NHS
North East and North Cumbria

Corporate	ICBP037 Risk Management Strategy

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EQUALITY IMPACT ASSESSMENT

Date	Issues
June 2022	None

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	Governance Manager, NECS	First Issue

Approval

Role	Name	Date
Approver	Executive Committee	July 2022

Contents

1. Introduction

For the purposes of this policy, NHS North East and North Cumbria Integrated Care Board will be referred to as “the ICB”.

The policy sets out the ICB approach to risk and the management of risk in fulfilment of its overall objectives. The principles are consistent with those within the NHS England’s (NHSE) risk management framework and NHSE’s risk management policy issued in 2019. The adoption and embedding within the organisation of an effective risk management framework and processes will ensure that the reputation of the ICB is enhanced and maintained, and its resources are used effectively to ensure business success, continuing financial strength and continuous quality improvement in its operating model.

As part of this policy, it is also acknowledged that not all risks can be eliminated. Ultimately it is for the organisation to decide which risks it is prepared to accept based on the knowledge that an effective risk assessment has been carried out and the risk has been reduced to an acceptable level as a consequence of effective controls.

At its simplest, risk management is good management practice and risk assessment provides an effective management technique for managing the organisation (through the identification of risks and the development of mitigating action). Through this policy the ICB is keen to ensure that risk management is not seen as an end in itself, but rather a part of an overall management approach that supports the organisation in developing achievable management action.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

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

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

The policy aims to:

- Ensure that risks to the achievement of the ICB’s objectives are understood and effectively managed
- Ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed

- Assure the public, patients, staff and partner organisations that the ICB is committed to managing risk appropriately

- Protect the services, staff, reputation and finances of the ICB through the process of early identification of risk, risk assessment, risk control and elimination.

This policy applies to all employees and contractors of the ICB.

Managers at every level have an objective to ensure that risk management is a fundamental part of the approach to integrated governance. All staff at every level of the organisation is required to recognise that risk management is their personal responsibility.

NHS providers and independent contractors are responsible for ensuring compliance with relevant legislation and best practice guidelines and for the development and management of their own procedural documents.

Independent contractors are also required to demonstrate compliance with risk management processes which are compatible with this policy.

2. Definitions of risk

The policy is based on the following definitions:

- **Risk** is the chance that something will happen that will have an impact on the achievement of the ICB objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring)

- **Risk appetite** is the organisation's unique attitude towards risk taking that in turn dictates the amount of risk that it considers acceptable

- **Risk management** is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk

- **Risk assessment** is the process used to evaluate the risk and to determine whether precautions are adequate or more should be done. The risk is compared against predetermined acceptable levels of risk

- **Risk response** is the process of doing everything possible to reduce the likelihood and/or impact of a risk towards zero. This process involves minimising the likelihood, eliminate completely, transferring the risk or partially treating the risk by mitigating actions to reduce the harm should it materialise

- **Residual risk** is the risk remining after the risk response has been applied

- **Target risk** is an indication of whether following existing or planned mitigating actions will result in the risk falling within acceptable levels for the organisation or

if there is a desire to reduce the risk further and that additional work will likely be required beyond that already in place or planned.

2.1 Examples of risk

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

- **Corporate risks** – operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues.

- **Clinical risks** – associated with our commissioning responsibilities and including service standards, competencies, complications, equipment, medicines, staffing, patient information.

- **Reputational risks** – associated with quality of services, communication with public and staff, patient experience.

- **Financial** – associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the QIPP programme.

- **Environmental including health and safety** – ensuring the well-being of staff and visitors whilst using our premises.

3. Approaches to risk management: principles, aims and objectives

The policy sets out the ICB's approach to the way in which, in general terms, risks are managed. This will be achieved by having a thorough process of risk assessment in place. It will provide a useful tool for the systematic and effective management of risk and will inform and guide staff as to the way in which all significant risks are to be controlled.

