Risk Management Policy

# Document Control:

|  |  |
| --- | --- |
| Policy Name | Risk Management Policy |
| Policy Number | MSEICB 017 |
| Version | 2.0 |
| Status | Final ICB Policy  |
| Author / Lead | Head of Governance and Risk |
| Responsible Executive Director | The Chief Executive has delegated responsibility to the Chief of Staff for risk management |
| Responsible Committee | Audit Committee |
| Date Ratified by Responsible Committee | 20 June 2022 |
| Date Approved by Board/Effective Date | 20 July 2023 |
| Next Review Date | 1 July 2025 |
| Target Audience | * Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/voluntary/work experience staff).
* Contractors engaged by the ICB.
* Staff from other MSE organisations who are members of ICB Committees/Sub-Committees and other groups.
 |
| Stakeholders engaged in development of Policy (internal and external)  | * Mid and South Essex CCG Governance Leads.
* MSE CCGs Audit Committees meeting in common.
* MSE ICB Audit Committee
 |
| Impact Assessments Undertaken  | * Equality and Health Inequalities Impact Assessment
 |

# Version History

| Version | Date | Author (Name and Title) | Summary of amendments made |
| --- | --- | --- | --- |
| 0.1 | 09/02/22 | Sara O’Connor, Head of Corporate Governance, MECCG | First draft of ICB Risk Management Policy |
| 0.2 | 22/02/22 | Viv Barnes, Director of Governance and Performance | Minor amendments made following review of first draft.  |
| 0.3 | 25/02/22 | David Triggs, Head of Corporate Governance, B&B CCG | Minor amendments |
| 0.4 | 04/03/22 | Sara O’Connor | Updated following comments received from Audit Committee members, 4 March 2022.  |
| 0.5  | June 2022 | Mike Thompson  | Review of policy with Chair of ICB.  |
| 1.0 | July 2022 | Sara O’Connor / Viv Barnes | Policy Reference number added to final draft and final formatting reviewed prior to uploading. |
| 2.0 | July 2023 | Sara O’Connor, Head of Governance and Risk | Amended to reflect new ICB Board Assurance Framework, mandatory risk management training for staff Band 8a and above, changes to job titles and other minor amendments.  |

# Contents

[1. Introduction 5](#_Toc137653181)

[2. Purpose 5](#_Toc137653182)

[3. Scope 6](#_Toc137653183)

[4. Definitions 7](#_Toc137653184)

[5. Roles and Responsibilities 9](#_Toc137653185)

[5.1. Chief Executive 9](#_Toc137653186)

[5.2. ICB Board 10](#_Toc137653187)

[5.3. Audit Committee 10](#_Toc137653188)

[5.4. Other ICB Committees, Sub-Committees and Groups 11](#_Toc137653189)

[5.5. Deputy Director of Governance and Risk 11](#_Toc137653190)

[5.6. Executive Director of Resources 11](#_Toc137653191)

[5.7. Executive Chief Nurse 12](#_Toc137653192)

[5.8. NHS Alliance Directors, Executive Directors and other Managers 12](#_Toc137653193)

[5.9. Policy Author 12](#_Toc137653194)

[5.10. Head of Governance and Risk 12](#_Toc137653195)

[5.11. All Members of ICB Staff 13](#_Toc137653196)

[5.12. Partnership Working 13](#_Toc137653197)

[6. Policy Detail 14](#_Toc137653198)

[6.1. Overview of Risk Management Process 14](#_Toc137653199)

[6.2. Description of Risks 17](#_Toc137653200)

[6.3. Controls and Assurances 17](#_Toc137653201)

[6.4. Risk Appetite 18](#_Toc137653202)

[7. Monitoring Compliance 18](#_Toc137653203)

[8. Staff Training 19](#_Toc137653204)

[9. Arrangements For Review 19](#_Toc137653205)

[10. Associated Policies, Guidance and Documents 19](#_Toc137653206)

[10.1. Associated Documents 19](#_Toc137653207)

[10.2. Associated Policies 20](#_Toc137653208)

[11. References and Sources of Further Information 20](#_Toc137653209)

[12. Equality Impact Assessment 20](#_Toc137653210)

[Appendix A - Equality Impact Assessment 21](#_Toc137653211)

[Appendix B – Strategic Objectives 23](#_Toc137653212)

[Appendix C – Impact Assessment Table 24](#_Toc137653213)

[Appendix D – Likelihood Assessment Table 26](#_Toc137653214)

[Appendix E – Risk Rating Matrix 27](#_Toc137653215)

[Appendix F – Example Risk Appetite 28](#_Toc137653216)

## Introduction

The Mid and South Essex (MSE) Integrated Care Board (‘the ICB’) works collaboratively across the Mid and South Essex Health and Care System (‘the ICS’) footprint to manage risks that have the potential to affect the achievement of its objectives. This policy sets out how the ICB will identify and manage risk.

