


Risk Management Policy

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Document Control

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1.0	1 April 2026	[Insert reviewer]	Initial version The Board of the ICB adopted the policy as approved.

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1. Introduction

- 1.1 This policy sets out the principles and requirements for Risk Management within the Central East Integrated Care Board. It aims to ensure a consistent and effective approach that supports the organisation's objectives, complies with statutory and regulatory requirements and promotes best practice.

2. Purpose and Scope

- 2.1 The purpose of this policy is to ensure effective risk management within the ICB by harmonises the three legacy approaches into a single, modern framework for the new Central East ICB. It:
- Embeds a consistent, proportionate and risk-based system of governance aligned to ISO 31000:2018 principles (leadership & commitment; integration; design; implementation; evaluation; improvement).
 - Reflects HM Treasury's Orange Book for public sector risk governance (governance & leadership; integration; collaboration & best information; processes; continual improvement; assurance and the risk control framework).
 - Aligns with the UK Corporate Governance Code (2024 revision) – especially Section 4 on audit, risk and internal control and the new Provision 29 on boards' declarations on the effectiveness of material internal controls.
 - Adopts the IIA "Three Lines Model" (2020) to clarify roles, independence and assurance.
 - Integrates best practice already in place across the three predecessor ICBs
- 2.2 This policy seeks to provide a single way of working that supports better decisions, transparency and value for our population while enabling appropriate, well-controlled risk-taking to deliver transformation.
- 2.3 This policy applies to all ICB activities (corporate, clinical commissioning, finance, digital, EPRR, transformation, place-based partnerships and programmes). It also sets expectations for system risk management in line with our ICS governance where risks to shared objectives are owned and managed collaboratively.

3. Definitions

3.1 Risk

An uncertain event or set of circumstances that, if it occurs, may have a positive or negative effect on the achievement of the ICB's objectives. Risks may arise from internal or external factors and may relate to clinical, corporate, financial, strategic, digital, workforce, or system-level issues.

3.2 Risk Event/Description

A concise statement describing what might happen, expressed using the *cause–risk–effect* model (e.g., *IF... THEN... RESULTING IN...*).

3.3 Cause

The underlying factor(s), conditions, or drivers that give rise to the risk. These may be organisational, environmental, procedural, behavioural, or systemic.

3.4 Impact / Effect

The potential consequence(s) if the risk were to materialise, aligned to the ICB's consequence categories (e.g., quality & safety, workforce & culture, finance, digital, commissioning, strategic leadership, etc.).

3.5 Risk Owner

The Executive Director or senior leader accountable for ensuring a risk is effectively managed, with appropriate controls, assurances, and actions in place. They are responsible for determining escalation or de-escalation based on risk level and appetite.

3.6 Risk Lead

The operational lead who supports the Risk Owner by coordinating assessments, drafting updates, collating evidence of controls and assurances, and maintaining the risk entry on relevant registers.

3.7 Controls

Existing measures, systems, behaviours, or processes in place to reduce the likelihood or consequence of a risk. Controls may be preventive, detective, or responsive.

3.8 Assurances

Evidence that controls are operating effectively.

Assurance aligns to the **Three Lines Model**:

- **Line 1:** Management controls and operational oversight
- **Line 2:** Organisational oversight functions (quality, governance, finance, IG, etc.)
- **Line 3:** Independent assurance (internal audit, external audit, regulators)

3.9 Key Risk Indicator (KRI)

A metric that provides an early signal of increasing risk exposure or emerging issues that may require intervention.

3.10 Inherent Risk

The level of risk before considering the impact of any controls or mitigations.

3.11 Current (Residual) Risk

The assessed level of risk *after* existing controls and assurances have been considered.

3.12 Target Risk

The desired level of risk exposure that aligns with the ICB's **risk appetite** and effective implementation of planned actions.

3.13 Risk Appetite

The amount and type of risk that the ICB is willing to accept in different domains to achieve its objectives. Appetite levels range from **None/Averse** to **Seeking/Significant**, and guide decision-making, escalation, and prioritisation.

3.14 Risk Tolerance

The acceptable variation around the ICB's risk appetite over a defined period, recognising operational realities and dynamic change.