The policy will:

- Ensure that risks to the achievement of ICB's objectives are understood and effectively managed

- Maintain a risk management framework to assure the ICB that strategic and operational risks are being effectively managed

- Ensure that risk management is a cohesive element of the internal control systems within the ICB's corporate governance framework

- Ensure that risk management is an integral part of the ICB culture and its operating systems

- Ensure that the ICB meets its statutory obligations including those relating to health and safety and data protection

- Assure all stakeholders, staff, and partner organisations that the ICB is committed to managing risk appropriately.

To achieve this, the ICB is committed to ensuring that:

- Risk management is embedded as an integral part of the management approach to the achievement of objectives

- The management of risk is seen as a collective and individual responsibility, managed through the agreed committee and management structures

- Patient feedback, complaints and staff feedback are used as an integral part of the approach to risk management

- Risk management support, training and development will be provided by the Commissioning Support Unit Governance Team.

4. Risk management framework

This policy sets out the ICB's risk management framework for how risk management will be implemented throughout the organisation to support the realisation of the strategic objectives. This includes the processes and procedures adopted by the ICB to identify, assess and appropriately manage risks and detailed roles and responsibilities for risk management.

4.1 Risk assessment

Whenever risks to the achievement of ICB's objectives have been identified, it is important to assess the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk assessment matrix is used, details of which are provided in appendix 2 of this policy.

This risk matrix is based on current national guidance which has been adapted to suit the ICB's agreed risk appetite. Using this standardised tool will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

Risks are assessed in terms of the likelihood of occurrence/re-occurrence and the consequences of impact. An initial risk rating is applied to the risk based on current controls. An action plan should be developed based on any gaps identified in putting control measures in place.

The risk action plan will identify further mitigating action to ensure adequate controls are in place. Risks are reassessed to take account of the effectiveness of the controls i.e. whether they are considered to be satisfactory, have some weaknesses or to be weak. Reassessment will determine a residual risk rating.

4.2 Categories of risk**:**

- Very high – the consequence of these risks could seriously impact upon the achievement of the organisations' objectives, its financial stability and its reputation. Examples include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability

- High – these are significant risks that require prompt action. With a concerted effort and a challenging action plan, the risks could be reduced within a realistic timescale

- Moderate – these risks can be reduced within a realistic timescale through reasonably practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements

- Low – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department

- Negligible (very low) – these risks cause minimal or limited harm or concern.

Once the category of risk has been identified, this will be entered onto the ICB's risk register. Please refer to 'section 7' below for further guidance on risk registers.

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

4.3 Degrees of control

The ICB can exert different levels of control or influence over risks depending on their source and type. Some risks can be largely mitigated or eliminated, however not all types of risk can be adequately or effectively dealt with in this manner. The risk management process will therefore be tailored to different risks depending on the perceived level of control and to some degree the risk appetite (how much more control to exert).

The ICB predominantly focuses on risks that are fully or partially within its sphere of control or influence (financial, operational, regulatory, compliance and strategic risks). However, there may be occasion where the source of a risk event threatening objectives is external. The ICB cannot prevent such external events from occurring and therefore management efforts will focus on the identification and mitigation of their impact, for example by putting contingency plans in place where significant external risks are identified.

The categories of control are as follows:

Risk category	Description
Category A: Full control	Preventable internal risks that can be controlled by the ICB (e.g. Health and Safety or payment processing)
Category B: Partial control	Strategic risks taken on by the organisation to achieve its corporate objectives. These risks may be partially within the control of the ICB (e.g. the risk associated with transformational change, or from investment in new sector improvement initiatives).
Category C: Limited or no control	External risk events and/or system-wide risks largely beyond the sole control or influence of the ICB. Examples may be the increasing risk of political uncertainty (i.e. EU Exit), a terrorist event or natural disaster; or from risk interdependencies across the wider health and social care system.

