies to all employees of the CCG including temporary employees, locums and contracted staff.

4.0 Definitions

4.1 Risk

Risk can be defined as 'the chance of something happening that will have an adverse impact on objectives' and is measured in terms of consequences and likelihood'

NHS risk can be categorised into 3 main headings (Clinical, Financial and Corporate or Organisational and Business) under which sit specific risk areas.

4.2 Clinical Risks

Clinical risks are defined as "those risks which have a cause or effect which is primarily clinical or medical". Examples include clinical care activities, consent issues and medicines management.

4.3 Financial Risks

These are defined as those whose principal effect would be a financial loss or a lost opportunity to meet business rules. Examples include poor financial control, fraud and ineffective insurance arrangements.

4.4 Corporate or Organisational and Business Risks

Corporate risks are defined as "those risks, which primarily relate to the way in which the CCG is organised, managed and governed". Examples include human resource issues and corporate governance risks concerning the establishment of an effective organisational structure with clear lines of authorities and accountabilities. The risk events can include inappropriate decision making and delegation of authorities. All can result in sub optimal performance and losses for the CCG.

4.5 Specific Risk Areas

Behind the comprehensive areas of risk above there are more clearly identified risk areas that the CCG may encounter and need to manage.

Change	These concern risks that programmes and projects do not deliver agreed benefits and within agreed budget and or/introduce new or changed risks that are not effectively identified and managed.
Clinical	These concern risks that arise directly from the commissioning of healthcare for patients. This includes safeguarding, clinical errors and negligence, healthcare associated infection and failure to obtain consent.
Conflict of Interest	This concerns risks in relation to both actual and perceived conflicts of interest. It is important that all conflicts of interest are managed effectively and that perceived conflicts are managed as well as actual conflicts.
Health and Safety	These concern risks around employer / employee related topics. At times risks may be identified which are managed by third parties but for which the situation and progress needs to be monitored by the CCG, an example would be buildings management.
Information & Technology	These concern the day to day issues the CCG is confronted with as it strives to deliver its strategic objectives. They can be anything from loss of data to failure of a key IT system. It covers risk events such as a technological breakdown, loss of hard or soft copy data, failure by a third party to deliver a service breakdown in partnership with third party, failure to manage internal change etc.

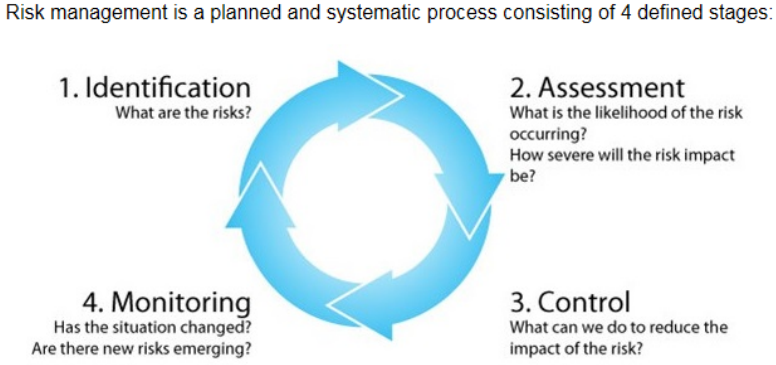
Information Governance	These risks include those related to data protection, information security and confidentiality and will apply to all data including clinical, corporate and data for secondary use. All types of data within the organisation will be covered including electronic, paper and oral information that is shared.
Legal & Compliance	These include risks around employment practices, employment legislation, the NHS Constitution, Freedom of Information Act, Civil Contingencies Act, Deprivation of Liberty and regulatory issues.
Operations	These concern the day to day issues the CCG is confronted with as it strives to deliver its strategic objectives. They can be anything from loss of key staff to process failure. It covers risk events such as failure by a third party to deliver a service for the operation, breakdown in partnership with third party, failure to manage internal change etc. Operational risks are largely short to medium term where frequency is high/medium likelihood and low to high impact.
People	These concern insufficient staff resources (capacity and capability). These risks can have a significant impact on the performance and reputation of the CCG.
Reputational	It is important that the reputation of the CCG is protected through robust systems of communication with stakeholders. Systems of communication with external stakeholders that contribute to minimising risk need to be in place, including regular meetings, patient surveys, publications and public meetings. The CCG has a large and diverse range of stakeholders with whom it needs to continue to develop engagement.
Strategic	These concern the long term strategic objectives of the CCG. They can be affected by external factors such as the economy, changes in the political environment, technological changes, and in legal and regulatory changes. The strategic risks are mainly significant risks that can potentially impact on the whole CCG and its ability to achieve its strategic objectives.

4.6 **Risk management**

Risk Management is “the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.” Australian / New Zealand Risk Standards 4360:1999.

4.7 **The Risk Management Process**

The Risk Management Process is “the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.” Australian / New Zealand Risk Standards 4360:1999.



4.8 **Significant Risks**

Significant Risks are those risks which, when measured according to NHS North Yorkshire CCG's risk matrix (See Section 8.4) are scored at 12 and above and therefore assessed to be high, serious or critical. The CCG will take an active and particular interest in the management of significant risks that align to the CCGs strategic objectives and will consider whether they need to be included on the Governing Body Assurance Framework for ongoing assurance. Significant risks not aligned to strategic objectives are included on the Corporate Risk Register (CRR) and managed by the Corporate Risk Review Group who is accountable to the Executive Directors.

4.9 **The Governing Body Assurance Framework (GBAF)**

The Governing Body Assurance Framework provides the organisation with a simple but comprehensive method for the effective and focused management of the principal risks that may impede or assist in the CCG meeting its strategic objectives. The risk registers are a key feeder to the GBAF. The GBAF serves as the key document to assure the Governing Body that risk management is firmly embedded in the organisation. One of the primary purposes of the Governing Body Assurance Framework is to identify gaps in control or assurance in relation to these principal risks. It also provides a structure for the evidence to support the Annual Governance Statement. This simplifies Governing Body reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

4.10 **The Corporate Risk Register (CRR)**

The Corporate Risk Register provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that may impede or assist the CCG in meeting its operational objectives. The CRR is managed by the Corporate Risk Review Group.

4.11 **The Directorate Risk Register (DRR)**

The Directorate Risk Register provides organisations with a simple but comprehensive method for the effective and focused management all risks scored 11 and below and are considered to be of a low or medium level risk to the CCG, whether at a strategic or operational level. The DRR is managed at a Directorate level and is managed through the Corporate Risk Review Group. Directorate Risk Registers include:

- Finance and Contracting
- Quality and Safety (Includes Medicines Management and Safeguarding)
- Corporate Services (includes CHC)
- Strategy and Integration
- Acute Commissioning

4.12 **The Issues Log (IL)**

Each Directorate will manage their own 'Issues Logs' within their own project area that are populated with the issues and risks that may occur. Issues can be in any area and therefore monitored at Directorate level. The key difference between a risk and issue is that an "issue" has already occurred and a "risk" is a potential issue that may or may not happen and can impact the project positively or negatively. It is necessary to plan in advance and work out mitigation plans for risks. For issues it will be necessary to act immediately to resolve them.