The ICB acknowledges that risks will arise during the commissioning of health services and tackling health inequalities in an innovative and effective way, but that taking risks can bring benefits and opportunities when managed appropriately. The ICB does not aim to create a risk-free environment, but rather one in which risk is appropriately identified and routinely managed via embedded structures and processes, to enable it and partner organisations to provide safe, high quality, and value for money services for the MSE population.

The ICB recognises the importance of involving and working with local partners and other stakeholders to identify, prioritise and manage shared risks. Consequently, a close working relationship will be forged with partners and stakeholders to establish a process to manage system wide risks as the ICS and ICP evolve.

## Purpose

This policy sets out the overarching framework and process for the management of ICB risks by the Board, members of staff and persons engaged in business on behalf of the ICB.

The aim of the policy is to establish and maintain a framework for risk management which:

* Supports the ICB in achieving its strategic objectives and realising the significant safety, quality, financial and other organisational benefits from effectively managing risk.
* Ensures processes are based on best practice, national guidance and take account of organisational needs.
* Promotes an integrated risk management approach across all areas of corporate and clinical/professional risk which is embedded within day-to-day operational functions across MSE.
* Assists the ICB Board in agreeing the Governance Statement which forms part of the Annual Report and Accounts.
* Ensures that risks are managed systematically and consistently to avoid the ICB, and members of the wider ICS being exposed to extreme levels of risk threatening the way in which they operate.

Resources available for managing risk are finite. The ICB will aim to achieve a prioritised and effective response to risk, whilst striking a balance between cost and benefit. The ICB will therefore take action to manage risk to a level which the ICB can justify as being tolerable. This will be achieved by the Board agreeing and reviewing the ICB’s ‘risk appetite’ on an annual basis as detailed in Section 6.4.

A risk management framework operated in isolation is ineffective unless it supports continual learning. The ICB will implement processes to ensure risks are adequately identified, analysed, prioritised, mitigated and reported/communicated at all levels of the organisation, including the ICB’s main committees and the Board. Regular reporting will enable the ICB to monitor changes in its risk profile and provide assurance that controls are effective (or not) and will enable learning to be shared.

The way in which those accountable for risk management should engage with the risk management process is depicted in the diagram below, adapted from HM Treasury: The Orange Book. Management of Risk – Principles and Concepts (2020) – referred to hereafter as ‘The Orange Book’.



## Scope

This policy applies to the following (collectively known as members of staff):

* + - Mid and South Essex (MSE) Integrated Care Board (ICB) members
		- Members of staff (including temporary/bank/agency/voluntary/work experience staff).
		- Contractors engaged by the ICB.
		- Members of staff from other MSE partner organisations who are members of ICB Committees/Sub-Committees, advisory groups/other groups or otherwise involved in ICB business.
	1. The policy applies to all areas of the ICB’s responsibilities and activities and all ICB premises and other assets.