4.4 Fraud, bribery and corruption risks

The ICB recognises the risk that fraud, bribery and corruption pose to its resources. This risk is included in the corporate (strategic) risk register with an appropriate internal risk owner identified. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by the ICB's counter fraud provider and as agreed in the counter fraud workplan and using a fraud risk planning tool. Regular meetings will be held between key ICB staff and the counter fraud specialist to review existing and emerging risks. Regular reports will be provided to the Audit Committee or equivalent to ensure effective executive and non-executive level monitoring of fraud, bribery and corruption risks.

4.5 Risk management process as a commissioner

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

4.6 Partnership working

The ICB may establish partnership working relationships with other agencies, including but not limited to other NHS organisations, local authorities, the voluntary sector, patient representatives and other ICBs.

In some cases, these arrangements will be intended to manage and reduce risk across the wider health and social care economy, for example arrangements around safeguarding. However, in other cases the existence of joint working

arrangements may pose challenges that need to be managed to ensure that objectives can be delivered.

Where such partnership arrangements exist, the ICB will ensure that they work closely and collaboratively with partners to ensure that risk management is fully integrated into joint working arrangements and to identify any risks that need to be captured and reported within the ICB's internal processes.

5. Risk appetite

The ICB aims to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However, there is the recognition that understanding the organisation's 'risk appetite' will ensure the ICB supports a varied and diverse approach to commissioning.

Risk appetite is the amount of risk that the organisation is prepared to accept, tolerate, or be exposed to at any point in time. It can be influenced by personal experience, political factors, and external events. Risks need to be considered in terms of both opportunities and threats and the consequent impact on the capability of the ICB, its performance, and its reputation.

6. Risk tolerance

Risk tolerance is the threshold level of risk exposure which, when exceeded, will trigger an escalation to bring the situation to the attention of a senior manager.

Any risks with a residual score of 12 or above (i.e. high or very high risk) should be escalated to the responsible ICB Executive Lead and immediately added to the ICB corporate risk register in order for the Audit Committee or equivalent to review and monitor the risk.

Moderate risks with a score between 8 and 10 will be managed and monitored at a directorate or place-based level.

Low risks with a score of 6 or lower will be managed and monitored at team level.

Any risks of concern even if not scoring as a high risk can be highlighted to the Audit Committee or for escalation to the ICB.

7. Risk register

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

The register contains a record of current and potential risks to the achievement of the corporate objectives as identified. The register is updated and reviewed on a quarterly basis at a minimum as requested by the ICB.

7.1 Corporate risk register

The ICB maintains a corporate risk register, which is a management tool to provide it with an overview of all significant 'live' risks facing the organisation and the action being taken to reduce them. The corporate risk register is underpinned by place-based risk registers, used to monitor and manage risks at a place-based level within the organisation.

The risks included within the corporate risk register are varied and cover the entirety of the ICB's activities, from health and safety risks to risks around the delivery of services and achieving financial balance. The corporate risk register is therefore populated from a number of different sources, including:

- Principal risks identified in the assurance framework in relation to corporate objectives where action needs to be taken to close an identified gap in control measures
- Risks identified by the ICB and via committee risk registers as being high or very high and requiring escalation to the Audit Committee
- Risks that have been identified at a place-based level that require escalation to the ICB
- Any risks arising out of the annual operating framework and the development of related action plans
- Risks identified through evaluation of incident and complaints reporting
- Risks identified through the evaluation of national incident reports.

The corporate risk register is a live document, maintained on an on-going basis by the governance lead and regular reports are provided to the ICB and relevant committees. The risk register is reviewed by the Audit Committee at least quarterly, or more frequently as required, with issues escalated to the governing body as appropriate.

Each place is responsible for maintaining its own place-based risk registers, ensuring monthly updating and reports to relevant committee as outlined in the ICB constitution. Each place-based risk register underpins the corporate risk register and records all relevant risks facing each place, along with supporting action plans to mitigate these as far as possible.