3.15 Risk Treatment

The actions taken to modify risk, which may include:

- **Treat** – implement actions to reduce the risk
- **Tolerate** – accept the risk where it is within appetite
- **Transfer** – shift elements of the risk (e.g., through contracts)
- **Terminate** – cease the activity giving rise to the risk

3.16 Board Assurance Framework (BAF)

The register of principal risks that threaten delivery of the ICB's strategic objectives. These risks typically have high significance (e.g., ≥ 15) or are designated by the Board as 'principal' due to their systemwide impact.

3.17 Corporate Risk Register (CRR)

The register that captures crosscutting, organisation wide risks of strategic or significant operational importance that require corporate visibility and oversight.

3.18 Directorate / Programme / Team Risk Registers

Local registers capturing operational risks that are best managed at team, directorate, or project level, with escalation to the CRR/BAF where criteria are met.

3.19 Dynamic Risk Management

An approach that integrates real time intelligence, KRIs, horizon scanning, and ongoing monitoring to anticipate changes in risk exposure and ensure responsive action.

4. Policy Statement

4.1 Central East ICB is committed to:

- Leadership & culture: Risk management is everyone's responsibility; the Board sets tone, appetite and oversight. Managers lead monthly risk reviews; openness, learning and accountability are expected behaviours.
- Integrated and dynamic: Risk thinking is embedded in strategy, planning, business cases, procurement and change. We use dynamic risk management with Key Risk Indicators (KRIs) where appropriate to anticipate change.
- System view: We operate with an ICB Corporate Risk Register (CRR), Board Assurance Framework (SRR/BAF) for shared organisational risks.
- Informed risk-taking: We treat, tolerate, transfer or terminate risk based on cost-benefit and risk appetite per domain. Opportunities are considered alongside threats.
- Assurance & improvement: Assurance follows the Three Lines Model and supports the Annual Governance Statement. Internal/external audit and periodic risk maturity assessments drive improvement.

All staff are expected to adhere to the requirements set out in this policy.

5. Roles and Responsibilities

5.1 The following have specific responsibilities in relation to this policy:

Board: Sets strategic direction; approves the policy, risk appetite and principal risks; receives regular BAF/CRR reports and an annual opinion on risk management effectiveness; issues a Provision 29 declaration on material internal controls (part of the UK Corporate Governance Code (2024)).

Chief Executive (Accountable Officer): Holds overall accountability; signs the Annual Governance Statement and ensures risk is embedded.

Executive Director of Corporate Services and ICB Development (Executive Risk Lead): Owns this Policy and the CRR/SRR/BAF process; ensures reporting quality, cadence and escalation are effective.

Executive Directors: Own risks within their portfolios (Risk Owners); convene reviews with Risk Leads; confirm escalations/de-escalations between Directorate registers, the CRR and SRR/BAF.

Audit and Risk Committee (ARC): Scrutinises the effectiveness of risk management, internal control and assurance; commissions internal audit, deep dives and oversees follow-up.

Finance Planning and Payer Function Committee/ Utilisation Management & Quality Improvement/ Remuneration and Workforce Committee: Provide subject-matter oversight for risks assigned to their respective remits, including high-risk operational risks impacting quality, performance or finance.

Management Executive Committee: Reviews and challenges risks held by other executive members prior to Board review. Holds responsibility for the Corporate Risk Register.

Executive Director of Strategy, Planning and Evaluation: Leads information risk; ensures Data Security Protection (DSP) Toolkit compliance and robust incident handling.

Caldicott Guardian (Executive Director of Utilisation Management – Medical Director): Protects the confidentiality of people's health and care information.

Data Protection Officer (DPO): Independent advice and oversight for UK GDPR/DPA 2018 matters including DPIAs.

Managers & All Staff: Identify, assess, record and manage risks and complete necessary training.

