NHS
Coastal West Sussex
Clinical Commissioning Group

Risk Management

Strategy, Policy and Procedure

Version	Date Issued	Details	Brief Summary of Change	Author
1.0	01/03/2018	Final	New document, amalgamating Risk Management Strategy and Policy into one document and incorporating recent changes to risk management procedure and use of Datix as the CCG's risk management tool.	Corporate Business Manager

For more information on the status of this policy, please contact:	
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Responsibility for review	Governance Team
Contributors	Governance Team Senior Leadership Team Internal Auditors: tiaa
Audience	All Staff

Contents

1. Introduction

This strategy and policy document sets out the structure, system and accountabilities for risk management within Coastal West Sussex Clinical Commissioning Group (CWS CCG) promoting high quality, safe, accountable healthcare, minimising risks to the organisation and our staff, and maximising available resources.

Risk management is closely linked with organisational rules, regulation and instructions to protect the health, safety and welfare of anyone affected by the organisations business. Any risks identified through the review on incidents and/or health and safety reviews must be reported to Heads of and included on the risk register using Datix (see section 8).

This policy should be read in conjunction with the following CCG policies:

- Freedom to speak up: raising concerns (whistleblowing) policy
- Health and safety policies
- Incident reporting and investigation policy and procedure
- CCG Constitution.

2. Purpose

CCG's are required to sign an Annual Governance Statement[1] to provide assurance that they have been properly informed about the totality of their risks and can evidence they have identified the CCG's objectives and managed the principle risks to achieving them. This includes all measures and practices that are used to control and manage risks. The system operates at all levels within the CCG and is continuously monitored for effectiveness.

Although not mandatory for commissioning only organisations, the CCG will continue to work to the best practice of the 'NHS Litigation Authority (NHSLA) Risk Management Standards[2]. These require a CCG approved strategy and policy for managing risk that identifies accountability arrangements, resources available and contains guidance on what may be regarded as acceptable risk within the CCG.

The purpose of this document is to define the strategy and policy that the CCG uses to ensure rigorous risk management processes, and provide the tools to assist staff to ensure, as far as is reasonably practicable, that all risks are identified and controlled appropriately.

3. Commitment

CWS CCG recognises that risk management is an integral part of good management practice and to be most effective it must become part of the organisation's culture. CWS CCG is therefore committed to ensuring that risk management forms a part of its philosophy, practice and planning (rather than being viewed or practiced as a separate programme) and that responsibility for implementation is accepted at all levels of the organisation.

The CCG acknowledges that the provision of appropriate training is central to the achievement of this aim (see section 12).

4. Definition of Risk and Risk Management

Risk can be defined as 'the possibility of incurring misfortune or loss' for example through the occurrence of an event that may either cause harm or have an impact upon patients, staff, visitors, partner organisations, strategic objectives, assets and/or reputation.

In particular:

- Any element which has the potential to damage or threaten the achievement of the

[1] Further information is available at http://www.dh.gov.uk/health/2012/03/annual-governance-statements/

[2] Further information is available at http://www.nhsla.com/Pages/Publications.aspx?library=safety%7cstandards

objectives, programme or service delivery of the organisation.
- Anything that could damage the reputation of the CCG and undermine the public's confidence in the organisation.
- Failure to guard against impropriety, malpractice, waste or poor value for money.
- Failure to comply with regulations or legislation such as those covering Health & Safety and the environment.
- An inability to respond to or manage changed circumstances in a way that prevents or minimises adverse effects on the delivery of the organisation's strategic objectives.

'Risk management involves managing to achieve an appropriate balance between realising opportunities for gains while minimising losses. It is an integral part of good management practice and an essential element of good corporate governance. It is an iterative process consisting of steps that, when undertaken in sequence, enable continuous improvement in decision-making, and facilitate continuous improvement in performance.' (Australian Standard, Risk Management AS/NZS 4360:2004).