5.0 Risk Appetite

5.1 What is an Acceptable Risk?

The CCG recognises that it is impossible, and not always desirable, to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health benefits for local residents. In order to establish a consistent framework for the assessment and management of risk, the CCG has adopted a Risk Assessment Matrix (See Section 8.4) and has determined the levels of authority at which risks should be addressed. Risks identified as being in the high, serious or critical categories are regarded as significant risks (scored 12 and above) and should be reported to the though either the Corporate Risk Register and/ or Governing Body Assurance Framework.

The CCG will, however, as a general principle seek to eliminate or reduce all identifiable risk to the lowest practicable level and control all risks which have the potential to: harm its staff, patients, visitors and other stakeholders; have a high potential for incidents to occur; would result in loss of public confidence in the CCG and / or its partner agencies; would have severe financial consequences which would prevent the CCG from carrying out its functions on behalf of its residents. The CCG is committed to achieving this through its holistic approach to risk management within the clinical and corporate governance agendas.

The CCG has determined that those risks identified as low or moderate in accordance with the risk matrix could be regarded as acceptable risks. Those risks both clinical and non-clinical identified as being in the high, serious or critical categories should be regarded as significant risk and where a manager cannot immediately introduce control measures to reduce the level of risk to an acceptable level, these should be managed through the risk register process. Consideration will be given to whether the risk impacts on a strategic objective and should be reflected in the Assurance Framework. High level risks not linked to strategic objectives will be escalated to the Corporate Risk Register.

5.2 NY CCG's Risk Appetite

An organisations risk appetite is 'the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point on time' (HMT Orange Book 2005).

The CCG's risk appetite helps staff and stakeholders understand the level of risk that the CCG is prepared to accept. This is not to say that risks may not be assessed as above the risk limits within the risk appetite statement. The risk appetite and the risk limits set out acceptable levels of risk.

NY CCG accepts that it is not possible to conduct business or develop the healthcare for North Yorkshire residents without recognising the impact of risk on its strategic objectives and corporate objectives and identifies an 'appetite' for each risk by selecting a target score. These are monitored by the Corporate Risk Review Group to ensure consistency across the organisation.

Methods of controlling risk must be balanced in order to support advancement and the effective use of resources in order to achieve substantial benefit. As a general principle, the CCG will seek to control all risks which have the potential to:

- Cause significant harm to patients, the local community, staff, visitors and any other stakeholders
- Severely compromise the reputation of the CCG

- Result in financial loss that may endanger the viability of the CCG
- Significantly jeopardise the CCG's ability to carry out its core purpose and/or meet its strategic objectives
- Threaten the CCG's compliance with law and regulation

Some risks may not be able to be mitigated with a significant risk score and on an individual risk basis the Executive Directors will agree where they deem this to be acceptable, taking into account timescales to change, external context and ability to influence. Any significant risks on the Governing Body Assurance Framework that are deemed acceptable by the Executive Directors will be required to be agreed with the Governing Body.

6.0 Accountability and Responsibility

6.1 Accountable Officer

The Chief Officer has overall accountability for the management of risk and is responsible for continually promoting risk management and demonstrating leadership, involvement and support. They, along with the Governing Body, have overall responsibility for the maintenance of financial and organisational controls and to ensure that effective risk management arrangements are in place. The Accountable Officer takes executive responsibility for ensuring that there are effective systems and processes in place and is responsible for ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG.

6.2 Chief Finance Officer

The Chief Finance Officer is responsible for advising on financial risks, investigating incidents of fraud and corruption. The Chief Finance Officer is the CCGs Senior Information Risk Owner (SIRO). The SIRO is responsible for reviewing and approving information asset risk assessments and ensuring that information risks are managed appropriately.

6.3 Chief Nurse

The Chief Nurse is responsible for advising on quality and safety risks. The Chief Nurse is the Caldicott Guardian who is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. The Chief Nurse is responsible to reviewing and approving Equality Impact Assessments.

6.4 The Director of Corporate Services, Governance and Performance

The Director of Corporate Services, Governance and Performance is responsible for:

- ensuring risk management systems are in place throughout the CCG and that risk management principles are embedded in organisational culture.
- ensuring the GBAF is regularly reviewed and updated.
- ensuring there is appropriate external review of the CCG's risk management systems, and that these are reported to the Governing Body.
- overseeing the management of risks as determined by the Corporate Risk Review Group (CRRG).
- ensuring risk action plans are put in place, regularly monitored and implemented.

6.5 **All Other Directors**

All other Directors hold executive responsibility for the risks to delivery of commissioned clinical service provision service redesign and Quality Innovation Productivity and Prevention (QIPP) / savings performance.

6.6 **Managers**

All managers should incorporate risk management within all aspects of their work and are responsible for directing the implementation of the CCG Risk Management Policy by:

- demonstrating personal involvement and support for the promotion of risk management
- ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility.
- setting personal objectives for risk management and monitoring their achievement
- ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable.
- ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis.
- 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.
- ensuring risks are escalated where they are of a strategic nature.

6.7 **Senior Governance Manager**

The Senior Governance Manager has responsibility for:

- ensuring that the Governing Body Assurance Framework and Corporate Risk Register are developed, maintained and reviewed by the Executive Directors, the Corporate Risk Review Group, and Committees as appropriate.
- providing advice on the risk management process.
- ensuring that the CCG's Governing Body Assurance Framework and Corporate Risk Register are up to date.
- working collaboratively with Internal Audit.

6.8 **All Staff (including contractor and agency)**

All staff have a duty to comply with the organisation's policies and procedures. Staff that require registration with a professional body must act at all times in accordance with that body's code of conduct and rules.

All staff working for the CCG are responsible for:

- 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 CCG rules, regulations, instructions, policies, procedures and guidelines.
- taking action to protect themselves and others from risks
- identifying and reporting risks to their line manager using the CCG risk processes and documentation
- ensuring incidents, claims and complaints are reported using the appropriate

procedures and channels of communication

- co-operating with others in the management of the CCG's risks
- attending mandatory and statutory training as determined by the CCG or their Line Manager.
- being aware of emergency procedures.
- being aware of the CCG's Risk Management Statutory and complying with the procedures.

7.0 Governance Structure

7.1 Governing Body

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:

- approval of the group's risk management arrangements
- reviews the Governing Body Assurance Framework three times per annum (twice in public and once at a workshop)
- receives as assurance the Corporate Risk Register twice per (this report includes a heat map, see example in appendix F)
- understanding any risks that may impact on the CCG's achievement of its strategic objectives
- monitors these via the Governing Body Assurance Framework (GBAF)
- approves and reviews strategies for risk management
- receives regular updates from the Accountable Officer within their report to the Governing Body, that identify any new significant risks
- demonstrates leadership, active involvement and support for risk management
- Where the CCG makes arrangements with NHS England or other CCGs to enter into collaborative commissioning, the Governing Body will oversee how risk will be managed and apportioned between parties.

7.2 Audit Committee

The Audit Committee provides the Governing Body with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance. The Audit Committee's primary role is to review the establishment and maintenance of an effective system of governance, internal control and risk across the whole of the CCGs activities. The Audit Committee also:

- Reviews of the group's annual accounts and governance statement.
- Approve the group's counter fraud and security management arrangements.
- Approval of appointment of internal auditors.
- Approval of External Auditors, their fee and any additional non-statutory audit work.
- Approve Information Governance policies of the CCG with the exception of those reserved to the Governing Body.