6. Processes and Procedures

6.1 The following processes must be followed to comply with this policy:

Risk appetite framework

The Board sets and annually reviews appetite across domains/ categories

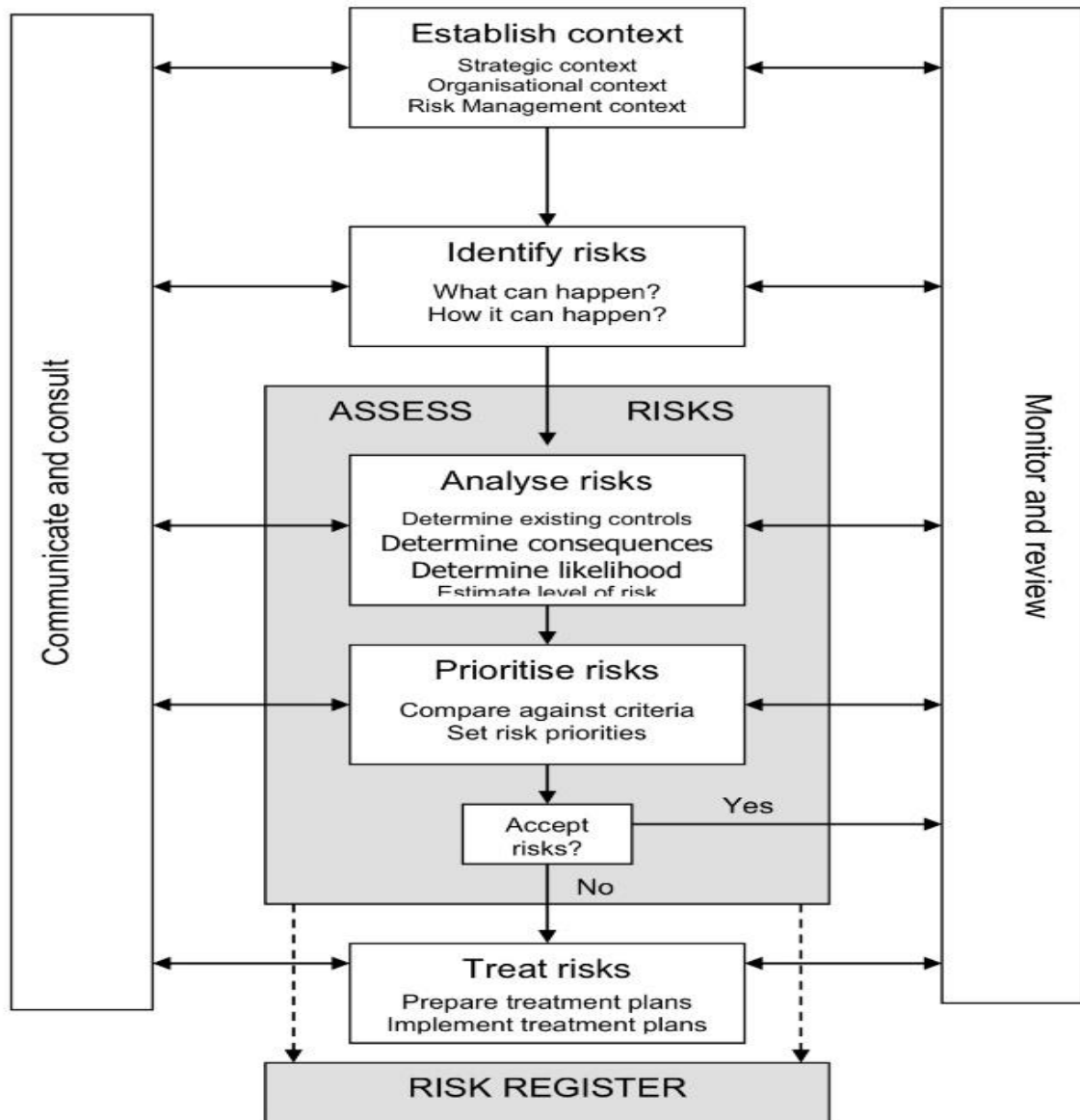
- Legacy statements from HWE and BLMK provide starting positions (e.g., 'seek/open' appetite for innovation and outcomes, 'cautious' for compliance). The Central East ICB will agree a consolidated statement in Quarter 1 of operation and publish ranges/thresholds used for escalation.
- Appetite is integrated into BAF templates and used to set target risk and intervention triggers.

Risk management process (ISO 31000-aligned)

- **Establish scope, context, criteria** – clarify objectives, stakeholders, internal/external context and risk criteria/appetite.
- **Identify risks** – use multiple routes: strategy and planning cycles; committee reviews; audits and learning; programme and project logs; incident and complaints analysis;

horizon scanning (incl. National Risk Register and Local Community Risk Registers for EPRR).