Risk Management in the organisation is undertaken through:

a) Analysis and evaluation of the likelihood and potential impact of risks.
b) Management of risks through development of action plans to terminate, treat, tolerate or transfer them, ensuring reduction of likelihood and/or severity of impact to an acceptable level.
c) Monitoring and reviewing risks and the implementation of their action plans by risk register review.
d) Communicating through a documented process, risks associated with an activity or process.
e) Application of the Incident Reporting and Investigation Policy and Procedure; however, where the cause of an incident cannot be immediately eliminated, the risk(s) identified as a result of any incident reported will then also go on to be managed proactively, through risk assessment and management.

5. Objectives of this document

There should be a holistic approach to risk management across the organisation which embraces financial, organisational, clinical and non-clinical risks and in which all parts of the CCG should be involved.

The CCG aims to take all reasonable steps in the management of risk with the overall objective of protecting patients, staff, the public and assets. A primary concern is the provision of safe, risk free environments together with working policies and practices which take into account assessed commissioning risks.

This document provides a framework, clarifying responsibilities and outlining the procedures for managing risks to the organisation's objectives. It aims to achieve the following:

- The integration of risk management with the CCG's Principal Objectives and with local (team or project) objectives that support these.
- Compliance with Department of Health and NHS England guidance
- Compliance with legislation.

In order to achieve these the CCG will adopt a pro-active approach with a risk management system which aims to meet its strategic objectives, preserve its assets and reputation and to provide protection against preventable injury and loss to employees, patients and the general public.

6. Duties and Responsibilities

The **Accountable Officer** has overall responsibility for ensuring that an effective risk management system is in place. They are also responsible for ensuring there is an adequate control system in place.

The **executive lead for Governance** is responsible for ensuring (and reporting to the Governing Body and the Audit and Assurance Committee) that systems and structures are in place for the

effective management of risk and appropriate organisational controls.

The **Company Secretary** has the delegated responsibility for managing the development and implementation of risk management systems and is responsible for ensuring that there are effective systems for risk management. They are responsible for the operational aspects of the risk registers and assurance frameworks and ensure that risks are recorded and reviewed regularly. They are responsible for compiling the CWS CCG Board Assurance Framework (see section 8) report.

The **Caldicott Guardian** ensures that the Caldicott principles for managing information and ensuring its security and integrity are adhered to by staff within the organisation.

The **Senior Information Risk Owner (SIRO)** has responsibility for managing Information Risks across the organisation.

In addition, all **Heads of Service** have particular responsibilities within these procedures which are to:

- Ensure that CWS CCG's risk management processes, including risk assessments, are adhered to within their scope of responsibility.
- Implement and monitor any risk management actions within their designated area.
- Delegate responsibility for the management and review of risks on Datix to Team Risk Leads and Risk Support Officers.
- Review a summary of all incidents within their teams or their scope of responsibility on a regular basis and disseminate this information to ensure that appropriate learning takes place to reduce future risks.
- Discuss with staff how they seek to achieve their individual objectives and consider how 'risks' related to achievement of their objectives are identified, prioritised and tackled.
- Ensure that all staff are given the necessary information and training to enable them to be aware of the risks to their local objectives, those in their work environment and of their personal responsibilities and to work safely.
- Where local actions are considered to be inadequate or if local resolution has not been satisfactorily achieved, senior managers are responsible for bringing these risks to the attention of the Governing Body, through executives.
- Have adequate knowledge of and/or access to all relevant legislation in order to ensure that compliance to such legislation is maintained.

All **Managers ar**e responsible for ensuring risk is included in regular 1:1 and/or supervision discussions with their team members. They also have a responsibility to ensure identified risks are recorded on the CCG Risk Management system, Datix (see 8.1).

CWS CCG Staff

Risk Management is the responsibility of all CWS CCG employees. They have a responsibility to co-operate with managers and they are encouraged to identify risks and notify their line managers, in order for risks to be captured, entered onto Datix and management appropriately.

All staff are responsible for ensuring they are familiar with and complying with this and other relevant policies and procedures.