Risks within the place-based risk registers that have been assessed as being high or extreme and meet the criteria for escalation will be escalated to the corporate risk register and included for review as part of this are cascaded to the Audit Committee monthly (or more frequently if it is required) for consideration around inclusion within the corporate risk register.

8. Risk Materialisation

If a risk materialises whilst being managed through the risk register, it should be recorded as an incident as per the agreed ICB process. Management of risks and incidents is interdependent since risks can be identified through the monitoring of incident themes and trends. If a particular type of incident continues to occur, this is an indication that there is a risk that requires management through the risk register.

If a risk materialises whilst being managed through the risk register, it should be considered whether it needs removing from the risk register. Reasons for occurrence should be analysed and evidence established as to whether a trend of similar incidents exists, that need to be managed through the risk register. If the risk is certain to materialise again or has the potential to re-occur, the risk should remain open on the risk register for on-going management in order to ensure that underlying causes are addressed. If there is no chance it could happen again, the risk should be closed with an explanation that the incident management process is being followed in order to invoke actions to deal with consequences.

The risk that has materialised should be recorded as an incident as per the ICB's incident reporting and management policy.

9. Assurance framework

All government departments, including NHS organisations, are required to provide an annual assurance statement that they have robust systems in place across their organisation to manage risk. This assurance forms part of the organisation's statutory accounts and annual report.

In order to produce an annual assurance statement as part of the annual report, the Board must be able to demonstrate that they have been kept properly informed about the risks facing the organisation and has received assurances that these risks are being managed in practice, including that any gaps in controls intended to manage risks have been identified and action taken to address them. The Board will be able to demonstrate that it has met this requirement through the establishment of a robust and formal assurance framework.

Together with this policy and the risk register, the assurance framework is the key document used by the Board to monitor the position in relation to risk management, providing it with a sound understanding of not only the key risks facing the organisation but also the action being taken to manage and reduce them.

The assurance framework is firmly connected to the organisation's principal objectives as set by the Board, and is a live document, maintained on an on-going basis by the governance lead. The assurance framework is monitored by the Audit Committee and Board on a six monthly basis.

The assurance framework sets out:

- the organisation's principal objectives
- any significant risks that may threaten the achievement of those objectives (detailed in the supporting strategic risk register)
- the key controls intended to manage these risks
- the assurance available to demonstrate that controls are working effectively in practice to manage risks together with the source of that assurance. any areas where there are gaps in controls and/or assurances; and how the organisation plans to take corrective action where gaps have been identified in either controls or the assurances available.

10. Implementation

This policy will be available to all staff to use through the public website for the ICB. It will also be available from the Executive Director of Corporate Governance, Communications and Involvement. All directors and managers are responsible for ensuring that relevant staff within their own directorates and teams have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

11. Training Implications

The Chief Executive (supported by the Executive Director of Corporate Governance, Communications and Involvement) will ensure that the necessary training or education needs and methods needed to implement this policy and supporting procedure(s)are identified and resourced as required. This may include identification of external training providers or development of an internal training process.

Regular training is key to the successful implementation of this policy and embedding a culture of risk management in the organisation. Through a robust training and education programme staff will have the opportunity to develop more detailed knowledge and appreciation of the role of risk management.

Staff are expected to undertake training every two years as a minimum requirement. Training and education in risk management will be offered through regular staff induction programmes and a rolling programme of risk management and training programmes.

12. Documentation

Other related policy documents:

- Incident reporting and management policy

Legislation and statutory requirements:

- NHS England Risk Management Policy 2017
- NHS England Risk Management Framework 2019
- Health & Safety: Policy & Corporate Procedures NHS England 2015
- NHS England Business Continuity Management Framework 2016
- Data Protection Act 2018
- Data Security and Protection toolkit
- General Data Protection Regulation (GDPR) 2016.