- Receives as assurance the Governing Body Assurance Framework and Corporate Risk Register twice per annum (this report includes a heat map – see appendix F).

7.3 **Corporate Risk Review Group**

The Corporate Risk Review Group (CRRG) is chaired by the Director of Corporate Services, Governance and Performance and is responsible for ensuring that the Governing Body Assurance Framework, Corporate Risk Register and Directorate Risk Register are regularly reviewed and updated by risk owners. The group will provide a level of scrutiny and challenge to the process of identifying and measuring risk, culminating in a cycle of continuous monitoring and review.

7.4 **Quality and Clinical Governance Committee**

The Quality and Clinical Governance Committee provides assurance on the quality of services commissioned and promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. The Quality Committee also approves policies of the CCG with the exception of those reserved to the Governing Body as an individual or Committee. Committees of the Governing Body will receive, for information only, any risks aligned to them on the Corporate Risk Register and GBAF.

7.5 **Finance, Performance and Commissioning Committee**

The Finance, Performance and Commissioning Committee provide assurance on financial issues relating to the CCG. The Committee also provides assurance on the delivery of the QIPP/savings programme; reviews the performance of the main services commissioned; receives commissioning proposals and business cases, and undertakes analysis and makes recommendations to the Governing Body. The Committee ensures that financial risk is an implicit part of reviewing performance and creating and reviewing business plans. Committees of the Governing Body will receive, for information only, any risks aligned to them on the Corporate Risk Register and GBAF.

7.6 **Primary Care Commissioning Committee**

The Primary Care Commissioning Committee provide assurance on issues relating to the commissioning primary care services (services provided in GP practices) from NHS England. Committees of the Governing Body will receive, for information only, any risks aligned to them on the Corporate Risk Register and GBAF.

7.7 **Executive Directors**

The Executive Directors provide assurance on all risks within the directorates and will receive a quarterly assurance report on all risks held within the Corporate Risk Register and GBAF. Any risks identified from meetings will be managed by the 'risk owner' who identified the risk. The 'risk owner' will discuss the risk with the Directorate Lead and before adding the risk to the Directorate Risk Register and if the risk is scored 12 or above the risk will be escalated through the appropriate channels.

8.0 Risk Management Process

8.1 **Risk Identification**

Identification of risk is the first part of an effective risk management strategy. A strong organisational commitment to risk management will ensure that risks identified at all levels in the organisation are properly managed. Risks can be escalated to the Governing Body through the Governance structures (see Appendix

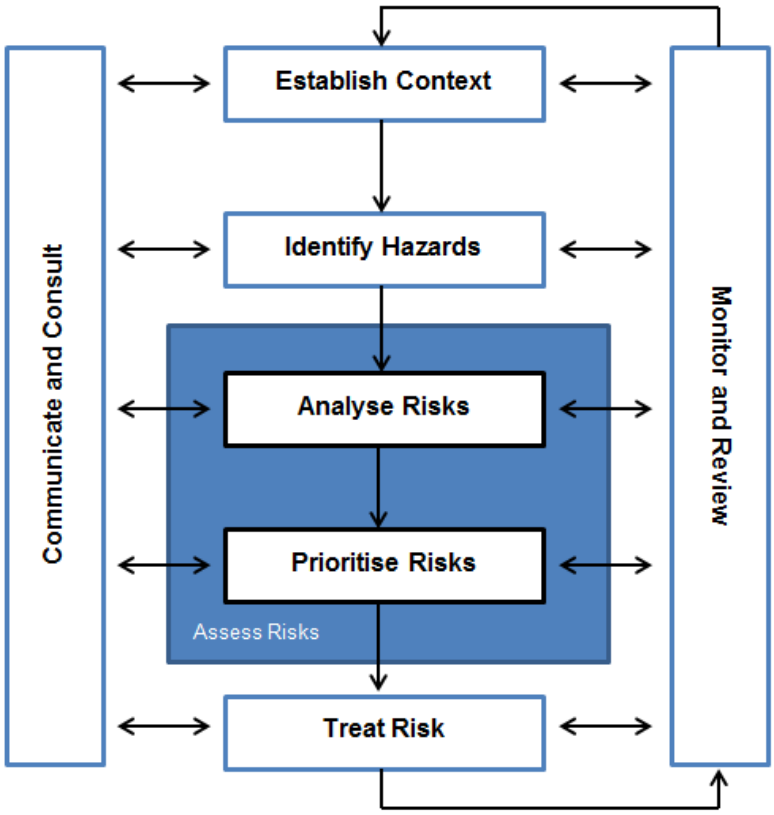
C) with the Corporate Risk Register being the consistent factor throughout the whole organisation.

All Directors and managers are required to identify risks specific to their own activities and circumstances. Risks may be identified from a number of sources, both internal and external. No valid risk will be excluded from the register due to its identification source. All staff are encouraged to be risk aware.

The Director of Corporate Services, Governance and Performance maintains a strategic overview of risk and is the chair of the Corporate Risk Review Group which meets monthly to discuss active risks.

8.2 Process for Identifying and Measuring Risk

The CCG has adopted a standard methodology consistent with the Australian Risk Management Standard AS/NZS 4360, also advocated by the National Patient Safety Agency, for identifying and measuring risks. The methodology is also in line with the standard in HM Treasury Orange Book 2004. This standard methodology will be applied across all organisation-wide assessments of risk.



The CCG has developed its own process for managing identified risks and escalating where appropriate (See Appendix B)

8.3 Risk Assessment and Risk Analysis

Risk assessment is the process for assessing and prioritising risk. Each risk will be evaluated in a consistent way using the risk matrix (See Section 8.4). Risks will be analysed by combining estimates of likelihood and consequence. By ensuring all risk assessments follow the same process of evaluation and calculation the

Governing Body can be assured that a continual, systematic approach to all risk assessments is followed throughout the organisation.

8.4 **Risk Assessment Matrix**

The CCG has adopted a risk assessment tool, which is based upon a 5 x 5 matrix. (Used by Risk Management AS/NZS 4360:1999) The Risk Matrix shown below is taken from the National Patient Safety Agency 'A Risk Matrix for Risk Managers' guidance published in January 2008.