Member Practices

It is recognised that member practices will have their own risk management processes in place. However, when individuals are undertaking the business of the CWS CCG this Risk Management Strategy, Policy and Procedures document will apply.

7. Risk Management Structure

The CCG **Governing Body** has the authority for the systems of internal control – financial, organisational, clinical and non-clinical. It seeks regular assurance through the Audit and Assurance Committee on whether the CCG's Risk Management system is in place and functioning properly and being regularly scrutinised. This enables them to provide a fully

informed Annual Governance Statement.

It receives progress updates against the Board Assurance Framework (see section 8), including risk reporting and analysis, and reviews key controls and assurances in place for those risks, as well as monitoring action plans for any identified gaps in controls or assurances.
The Governing Body receives assurance that risks and management processes are being effectively scrutinised by the Audit and Assurance Committee.

The Head of Internal Audit (TIAA) is responsible for providing a formal, annual Opinion on the organisation's system of internal control, based on an agreed programme of Internal Audit work. The Opinion is designed to inform the Accountable Officer's completion of the Annual Governance Statement.

The **Audit and Assurance Committee (AAC)** provides an objective view on internal control and risk management to the Governing Body that is independent of executive and line management. It provides assurance as to the robustness of risk management systems and the level of deployment with CWS CCG. It scrutinises the Corporate Risk Register and the Board Assurance Framework and provides assurance that individual risks are being effectively managed and that the actions to treat the high level risks are sufficient and are having the desired effect within the agreed timescales. It periodically reviews any other relevant risk documentation. The detailed scrutiny of risks by the Audit Assurance Committee ensures that appropriate controls and assurances are in place to manage the mitigation of significant risks.

The **Quality Committee** scrutinises the clinical risks and Board Assurance Framework and provides assurance that individual clinical risks are being effectively managed and that the actions to treat the high level risks are sufficient and are having the desired effect within the agreed timescales. It periodically reviews any other relevant risk documentation.

The **Operations and Performance Programme Board (OPPB)** scrutinises the corporate risks relating to finance and performance and the Board Assurance Framework and provides assurance that individual corporate risks are being effectively managed and that the actions to treat the high level risks are sufficient and are having the desired effect within the agreed timescales. It periodically reviews any other relevant risk documentation.

The **Primary Care Commissioning Committee (PCCC)** scrutinises the risks relating to Primary Care Commissioning and provides assurance that risks are being effectively managed and that the actions to treat the high level risks are sufficient and are having the desired effect within the agreed timescales. It periodically reviews any other relevant risk documentation.

The **Public Engagement Committee (PEC)** scrutinises the risks relating to public engagement and provides assurance that risks are being effectively managed and that the actions to treat the high level risks are sufficient and are having the desired effect within the agreed timescales. It periodically reviews any other relevant risk documentation.

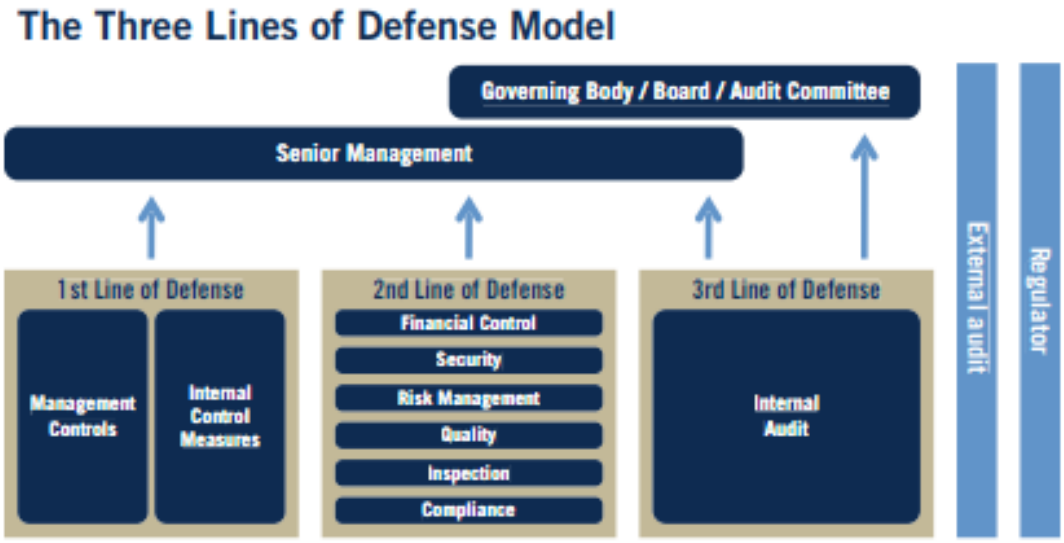
The **Senior Leadership Team (SLT)** is responsible for the operational delivery of agreed strategy and strategic commissioning intentions and as such also reviews the organisation's risks associated with its operation and commissioning functions. SLT further ensures the organisation is aware of and complies with its legal and statutory obligations and operates in a safe and legally compliant manner. SLT approves the addition of new risks onto Datix as well as any to be closed.

