Risk Management Policy

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Caring for each other, working together and always improving.

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

Swansea Bay University Health Board (SBUHB) is committed to providing safe and effective, high quality healthcare. We mandate a culture and environment, which minimises and actively seeks to reduce risk and promotes the health, safety and well-being of patients, staff, visitors and the general public.

Policy Owner: Director of Corporate Governance
Approved by: [For Health Board Approval]
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Contents

1 RISK MANAGEMENT POLICY STATEMENT

Swansea Bay University Health Board (SBUHB) is committed to providing safe and effective, high quality healthcare. We mandate a culture and environment, which minimises and actively seeks to reduce risk and promotes the health, safety and well-being of patients, staff, visitors and the general public.

The Health Board recognises that all health service activity carries risks including harm to patients which need to be managed through a systematic framework. This will ensure that risks to patient and staff safety and the organisations objectives are identified, assessed, eliminated or minimised so far as is reasonably practicable. The aim being to minimise the chance of the risk being realised, although where this has not been possible then we will review, learn and share the learning to minimise the likelihood of reoccurrences in an open and fair culture.

All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. SBUHB encourages staff to take ownership of their responsibilities through a two-way communication process, with appropriate training and support, to identify and manage risk. To support the development of good risk management practice in the organisation SBUHB aims to ensure:

- The risk management process is robust, integral to the day to day operation of the organisation, consistent and supports the achievements of SBUHB's objectives;
- We have a safe environment for patients, staff and visitors through the identification of hazards and the management of risks;
- There is an open and fair culture and staff can highlight and discuss risks openly;
- Risk management is linked to clinical audit to prioritise risk based audits and risks identified following audit are risk assessed and managed;
- The level of risk appetite is clear and tolerance is defined to support innovation at an agreed level of risk;
- A safe, high quality service is provided promoting continuous improvement;
- Awareness of risk management is raised through education/training and guidance to ensure awareness and effective management of potential hazards/risks and how they can be minimised;
- There is a culture of learning from everything we do to improve safety in SBUHB, compliance with legislation and continuous improvement by using the Health & Care Standards in Wales as a framework;
- Roles, responsibility and accountability for risk management is clear and well documented within policies, procedures and job descriptions.

Ensuring robust risk management systems are in place will enable the organisation to:

- Be proactive rather than reactive;
- Identify and treat risks within the organisation;
- Improve identification of opportunities and threats;
- Comply with legislation and regulations.

…… ……
Signed: **Chief Executive** **Date**

2 AIM OF THE POLICY

The policy aims to set out a framework for consistent management of risk within the Health Board and support the achievement of the risk management objectives:

- Embed risk management at all levels of the organisation using a consistent framework;
- Create a culture which supports risk management;
- Provide the tools to support risk management;
- Provide the training to support risk management;
- Embed the Health Board's risk appetite in decision making.

The Health Board's risk management system will also support the compilation of the Annual Governance Statement (AGS).

Risk Management is an iterative process consisting of well-defined steps which, taken in sequence, support better decision making by contributing a greater insight into risks and their impacts. It is also a dynamic process and as such will require different groups and individuals to be involved in the process at different times. SBUHB recognises that Risk Management is an integral part of good management practice and if successful will lead to:

- Well defined strategies & policies being put into practice in all relevant parts of the organisation which are regularly reviewed;
- High quality services delivered efficiently and effectively;
- Performance being regularly and rigorously monitored with effective measures implemented to tackle poor performance;
- Compliance with legislation and regulations;
- Information used by SBUHB being relevant, accurate, reliable and timely;
- Financial resources are safeguarded by being managed efficiently and effectively;
- Human and other resources being appropriately managed and safeguarded.

SBUHB will therefore integrate risk management into the day to day management and business plans aligned to its corporate objectives, and will not be practiced as a separate programme. This is a key concept in risk management becoming the business of everyone in the organisation.

3 RISK MANAGEMENT ROLES AND RESPONSIBILITIES

3.1 Chief Executive

As Accountable Officer the Chief Executive has responsibility for ensuring that the Health Board meets all of its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of governance. This responsibility encompasses the elements of financial control, organisational control, quality, health & safety and risk management.

Each year the Chief Executive sets out the risk management arrangements and issues within the Health Board within the Annual Governance Statement (AGS) which forms part of the Annual Accounts and Accountability report, which are scrutinised by the Audit Committee.

3.2 Director of Corporate Governance

The Director of Corporate Governance has specific responsibilities for Risk Management and will support the Chief Executive by providing competent advice and support in the development of effective systems and arrangements to help facilitate the management of risk, this will include arranging to:

- Produce and regularly review the Risk Management Policy;
- Ensure there is a robust risk management system in operation in the Health Board;
- Ensure through the Risk Scrutiny Panel that an effective process is in place to support the escalation and reporting of risks;
- Draft the Risk Management section of the Annual Plan/IMTP;
- Ensure key risks are co-ordinated and reported to the Executive Team, Board Committees and Health Board;
- Produce the Annual Governance Statement and Accountability report, ensuring that high level risks are reported upon.

In undertaking this role, the Director of Corporate Governance is supported by the Head of Patient Experience, Risk and Legal Services and Assistant Head of Risk & Assurance.

3.3 Executive Director of Nursing and Executive Medical Director

The Executive Director of Nursing is the Executive Director with lead responsibility for ensuring the effective operation of risk management processes.

In this role, he/she is supported by the Executive Medical Director, and together they provide clinical expertise and leadership to the oversight of clinical risk management.