Best practice guidance:

- NHS Audit Committee Handbook, 4th edition (2018)
- The Healthy NHS Board: Principles for Good Governance (2013)
- Building the Assurance Framework: A practical guide for NHS Boards March 2003. Gate log Reference1054

13. Monitoring, review and archiving

13.1 Monitoring

The ICB will review the policy in accordance with the specified review date, unless legislation or new guidance to ensure it continues to be compliant with good practice.

Risk management assurance will be reported to the appropriate ICB committee via the governance assurance report. Senior leads will ensure that teams review their risk registers on a quarterly basis (or within individually agreed review times).

The ICB's internal auditors carry out an annual audit of governance and risk management. The effectiveness of the ICB's controls in relation to risk is considered as part of this audit, the outcome of which is reported to Audit Committee. .

13.2 Review

The ICB will ensure that this policy document is reviewed in accordance with the specified review date. No policy will remain operational for a period exceeding two years without a review taking place.

Staff who become aware of any change which may affect the policy should advise the Executive Director of Corporate Governance, Communications and Involvement who will then consider the need to review the policy or procedure outside of the agreed timescale for revision. For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

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

13.3 Archiving

The ICB will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: A guide to the management of health and care records 2021.

Appendix 1: Schedule of Duties and Responsibilities

ICB	The ICB is responsible for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements • ensuring the implementation of an effective risk management framework, supporting risk management systems and internal control • continually promote risk management and demonstrate leadership, involvement and support • ensuring an appropriate committee structure is in place and developing the corporate governance and assurance framework ensuring all directors and senior leads are appointed with managerial responsibility for risk management.
Executive Director of Finance	The Executive Director of finance has a responsibility for: • providing expert professional advice to the ICB on the effective, efficient and economic use of the ICB's allocation to remain within that allocation and identify risks to the delivery of required financial targets and duties • ensuring robust risk management and audit arrangements are in place to make appropriate use of the ICB's financial resources • ensuring appropriate arrangements are in identify risks and mitigating actions to the delivery of QIPP and resource releasing initiatives incorporating risk management as a management technique within the financial performance management arrangements for the organisation.
Executive Director of Corporate Governance, Communications and Involvement	The Executive Director of Corporate Governance, Communications and Involvement is the lead for risk management and has a responsibility for: • ensuring risk management systems are in place throughout the ICB, co-ordinating risk management in accordance with this policy • ensuring the assurance framework is regularly reviewed and updated • ensuring that there is an appropriate external review of the ICB's risk management systems and that these are reported to the governing body • overseeing the management of risks as identified by the quality, safety and risk committee, ensuring risk action plans are put in place, regularly monitored and implemented • incorporating risk management as a management technique within the performance management arrangements for the organisation • ensuring that systems are place for assuring the commissioning of high quality and safe services, and the on-going monitoring of the same ensure incidents, claims and complaints are and managed used the appropriate procedures.
Executive Leadership Team	Members of the Executive Leadership Team will: • Maintain awareness of the main risks facing the organisation • Take ownership where relevant of principal (strategic) risks that pose a threat to the achievement of strategic objectives and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates to the ICB • Take or delegate ownership, where relevant, of risks that pose a threat to the achievement of objectives or the business of the ICB and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates are added to the risk register • Ensure the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective.