## Definitions

* **Strategic Objectives –** the main objectives (aims) agreed by the ICB as set out in the MSE Health and Care Partnership Strategy, against which all risks are mapped. The ICB will also set other objectives, including those set out within ICP and Alliance Plans. The ICB’s current strategic objectives are set out in **Appendix B** and will be reviewed annually.
* **Hazard** - any source (incident/event/circumstances) of potential damage, harm or adverse effect on someone, something, the organisation or the environment.
* **Risk** – the potential of a situation or event to impact on the achievement of specific objectives. Risks can arise in many ways and include clinical, non-clinical, financial, environmental, workforce, equality and diversity and reputational risks. In the Orange Book, risk is defined as the “uncertainty of outcome, whether positive opportunity or negative threat, of actions and events”.
* Risk is characterised by two factors, being a combination of the
	+ **consequences/impact** of a hazard and the
	+ **likelihood** of occurrence.
* **Risk Rating** - the level of risk at a particular point in time (i.e. initial, current or target risk rating) expressed by calculating the risk rating score by using the impact and likelihood assessment tables at **Appendices C and D** and the risk rating matrix at **Appendix E**. Depending on the score, risks will be categorised as Red, Amber, or Green (often referred to as the ‘RAG’ rating).
* **Inherent Risk** - the level of exposure arising from a specific risk before any action has been taken to manage it. This is often referred to as the ‘initial risk rating’
* **Residual Risk** - it is the level of exposure arising from a specific risk after mitigating action has been taken to manage it.
* **Risk Appetite** - also known as the ‘target risk rating’, it is the amount of risk that the organisation is prepared to accept, tolerate, or be exposed to at any one point in time.
* **Strategic Risk** - a risk with the potential to have significant impact upon the achievement of strategic objectives affecting the whole or several areas of the organisation (as opposed to one department). These risks have the highest potential for external impact. Red rated/extreme risks will be recommended by the Responsible Director/Committee to the Board for consideration as strategic risks and inclusion on the BAF.
* **Operational Risks** – a risk that is most likely to impact on an organisation’s ability to undertake its day-to-day internal functions in a safe and efficient manner. These risks tend to affect one department or a specific area of business. Operational risks will be escalated to the Board for consideration as a strategic risk (and inclusion on the BAF) if they are risk rated ‘red/extreme’.
* **Project Risks** – a risk associated with a specific project that is not likely to have an impact beyond the remit/lifetime of that project. Risks or issues identified during the project will be rated having regard to the context of each project. Consequently, highly rated project risks might not need to be included on the corporate risk register or BAF. However, project managers should ensure that any significant risks that might compromise the success of the project are escalated to the Director with responsibility for the project so they can consider including the risk on the corporate register or BAF, taking advice from the Governance Lead in this regard.
* **Risk Management** - a proactive and integral approach to the management of those risks that might affect the achievement of an organisation’s objectives.
* **Integrated Risk Management** - the management of risk across the organisation at varying levels via a range of processes. In addition to the maintenance of the risk register and BAF, this includes undertaking specific risk assessments, performance reporting and the management of incidents, complaints, and claims. Taking an integrated risk management approach enables the triangulation of data/findings and the sharing of learning.
* **Risk Profile** - the documented overall assessment of the range/type, number and rating of risks faced by the organisation.
* **Risk Materialisation** – the time at which a hazard or adverse circumstances thought possible occur.
* **Controls** - measures implemented to reduce risk and prevent harm. These include systems and structures, processes, policies, guidelines, professional practice, and training.
* **Assurances** – evidence relied upon by the organisation to provide it with a level of assurance that its controls are effective (positive assurance) or ineffective (negative assurance). Sources of assurance can be internal or external, with the latter considered to provide a higher level of assurance. Types of assurance include internal/external audits, inspections by regulatory and professional bodies (e.g., Care Quality Commission inspections), monitoring reports to Board/committees, testing of financial, IT and other systems, and assessment of the ICB’s systems and processes against specific standards.
* **Board Assurance Framework (BAF)** – the key document used to record and report to the Board significant risks (strategic risks) to achieving its strategic objectives, listing controls/action being taken and sources of assurance. It is used to support the Governance Statement that the Chief Executive is required to sign-off at the end of each financial year.
* **Risk Register** - a document detailing all risks identified by the organisation, similar in format to the BAF. The ICB will maintain a central repository/database of all risks to enable risk registers to be produced for departmental/committee and other meetings.
* **Responsible Executive Director** - the Executive Director with overall responsibility for managing risks within their remit. These individuals will be identified on the risk register and BAF.
* **Risk Lead** – the operational lead (i.e., a senior manager or workstream lead) who has been delegated responsibility for managing specific risks. These individuals will be identified on the risk register and BAF and are responsible for ensuring action is taken to mitigate risks and for providing updates on their status for inclusion on the risk register and BAF.

## Roles and Responsibilities

### Chief Executive

* + 1. The Chief Executive of the ICB has overall accountability for effective risk management within the ICB in line with legislation and guidance issued by NHS England and Improvement (NHSE/I).
		2. The Chief Executive will report annually to the ICB Board on the adequacy of internal control and risk management within the Governance Statement that forms part of the Annual Report and Accounts.

### ICB Board

* + 1. The Board is accountable and responsible for ensuring that the ICB has an effective programme for managing risks that might compromise the achievement of its objectives. The Board will seek regular assurance via the Board Assurance Framework (BAF), from its committees, partner organisations and other sources regarding the effectiveness of controls and will ensure further mitigating action is taken where necessary.
		2. The Board will decide which risks will be categorised as strategic risks for inclusion on the BAF. Recommendations for strategic risks will usually be made by the Chief Executive Officer in conjunction with the relevant Responsible Executive Director(s) and ICB Chair or by the relevant ICB Committee. The Board has authority to:
* Accept operational risks which have been rated red/extreme as strategic risks. If Board members are of the opinion that a red/extreme rating is not justified at the current time, the risk will be re-rated appropriately and remain an operational risk.
* Accept lower rated risks as strategic risks if circumstances merit regular Board level oversight, for example, where a lower-rated risk has the potential to significantly impact on interdependent strategic risks.
* Close existing strategic risks or de-escalate them to operational level.
* Agree that risks not yet included on the ICB’s risk registers or BAF are added.
* Prioritise action required to mitigate risk.
	+ 1. The BAF will be updated bi-monthly and presented to each publicly held Part I ICB Board meeting.
		2. Strategic risks on the BAF will be cross-referenced against relevant risks on the operational risk register.
		3. The BAF will include a summary of the ICB’s main providers’ top rated (red) risks.