3.4 Executive / Corporate Directors

Each Executive / Corporate Director is responsible for managing risk within their area of responsibility. This means they are responsible for ensuring that:

- Staff are aware of the Risk Management Policy, are aware of their responsibilities, and understand the extent to which they are empowered to take risk;
- Staff are appropriately trained in risk assessment and management;
- Directorates adopt an open and fair culture;
- Hazards and risks are identified, assessed and managed using a consistent approach;
- Incidents are reported and investigated promptly and effectively to ensure that lessons are learned and shared, and there is continuous improvement;
- Appropriate governance arrangements are established to oversee the management of risks, and to ensure action is taken to manage risks to an acceptable level in line with the Board's risk appetite;
- There are mechanisms in place for identifying, managing and alerting the Board to significant risks within their areas of responsibility through regular, timely and accurate reports to the Management Board/Executive Team, relevant Board Committees and the Board;
- There are mechanisms in place to learn lessons from any incidents or untoward occurrences and that corrective action is taken where required;
- Their Directorate Risk Registers are regularly reviewed and updated within the RL Datix software system, and that risks requiring escalation are escalated via the Risk & Assurance Team for inclusion on the Health Board Risk Register;
- Directorate risk registers are linked to the Health Board's objectives as set out in the Integrated Medium Term Plan (IMTP);
- There is compliance with Health Board policies, legislation and regulations and professional standards for their functions.
- Staff are released to attend mandatory/statutory training;
- Staff receive regular PADR/Appraisals.

A schedule setting out key areas of responsibility of individual Directors is set out in detail in the Scheme of Delegation appended to the SBUHB Standing Orders. This is supplemented by individual job descriptions and the Executive Director portfolio of responsibilities.

3.5 Head of Patient Experience, Risk & Legal Services

The Head of Patient Experience, Risk & Legal Services acts on behalf of the Director of Corporate Governance to achieve high standards of risk management for the Health Board, including the ongoing review and development of the Risk Management Policy. Responsibilities include continuing development of a proactive risk management culture and practice throughout the organisation; actively promoting and ensuring good risk management practices, and the achievement of national risk management standards.

3.6 Assistant Head of Risk & Assurance

The Assistant Head of Risk & Assurance is the Health Board lead for all aspects of risk management. He/she will establish and maintain a proactive and integrated approach to risk management through the development and maintenance of robust and effective policies, procedures, systems and processes to ensure that:

- The Health Board's risk management system and processes is 'fit for purpose' and meet the relevant statutory and regulatory requirements;
- Risk management is embedded across the organisation.

3.7 Assistant Director of Health & Safety and The Head of Health & Safety

The Assistant Director of Health & Safety and the Head of Health and Safety, supported by the Health & Safety Department, are responsible for:

- Policy development and implementation with respect to health & safety risk;
- Providing professional advice in respect of health and safety management;
- Ensuring that health board risk management methodology is applied to health & safety risks;
- Reporting on health & safety risks and mitigations to the Health & Safety Committee.

3.8 Specialist Advisors

There are a number of specialist advisers within the Health Board who provide advice on specific areas of risk management. These include:

- Safeguarding
- Fire
- Health & Safety
- Infection Prevention & Control
- Information Governance
- Medical Devices
- Radiation Protection
- Resuscitation
- Security Management.

3.9 Operational Risk Management Arrangements

The Service Group Directors (Service Director, Director of Nursing and the Medical Director/Dental Director) have devolved responsibilities for risk management and are responsible for ensuring that:

- Staff are aware of the Risk Management Policy, are aware of their responsibilities, and understand the extent to which they are empowered to take risk;
- Staff are appropriately trained in risk assessment and risk management;
- Service Groups adopt an open and fair culture;
- Hazards and risks are identified, assessed and managed using a consistent approach;
- Incidents are reported and investigated promptly and effectively to ensure that lessons are learned and shared, and there is continuous improvement;
- High unresolved risks are reported to the appropriate Executive Director swiftly;
- Appropriate governance arrangements are established to manage risks to an acceptable level;
- Service Group risk registers are regularly reviewed, updated and used as a tool to proactively manage risks and to provide assurance regarding the same;
- Service Group risk registers are linked to the Health Board's objectives as set out in the Integrated Medium Term Plan (IMTP);
- Staff are released to attend mandatory/statutory training;
- Staff receive regular PADR/Appraisals.

3.10 Ward / Departmental Managers

Ward / Department Managers are responsible for:

- Promoting an open and fair culture for staff to report incidents;
- Promptly investigating incidents and supporting staff through the process;
- Completing or ensuring risk assessments are completed and, as a minimum, reviewing them on an annual basis;
- Recording risks identified from risk assessments, rated 9 and above, into the Service Group's risk register and;
- Monitoring & ensuring staff attendance at mandatory/statutory training.

3.11 Independent Primary Care Contractors

The Primary Community & Therapies Service Group is responsible for working with independent contractors to ensure that appropriate arrangements are in place to effectively manage risk. This is carried out through the review of the governance self-assessments for each profession.

3.12 All Employees

Everyone working in SBUHB has a responsibility to continuously improve patient safety, minimise risk and to ensure that they:

- Comply with policies, procedures, protocols and guidelines;
- Complete risk assessments and report hazards and incidents;
- Inform their manager of risks which they have identified;
- Ensure that there is an open and fair culture in their work place; and
- Identify their own and others training needs.

4 RISK MANAGEMENT REPORTING STRUCTURE

The Risk Management Reporting structure is presented at **Appendix A** and outlines SBUHB's structural arrangements for the risk management process. The remainder of this section sets out the roles and responsibilities of the component parts of this structure and its relationship to the risk management process.

4.1 Health Board

The SBUHB Board shall:

- Critically review and endorse the Risk Management Policy and associated strategies for managing risk;
- Deliberate annual reports and annual assurance statements;
- Consider where lessons may be learned from clinical/non-clinical incidents to foster continuous improvement;
- Consider any legal claims in accordance with the Health Board's Standing Orders and Standing Financial Instructions;
- Consider where lessons may be learned from significant complaints, "no harm incidents" and other incidents to foster continuous improvement;

The Health Board will receive a report on Risk Management and the Health Board Risk Register three times a year. Additionally, it will receive assurance on the effectiveness of implementation of the Risk Management Policy through the Audit Committee.

Each Executive Director will ensure their Directorate/Service Group risk register is up to date and risks are regularly considered for inclusion on the Health Board Risk Register. The risk information will be used to formulate the Annual Plan/IMTP. The Plan would then be approved by the Executive Board, Audit Committee and Board. Risks to the achievement of the Board's plans (including those set out within service changes/developments) will be considered within reports to the Board, its Committees and the Management Board to support decision making. The principle controls identified to manage risks to delivery of the health board's strategic objectives and plans will be captured within the BAF – significant gaps in control and/or assurance will also be identified.