Audit Committee	The Audit Committee has overall responsibility for overseeing the implementation of this policy and will: • Review all risks on the corporate risk register and monitor progression of stated action on a quarterly basis. Ensure the established processes to manage risk is in place and provide support for action where necessary • Ensure the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective. Escalate issues to the governing body as appropriate, in particular the identification of new, significant risk or areas of concern of risks graded very high or high to the ICB.
Senior Leads	All senior leads have a responsibility to incorporate risk management within all aspects of their work and are responsible for ensuring the implementation of this policy by: • demonstrating personal involvement and support for the promotion of risk management • ensuring staff under their management are aware of their risk management responsibilities in relation to this framework • setting personal objectives for risk management and monitoring their achievement • ensuring risk are identified, managed and mitigating actions are implemented in functions for which they are accountable • ensuring a risk register is established and maintained that relates to their area of responsibility, ensuring risks are escalated where they are of a strategic in nature.
Risk owners	Responsible for managing individual risks and providing updates on the management of those risks and identifying and carrying out action plans to mitigate risks.
All Staff	Risk management is everybody's responsibility and all staff must be familiar with the main risks in their area of activity
CSU Staff	Whilst working on behalf of the ICB, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the ICB, however they will continue to be governed by all policies and procedures of their employing organisation.
Counter Fraud Specialist	Manages counter fraud activities on behalf of the ICB.

Appendix 2: Risk Assessment

To manage risks effectively, it is crucial to ensure that both the initial (inherent) and residual risk is assessed.

The initial (inherent) risk assessment gives an indication of the impact of the risk should controls fail. The residual risk assessment shows the current level of the risk remaining after mitigating controls are applied.

A standardised approach is taken across the ICB to analyse and measure risk, this is detailed below. Managers must ensure that, for their area, risk assessments are carried out and documented, and that the necessary control measures are implemented in order to reduce risks. The level of detail in the risk assessments and any subsequent action taken should be proportional to the risk.

Step 1: Determine the consequence score

This is offered as guidance when completing a risk assessment, either when an incident has occurred or if the consequence of potential risks is being considered.

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Note consequence will either be negligible, minor, moderate, major or catastrophic.

Table 1: Consequence score

Impact	1. Very Low	2. Low	3. Moderate	4. High	5. Very High
A. Injury	Minor injury not requiring first aid.	Minor injury or illness, first aid treatment needed.	RIDDOR / Agency reportable.	Major injuries or long-term incapacity / disability.	Death or major permanent incapacity.
B. Patient experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience – readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience.
C. Service / business interruption	Loss / interruption>1 hour.	Loss / interruption>8 hours.	Loss / interruption>1 day.	Loss / interruption>1 week.	Prolonged loss of service or facility.
D. Staffing and skill mix	Short term low staffing level temporarily reducing service quality	Ongoing low staffing level reducing service quality.	Late delivery of key objective / service due to lack of staff. Ongoing unsafe staffing	Uncertain delivery of key objective / service due to lack of staff.	Non-delivery of key objective / service due of lack of staff.
E. Financial / asset	Funded/partially funded between £0 and £10k. Unfunded between £0 and £10k	Funded/partially funded between £10k and £50k. Unfunded between £10k and £25k	Funded/partially funded between £50k and £100k. Unfunded between £25k and £50k	Funded/partially funded between £100k and £1m. Unfunded between £50k and £500k	Funded/partially funded over £1m. Unfunded over £500k
F. Inspection / audit	Minor recommendations. Minor noncompliance with standards and/or policies.	Recommendations given. Non-compliance with standards and/or policies.	Reduced rating. Challenging recommendations. Non-compliance with core standards and/or policies.	Enforcement action. Critical report and Low rating. Major noncompliance with core standards and/or policies.	Prosecution. Zero rating Severely critical report.
G. Adverse publicity / reputation	Rumours.	Short term damage with stakeholders Minor effect on staff morale.	Longer term damage with individual stakeholders Significant effect on staff morale.	Widespread stakeholder damage Local media > 3 days	Sustained and widespread stakeholder damage National media > 3 days
H. Data Security and Protection	There is absolute certainty that no adverse effect can arise from the breach	A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be: The cancellation of a procedure but does not involve any additional suffering. Disruption to those who need the data to do their job.	An adverse effect may be: Release of confidential information into the public domain leading to embarrassment. Unavailability of information leading to the cancellation of a procedure that has the potential of prolonging suffering but does not lead to a decline in health. Prevention of someone doing their job such as cancelling a procedure that has the potential of prolonging suffering but does not lead to a decline in health.	Potential pain and suffering / financial loss: Reported suffering and decline in health arising from the breach. Some financial detriment occurred. Loss of bank details leading to loss of funds. Loss of employment.	Death / catastrophic event: A person dies or suffers a catastrophic occurrence.