### Audit Committee

* + 1. The Audit Committee has responsibility for monitoring the ICB’s compliance with this policy and is the ‘sponsoring committee’ referred to in Section 9 below.
		2. The Audit Committee will seek assurance that risks are being appropriately and robustly managed via receipt of a report on the BAF, the minutes of other ICB committee meetings and other reports on specific issues requested by the committee.
		3. The Audit Committee will review the outcome of the annual internal audit of governance and risk management arrangements which, along with other assurances received, will enable the committee to recommend the Governance Statement is signed-off by the Chief Executive at the end of each financial year.
		4. The Audit Committee also has responsibility for reviewing and monitoring any specific risks within its remit and for providing regular assurance to the ICB Board, including escalation of significant risks where necessary.

### Other ICB Committees, Sub-Committees and Groups

* + 1. Other ICB committees, sub-committees or groups have responsibility for reviewing and monitoring specific risks within their remit and for providing regular assurance to the ICB Board (or in the case of sub-committees, to the relevant committee) and escalation of significant risks where necessary.
		2. ICB Committees will recommend red rated risks within their remit are categorised as strategic risks for inclusion on the BAF.
		3. ICB Committees will also recommend removal of strategic risks from the BAF, or their closure, as appropriate.

### Chief of Staff

* + 1. The Chief Executive, supported by the Deputy Director of Governance and Risk has delegated overarching responsibility for risk management to the Chief of Staff, with each Executive Director being responsible for risks aligned to their functions.

### Executive Director of Resources

* + 1. The Director of Resources has delegated responsibility for financial risk management and will ensure:
		- The effectiveness of the ICB’s financial control systems.
		- Significant financial risks faced by the ICB are identified and managed effectively.
		- Audit Committee and Internal Audit effectively perform their roles in assuring the ICB’s system of internal control.
		- Robust counter fraud arrangements are in place and comply with NHS standards in relation to counter fraud.
		1. The Executive Director of Resources also acts as the ICB Senior Information Risk Owner.

### Executive Chief Nurse

* + 1. The Executive Chief Nurse has lead responsibility for the safety and quality of services and is accountable for safeguarding children and adults, working in partnership with responsible local authorities and other key agencies to ensure that the ICB’s statutory safeguarding duties are met.
		2. The Executive Chief Nurse provides assurance to the Boards regarding patient safety and quality within commissioned services in line with local and national legislation and guidance and will ensure that any associated risks are appropriately captured on the risk register and escalated to the Board and BAF where necessary.
		3. The Executive Chief Nurse also acts as the ICB Caldicott Guardian.

### NHS Alliance Directors, Executive Directors, and other Managers

* + 1. NHS Alliance Directors, Executive Directors and other managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility and that they comply with the requirements of the ICB’s risk management arrangements, including regularly reviewing risks with their staff at directorate/departmental meetings and reporting risks to the appropriate Committee or Board, including making recommendations to add, close or re-categorise risks as appropriate.
		2. They are responsible for ensuring that all members of their staff are aware of risks relevant to their area of work and of their personal responsibilities as set out in section 5.11 of this policy. They must ensure their staff receive appropriate information, instruction, and training to enable them to undertake their roles effectively and safely.
		3. Responsible Executive Directors may delegate the management of some of the operational risk management processes to an appropriate senior manager, who will be named as the ‘Risk Lead’ on the risk register/BAF.

### Policy Author

* + 1. The policy author will have responsibility for developing and updating the policy in line with Section 9.

### Head of Governance and Risk

* + 1. The Head of Governance and Risk, reporting to the Deputy Director of Governance and Risk has responsibility for managing the risk management process, including liaising with risk leads for updates, production of the BAF and risk registers for Board/Committee meetings, and provision of risk management training.

### All Members of ICB Staff

* + 1. All members of staff are individually responsible for:
		- Familiarising themselves with the content of this policy and associated procedures and following these.
		- Identifying, assessing, and putting systems in place to mitigate any risks to the achievement of the ICB’s strategic objectives and those within their remit, to ensure risks are managed and escalated where appropriate through the risk register and associated processes.
		- Reporting incidents/accidents and near misses using the ICB incident reporting procedure.
		- Being aware of their duty under legislation to maintain safe working practices and to take reasonable care of their own health, safety, and welfare and that of others by complying with all relevant ICB policies, procedures and guidance.
		- Being aware of any emergency procedures relevant to their role and place of work, e.g., security/lockdown and fire safety procedures.
		- Completing their mandatory training and attending risk management training and development events relevant to their role.