The Health Board will appropriately delegate its responsibilities and functions in accordance with the arrangements set out in this document and its Standing Orders. The Health Board is responsible for the system of internal control, including risk management. The Audit Committee will provide assurance that risk management systems are in place and functioning properly to minimise risk.

4.2 Committees of the Board

Each risk within the Health Board Risk Register will be assigned to a Committee of the Board. Reports will be submitted to the Committees no fewer than three times a year to accompany the

specific Health Board Risk Register (HBRR) entries assigned to the Committees. The Committees will review the assigned risks and actions taken to address them, and consider any additional information or action required to support scrutiny and the provision of assurance to the Board. The Terms of Reference for each Committee are set out in the Standing Orders approved by the Health Board and are available on the Intranet

Each risk entry within the Health Board Risk Register indicates the Committee nominated for its oversight. The Audit Committee oversees the overall operation of the system of risk management and will review arrangements to oversee new risks.

4.2.1 Audit Committee

The Audit Committee is responsible for providing assurance to the Board that an effective system of integrated governance, risk management and internal control, has been established and maintained across the whole of the organisation's activities (clinical and non-clinical), which supports the achievement of the organisation's objectives. It does this by considering independent and objective reviews of corporate governance and risk management arrangements, including compliance with legislation, regulatory guidance, and regulations governing the NHS. The Committee will:

- Review the adequacy and effectiveness of the Health Board's organisational risk management structures, processes and responsibilities, and the appropriateness of any risk and control related disclosure statements;
- Review the Health Board Risk Register (HBRR) three times a year or as the Board determines;
- Monitor the Board Assurance Framework (BAF), and ensure its presentation to the Board at intervals that the Board determines;
- Assess the effectiveness of management of the organisation's principal risks and the system of internal control;

As part of its integrated approach, the committee will have effective relationships with other key committees (for example Quality and Safety Committee) so that it understands processes and linkages.

The Internal Audit function will, through a programme of work based on risk, provide SBUHB with independent assurance of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the Public Sector Internal Audit Standards.

4.2.2 Quality & Safety Committee

The Quality & Safety Committee is responsible for providing the Board with assurance that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the health board's activities. The Committee will consider any relevant risks within

the Health Board Risk Register (HBRR) as they relate to the remit of the Committee, and report any areas of significant concern to the Audit Committee or the Board as appropriate.

4.2.3 Performance & Finance Committee

The Performance & Finance Committee is responsible for providing assurance to the board in relation to the arrangements for developing and improving its financial and non-financial performance management arrangements to ensure the organisational aims and objectives are achieved. The committee will consider any relevant risks within the Health Board Risk Register (HBRR) as they relate to the remit of the Committee, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.

4.2.4 Workforce and Organisational Development (OD) Committee

The Workforce and OD Committee's focus is on all aspects of workforce as a resource aimed at ensuring the strategic and operational workforce agenda, priorities and work plan enables the delivery of the Health Boards objectives and supports quality and safety of healthcare and employment practice. The Committee will seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the delivery of the workforce & OD agenda across the full range of the Health board's services and oversee the delivery of agreed workforce priorities.

4.3 Management Board & Executive Team

The Management Board (MBD) in its role as the senior decision making forum of the Health Board is responsible for the operational management and monitoring of the organisation's most significant operational risks and strategic risks. It does this by receiving reports on the Health Board Risk Register (HBRR) and the Board Assurance Framework (BAF) from the Corporate Governance team, and exception reports from management highlighting organisational issues and risks, agreeing actions to address them and monitoring their delivery.

The Management Board will periodically receive Risk Reports accompanied by the Health Board Risk Register for review and endorsement

In the event of a major business continuity event such as a pandemic (e.g. COVID 19), when Committees may be stood down to support business requirements, the Executive Team will receive the Health Board Risk Register as a standing agenda item at each meeting to ensure effective monitoring.

4.4 Risk Management Group

The Risk Management Group is a formal management group established by the Chief Executive to discharge the responsibility of the Executive Team for the oversight and improvement of arrangements for the operational management of organisational risk. The function of the Group is to:

- Oversee the Health Board's risk management arrangements and implementation of policy to ensure consistency across the Health Board;
- Ensure that suitable processes are in place to identify, assess, monitor and manage operational risks;
- Ensure a cohesive functional link between the Health Board's corporate governance and risk management arrangements and those of the Service Groups;
- Ensure that risk management matters requiring intervention are brought to the attention of the Executive Directors;
- Ensure risks relating to hosted services and shared partnerships are considered and reported as appropriate to the Management Board;
- Where appropriate, refer Service Group risks with significant potential impact on the health board on to the Management Board.

The Management Board Risk Reports will include key matters arising from meetings of the Group. Terms of reference for the Risk Management Group are attached at **Appendix B**.

4.5 Risk Scrutiny Panel

The Risk Scrutiny Panel is responsible for the review of risks escalated by Service Groups for inclusion in the Health Board Risk Register and the review of arrangements in place for the management of the most significant risks within the Health Board Risk Register. The Panel meets on a monthly basis. Terms of reference for the Risk Scrutiny Panel are attached at **Appendix C.**

4.6 Quality & Safety Framework – Incidents, Complaints & Claims

Incidents are managed and reported in accordance with "Putting Things Right" regulations and the Health Board's associated Concerns Management Policy. Incidents are analysed for themes and trends and, for serious incidents a Root Cause Analysis Investigation is undertaken. These aim to ensure that there is learning from incidents, and that this is used to drive quality improvement, and reduce the future likelihood of adverse events and avoidable harm to patients/users. Incident themes and trends may inform risk identification and assessment. Information on incidents is considered at the **Patient Safety & Compliance Group**.

Complaints are risk assessed in terms of the severity of the complaint and likelihood of the circumstances reoccurring. The Corporate Concerns Assurance Team grade complaints and support Service Groups to investigate their complaints. In addition, analyses of serious complaints are presented to the **Patient & Stakeholder Experience Group**. Complaint themes and trends may inform risk identification and assessment. Action plans produced to reduce the risk of complaints reoccurring are reviewed and monitored by the Group, which provides a mechanism for sharing of lessons learned from investigations across the Health Board.

Claims are managed in accordance with the Claims Management Policy. Claims management, themes and trends are reviewed by the **Patient & Stakeholder Experience Group**, which

provides a mechanism for sharing of lessons learned from investigations across the Health Board.