Step 2: Determine the likelihood score

Now determine what is the likelihood of the impact occurring. The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. The frequency-based score will either be classed as rare, unlikely, possible, likely or almost certain.

Table 2: Likelihood score

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	Only occurs in exceptional circumstances, > 5-year period	Could occur at sometime within 1 to 5 years	Could occur in the next 12 months	Will probably occur in the next 6 months	Expected to occur in the next 3 – 6 months

Step 3: Assigning a risk rating

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

Table 3: Risk rating = consequence x likelihood (C x L)

	Likelihood				
	1	**2**	**3**	**4**	**5**
Consequence	**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 Low	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1 - 6	Low risk
	8 - 10	Moderate risk
	12 - 16	High risk
	20 - 25	Extreme risk

Appendix 3: Equality Impact Assessment Screening

Step 1

As a public body organisation we need to ensure that all our strategies, policies, services and functions, both current and proposed have given proper consideration to equality and diversity, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership, Carers and Health Inequalities).

A screening process can help judge relevance and provides a record of both the process and decisions made.

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Julie Rutherford Role: Senior Governance Officer NECS

Title of the service/project or policy:

Risk Management Policy

Is this a:

☑	Strategy / Policy	☐	Service Review	☐	Project

If other, please specify:

What are the aim(s) and objectives of the service, project or policy:

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

Who will the project/service /policy / decision impact?

Consider the actual and potential impacts:

- [✓] Staff
- [✓] service users/patients
- [✓] other public sector organisations
- [ ] voluntary / community groups / trade unions
- [ ] others, please specify:

Questions	Yes	No
Could there be an existing or potential impact on any of the protected characteristic groups?	Yes	
Has there been or likely to be any staff/patient/public concerns?	Yes	
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	Yes	
Could this piece of work affect the workforce or employment practices?	Yes	
Does the piece of work involve or have an impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations	Yes	

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document.

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Executive Committee	Approver	July 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Equality Impact Assessment

This EIA should be undertaken at the start of development of a new project, proposed service review, policy or process guidance to assess likely impacts and provide further insight to reduce potential barriers/discrimination. The scope/document content should be adjusted as required due to findings of this assessment. This assessment should then be updated throughout the course of development and continuously updated as the piece of work progresses.

Once the project, service review, or policy has been approved and implemented, it should be monitored regularly to ensure the intended outcomes are achieved.

This EIA will help you deliver excellent services that are accessible and meet the needs of staff, patients and service users.

This document is to be completed following the STEP 1 – Initial Screening Assessment

Step 2 Evidence Gathering

Name of person completing EIA:
Title of policy/strategy/guidance: Risk Management Policy
Existing: ☐ New/proposed: ☑ Changed: ☐
What are the intended outcomes of this policy/service/process? **Include outline of objectives and aims.** The purpose of this policy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The Policy sets out an organisation wide approach to managing risk, in a simple, straightforward and clear manner the intentions of the ICB for timely, efficient and cost-effective management of risk at all levels within the organisation. The Policy aims to: • To ensure that risks to the achievement of the ICB's objectives are understood and effectively managed • To ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed • To assure the public, patients, staff and partner organisations that the ICB is committed to managing risk appropriately.
Who will be affected by this policy/strategy /guidance? (please tick) ☐ Consultants ☐ Nurses ☐ Doctors ☑ Staff members ☐ Patients ☐ Public ☐ Other If other please state:

Current Evidence/Information held	Outline what current data/information is held about the users of the service / patients / staff / policy / guidance? Why are the changes being made?
(Census Data, Local Health Profile data, Demographic reports, workforce reports, staff metrics, patient/service users/data, national reports, guidance ,legislation changes, surveys, complaints, consultations/patient/staff feedback, other)	Workforce data