Risk assessment involves assessing the possible consequences of a risk should it be realised, against the likelihood of the realisation (i.e. the possibility of an adverse event, incident or other element having the potential to damage or threaten the achievement of objectives or service delivery, occurring). Risks are measured according to the following formula:

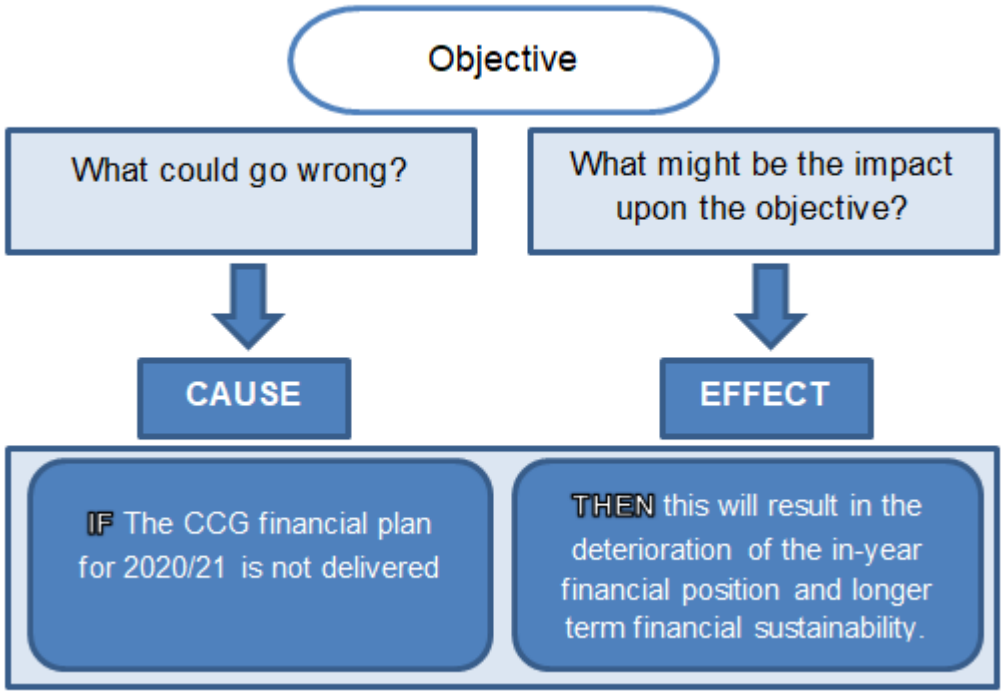
Likelihood x Consequences = Risk

All risks need to be rated on 2 scales, Likelihood and Consequence using the scales below.

The severity of the consequence and the impact of the risk occurring is demonstrated with examples of descriptors in Appendix A.

8.5 **Example of Constructing a Risk**

Step 1: Identify and Describe the Risk



Step 2: Identify Directorate Lead, Risk Owners and Assurance Committee

The Directorate Lead will be a Director of the CCG and the Risk Owner is likely, but not always, the individual that identified the risk. The risk needs to be aligned to the most appropriate Committee as an assurance measure.

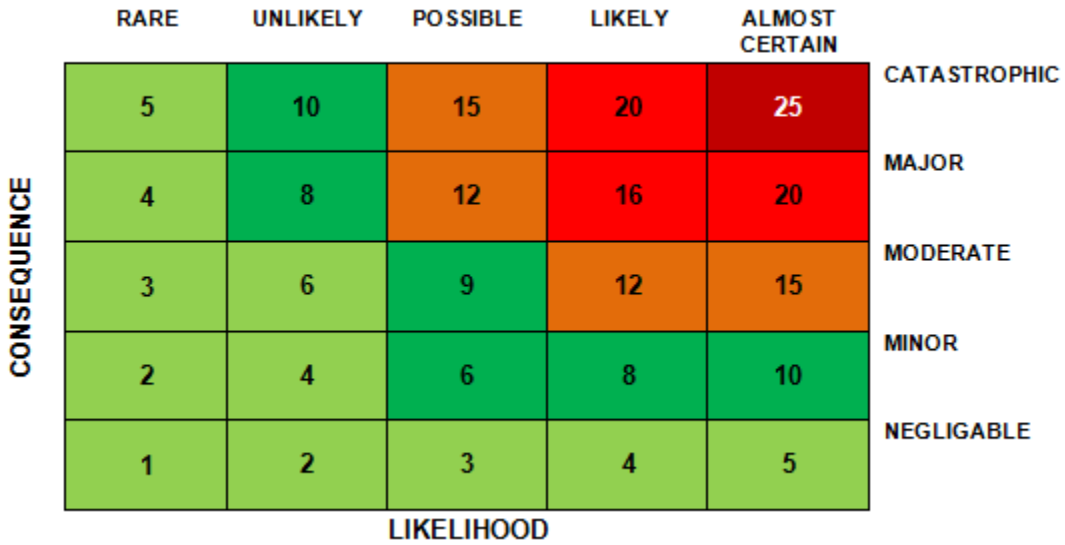
Step 3: Evaluate the Risk
The Risk Owner should evaluate the risk and determine the following:

- If there is a quantifiable financial risk (this could be on a scale)
- Positive controls and existing assurance already in place
- Determine the initial risk score using the matrix
- The Risk Owner should determine the level of risk that the CCG is willing to accept and determine the risk appetite score using the risk matrix.
- Identify any gaps in control and assurance
- Identify Suitable Controls and Actions to Mintage Against the Risk

Step 4: Implement Controls
The Risk Owner will work closely with others to implement any controls.

Step 5: Monitor and Measure Effectiveness
Each risk will be monitored by the Risk Owner and Directorate Lead. The Corporate Risk Review Group will seek assurance to ensure risks are being managed effectively. A Risk Management Timetable demonstrates how the Governing Body, Committees, Executive Directors and Corporate Risk Review Group will receive assurance (Appendix .

Risk Matrix



1 – 6	Low
7 –11	Medium
12 –15	High
16 –20	Serious
21 – 25	Critical

Likelihood		Broad Description of Frequency	Time Frame Descriptors of Frequency
1	Rare	This will probably never happen / recur	Not expect to occur for years
2	Unlikely	Do not expect it to happen/ recur but it is possible it may do so.	Expected to occur at least annually.
3	Possible	Might happen / recur occasionally.	Expected to occur at least monthly.
4	Likely	Will probably happen / recur but it is not a persistent issue	Expected to occur at least weekly.
5	Almost Certain	Will undoubtedly happen / recur, possibly frequently.	Expected to occur at least daily

Consequence				
	Domain	Quality	Statutory Duty / Inspection	Business Objectives / Projects
1	Negligible	Peripheral element of treatment suboptimal	No or minimal impact or breech of guidance / statutory duty	Insignificant cost increase / schedule slippage.
2	Minor	Overall treatment or service suboptimal	Breech of statutory legislation. Reduced performance rating.	<5 per cent over project budget. Schedule slippage.
3	Moderate	Treatment or service has significant reduced effectiveness.	Single breech of statutory legislation. Challenging eternal recommendations / improvement notice.	5 – 10 percent over project budget. Schedule slippage.
4	Serious	Non-compliance with national standards with significant impact to patients if unresolved.	Enforcement action. Improvement notices.	Non-compliance with national 10-25 percent over project budget. Schedule slippage.
5	Catastrophic	Totally unacceptable level or quality of treatment / service.	Multiple breeches in statutory duty.	Incident leading >25 percent over project budget.

8.6 **Risk Level and Management Responsibility for Different Levels of Risk**

Each Directorate and project area will have a risk register where all assessed risks are reported and held. It is for each Directorate to own and maintain these registers with the support of the Governance Team.

The Corporate Risk Review Group is responsible for ensuring that the Governing Body Assurance Framework, Corporate Risk Register and Directorate Risk Register are regularly reviewed and updated by risk owners. The group will provide a level or scrutiny and challenge to the process of identifying and measuring risk, culminating in a cycle of continuous monitoring and review.