The **Governance Team** manages the risk reporting process across the CCG.

8. Risk Management System

The risk management system is designed to focus management attention on risks at the appropriate level in the organisation. In particular it is designed to set the most significant risks to 'principal' business objectives before the Governing Body in order that resources can be applied to implement controls that mitigate the risks, and to gain assurances that those controls are effective.

Managers have overall responsibility for implementing and maintaining an effective 'system of internal control'. In the Three Lines of Defence model (illustrated below), management control is the first line of defence in risk management, the various risk control and compliance oversight functions established by management are the second line of defence, and independent assurance is the third. Each of these three "lines" plays a distinct role within the organization's wider governance framework.



Adapted from ECIIA/FERMA *Guidance on the 8th EU Company Law Directive, article 41*

The Risk Management Strategy, Policy and Procedure sets out how the system delivers this. The key components of the CCG's Risk Management System are Datix, the Corporate Risk Register and the Board Assurance Framework.

8.1 Datix: Risk Management Tool

All team managers have responsibility to record identified risks on the CCG Risk Management system, Datix. This ensures risks at all levels are held in a central location which is fully auditable. (See Appendix C)

With Datix, individual teams keep their own risk registers on a single system. This information feeds in to the organisation-wide risk register, giving a prioritised portfolio of risks across the entire organisation. Risks are entered as 'strategic', 'team' or 'project' depending on the level of objective they are a risk to the achievement of. This enables teams to manage risk at the appropriate level.

'Strategic' risks are those which appear in the Board Assurance Framework (BAF, see below), and can only be entered onto Datix by the Governance Team. They are risks to the achievement of the CCG's Principle Business Objectives. The Risk Action Owner for these risks is the Senior Responsible Officer for the relevant Principal business Objective. The BAF and Strategic Risks are reviewed by SLT quarterly.

'Team' risks are risks to the achievement of team or organisational objectives and can be entered onto Datix by anyone in the CCG. They are managed within the team by Heads of and Team Risk Leads. Those with an initial (pre-mitigation) score of 12 or more are reviewed by SLT and AAC quarterly via the Corporate Risk Register (see below).

'Project' risks are risks to the achievement of project objectives and are reviewed at team level only. They may be scored highly in relation to the achievement of team and consequently, corporate objectives, however they are not escalated to SLT or AAC via the Corporate Risk Register. If a Manager feels that a project risk has become a team risk (i.e. it has escalated and has a potential impact on the achievement of team/corporate objectives), they can re-categorise the risk as 'team' as part of their regular review.

There are how to guides on the Datix page on the staff intranet, along with a link to the tool. Advice and training on the use of Datix is available from the Governance Team.

8.2 Corporate Risk Register (on Datix)

The Corporate Risk Register (CRR) reports on all 'team' risks on Datix that were assessed as high (12+ pre mitigation) or extreme (16+ pre mitigation), according to the matrix available in Appendix B. The CRR is reviewed by SLT and the AAC on a quarterly basis. (See the flowchart in Appendix A).