4.7 Health Board Specialist Groups

In addition to the above there are a number of specialist groups/committees (e.g. Infection Prevention & Control Committee, Medical Devices Group) in the Health Board which have specific responsibility for managing the risk associated with their functional area. The reporting arrangements for these groups are described within the Health Board's Quality Management Framework.

4.8 Service Group Boards & Governance Groups

The Chief Operating Officer reports directly to the Chief Executive and is responsible for the following Service Groups:

- Mental Health and Learning Disabilities
- Morriston Hospital
- Neath Port Talbot and Singleton Hospitals
- Primary Community and Therapies

Each Service Group has a Service Group Board, which is ultimately responsible for management of its operational risks. The Service Group Board will ensure that risks that cannot be managed within the service alone or are assessed as exceeding the health board's risk appetite, and which may impact on the health board's strategic objectives, are escalated to the Risk & Assurance Team for consideration by the Risk Scrutiny Panel. The Panel evaluates escalated risks in the context of the wider health board objectives, seeking further information from the service or advice where required from appropriate expertise in the Health Board. Where appropriate risks are forwarded to an Executive Director lead for their agreement to add to their Directorate risk register or the Health Board Risk Register.

Each Service Group Board will establish processes for the review of new risks and the oversight of those accepted onto their risk registers. These will indicate arrangements for escalation of risk within the Group to its Board and the role of local management / governance groups.

4.9 Corporate Directorates

There are eleven Corporate Directorates:

- Chief Operating Officer
- Director of Corporate Governance
- Medical Director
- Director of Nursing
- Director of Therapies & Health Sciences

- Director of Finance & Performance
- Director of Workforce & OD
- Director of Strategy
- Director of Digital
- Director of Public Health
- Director of Insight, Engagement & Communication

Each Executive Directorate is responsible for ensuring any significant risk within their portfolio of responsibilities is reported to the Management Board and linked into the planning process / capital planning programme by identifying risks against the Board Objectives within the Annual Plan/IMTP.

5 RISK MANAGEMENT PROCESS

This section of the document sets out an approach to the assessment of risk and the development of an integrated framework for risk management for the Health Board. When considering risk management, it is important to understand the Health Board's risk appetite and risk tolerance to specific risks may change over time, subject to influential factors at a strategic, tactical and operational level.

Risk appetite is about the pursuit of risk and risk tolerance is about what the Health Board will allow management levels within the organisation to deal with. Both risk appetite and risk tolerance are inextricably linked to performance over time.

The Health Board's Board is explicitly responsible for determining the nature and extent of the significant risks the organisation is willing to take to achieve strategic objectives.

5.1 Methodology

The methodology for identifying risk used within Health Board is the Australian/New Zealand model AS/NZ; Guidance upon acceptable risk is addressed within this methodology to assist managers to make informed decisions as to the extent of the risk and the application of appropriate action thereafter.

For each issue/risk identified the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the issues and attempts to assess the likelihood/probability of the event occurring and the effect/impact it could have on the Health Board. This process ensures that the Health Board assesses its risks in a structured way, and prioritises the allocation of its resources towards managing those risks with the greatest potential impact on the organisation**.** A risk assessment grading matrix is used to promote a consistent approach to risk assessment (See **Appendix D**).

The Health Board uses the risk module of the Datix System to record and monitor its risks. Ideally all risks should be recorded on Datix – as a minimum all risks rated 9 and above must be recorded within the risk management database. The Board-level Health Board Risk Register represents the health board's strategic risks and its most significant operational risks. It is updated by Executive Directors monthly, endorsed by the Management Board periodically during the year and published within meeting papers when received by the Board.

5.2 Establish the context

Establish the strategic, organisational and risk management context in which the rest of the process will take place. Criteria against which risk will be evaluated should be established and the structure of the analysis defined.

The context can include the financial, operational, competitive, political (public perceptions/image), social, client, cultural and legal aspects of the Health Board's functions.

Within these areas it is critical to identify the internal and external stakeholders/partners which may include any of the following: Welsh Government, patients, staff and contractors. Once the stakeholders/partners have been identified it is important to consider their objectives, take into account their perceptions, and establish communication policies with these parties. It is also important to consider these issues when considering relationships inside and outside the NHS the behaviour of the “partners” and the organisation and how this will affect any risks identified.

5.3 Risk Identification

Risk identification can be undertaken on an individual basis or as part of a multidisciplinary team and can be reactive or proactive and linked to strategic objectives, underpinning the assurance framework, or operational services we provide.

5.3.1 Strategic Risk and IMTP

Strategic risks are those risks associated with the achievement of aims and objectives of the Health Board, including those set out in the Integrated Medium Term Plan (IMTP).

The IMTP sets out the organisational objectives over a three-year period. The risk of not achieving the objectives and the risks to achieving objectives will be highlighted, as appropriate, to the Health Board, stakeholders and partners. Significant risks to health board objectives will be identified and monitored within the Health Board Risk Register**.** This will be a "top down" approach, undertaken collectively by the members of the Executive Board.

5.3.2 Operational Risks

These are the risks associated with the direct delivery of services by the organisational services i.e. risks arising from operational activities.

These risks will be identified via a "bottom up" approach undertaken by the staff within individual Service Groups overseen by the Service Group Management Boards. They are captured in operational risk registers maintained by those services within the Datix system. Where operational risks are assessed to be at a level that exceeds the Health Board’s risk appetite with potential to impact on strategic objectives, these will be escalated to Executive Director level for potential capture within the Health Board Risk Register.

5.4 Analyse/Evaluate risks

It is important to describe risks clearly, identifying the key causes and potential consequences associated with them, as this assists with their assessment and management. Having described risks, the next step is to identify the existing controls and analyse risks in terms of consequence and likelihood in the context of those controls. The analysis should consider the range of potential consequences and how likely those consequences are to occur. This enables risk to be ranked so as to identify management priorities. If the levels of risk established are low, then

risks may be tolerable, and treatment may not be required. Consideration should be given to the balance between potential benefits and adverse outcomes of managing these risks.