All risks will be reviewed at the Corporate Risk Review Group and agreed new risks scored at 12 or above will be reported to the Executive Directors for inclusion on the Corporate Risk Register or Governing Body Assurance Framework.

Each risk reported on the Corporate Risk Register and Governing Body Assurance Framework is assigned a unique reference number by the Senior Governance Manager.

Risks on the Corporate Risk Register and Governing Body Assurance Framework will be aligned to a Committee of the Governing Body. These Committees will receive quarterly, for information only, any risks aligned to them on the Corporate Risk Register and GBAF.

Any risks escalated to the Governing Body Assurance Framework are mapped to the Strategic Objectives identified in the Assurance Framework by the Senior Governance Manager in agreement with the Director of Corporate Services, Governance and Assurance and the Director identified as Risk Owner.

An initial risk assessment is recorded for each risk; this is an assessment of the risk without mitigating actions. A current risk assessment is recorded. This is the risk score once mitigating actions have been agreed and work has started to implement them. This could be the same as the initial risk if no actions have yet been taken. Once actions have been agreed and started to be implemented this should reduce. The risk appetite / target risk level for each risk is given. Actions to mitigate risks are reported alongside the internal controls in place to manage the risk and sources of assurance. Target dates for the completion of actions are given and the identified Risk Owner is shown. The rating for the level of assurance available is provided. A summary risk tracker sits alongside the Governing Body Assurance Framework and Corporate Risk Register and shows progress towards achieving the risk limits in the risk appetite. See Appendix D and E for an example of the GBAF and CRR.

The below table shows the action required to reduce the risk score depending on the risk rating.

Risk Rating	Risk Description	Action Required to Reduce Risk Score
1 – 6	**Low**	• Refer to Lead Director for action. • Managed by the Directorate and the CRRG. • Quick, easy measures must be implemented immediately and further action planned for when resources permit. Managed by routine procedure. • Reassess as appropriate. Actions managed locally. • Possibly no actions required – risk accepted/tolerated

7 – 11	**Medium**	• Refer to Lead Director for action. • Managed by the Directorate and the CRRG. • Actions implemented as soon as possible but no later than a year. • Appropriate controls to be implemented and monitored. • Reassess regularly.
12 – 15	**High**	• CRRG to refer to Director to agree whether risk should be escalated to CRR or GBAF • Take steps to make the situation safe. • Implement available controls. Will require plan which sets out actions to be taken to reduce level of risk to be • Implemented as soon as possible and no later than 6 months. • CRRG to receive monthly updates. • Executive Directors receive quarterly reports from the CRR and GBAF • Committees will receive quarterly, for information only, any risks aligned to them on the CRR and GBAF. • GB reviews GBAF three times per annum; twice at meetings, once at a workshop. • GB receives as assurance the CRR in its entirety twice per annum. • AC receives as assurance the GBAF, CRR and DRR in their entirety twice per annum.
16 – 20	**Serious**	• CRRG to refer to Director to agree whether risk should be escalated to CRR or GBAF • Take steps to make the situation safe. • Implement available controls. Will require plan which sets out actions to be taken to reduce level of risk to be • Implemented as soon as possible and no later than 6 months. • CRRG to receive monthly updates. • Executive Directors receive quarterly reports from the CRR and GBAF • Committees will receive quarterly, for information only, any risks aligned to them on the CRR and GBAF. • GB reviews GBAF three times per annum; twice at meetings, once at a workshop. • GB receives as assurance the CRR in its entirety twice per annum. • AC receives as assurance the GBAF, CRR and DRR in their entirety twice per annum.
21 – 25	**Critical**	• CRRG to refer to Director to agree whether risk should be escalated to CRR or GBAF • Take steps to make the situation safe. • Implement available controls. Will require plan which sets out actions to be taken to reduce level of risk to be • Implemented as soon as possible and no later than 6 months. • CRRG to receive monthly updates. • Executive Directors receive quarterly reports from the CRR and GBAF • Committees will receive quarterly, for information only, any risks aligned to them on the CRR and GBAF. • GB reviews GBAF three times per annum; twice at meetings, once at a workshop. • GB receives as assurance the CRR in its entirety twice per annum. • AC receives as assurance the GBAF, CRR and DRR in their entirety twice per annum.

8.7 **Reviewing and Monitoring of the Corporate Risk Register and GBAF**

Maintenance of the Corporate Risk Register and Governing Body Assurance Framework will be undertaken by ensuring all risks are managed by their 'Review Date'. An audit of the Corporate Risk Register and Governing Body Assurance Framework will determine performance in this respect. Review of risks must be undertaken within the Directorates who should ensure that all controls are in place and any actions necessary are properly recorded and met. Risk must be reviewed at least quarterly. The risk rating should gradually decrease from the initial score to meet the target score – the current score is the only rating that will change, eg:

TIME	Q1	Q2	Q3	Q4
Initial Risk Rating	16	16	16	16
Current Risk Rating	16	12	6	4
Target Risk Rating	4	4	4	4

If the current risk rating is not reducing then the actions that have been put in place to address the risk must be reviewed, as it would appear that the actions are not effective at reducing the risk.

8.8 **Closing Risks**

An active Risk Register contains the risks that are relevant to the organisation that are being addressed. Once a risk has reached its target rating (and is at an acceptable level of risk) it may be closed after agreement at the Corporate Risk Review Group.

In some cases the actions will reduce the risk but the residual level will remain high. If the conclusion of the Directorate is that no further action can be taken to reduce the risk the recommendation to close it and accept the risk at the remaining level must be escalated to the Corporate Risk Review Group. If actions can be taken but these will be costly, all options must be escalated to the Executive Directors for a decision on whether to accept the risk to the organisation or take further action.

Closed risks can always be accessed on the log of closed risks and re-opened if circumstances change. However, it is good practice to only close if the risk has been removed or is time-limited only.

9.0 Partnership to Minimise Risk

It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks is most difficult to ascertain. Only by working closely and collaboratively with a wide range of partner organisations can these risk areas be identified and properly managed and be afforded an appropriate priority within the risk action plan.

NHS North Yorkshire CCG will endeavour to involve partner organisations in all aspects of risk management as appropriate.

10.0 Risk Awareness Training

Through the implementation of the Risk Management Framework and appropriate training, it is anticipated that members of the Governing Body and CCG staff of the will develop a deeper understanding of the breadth of their statutory duties of care. This should lead to staff and others being positive about identifying potential risks and in reporting incidents and near misses, and hence learning about how to minimise risk, freely participating in audits and having ownership of policies,

procedures and guidelines. Managers in particular must appreciate the value of their contribution to risk management through the implementation of the risk assessment process within their sphere of responsibilities.

To enable the Risk Management Framework to be fully implemented, training sessions and workshops will be set up for managers, staff and clinical professionals. The sessions will include:

- Introduction to and refresher training for risk management and governance as appropriate to the roles and responsibilities within CCG and in respective roles in support of the CCG
- As part of the induction process for all new Governing Body Members.
- The provision of appropriate resources to provide Governing Body development on risk management.

11.0 Monitoring and Review

This strategy will be reviewed every three years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

The CCG monitors and reviews its performance in relation to the management of risk, and the continuing suitability and effectiveness of the systems and processes in place to manage risk through a programme of internal and external audit work, and through the oversight of the CCG Governing Body and the Audit Committee. All directorates and committees, however, monitor the risks allocated to them.