- **Articulate clearly** – use cause–risk–effect: IF (cause), THEN (risk event), RESULTING IN (effect/impact).
- **Analyse & score** – apply the NHS 5×5 matrix (likelihood 1–5 × consequence 1–5) with descriptors/calibrations drawn from the legacy policies; record inherent, current and target risk; map existing controls and the strength of assurance (See risk matrix at Appendix 3 and risk appetite Appendix 4).
- **Evaluate** – compare to appetite; prioritise; decide on treatment (treat, tolerate, transfer, terminate) with SMART actions and owners.
- **Monitor & review** – monthly at team/directorate; monthly Risk Oversight Group; Committee quarterly, Board at least bi-annually; dynamic KRIs monitored where defined.
- **Communicate & consult** – throughout the cycle, including with partners for system risks.



Registers, escalation and reporting

Risk registers

- **Project/Programme & Team/Directorate Registers** – maintained and reviewed monthly; most risks are managed here.
- **Corporate Risk Register (CRR)** – contains organisation-wide, cross-cutting or deep-impact risks requiring corporate visibility/action.
- **System Risk Register / Board Assurance Framework (SRR/BAF)** – principal risks to ICB linked to strategic objectives; typically ≥ 15 or designated “principal risks” by the Board.

Escalation & de-escalation criteria

- Escalation requires sustained trajectory outside acceptable tolerance or possible mitigations outside local control. Acceptance requires a demonstrable impact on one or more of the key performance measures identified in the “Our Way” strategy document with a tangible impact on one of the key strategic priorities.
- De-escalation where controls/assurance demonstrably reduce current score towards target and risk can be locally managed.

Reporting cadence

- **Monthly:** Executive review of all HIGH/RED risks; Management Executive Committee for peer challenge to KRIs and actions.
- **Each ARC:** Full BAF and CRR summary; deep-dives by theme as required.
- **Quarterly Board:** BAF and risk appetite review where required.

Assurance mapping and the Three Lines

We map controls and **sources of assurance** to each risk and assess their strength (e.g., Substantial/Reasonable/Limited/None), explicitly distinguishing:

- **Line 1:** Business management, performance and quality controls;
- **Line 2:** Oversight functions (governance/compliance/quality/finance/H&S/IG);
- **Line 3:** Independent assurance (internal audit, external audit, regulators, peer reviews).

Tools, data and KRI approach

- We will maintain risk management software to support an enterprise risk management approach.
- **KRIs** may be defined for selected principal risks (e.g. elective recovery, workforce capacity, financial position) and monitored with agreed thresholds and early warning triggers to prompt intervention.

Monitoring, maturity and continuous improvement

- Internal Audit will provide periodic opinions; External Audit/Regulators provide independent assurance and prompts for improvement.
- We will conduct an annual risk maturity assessment aligned to HM Treasury guidance (Orange Book and associated tools) and benchmark against NHS peers.
- The Corporate Services Senior Manager will produce an Annual Risk Management Report for ARC/Board, covering training uptake, audits, KRI performance, thematic insights and policy compliance.

Training and capability

- Role based sessions for Risk Owners/Leads and committee members; system training and KRI basics where applicable.

7. Statutory and National Guidance

7.1 This policy has been developed with reference to the following statutory and national guidance:

- HM Treasury guidance (Orange Book and associated tools)
- NHS Providers – The Essentials of Risk Management
Guidance on governance, risk culture, risk appetite, assessment, and system-wide risk management. [nhsproviders.org]
- NHS Resolution – Risk Management Policy and Procedure
Includes corporate governance requirements, risk registers, risk matrices, escalation processes, and definitions. <https://resolution.nhs.uk/wp-content/uploads/2020/04/Risk-Management-Policy-and-Procedure-CG04.pdf>
- NHS Resolution – Corporate Risk Management Governance
Outlines governance structures for risk management and escalation within NHS Resolution. <https://resolution.nhs.uk/governance-policies/risk-management/>

8. Stakeholder Engagement Record

8.1 The following stakeholders were engaged in the development / review of this policy:

Role/Group	Date of Engagement	Summary of Feedback
Governance Leads	March 2026	Draft agreed

Accessibility Statement

This policy is available in alternative formats upon request, including large print, Braille and translated versions, to ensure accessibility for all staff and stakeholders.