Each risk is graded based around an analysis of the likelihood of the risk materialising and its impact should it materialise. Whilst there are quite complex models available, a simple model has been adopted and it is important to recognise that discussion of the risks is essential to determine within the risk description what the actual risk level is at the time of identification and review. In addition, the description should set out the consequences of not taking the actions identified, to support and inform management decisions and the IMTP process.

Risks have been grouped into four categories according to the scores arising from the assessment of likelihood and consequence:

Risk Level	Assessed Score	HBRR Heat-mapping
High	16 - 25	Red
Medium	9 – 15	Amber
Low	5 – 8	Yellow
Minimal	1 – 4	Green

Having assessed the level of risk, consideration should be given to what further action is required. The decision to take further action / introduce additional controls should consider the level of the risk, its relative priority in comparison to other risks being managed within the service, and the Board's risk appetite (see next section).

5.5 Risk Management and Control

For identified risks, the organisation will agree a programme of actions to manage and control the risks. This will take into account value for money, quality of service delivery, quality and reliability of the evidence to support the identified risk and the impact upon the organisation, stakeholders and partners. Consideration will be given to how to develop and implement specific cost-effective strategies to increase benefits and reduce potential costs. The SBUHB will use the following approaches to risk control:

5.5.1 Risk Appetite and Tolerance

The Health Board defines risk appetite as 'the amount of risk we are willing to seek or accept in the pursuit of long-term / strategic objectives.' It is key to achieving effective risk management and should be considered before risks are addressed.

It is not possible to eliminate all risks which are inherent in achieving our objectives and fulfilling our statutory obligations, and so we may need to consider and/or accept a certain degree of risk where it is in our, patients' or staff best interests i.e., where taking managed risk (in keeping with

our statements of risk appetite) may result in positive benefits for our patients, service users, staff and visitors.

Risk Appetite and Risk Tolerance set boundaries for the level of risk that Swansea Bay University Health Board, and the Service Groups, Divisions and departments, are prepared to accept throughout the course of ongoing operations. Establishing these parameters should facilitate the ability to set a proportional response to risk in the context of business objectives.

Having a defined risk appetite strategy helps to consider how much risk is appropriate in the course of performing activities, and it can be used to assess and prioritise the management of risks that are determined to be outside of the agreed appetite and tolerance set by the Board.

The Board has agreed a Risk Appetite Statement that expresses the type and level of risk it is prepared to tolerate in pursuit of its objectives (attached at **Appendix E**). The Statement should be used by staff to guide decisions on their management of risks.

Managers may take risk management decisions on the basis of their delegated financial authority and the devolved responsibilities set out in the Scheme Delegation within the Standing Orders.

5.5.2 Risk Decisions

Treat the Risk - Treat by taking action to contain the risk to an acceptable level using internal controls which include:

- **Reactive controls** – these controls are designed to identify occasions of undesirable outcomes having been achieved – after the event so only appropriate when it is possible to accept the loss or damage incurred e.g. post implementation reviews to detect lessons to be learnt from projects for application in future work;
- **Proactive controls** – designed to ensure a particular outcome is achieved or to ensure an undesirable event is avoided e.g. health and safety guidelines;
- **Preventative controls** – limit the possibility of an undesirable event being realised e.g. separation of duties;
- **Corrective controls** – to correct undesirable outcomes which have been realised – provide a route of recourse to achieve some recovery against loss or damage e.g. design contract terms to allow recovery of overpayment.

Terminate the Risk – decision not to take the risk. This might be where the level of risk outweighs the possible benefits, and the risk is terminated by not doing something or doing something differently thereby removing the risk (where it is feasible to do so).

Transfer the Risk – decision is made to transfer the risk to others, e.g., through insurance, contracting out the provision of service or paying a third party to take it on. Overall accountability for the risk may still remain with the Health Board and therefore assurance would still need to be gained in this area. Many areas of business and reputational risk cannot be transferred at all.

Tolerate the Risk – decision to accept the risk without further action to reduce it. This decision might be taken typically where a risk is within the health board appetite and the manager wishes to focus resources on other, greater risks. The risk should continue to be monitored.

Action plans will be developed to set out the steps required to manage each risk and will include the approach chosen to control the risk as detailed above. Where additional resources are required to effectively manage a risk, this will be linked into the Health Board's business planning process.

5.5.3 Escalation of Risks

On a monthly basis the Service Groups and Corporate Directorates are requested to escalate risks for consideration for entry on the HBRR. Risks for escalation beyond the Service Group should be agreed by Service Group Directors. Risks considered for escalation would be those that cannot be managed within the Service Group alone and/or are assessed as exceeding the health board's risk appetite, and which may impact on the health board's strategic objectives. Risks of 12 and above within individual Service/Department risk registers should trigger consideration by the Service Group/Corporate Directorate for oversight. Risks less than 12 may be managed by the Service/Corporate departments.

Escalated risks are considered by the Risk Scrutiny Panel. To support effective review, the Panel requests the following information:

- Clear description of the risk;
- Current risk score;
- Rationale for score and any supporting data/information;
- Brief description of main controls in place and their effectiveness;
- Any further actions being taken to reduce the risk and timescale;
- Reason for escalation

The Panel evaluates escalated risks in the context of the health board objectives, seeking further information from the Service Group or advice where required from appropriate expertise in the Health Board. Where agreed, risks are forwarded to an Executive Director lead for their agreement to add to their Directorate risk register or the Health Board Risk Register. Executive Directors may also identify and escalate risks directly for inclusion within the Health Board Risk Register.

In addition to the above, individual risks which are thematically connected may be considered for escalation to the Health Board Risk Register. These may be identified from reports &

discussions at corporate management groups or from thematic reviews of the risk register. The Risk Scrutiny Panel will oversee the escalation and reporting of these risks.

The process for escalation and de-escalation of risks is illustrated at **Appendix A**.

5.6 Communicate and Consult

It is imperative that risk owners communicate and consult with internal and external stakeholders and partners as appropriate at each stage of the risk management process, and concerning the process as a whole. The frequency of the communication will vary depending upon the severity of the risk and should be discussed and agreed with the stakeholders and partners. This process will be led by the person nominated as the lead to manage the risk and for communication with external stakeholders this will be the appointed Executive Director lead for the risk.