### Partnership Working

* + 1. The interface between organisations is often where significant risks arise due to a lack of clarity regarding responsibility and accountability. The ICB will work closely and collaboratively with its partner organisations to reduce the possibility of this occurring by strengthening and integrating risk management arrangements as the ICS and ICP develop.
		2. The ICB will endeavour to involve partners in all aspects of risk management as appropriate. Key partners include GP Practices, providers of shared services to the ICB, provider Trusts, independent sector providers, local authorities, the Police, statutory and voluntary bodies and patient representative groups.
		3. The ICB will work with key stakeholders on identified risks, including child protection, discharge arrangements, workforce planning, in accordance with joint structures that exist between agencies. These arrangements include Partnership Boards and oversight groups such as the System Leaders Executive Group (SLEG), System Finance Leaders Group (SFLG) and System Oversight and Assurance Group (SOAG).

## Policy Detail

### Overview of Risk Management Process

* + 1. The ICB has adopted the Australia/New Zealand risk management model, advocated within the Orange Book, which sets out the following stages to manage risk:
		- Establish the context
		- Identification of hazards
		- Analyse risk
		- Prioritise risk
		- Treat risk
		- Monitor and review
		- Communicate and Consult.

The table below summarises this model:



* + 1. **Establishing the context** defines the scope for the risk management process and sets the criteria against which risks will be assessed. The scope should be determined within the context of the ICB’s objectives.
		2. **Identification of Risk** will generate a comprehensive list of risks based on events that might create, enhance, prevent, degrade, accelerate, or delay the achievement of objectives. The ICB will use a wide range of information and horizon scanning to identify risks across the ICS footprint and beyond. To embed risk management a combined ‘top-down’ and ‘bottom-up’ approach will be taken with all staff, workstreams, departments and local Alliances encouraged to report risks that might affect their ability to meet their specific objectives, affect patient care or affect the work life balance of ICB staff. Identified risks will be mapped against workstreams/departments/ Alliances in accordance with the ICB’s organisational structure.
		3. **Analysis of Risks** involves developing an understanding of the risk, including whether it could have multiple (positive or negative) consequences and the impact of these, its interdependence with other risks, and taking a decision on how to treat it. The effectiveness of existing controls should be considered.
		4. **Risk Evaluation** involves the scoring/rating of risks, to determine their initial and current risk rating to assist with prioritisation of risks. Risk ratings must be regularly reviewed. A rationale for any changes made to risk ratings must be provided on the risk register/BAF. The Governance Lead will assist risk leads to adopt a consistent approach to the scoring of risks as part of risk update meetings or related correspondence.
		5. **Prioritisation** of risk treatment implementation will ensure that the most highly rated risks are given precedence and will determine the organisational level to which the risk must be reported. Prioritisation should be in accordance with legal, regulatory, and other organisational requirements and imperatives.
		6. **Treatment of Risks** - Addressing risk can turn uncertainty to the ICB’s benefit by constraining threats and taking advantage of opportunities.

There are four broad categories of how risks are managed:

* **Tolerate:** A decision is taken to accept the risk involved and to not take further action to mitigate. This might be because it is within the ICBs’ risk appetite; the ability to reduce the risk is very limited; or the cost of acting is disproportionate to the potential benefit gained. Any ‘tolerated’ risks must have contingency plans developed for managing the impact/consequences should the risk materialise.
* **Treatment:** Most risks are addressed this way by introducing new or strengthening existing controls to reduce the level of risk to an acceptable level.
* **Transfer:** This can be achieved by conventional insurance or by contracting the service to another provider / third party. The relationship with the body to whom the risk is transferred should be managed effectively to successfully transfer the risk. However, in some cases, the risks will not be fully transferrable and consequently the ICB might retain some element of risk such as those relating to its statutory duties or reputational damage.
* **Terminate**: Depending on the type of risk and the ICB’s risk appetite, the only sensible option might be to terminate the risk. For example, by decommissioning a service or terminating specific activity. This is a limited option in the NHS and the impact must therefore be fully considered before a decision is made.
	+ 1. Once the most appropriate way of treating a risk has been agreed, an action plan will be drawn up and implemented.
		2. Each stage of the risk management process should be documented to evidence a systematic approach for audit purposes, to develop the ICB’s knowledge of risk to aid decision-making, and to facilitate monitoring/consultation and communication of risks.
		3. The arrangements for reporting risks, dependent on their current rating, is as follows:
* **Extreme / Red risk (score of 15 or above):**  Immediate action required. The Responsible Executive Director and Risk Lead must take responsibility for development and implementation of an appropriate risk action plan and ensure progress against this is reported to the relevant committee and ICB Board. Risks rated ‘red/extreme’ will be recommended by the Responsible Executive Director/Committee to the ICB Board for inclusion on the BAF where appropriate (see section 5.2.2.), noting that strategic risks on the BAF may cover one or more risk on the risk register.
* **High / Amber risk (score between 8 and 12):**  Within one month an appropriate action plan must be agreed, usually with a deadline for completion within 6 months. To be reported to the relevant committee.
* **Low / Green risk (score between 1 and 6):** Acceptable risk. Periodic monitoring and review to be undertaken at Directorate/Departmental level to ensure that risk has not escalated, and controls remain effective.