Implementation Plan

Development and Consultation: As above

Dissemination: ICB website and intranet

Training: Provided as required dependant on role

Monitoring: Audit & Risk Committee

Review: Audit & Risk Committee and ICB Board

Equality, Diversity, and Privacy: See Appendices

Associated Documents: N/A

References: N/A

Appendix 1: Equality Impact Assessment

Please answer the questions against each of the protected characteristic and inclusion health groups. If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken. It is against the law to discriminate against someone because of these protected characteristics. For support and advice on undertaking EQIAs please contact: agcsu.equalities@nhs.net

Name of Policy:	Risk Management Policy
Date of assessment:	23/03/2026
Screening undertaken by:	Michelle Evans-Riches Head of Governance BLMK

Protected characteristic and inclusion health groups.	Could the policy create a disadvantage for some groups in application or access? (Give brief summary)	If Yes - are there any mechanisms already in place to mitigate the potential adverse impacts identified? If not, please detail additional actions that could help. If this is not possible, please explain why
<p>Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination:</p> <p>https://www.equalityhumanrights.com/en/equality-act/protected-characteristics</p>		
<p>Age</p> <p>A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).</p>	N/A	
<p>Disability</p> <p>A person has a disability if she or he 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.</p>	N/A	
<p>Gender reassignment</p> <p>The process of transitioning from one gender to another.</p>	N/A	
<p>Marriage and civil partnership</p> <p>Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also</p>	N/A	

have their relationships legally recognised as 'civil partnerships'.

Pregnancy and maternity

N/A

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. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Race

N/A

Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.

Religion or belief

N/A

Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Sex

N/A

A man or a woman.

Sexual orientation

N/A

Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.

Carers

N/A

Individuals within the ICB which may have carer responsibilities.

Please summarise the improvements which this policy offers compared to the previous version or position.

N/A

Has potential disadvantage for some groups been identified which require mitigation?

No

Appendix 2: Data Protection Impact Assessment

Screening questions to determine if a full DPIA is required. Guidance on handling personal and sensitive data.

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via **(insert email address once confirmed)**

A DPIA is a process to help you identify and minimise the data protection risks. You must do a DPIA for processing that is likely to result in a high risk to individuals. You can use our screening checklist below to help you decide when to do one. If you have answered 'Yes' to any of the 10 screening questions, you must then carry out a full DPIA using the Stage 2 form, which is also available on the Intranet in the IG section.

Name of Policy:	Risk Management Policy
Date of assessment:	23/03/2026
Screening undertaken by:	Michelle Evans-Riches Head of Governance BLMK

Stage 1 – DPIA form

please answer 'Yes' or 'No'

1. Will the policy result in the processing of personal identifiable information / data? This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	No
2. Will the policy result in the processing of sensitive information / data? This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	No
3. Will the policy involve the sharing of identifiers which are unique to an individual or household? e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	No
4. Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information? Pseudonymised data - where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. Anonymised data - data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	No
5. Will the policy result in organisations or people having access to information they do not currently have access to?	No
6. Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?	No
7. Does the policy result in the use of technology which might be perceived as being privacy intruding? e.g., biometrics, facial recognition, CCTV, audio recording etc.	No
8. Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them?	No

Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	
9. Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?	No
10. Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive? e.g., personal email, text message etc.	No

Appendix 3: Risk Matrix Process Flow Diagram

Risk Category	1 – Lowest Impact	2 – Minor Impact	3 – Moderate Impact	4 – Major Impact	5 – Highest Impact
Access, Experience & Inequalities	Minimal change in access satisfaction; no measurable effect on RTT, detection or A&E.	Localised access delays; slight RTT increase; minor satisfaction decline.	Noticeable access problems across services; reduced MH treatment; inequality gap widens.	Widespread difficulty accessing care; Stage 1–2 cancer detection decrease; A&E increased significantly.	System-wide access failure; severe dissatisfaction; major KPI collapse across RTT, A&E, detection, SMI.
Financial Sustainability & Value	No material PPPY change; efficiencies hold.	<1% PPPY overspend; small avoidable utilisation increased.	1–5% overspend; RTT increase; time spent in A&E increase due to weak upstream investment.	5–10% overspend; low-value activity persists; KPIs 6,7,8 worsen.	>10% overspend; cannot shift care earlier; system KPIs collapse.
Commissioning, Contracting & Market Management	Minor contract delay; no KPI shift.	Local provider issues affect access/RTT slightly.	Multi-pathway performance decline: RTT increased, A&E increased, detection decreased.	Market instability harms access, early detection, MH, advanced illness KPIs.	Market failure stops pathway delivery; system-wide KPI collapse.
Quality, Safety & Reliability	Minor process issue; no KPI impact.	Small reliability decline; slight	Significant safety/quality lapses; lower cancer	Serious safety events: SMI beds increased; advanced illness bed days	Widespread unsafe care; severe harm;