8.3 Board Assurance Framework (on Datix)

CWS CCG's Board Assurance Framework (BAF) sets out the organisation's principal business objectives and critical success factors along with the key risks which may compromise their achievement. The BAF also contains details of key controls and assurances as well as any gaps in controls and assurance.

Details of other risks in excess of the CCG's risk tolerance threshold (a pre mitigation score of 15 or above) are also submitted for scrutiny at the Governing Body alongside the BAF to ensure that members are aware of the principal risks facing the organisation.

9. Risk Assessment

The process for the consistent assessment of risks (including use of the National Patient Safety Agency Risk Model Risk Matrix) is contained in Appendix B of this document. All risks identified should be brought to the attention of immediate Line Managers who will have responsibility for making an initial assessment of the risk. The agreed risk should then be entered onto Datix and approved by the Team Risk Lead and/or Head of Service.

10. Risk Management Process

Regular reviews are undertaken across the organisation to ensure that new risks are identified and assessed, that existing risks and their mitigating actions are entered onto Datix and kept up to date and that risks are closed as appropriate. (See the flowchart in Appendix A.)

As a commissioner of services, regular review of provider Board Assurance Frameworks will enable CWS CCG to cross check for possible risks arising which it may not otherwise be sighted on. This will take place quarterly via publically available Board papers.

11. Risk Appetite Statement

CWS CCG is committed to the active management of risk, recognising that risks need to be considered in terms of both opportunities and threats. The CCG will not accept risks that impact on patient safety in any material way and any risks to safe care will be assessed, monitored and mitigated where possible. The CCG will take a cautious approach to risks that impact upon other aspects of quality, finance and regulatory compliance. The CCG has a greater appetite to pursue innovation and collaboration, including potential reputational risk, taking measured opportunity where progress against strategic objectives is anticipated.

12. Training

Risk Management training is made available to all staff. A full range of mandatory training packages are made available to all relevant staff and is provided via the e-learning system and compliance recorded via the electronic staff record.

13. Consultation and Communication with Stakeholders

The organisation has a duty to keep relevant stakeholders informed and, where appropriate, to consult them on the management of significant risks faced by the organisations. This is particularly important where risks are shared with or may impact upon partner organisations.

14. Ratification Process and Review

This document is approved by the Audit & Assurance Committee. It will be reviewed every 24 months or earlier as required in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of the organisation.

15. Dissemination and Implementation

Following ratification this strategy and policy will be made available to all staff via the intranet. All staff will be notified of its existence through a variety of communication channels and training materials will be reviewed. Managers will be responsible for ensuring that staff are aware of the document. New staff will be alerted to the strategy and policy at induction training.

16. Monitoring, Compliance and Effectiveness

CWS CCG will review its performance in the area of risk management through a specific annual internal audit on the Risk and Assurance Processes carried out by the internal auditors TIAA. This annual audit is reported to the Audit and Assurance Committee and will form the basis of the annual Head of Internal Audit Opinion on the organisation's arrangements for risk management and internal control.

Teams carry out a review of the risks in their areas of responsibility at least monthly to identify any new risks and update existing risks and mitigating actions.

The Accountable Officer will review compliance with, and effectiveness of the risk management and internal control system annually in preparing the Annual Governance Statement.
Any trends resulting from possible policy non-compliance will be raised with staff through management routes.

Relevant committee Terms of Reference will be reviewed annually to maintain accuracy and appropriate focus.