### Description of Risks

Risks will be described on risk registers and the BAF in the following format:

“If this happens/As a result of *(description of potential hazard/circumstances)*

There is a risk that *(explanation of what could happen)*

Resulting in *(description of potential consequences)”*

### Controls and Assurances

* + 1. Existing controls and sources of assurance will be mapped against each risk.
		2. The effectiveness of controls will be regularly monitored by managers and via the identified assurance processes. Where gaps in controls are identified, action will be taken to address these considering the ICB’s risk appetite and the cost/benefit of doing so (see paragraph 2.3 above and 6.4 below)
		3. Where a specific risk’s score does not reach its ‘target rating’ and has remained static over three iterations of the BAF or risk register, the relevant Director/manager may be required to attend the relevant Committee/Board meeting to explain the reasons for this and provide assurance regarding action being taken.

### Risk Appetite

* + 1. The ICB’s risk appetite is the amount of risk that the organisation is prepared to accept, tolerate, or be exposed to at any one point in time. Setting the risk appetite assists with the prioritisation of risk.
		2. The ICB Board will express the risk appetite score/rating for relevant categories of risk by using the 5 x 5 matrix used for assessing risk at **Appendix E.**
		3. The risk appetite will be recorded as the ‘target score/rating’ for each risk on the risk register and BAF to enable the ICB Board and committees to monitor when this has been achieved. Once the target score/rating is achieved, a decision will be taken whether it is appropriate to close the risk.
		4. For the purposes of agreeing risk appetite, risks will be categorised as below:
* Finance
* Fraud and Negligent Financial Loss
* Clinical Quality & Patient Safety
* Statutory & Regulatory Compliance
* Reputation
* Partnerships, Engagement and Collaborative Working
* Innovation and Transformation
* Provider Performance
* Commissioning
* National Policy
* Clinical Engagement
* Information Security
	+ 1. The ICB’s agreed risk appetite is set out at **Appendix F.**

## Monitoring Compliance

* + 1. The Governance Lead is responsible for monitoring the ongoing compliance with this policy and ensuring that an appropriate risk management culture is embedded across the ICB.
		2. The Audit Committee is accountable to the Board for ensuring that the risk management process is effective and will ensure that the Annual Internal Audit Plan incorporates yearly assurance to the Board on the robustness of the ICB’s risk management arrangements to support completion of the Governance Statement.

## Staff Training

* + 1. All staff will be made aware of the Risk Management Policy as part of their local induction by their line manager including their role and the forms of support available to them. Line managers will be responsible for ensuring that employees’ ongoing risk management training needs are assessed during induction and reviewed annually via the staff appraisal process.
		2. The Governance Lead will provide ongoing risk management support to relevant staff and will offer one-to-one meetings with all Risk Leads or attendance at team meetings to assist in the review of their risks prior to each Board or Committee meeting.
		3. The Governance Lead will also offer risk awareness training to supplement mandatory risk management training for staff at Band 8a and above via the e-learning portal as required.

## Arrangements For Review

* + 1. This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.
		2. If only minor changes are required, the responsible Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

## Associated Policies, Guidance and Documents

### Associated Documents

* Board Assurance Framework
* Risk Registers
* Risk Management Training Slides
* General Risk Assessment Template

### [Associated Policies](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies)

* Anti-Fraud, Bribery and Corruption Policy
* Health & Safety Policy
* Information Governance Policy
* Management of Conflicts of Interest Policy (including Gifts and Hospitality, Commercial Sponsorship and Outside Employment)
* Raising Concerns Policy
* Standards of Business Conduct Policy

## References and Sources of Further Information

* The Orange Book: Management of Risk – Principles and Concepts; HM Treasury, October 2004.
* Risk Management Assessment Framework: a tool for departments: HM Treasury, July 2009
* NHS England: Risk Management Policy and Process Guide
* National Patient Safety Agency: Risk Assessment Programme Overview
* Department of Finance and Personnel: Policy and Framework for Risk Management
* HM Treasury: Managing Risks with Delivery Partners
* HM Treasury: Thinking about Risk (Managing your risk appetite: A Practitioner’s Guide)
* COSO: Enterprise Risk Management – Integrated Framework
* COSO: ERM Risk Assessment in Practice
* COSO: Enterprise Risk Management – Understanding and Communicating Risk Appetite
* COSO: Internal Control – Integrated Framework.