Effective internal and external communication is important to ensure that those responsible for implementing risk management, and those with a vested interest understand the basis on which decisions are made and why particular actions are required. Internal stakeholders can include any managers which the risk identified may impact on their service or staff. External stakeholders will vary depending on the type of risk and the risk lead for the Service Group will need to consider which external stakeholders will need to be notified. All significant risks will be reported to the Welsh Government through the weekly brief from NHS Bodies and quarterly performance review meetings.

There will be occasions when a risk is shared with another health organisation, for example in the instance of Service Level Agreements (SLAs) for the delivery of services across organisations. In this case the Risk & Assurance Team can share these risks with the relevant health organisations through the risk management database on the request from Service Groups.

6 RISK REGISTERS & MONITORING RISKS

6.1 Operational Risk Registers

The Health Board uses the DatixWeb system risk module for collating risks into an organisational risk register. Risk information captured by the module enables managers to:

- Record status of the risk (New/Accepted/Rejected/Closed)
- Describe the risk
- Indicate the Risk Owner (and Executive Lead for Board-level risks)
- Indicate the Service Group / Corporate Directorate responsible for the risk
- Summarise current controls in place
- Summarise assurances in place
- Categorize the risk by type
- Record the level of the risk (Inherent/Current/Target Risk Scores)
- Record progress notes and other updates
- Record further actions being taken.

The development & maintenance of risk registers, will include the consideration of risks associated with the following:

- Legislation and regulations;
- National and local targets;
- Deficiencies with various Healthcare Standards;
- Findings from department specific and organisational wide hazard reports and risk assessments;
- Underlying "root" causes of incidents complaints and claims;
- Underlying causes related to poor trends identified from key performance indicators;
- Actions to reduce risks which could not be or were not implemented for various reasons, such as resource limitations; and
- Any other source of information that could be considered to be threat to patient, staff, visitors, environmental safety or the organisation's wellbeing.

A Service Group / Directorate Risk Register comprises the aggregation of operational risks associated with that Service Group recorded within the Datix risk database. Identifying and logging risks within services will ensure that the Service Groups are aware of the risks and, following consideration of any existing controls in place, whether other options exist to further reduce or eliminate the risk. Actions will be agreed and monitored by the Service Group Boards setting out action to be taken to manage risks prioritised for reduction within the Service Group. Where these cannot be managed to an acceptable level within the Service Group consideration should be given to escalating them corporately (see earlier section on Escalation of Risks)

6.2 Health Board Risk Register (HBRR)

The Health Board's Risk Register can be described as *"a log of all the risks that may threaten the success of the Health Board in achieving its declared aims and objectives*." The Board-level Health Board Risk Register (HBRR) represents the health board's strategic risks and its most significant operational risks. The template for presentation of the HBRR at Board and Committees is attached at **Appendix F**.

The Head of Patient Experience, Risk and Legal Services will coordinate the Health Board Risk Register (HBRR) and produce a SBUHB Risk Register Report highlighting those risks that exceed the Board's risk appetite and the actions being taken to address them. The Management Board will oversee and endorse the Health Board Risk Register (HBRR) which will then be reported to the Audit Committee.

7 RISK MANAGEMENT TRAINING

The Risk Management Policy will be supported by training to ensure staff have an understanding of the principles and practice of assessment and management of risks, and to promote an open and fair culture focusing on learning and sharing lessons. Ward/Department Managers will be primarily responsible for managing risk and a minimum of 2 members of staff, including the Manager, will be trained. These staff will be expected to oversee the risk assessments carried out in their area of work and be responsible to cascade this training to their staff with particular reference to:

- General principles and objectives of risk management;
- Role of staff in the risk management process;
- Reporting systems and structures;
- Risk identification, description and assessment;
- Controls & Actions;
- Risk review and the use of the risk register.

All training provided to staff (of whatever grade) is to be recorded centrally using the Electronic Staff Record (ESR) and training should be refreshed every three years. Managers can book their staff onto the training earlier if a training need is identified through an individual's personal development review.

8 GLOSSARY

Risk Appetite
The amount of risk that an organisation is willing to seek or accept in the pursuit of its long term objectives.

Risk Tolerance
The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its long term objectives.

Risk Analysis
Systematic use of information to identify opportunities and threats and to estimate the likelihood of occurrence and severity of the impact

Risk Assessment
The approach and process used to prioritise and determine the likelihood of risks occurring and their potential impact on the achievement of objectives.

Risk Identification
Determination of what could pose a risk; the process to describe and list sources of risks (opportunities and threats).

Risk Management
The process of identifying and assessing risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress. This provides a disciplined environment for proactive decision making.

Risk & Assurance Framework
As an integral aspect of planning and performance management, sets the context within which risks are managed in terms of how they will be identified, analysed, controlled, monitored and reviewed.

Risk Management Matrix
Tool to assess the overall risk rating using a 5x5 matrix based on the impact of the risk and the likelihood of the risk being realised.

Risk Owner
An individual who is responsible for ensuring that a risk is managed and controlled.

Risk Rating / Score
The overall score given to a risk based on an assessment of both its likelihood of being realised and its potential impact, measured on a scale of 1 (lowest) to 25 (highest).

Strategic Risk
Risk concerned with where the organisation wants to go, how it plans to get there and how it can ensure success.

Terminate
Remove the risk by termination of the activity that brings it about or doing things differently.

Tolerate
Continue with a risk as it is at a reasonable level but monitor regularly.

Transfer
Transfer the risk to a third party such as insurance.

Treat
Control the risk by taking contingent or containment action e.g. security checks etc.