12.0 References

- DOH 1999 – HSC 1999/123 Controls Assurance Statement 1999/2000: Risk Management & Organisational Control, DoH London
- DOH 2003 – Building the Assurance Framework, DOH, London Australian / New Zealand Standard: Risk Management 4360:1999
- DOH (2012) The Functions of Clinical Commissioning Groups Gateway Reference 17005
- NPSA (2008) A Risk Matrix for Risk Managers, NPSA
- NPSA (2010) *National Framework for Reporting and Managing Serious Incidents*
- National Quality Board (2010) *Review of Early Warning Systems in the NHS*

13.0 Associated Documentation

- NY CCG Constitution: includes Standing Orders and Terms of Reference of Statutory Committees
- Corporate Governance Handbook: includes Scheme of Reservation and Delegation, Operational Scheme of Delegation, Terms of Reference of Non-Statutory Committees.
- Business Conduct Policy
- Conflict of Interest Policy
- Serious Incident, Incident and Concerns Policy
- Policy for the Reporting and Management of Patient Complaints
- Whistleblowing Policy
- Local Anti-Fraud, Bribery and Corruption Policy
- Health and Safety Policy
- Emergency & Business Resilience Plan
- Relevant Human Resource Policies

Likelihood and Consequence Descriptors

Risks are first judged on the *probability* of events occurring so that the risk is realised. Enter a number (1-5) indicating the probability of the risk occurring. Please refer to the definition scale below.

		Descriptors of frequency	Time framed descriptors of frequency
1	Rare	This will probably never happen/recur	Not expected to occur for years
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so	Expected to occur at least annually
3	Possible	Might happen or recur occasionally	Expected to occur at least monthly
4	Likely	Will probably happen/recur but it is not a persisting issue	Expected to occur at least weekly
5	Almost certain	Will undoubtedly happen / recur, possibly frequently	Expected to occur at least daily

Severity of consequence and impact of the risk occurring

Based on the above judgments a risk assessment can be made of the potential future risk to stakeholders and the organisation as follows:

Light Green	Negligible
Green	Low Risk
Amber	Moderate Risk
Red	High Risk
Dark Red	Extreme Risk

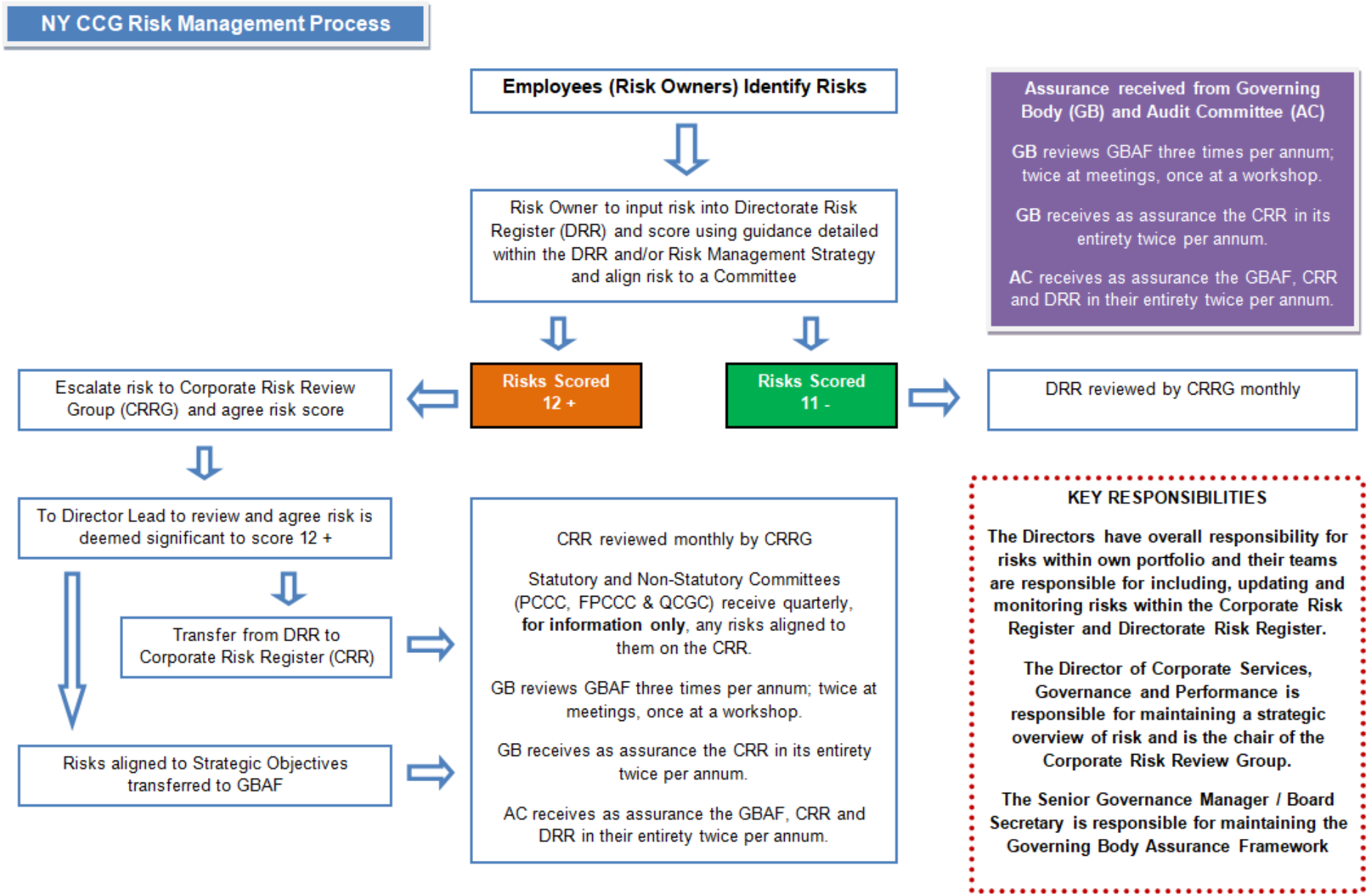
	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Serious**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
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 / media interest Damage to an individual's reputation.	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Damage to a team's reputation	Local media coverage – long-term reduction in public confidence Damage to a services reputation	National media coverage with <3 days service well below reasonable public expectation Damage to an organisation's reputation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence (NHS reputation)

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 met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not 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
Data Loss / Breach of Confidentiality	Potentially serious breach. Less than 5 people affected or risk assessed as low e.g. files were encrypted	Serious potential breach and risk assessed high e.g. unencrypted clinical records. Up to 20 people affected	Serious breach of confidentiality e.g. up to 100 people affected	Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