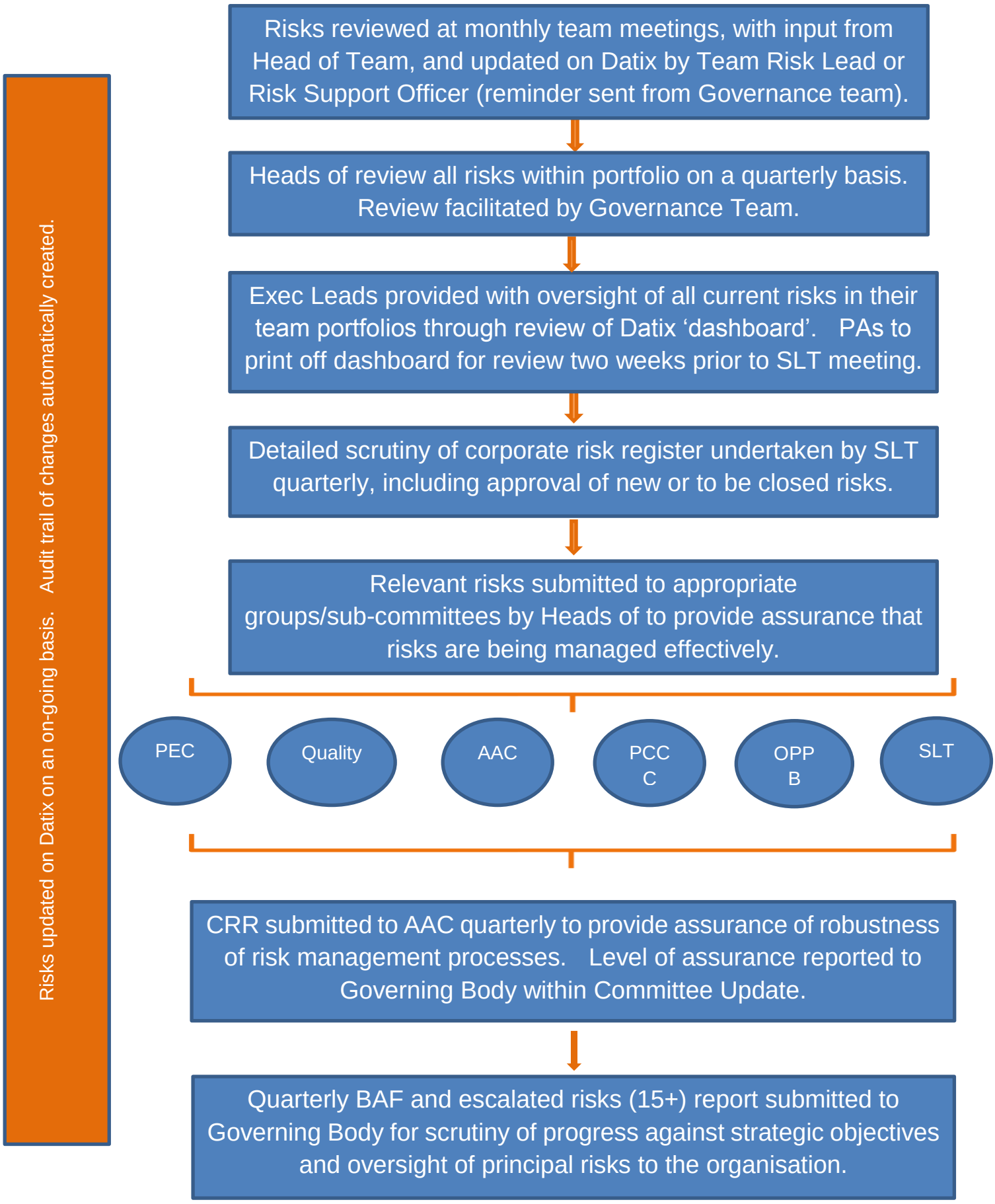
17. References

- NHS Resolution (NHSLA) Risk Management Standards
- Australian/New Zealand Standard ISO 31000:2009 Risk Management – Principles and guidelines
- National Patient Safety Agency Risk Assessment Tool 2004 for assessment of levels of incident investigation
- Integrated Governance Handbook, Department of Health, 2006