## Equality Impact Assessment

The EIA has identified a positive impact and is included at **Appendix A**.

## Appendix A - Equality Impact Assessment

**INITIAL INFORMATION**

|  |  |
| --- | --- |
| **Name of policy and version number:** Risk Management Policy**Version:** 1.1 | **Directorate/Service**: Corporate / Chief Executive’s Office  |
| **Assessor’s Name and Job Title:** Sara O’Connor, Head of Governance and Risk MSE ICB.  | **Date:** 18 February 2022 and reviewed 14 June 2023. |

|  |
| --- |
| **OUTCOMES** |
| *Briefly describe the aim of the policy and state the intended outcomes for staff*  |
| The Risk Management Policy will support the organisation and staff to achieve a consistent method for identifying and managing/mitigating risks which threaten to achieve the organisation’s strategic and other objectives.  |
| **EVIDENCE** |
| *What data / information have you used to assess how this policy might impact on protected groups?* |
| The ICB regularly monitors the make-up of its workforce, including protected groups.  |
| *Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?*  |
| The policy has been shared with the CCG Governance Leads and MSE CCG Audit Committee members/attendees, including internal audit.  |

**ANALYSIS OF IMPACT ON EQUALITY**

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

* ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
* ***Negative outcome*** *–**protected group(s) could be disadvantaged or discriminated against*
* ***Neutral outcome*** *–**there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative, or neutral. Consider direct and indirect discrimination, harassment, and victimisation.

| ProtectedGroup | Positiveoutcome | Negativeoutcome | Neutraloutcome | Reason(s) for outcome |
| --- | --- | --- | --- | --- |
| Age | X |  |  | The policy refers to equality and diversity risks (4.3) and makes it clear that all staff are able to raise risks that might affect their work life (6.1.3). |
| Disability(Physical and Mental/Learning) | X |  |  | As above |
| Religion or belief | X |  |  | As above |
| Sex (Gender) | X |  |  | As above |
| Sexual Orientation | X |  |  | As above |
| Transgender / Gender Reassignment | X |  |  | As above |
| Race and ethnicity | X |  |  | As above |
| Pregnancy and maternity (including breastfeeding mothers) | X |  |  | As above |
| Marriage or Civil Partnership | X |  |  | As above |

|  |
| --- |
| **MONITORING OUTCOMES** |
| Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals. |
| *What methods will you use to monitor outcomes on protected groups?* |
| Regular review of the BAF and risk registers, which include risks relating to equality and diversity and workforce and ensuring that appropriate mitigating action is taken to address these risks.  |

|  |
| --- |
| **REVIEW** |
| *How often will you review this policy / service?*  |
| Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice. |
| *If a review process is not in place, what plans do you have to establish one?* |
| N/A |

## Appendix B – Strategic Objectives

1. Reducing Health Inequalities
2. Creating Opportunities
3. Supporting Health and Wellbeing
4. Bringing Care Close to Home
5. Improving and Transforming Our Services