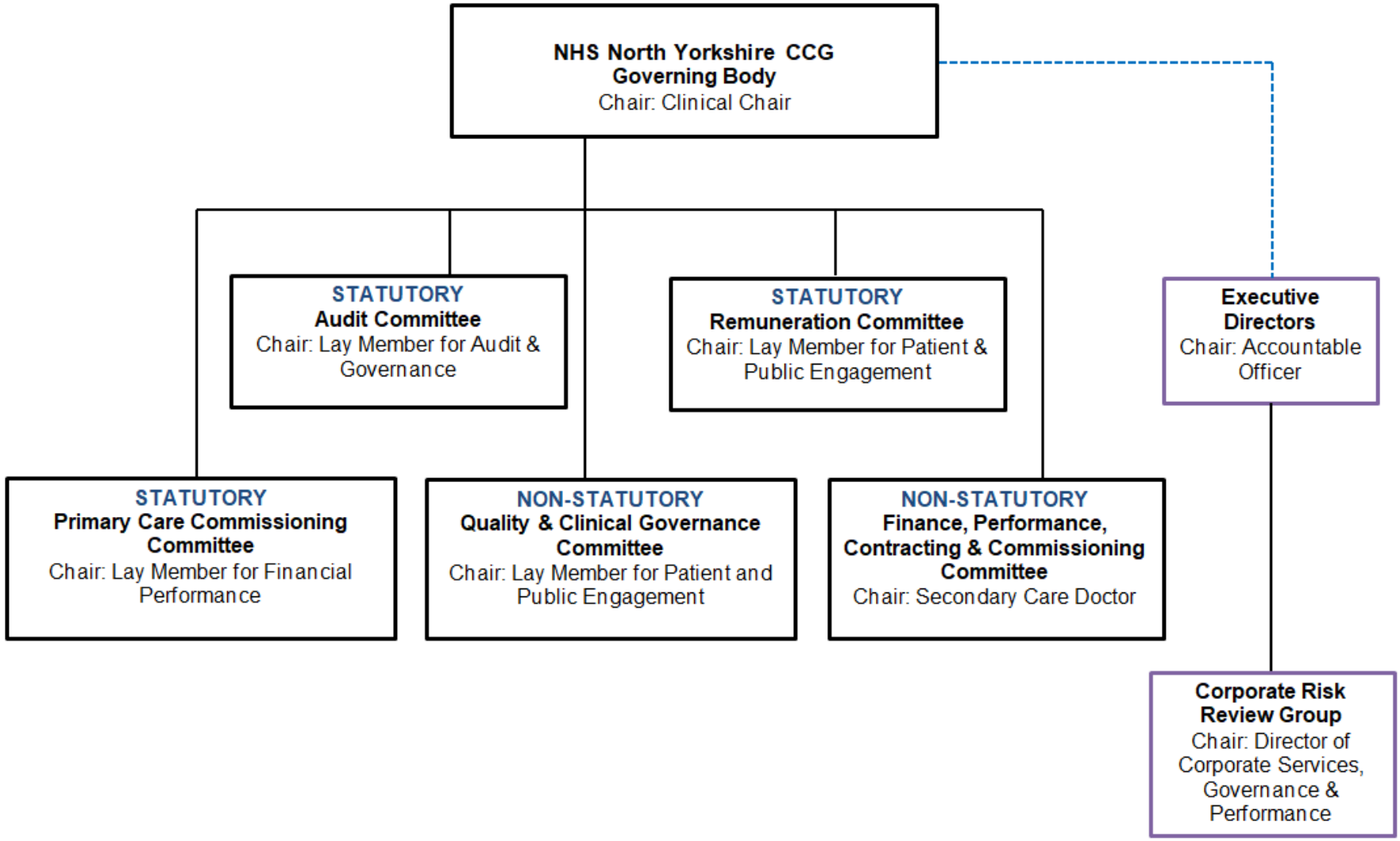
Risk Management Flow Chart

Appendix B



NHS North Yorkshire CCG Governance Structure

Appendix C



NY CCG Governing Body Assurance Framework Sample

GBAF REF: 1-1	**Strategic Objective 1: Quality, Safety and Continuous Improvement** To ensure that the care we commission is of a high quality / safe and sustainable, improves health outcomes and wellbeing and provides a good patient experience.	**Committee:** Quality and Clinical Governance Committee	**Last Reviewed by Committee:** XX MONTH 2020
		Executive Risk Owner: Director of Corporate Services, Governance & Performance	**Last Reviewed GB:** XX MONTH 2020

Principle Risk 1:
Operational challenges including capacity issues in services commissioned by the CCG and provided in the community may impact on the timeliness of assessment, quality of services and support for vulnerable people in their own home.

NHSE Assurance Domain:
1 – Better Health

Positive Assurance and Existing Controls in Place

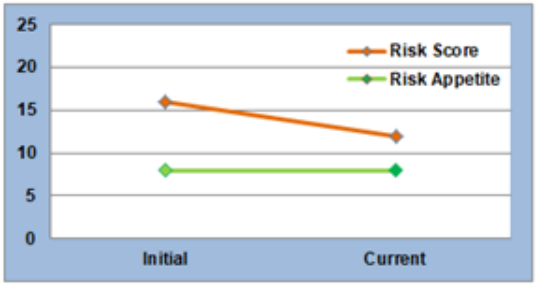
- Achievement of Improvement and Assessment Framework indicators aligned to continuing healthcare
- Programme Director appointed and CHC Programme Board established to ensure delivery of the national framework for continuing healthcare and the QIPP programme.
- Standard Operating Procedures / commissioning policies in place
- More effective and responsive fast track pathway of provision established
- Community team meetings including service managers and CCG quality leads commenced.
- Community team meetings including service managers and CCG quality leads commenced to understand pressures and discuss solutions.
- CHC Recommendations have been added to the internal audit recommendations log by Senior Governance Manager and are monitored by SMT.
- Service Specification has been developed.
- Working with Provider Alliance to make those operational changes.

Gaps in Control and Assurance (where we are failing to put controls in place / failing to gain evidence that our controls are effective)

- Capacity and capability in CHC operational and administrative teams subject to review
- Underachievement of IAF CHC indicators
- Service specification for commissioning care teams agreed still requires implementation date

Risk Rating

Initial Risk			Current Risk			Risk Target		
L	C	Rating L x C	L	C	Rating L x C	L	C	Rating L x C
4	4	16	3	4	12	1	4	4



TIME	Q1 (2020)	Q2 (2020)	Q3 (2020)	Q4 (2021)
Initial Risk Rating	16			
Current Risk Rating	12			
Target Risk Rating	4			

Mitigating Action Plan (plans to address gaps in control)	Action Target Date	Action Lead
Consider reducing score at the next Corporate Risk Review Group	June 2020	Director of Corporate Services, Governance & Performance
CHC capacity & capability review will be form part of NHSE CHC review	June 2020	CHC Programme Director