18. Bibliography

- The Risk Management Process, Federation of European Risk Management Associations (FERMA), 2005
- A Risk Management Standard, The Association of Insurance and Risk Managers, (AIRMIC), 2002
- International Organisation for Standardisation (ISO) /IEC Guide 73:2009 Risk Management
- Risk and Public Services, The London School of Economics and Political Science 2009
- HMT Orange Book, 2005
- Good Governance Institute Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision making

APPENDIX A – Process for Risk Management and Scrutiny



Appendix B – Model Risk Matrix

Further guidance is available at http://www.nris.npsa.nhs.uk

Instructions for use

a. Define each risk explicitly in terms of the cause or source of the risk, the possible risk event and the adverse impact(s) that might arise.

b. Determine the impact score (I) for the potential adverse outcome(s) using table 1. Choose the most appropriate 'domain' for the identified risk from the left hand side of the table then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the score, which is the number given in the top of the column.

c. Then determine the likelihood score (L) for the risk event using table 2. Calculate the score of the likelihood either by the frequency of occurrence of the adverse outcome or the probability of the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine the most appropriate score.

d. The risk score automatically calculates by multiplying the impact by the likelihood: I (impact) x L (Likelihood) = R (risk score).

e. Use the score and table 3 to identify the level at which the risk will be managed in the organisation. Assign priorities for remedial action. Report the risk to the Corporate Business Team for inclusion in the Corporate Risk Register, if at the appropriate level.

Table 1 – Example descriptors of different impact socres

	Impact (consequence) score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Area	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
1. **Impact on the safety of patients, staff or public**	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
2.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 Multiple complaints/ independent review Low performance rating Critical report Significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Inquest/ombudsman inquiry Gross failure to meet national standards Gross failure of patient safety if findings not acted on

	Impact (consequence) score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Area	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
3. 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
4.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
5.Adverse publicity / reputation. ***Develop the respect and engagement of our membership***	Rumours Potential for public concern	Local media coverage Short-term reduction in public confidence	Local media coverage Long-term reduction in public confidence	National media coverage <3 Days Service well below reasonable public expectation	National media coverage with >3 days service well below reasonable Public expectation. MP concerned (questions in the House). Total loss of public confidence
6.Business objectives/ projects	Insignificant cost increase Schedule slippage	Elements of public expectation not being met. <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 to >25 per cent over project budget

	Impact (consequence) score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Area	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
7.Finance	Small loss Risk of claim remote Loss/interruption of >1 hour Minimal or no impact on the environment	Loss of 0.1–0.25 per cent of budget Claim less than £10,000 Loss/interruption of >8 hours Minor impact on environment	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000 Loss/interruption of >1 day Moderate impact on environment	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 Loss/interruption of >1 week Major impact on environment	Schedule slippage / Failure to meet specification/ slippage. Key objectives not Met / Non-delivery of key objective Loss of >1 per cent of Budget. Payment by results Claim(s) >£1 million Permanent loss of service or facility Catastrophic impact on environment

Table 2 - Likelihood score (L)

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

Table 3 - Risk Scoring = impact x likelihood (I x L)

Impact/ Consequence	**Likelihood**				
	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

Table 4 – 'Team' Risk Action and Reporting/Monitoring Requirements

Score	Risk	Action	Reporting/monitoring requirements
1-6	Low	Tolerate/manage through normal control measures.	Report to **local manager**. Manage and monitor at **team level**.
7-11	Moderate	Consider treat/review control measures.	Report to **local manager.** Managed by **local manager**. Monitored by **local manager**.
12-14	High	Treatment plans to be developed, implemented and monitored.	Enter onto **corporate Risk Register**. Monitored by OPCO monthly and CCE quarterly. Scrutinised by the Audit and Assurance Committee quarterly.
15-25	Extreme	Immediate action required. Treatment plans to be developed, implemented and monitored.	Enter onto **corporate Risk Register**. Monitored by OPCO monthly and CCE quarterly. Scrutinised by the Audit and Assurance Committee quarterly. Monitored by the Governing Body (Assurance).

APPENDIX C

RISK PROCESS ON DATIX