## Appendix C – Impact Assessment Table

| Level | Objectives / Projects | Clinical / Injury | Patient Experience | Complaints / Claims | Service / Business Interruption | Staffing and Competence / HR / OD | Financial / Materiality | Adverse Publicity / Reputation |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1Low | Insignificant cost increase / schedule slippageBarely noticeable reduction in scope or quality. | Minor Injury not requiring first aid. | Unsatisfactory patient experience not directly related to patient care. | Locally resolved complaint. | Loss / interruption > 1 hour. | Short term low staffing level temporarily reduces service quality (<1 day) | < £50k | Rumours |
| 2 Medium | Less than 5% over budget / schedule slippage.Minor reduction in quality / scope. | Minor injury or illness, first aid treatment needed. | Unsatisfactory patient experience partly related to patient care – readily resolvable. | Justified complaint peripheral to clinical care. | Loss / interruption > 8 hours. | On-going low staffing level reduces service quality. | £50k – < £100K | Local media – Short-term.Minor effect on staff morale / service. |
| 3High | 5-10% over budget / schedule slippage.Reduction in quality or scope. | Moderate injury or illness, requiring first aid or medical treatment i.e. fractures.RIDDOR / Agency Reportable. | Mismanagement of patient care. | Below excess claim. Justified complaint involving lack of appropriate care. | Loss / interruption > 1 day. | Late delivery of key objective / service due to lack of staff.Minor error due to poor training.On-going unsafe staffing level. | £100K – < £500K | Local media – Long-term.Significant effect on staff morale / Service. |
| 4Major | 10-25% over budget / schedule slippage.Doesn’t meet secondary objectives. | Major injuries, or long-term incapacity / disability (loss of limb) | Serious mismanagement of patient care. | Claim above excess level. Multiple justified complaints. | Loss / interruption > 1 week. | Uncertain delivery of key objective / service due to lack of staff.Serious error due to poor training. | £500K -< £1m | National Media - < 3 days. |
| 5Critical | >25% over budget / schedule slippage.Doesn’t meet primary objectives. | Death or major permanent incapacity. | Totally unsatisfactory patient outcome or experience. | Multiple claims or singe major claim. | Permanent loss of service or facility. | Non delivery of key objective / service due to lack of staff.Loss of key staff.Critical error due to insufficient training. | >£1m | National media - > 3 days.MP Concern (questions in House) |

## Appendix D – Likelihood Assessment Table

## Appendix E – Risk Rating Matrix

|  |  |  |
| --- | --- | --- |
|  |  | **Severity of Impact** |
|  |  | **Negligible****(1)** | **Minor****(2)** | **Moderate****(3)** | **Major****(4)** | **Critical****(5)** |
| **Likelihood of Occurrence** | **Rare****(1)** | **1** | **2** | **3** | **4** | **5** |
| **Unlikely****(2)** | **2** | **4** | **6** | **8** | **10** |
| **Possible****(3)** | **3** | **6** | **9** | **12** | **15** |
| **Likely****(4)** | **4** | **8** | **12** | **16** | **20** |
| **Almost certain****(5)** | **5** | **10** | **15** | **20** | **25** |

## Appendix F –Risk Appetite

| **Risk Category** | **Appetite** | **Acceptable Risk Score** | **Rationale** |
| --- | --- | --- | --- |
| Finance | Moderate | 10 | The ICB will seek to reduce risk levels to moderate and will seek to avoid risks above this level. However, this should not underestimate the challenges that the ICB will have in maintaining expenditure within allocated resources limits.  |
| Fraud and negligent financial loss | Low | 5 | The ICB will not tolerate financial losses from fraud and negligent conduct as this represents corporate failure to safeguard public resources. |
| Clinical Quality and Patient Safety | Low | 5 | The ICB holds patient and staff safety in the highest regard and will not accept any risks that threaten this.The ICB will commission high quality services for our patients. We will only rarely accept risks which threaten that goal. |
| Statutory and Regulatory Compliance | Low | 5 | The ICB will comply with all applicable legislation and will not accept any risk which (if realised) would result in non-compliance. |
| Reputation | Moderate | 10 | The ICB will maintain high standards of conduct and will not accept risks as a result of circumstances that may cause reputational harm, such as a loss of loyalty, respect or commitment from stakeholders, and/or undermine public confidence.  |
| Partnerships, Engagement and Collaborative Working | High | 12 | The ICB will work with practices and other organisations (including but not restricted to other CCGs and Local Authorities) to ensure the best outcome for patients and communities. The ICB is willing to accept the risks associated with a collaborative approach. |
| Innovation and Transformation | High | 12 | The ICB encourages a culture of innovation and are willing to accept risks associated with this approach where they do not threaten risk areas that the ICB is not prepared to accept (as defined above e.g. quality patient care / safety). |
| Provider Performance | Moderate | 8 | The ICB accepts that Provider performance is challenged and there are underlying workforce deficits which mean that changes of performance can take some time to realise. |
| Commissioning | Moderate | 8 | Innovative approaches for commissioning incorporate an inherently high level of risk, which can impact on the delivery of outcomes. |
| National Policy | Low | 5 | The ICB will follow national policy. |
| Clinical Engagement | Low | 5 | The ICBs place importance on the positive effects of clinical engagement and will endeavour to manage issues that risk this. |
| Information Security | Low | 5 | The ICB has low appetite for the loss or breach of its business and customer data in pursuit of its objectives. The security of physical and digital information assets will be protected as per the requirements of the Data Security Toolkit via information governance and information technology policies and procedures and regular testing of these, to ensure that the necessary data flows between partner organisations are maintained effectively and are secure.  |