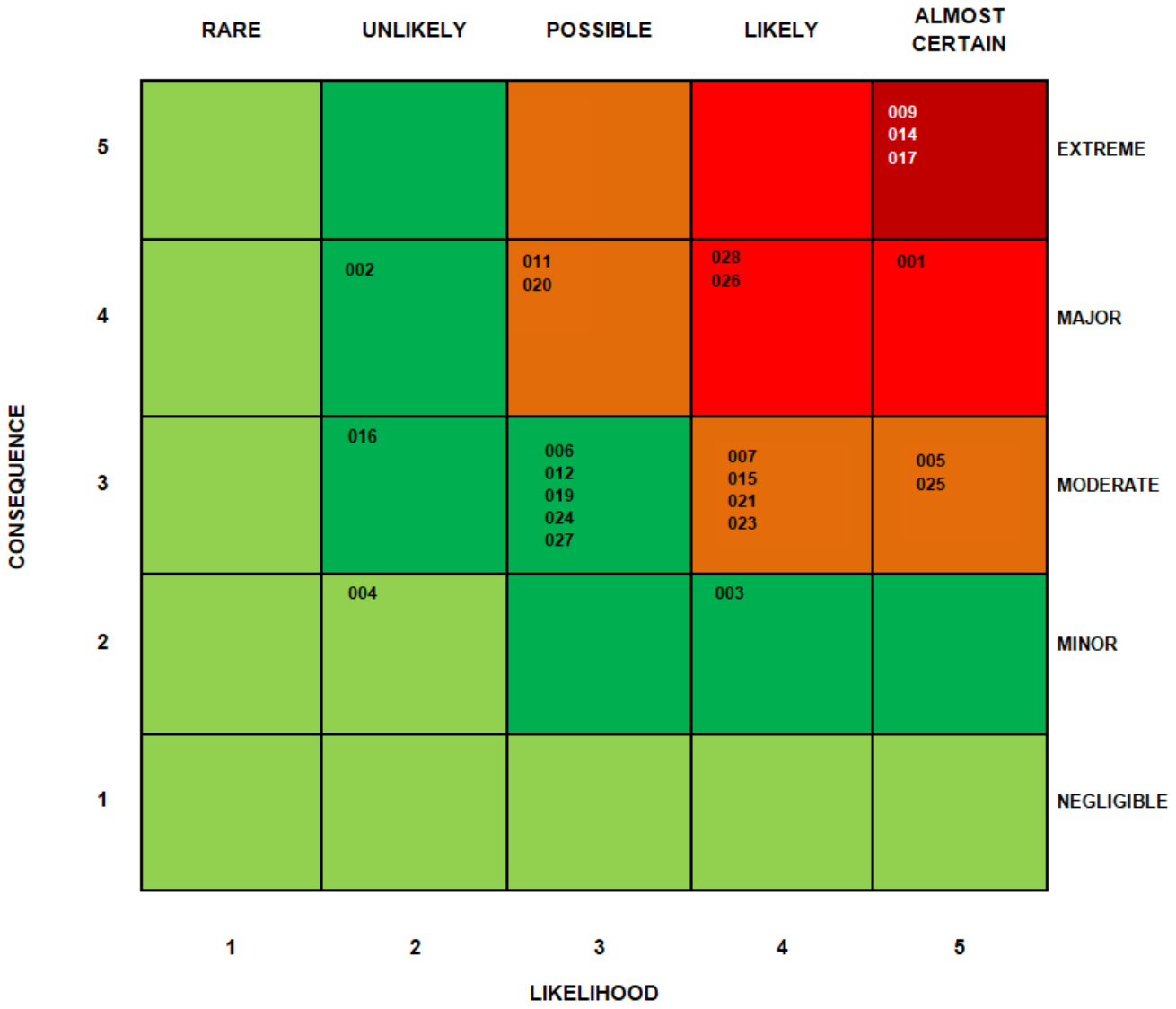
NY CCG Corporate Risk Register **Sample**

Appendix E

North Yorkshire CCGs Corporate Risk Register

								Likelihood (L) X Consequence (C) = Risk Score									L X C = Risk Appetite					
Assurance Committee	Risk ID	Date Risk Added	Risk Description	Executive Risk Owner	Lead Officer	Quantifiable Financial Risk	Positive Controls & Existing Assurance in Place	Initial L 1-5	Initial C 1-5	Initial Score (1-25)	Current L 1-5	Current C 1-5	Current Score (1-25)	Gaps in Control and Assurance	Actions Required and Action Lead Identified	Target Date for Action	L 1-5	C 1-5	RA (1-25)	Status	Date Last Reviewed	NOTES - AREAS TO DISCUSS WITH RISK MANAGEMENT LEADS
Finance, Performance, Contracting & Commissioning Committee	**NY 003**	31/05/19	Failure to identify and implement sufficient schemes to deliver QIPP 19/20 plan impacting the financial recovery plan.	Director of Strategy and Integration - NY CCGs	Christian Turner - Head of Business Change (HaRD)	£4.9m	New QIPP strategy developed across all three North Yorkshire CCGs, aligning savings programmes to five key areas. Transformation & Delivery (T&D) Programme Board takes oversight of all change projects including QIPP. Fixed income contract in place for £102.7m with HDFT with shared risk arrangements. Delivering the agreed value will deliver savings of £2m. Governance arrangements with HDFT strengthened to ensure close link between programmes of change and operational business. Planned care demand management key programme within the new NY QIPP strategy. CHC programme board in place with identified programme areas including data cleansing. RightCare opportunities being reviewed across the three NY CCGs with up-to-date data. Head of Nursing and Quality sits on CHC Programme Board Medicines Management QIPP programme in place and QIPP Delivery Group in place.	3	5	15	3	5	15	Additional schemes for implementation that will support delivery of savings to meet existing QIPP requirement and above.	Continue to work existing programme areas to maximise opportunities with all three NY CCGs.	Ongoing	2	4	8	Open	00/00/20	

NY CCG Risk Heat Map Sample



Appendix G

NHS North Yorkshire Clinical Commissioning Group
Risk Management Timetable April 2020 – March 2021

Meeting	Purpose	APR 2020	MAY 2020	JUN 2020	JUL 2020	AUG 2020	SEP 2020	OCT 2020	NOV 2020	DEC 2020	JAN 2021	FEB 2021	MAR 2021
Governing Body (GB)													
Governing Body Assurance Framework (Public)	To Approve			*						X			
Governing Body Assurance Framework (Workshop)	To Review			*				X					
Corporate Risk Register	To Assure			*						X			
Executive Directors (ED)													
Governing Body Assurance Framework	To Review					X			X			X	
Corporate Risk Register	To Review					X			X			X	
Directorate Risk Register	To Review					X			X			X	
Audit Committee (AC)													
Governing Body Assurance Framework	To Assure						X					X	
Corporate Risk Register	To Assure						X					X	
Directorate Risk Register	To Assure						X					X	
Primary Care Commissioning Committee (PCCC)													
Governing Body Assurance Framework (Aligned Risks Only)	For INFO						X		X			X	
Corporate Risk Register (Aligned Risks Only)	For INFO						X		X			X	
Quality & Clinical Governance Committee (QCGC)													
Governing Body Assurance Framework (Aligned Risks Only)	For INFO						X			X			X
Corporate Risk Register (Aligned Risks Only)	For INFO						X			X			X
Finance, Performance, Contracting & Commissioning Committee (FPCCC)													
Governing Body Assurance Framework (Aligned Risks Only)	For INFO						X			X			X
Corporate Risk Register (Aligned Risks Only)	For INFO						X			X			X
Corporate Risk Review Group (CRRG)													
Governing Body Assurance Framework	To Review				X	X	X	X	X	X	X	X	X
Corporate Risk Register	To Review				X	X	X	X	X	X	X	X	X
Directorate Risk Register	To Review				X	X	X	X	X	X	X	X	X

* Risk Management Strategy approved