		RTT increased or A&E increased.	detection; MH crisis increased.	increased; RTT breaches increased.	catastrophic KPI deterioration.
Organisational Capacity, Capability & Culture	Small capability gap, no KPI change.	Local delays; training gaps cause small MH and access declines.	Workforce gaps delay access & MH treatment; RTT increased.	Unsafe staffing >5 days; SMI beds increased; A&E increased.	Workforce breakdown; system cannot deliver reliably; KPIs collapse.
Data, Digital & Intelligence	Minor data issues; no KPI effect.	Reporting delays slow improvement of RTT/detection.	Gaps in PHM data worsen A&E, MH outcomes, proactive care.	Major outage/digital triage failure; RTT increased; A&E increased; access worsens.	System-wide digital failure; screening/triage collapse; catastrophic KPI impact.
Partnerships, Neighbourhoods & Integration	Minor integration issue; negligible outcome shift.	Delayed info-sharing; small MH and advanced illness coordination effects.	Reduced neighbourhood coordination: A&E increased, SMI increased, advanced illness beds increased.	Breakdown in local integration: RTT delays increased; crisis presentations increased.	System-wide partnership failure; NHT collapse; severe KPI deterioration.
Transformation & Delivery Discipline	Minor schedule slip; no KPI change.	Slippage affects one pathway (RTT or access).	Several pathways fail to scale: MH access decrease; early detection decrease; A&E increase.	“Improve-codify-scale” fails; KPIs for detection, RTT, utilisation worsen greatly.	Transformation failure across system: access, detection, A&E, PPPY collapse.
Population Health Outcomes	Minimal outcome change.	Slight worsening in chronic	Noticeable decline in detection, MH	Significant outcome deterioration; advanced illness crises increase.	System-wide failure in PH outcomes;

		condition outcomes.	treatment, SMI outcomes.		severe KPI damage.
Utilisation, Flow & Demand Management	Minor inefficiency; no KPI change.	Slight A&E increase or RTT increase.	Flow issues cause RTT increase, A&E increase, SMI increase.	Severe, sustained delays; high emergency demand; advanced illness beds increase.	Demand overwhelms system; catastrophic KPI deterioration including finance failure.

Score	Descriptor	Typical Indicators
1 – Rare	Highly Unlikely	No history of occurrence. Controls fully effective. External environment stable.
2 – Unlikely	Possible but not expected	Occasional past occurrence. Controls largely effective. Emerging external pressures.
3 – Possible	Reasonable chance	Known issue in similar organisations. Some control gaps. Increasing external pressures.
4 – Likely	More likely than not	Regular past occurrence. Significant control gaps. External environment volatile.
5 – Almost Certain	Expected to occur	Repeated occurrence. Controls ineffective. Strong external

Appendix 4: Risk Appetite

TBD by Board

Appetite Level	Definition	When It Applies
None / Avoid	The ICB will not accept any risk exposure in this area. Even minimal risk is unacceptable. Absolute focus on prevention, elimination, and compliance.	Statutory duties, regulatory/legal compliance.
Minimal / Low	The ICB has a very cautious approach. It will only accept risks that are unavoidable in order to deliver mandatory functions. Risks must be tightly controlled and continuously monitored.	Finance (meeting control totals), governance, estates compliance.
Cautious / Moderate	The ICB is prepared to accept limited risk where there is potential benefit but expects strong mitigations and assurance in place. Exposure is tolerable if proportionate and/or time limited.	Workforce management, operational delivery, contracting.
Open / Balanced	The ICB is willing to accept greater risk where it is necessary to achieve strategic objectives or enable innovation. Controls must remain proportionate, but higher exposure is justified by the opportunity.	Strategic change, OD, communications & engagement.
Seeking / High	The ICB actively seeks risk to pursue significant improvement, transformation, or innovation. Appetite is high where the potential reward is substantial, recognising that failure is possible. Controls still apply, but tolerance for uncertainty is greatest.	Innovation, pilots, new care models, digital transformation (with safeguards).
Significant / Confident	The ICB is confident in setting higher levels of risk appetite because the opportunity or potential reward are substantial. Controls should be sought but it is accepted that mitigations may be beyond the ICB's authority. Horizon scanning and response systems including emergency preparedness and response are robust.	Investment or change with national support including mandatory and unavoidable reform.