9 REFERENCES

1. Building the Assurance Framework: *A Practical Guide for NHS Boards* (Department of Health, Gatelog Ref 1054, March 2003)

3. BS ISO 31000 Risk management – Principles and guidelines on implementation (British Standards Institute, DPC/30182164 DC, May 2008)

Identifying risk, taking action: Monitor's approach to service performance in NHS foundation trusts (Monitor, IRREP 02/03,)

Audit Committee Handbook June 2012

Leading health and safety at work – Leadership actions for Directors and Board Members (Institute of Directors and Health and Safety Executive, INDG417, 09/09)

Risk Assessment Framework: a tool for departments (HM Treasury, ISBN 978-1-84532-625-8, July 2009)

Risk Essentials – A Risk Management Framework (Welsh Government, Version 2, October 2006)

Risk Management in the NHS (NHS Management Executive, December 1993)

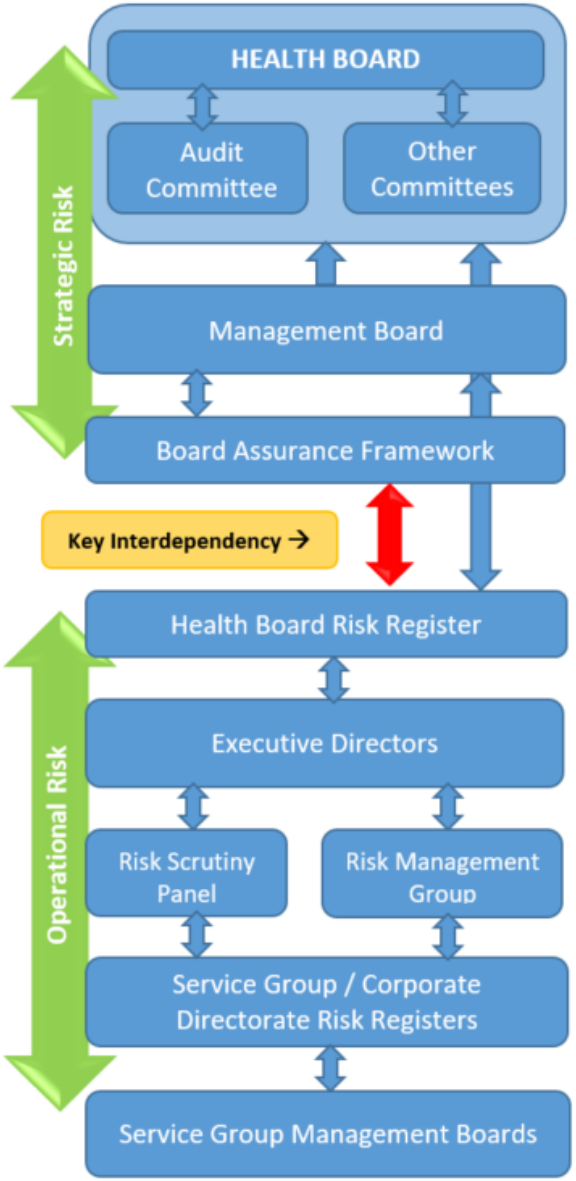
The Orange Book: Management of Risk – Principles and Concepts (HM Treasury, ISBN 1-84532-044-1-1, October 2004)

Your Risk & Assurance Framework: A structured approach – (Welsh Government, December 2009)

A RISK MANAGEMENT REPORTING, ESCALATION & ASSURANCE FLOW

Appendix A

FLOW OF RISK INFORMATION



ESCALATION / DE-ESCALATION OF RISKS

The Board's Assurance Framework (BAF) provides the organisation with a framework for identifying which of the Health Board's objectives are potentially at risk because of inadequacies in controls or insufficient assurance about them. The Health Board promotes an open culture and encourages staff to operate in a transparent manner when identifying, understanding, responding and escalating risks.

The Board Assurance Framework has a key interdependency with the Health Board Risk Register. Significant risks in the HBRR have the potential to impact on related strategic objectives, as detailed within the BAF. The HBRR provides a dynamic picture of those strategic risks and of the most significant operational risks.

Risks agreed by Risk Scrutiny Panel are forwarded to an appropriate, nominated lead Executive Director for approval to add to the HBRR. (Some risks raised directly with Executive Directors via other health board meetings, may be identified for addition directly by those Executive Directors.)

The Risk Scrutiny Panel receives risks escalated (and de-escalated) by Service Groups. It appraises the risk described, the controls in place, the risk level assessment (in the context of the Health Board's wider business objectives) and the actions being taken/planned and agrees whether addition to the HBRR (or linkage to an appropriate pre-existing risk) as a significant operational risk for detailed Board oversight is appropriate.

Service Group Directors consider risks exceeding the Board's risks appetite, controls in place and the actions and timescales agreed for their reduction, and where appropriate agree escalation to Executive Director level. Additionally, any significant risks requiring reduction, but for which action is required is outside of the control of the Service Group and this action cannot be agreed/taken within a reasonable timeframe, may be escalated to Executive Directors for review/support (typically via Risk Scrutiny Panel).

Services identify, describe and assess risks and the controls and actions taken to manage them within operational risk registers. Risks are reviewed within local governance structures. Service Group Management Boards consider the Service Group Risk Register, with a focus on the most significant risks (typically risks assessed as scoring 12 or above might trigger oversight at this management level).

ASSURANCE

Health Board will receive the BAF and HBRR three times during the year and endorse the risks and the actions being taken to mitigate.

Audit Committee reviews the effectiveness of the overall risk management framework. The Audit Committee will receive the BAF and HBRR for scrutiny and challenge, considering the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, and the effectiveness of the management of the principle strategic and most significant operational risks. The Committee also oversees the allocation of risks to other Committees for scrutiny.

Other committees of the Board scrutinise and challenge the arrangements for delivering health board objectives assigned to them and those HBRR risks that have a key interdependency and exceed the Board's risk appetite.

The Management Board will periodically receive the BAF and HBRR for review and endorsement. Risk Reports will include summarised outcomes of Risk Scrutiny Panel and Risk Management Group meetings.

Each risk on the HBRR is owned by a lead Executive Director. They are responsible for ensuring the effective management of that risk and ensuring that the HBRR entry remains relevant and up to date.

The Risk Scrutiny Panel will review the highest scoring HBRR risks (with a focus on those above the board risk appetite) and appraise the scoring and effectiveness of treatment actions.

The Risk Management Group will review the arrangements in place to manage operational risks within service groups / corporate directorates, and advise on areas for improvement.

Specialist groups may provide expert advice on significant risks and risk themes and consider the adequacy of the controls in place. Further action to be taken to mitigate the risks and endorse or challenge the risk entries.

Risk Management Group
Terms of Reference

(DRAFT MARCH 2023)

1. PURPOSE, ROLE AND FUNCTION OF THE GROUP

1.1 The Health Board Risk Management Group (the "Group") is a formal management group established by the Chief Executive to discharge the responsibility of the Executive Team for the oversight and improvement of arrangements for the operational management of organisational risk (the Role of the Group).