Step 3 Full Equality Impact Assessment

The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. Outline what impact (or potential impact) the new policy/strategy/guidance will have on the following protected groups:
Age *A person belonging to a particular age*
There is no impact on any staff member belonging to a particular age group. Should risk training be required for this policy there are accessible venues across the ICB footprint with good IT facilities for presentations with several screens placed within each room and training can also be delivered remotely over Microsoft Teams.
Disability *A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities*
Positive impact, risks will be reviewed and actions will be put in place to mitigate any further risk. Staff can get assistance to report and manage a risk from the NECS Governance Team if required. The policy will be made available via the ICB's intranet and can be made available in other formats where required, such as Braille, Audio, easy read etc. Should risk training be required for this policy there are accessible venues across the ICB footprint with good IT facilities for presentations with several screens placed within each room and training can also be delivered remotely over Microsoft Teams.
Gender reassignment (including transgender) and Gender Identity *Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.*
Positive impact, staff can get assistance to report and manage a risk from the NECS Governance Team if required. The content of the policy does not include vocabulary that should cause offense.
Marriage and civil partnership *Marriage is defined as a union of a man and a woman or two people of the same sex as partners in a relationship. Civil partners must be treated the same as married couples on a wide range of legal matters*
Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required. The content of this policy does not negatively impact on marriage and civil partnership.
Pregnancy and Maternity *Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.*
Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of this policy does not negatively impact on pregnancy and maternity.

Should risk training be required consideration will be made to those on maternity/paternity leave to ensure they are included when they return to work.

Race

It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of the policy does not include vocabulary that should cause offense.

The policy can be made available in other languages, interpreters can also be made available if applicable.

Religion or Belief

Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of this policy does not negatively impact on religion or belief and does not include vocabulary that should cause offense.

Sex/Gender

A man or a woman.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The policy has no impact on sex/gender and does not discriminate between males and females.

Sexual orientation

Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The policy uses appropriate language and does not negatively impact on sexual orientation.

Carers

A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the CSU Governance Team if required.

Should risk training need to be provided consideration will need to be made to those with carer responsibilities to ensure that consideration is given to part time working as well as caring responsibilities.

Other identified groups relating to Health Inequalities

such as deprived socio-economic groups, rural areas, armed forces, people with substance/alcohol abuse and sex workers.
(Health inequalities have been defined as "Differences in health status or in the distribution of health determinants between different population groups."
Health inequalities can therefore occur across a range of social and demographic indicators, including socio-economic status, occupation, geographical locations.)

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the CSU Governance Team if required.

Step 4 Engagement and Involvement

Have you engaged stakeholders in testing the policy/guidance or process proposals including the impact on protected characteristics?
SIRMS users and ICB Committee Members - via bulletins, communications, training sessions and contact with members of the CSU Governance Team who are always contactable for help and assistance.
If no engagement has taken place, please state why:

Step 5 Methods of Communication

What methods of communication do you plan to use to inform service users/staff about the policy/strategy/guidance?
☑ Verbal – through focus groups and/or meetings ☑ Verbal - Telephone ☐ Written – Letter ☑ Written – Leaflets/guidance booklets ☑ Email ☑ Internet ☑ Other
If other please state: Via SIRMS (Safeguard Incident and Risk Management System)

Step 6 Potential Impacts Identified – Action Plan

Ref no.	Potential/actual Impact identified	Protected Group Impacted	Action(s) required	Expected Outcome	Action Owner	Timescale/ Completion date
NA		All	Risk Management Training to staff and incident managers to promote quality of risk reporting & data.	Positive - increased awareness of process and support on offer.	**WM**	**Ongoing**

Sign off

Completed by:	Wendy Marley Senior Governance Officer
Date:	07 June 2022
Presented to: (appropriate committee)	
Publication date:	