1.2 The Function of the Group is to:

1.2.1 Oversee the Health Board's risk management arrangements and implementation of policy to ensure consistency across the Health Board;

1.2.2 Ensure that suitable processes are in place to identify, assess, monitor and manage operational risks;

1.2.3 Ensure a cohesive functional link between the Health Board's corporate governance and risk management arrangements and those of the Service Groups;

1.2.4 Ensure that risk management matters requiring intervention are brought to the attention of the Executive Directors;

1.2.5 Ensure risks relating to hosted services and shared partnerships are considered and reported as appropriate to the Management Board;

1.2.6 Where appropriate, refer Service Group risks with significant potential impact on the health board on to the Management Board.

2 AUTHORITY AND ACCOUNTABILITY

2.1 The Group is authorised by the Executive Team, and by the authority delegated to the individual members of the Group, both in the Scheme of Delegation and Risk Management Policy, and from time to time by the RMG Chair as recorded in the minutes of meetings, to undertake activities, and access staff and information required, to discharge its role as set out above.

2.2 The functions and actions of the Group do not replace the individual responsibilities of Executive Directors as set out in job descriptions and other forms of delegation of duties, including the health board's Risk Management Policy. Individual Directors remain accountable to the Chief Executive for the management of risk. Service Group Directors are accountable for the management of risk within their services.

3 REPORTING

3.1 The Group shall report to the Management Board following its meetings.

3.2 The Group will support the ongoing review of the Health Board Risk Register and Board Assurance Framework documentation, through the periodic receipt and review of each.

The Group's activities will inform risk register content and so support reporting to the Board and its Committees.

4 MEMBERSHIP

4.1 The following officers, or their nominated deputy, shall be members of the Risk Management Group, representing each of their respective corporate directorates and service groups:

- Executive Director of Nursing (Chair)
- Executive Medical Director (Deputy Chair)
- Director of Corporate Governance
- Assistant Director of Finance
- Deputy Chief Operating Officer
- Assistant Director of Strategy
- Assistant Director of Workforce and Organisational Development
- Assistant Director of Therapies & Health Science
- Digital Services Business Manager
- Representatives from each Service Group (if not one of the Service Group Directors, then typically the Governance/Quality & Safety lead)
- Risk leads from hosted agencies.

Additionally, the following members will represent corporate teams supporting concerns management, risk management, and board assurance:

- Head of Compliance
- Head of Patient Experience, Risk & Legal Services
- Assistant Head of Risk & Assurance

4.2 The following shall have a standing invitation to attend meetings from the Chair to provide specialist advice to the Group:

- Head of Health & Safety
- Assistant Director of Operations (Estates)
- Emergency Planning and Business Continuity Lead
- Pharmacy Representative

Representatives from Shared Services Partnership may be invited to attend meetings when shared risks are to be discussed.

4.3 Only members, or their nominated deputy, have the right to attend meetings. Other managers may be required to attend at the discretion of the Chair of the Group.

4.4 Members are expected to attend three of the four scheduled meetings within any twelve-month [12] period. A nominated deputy may attend to make up the quorum.

4.5 In the absence of the Chair of the Group, the Vice Chair will chair the meeting.

5 QUORUM

5.1 The quorum necessary for the transaction of business shall be four [4] members, of which one must be either the Chair or Vice Chair.

5.2 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the powers and discretions exercisable by the Group.

5.3 In exceptional circumstances, where a meeting is inquorate, a decision may be taken to proceed to consider any urgent matters. However, the absence of quorum will be recorded when reporting to the Management Board. Any decisions / recommendations made will be reported to the next meeting for endorsement.

6 DUTIES

The Health Board Risk Management Group shall undertake the following duties:

6.1 Risk Management Policy

6.1.1 Formulate, review, revise and recommend corporate policy/strategy on risk management, based on the risk appetite, risk attitudes and risk exposures identified by the Board, for recommendation to the Management Board, and approval by the Board.

6.2 Risk Management

6.2.1 Ensure that the material risks facing the Health Board are identified and that appropriate arrangements are in place to manage & mitigate those risks.

6.2.2 Regularly review risk registers and ensure the risk profile and associated mitigating actions are congruent with the Health Board risk appetite, or escalated where appropriate.

6.2.3 Ensure that Health Board Risk Management functions have an effective mandate to roll-out the risk management structure & procedures to Service Groups to ensure compliance with Health Board policies, procedures and standards.

6.2.4 Ensure that satisfactory risk management and internal control requirements are in place for the Chief Executive to sign the Annual Governance Statement.

6.3 Procedural Documents and Corporate Record Keeping

6.3.1 Prepare, review, revise and approve any supporting operational procedures and protocols that impact on the way that risk management responsibilities are discharged within service groups and directorates documents.

6.3.2 Maintain and monitor a Schedule of Matters Arising in relation to agreed actions and performance-manage each action to completion.

6.3.3 Maintain the corporate records and evidence required to support the Board Assurance Framework document, and pursue gaps in evidence and assurance to secure the successful achievement of the Board's objectives.

7 SECRETARIAT SERVICES

7.1 Director of Corporate Governance shall provide secretariat support to the Group.

7.2 Notice and Conduct of Meetings

7.2.1 The Secretary shall call routine meetings of the Group at the request of the Chair not less than seven [7] clear days prior to the date of the meeting. The Chair may call extraordinary meetings in the event of urgent business with no prior notice.

7.2.2 The agenda shall be agreed by the Chair in consultation with the Director of Corporate Governance.

7.2.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Group and where appropriate, other persons required to attend, no later than three working days before the date of the meeting.

7.2.4 Supporting papers shall be provided to members and to other attendees as appropriate, at the same time.

7.3 Minutes of Meetings

The Secretary shall:

- Minute the proceedings and resolutions of the Group, including the names of members present and others in attendance,
- Maintain a Schedule of Matters Arising to record and track the progress of actions delegated for action by the Group,
- Make available the Minutes and the Schedule of Matters Arising within five working days of meetings of the Group.

Members shall:

- Ensure the minutes from the Risk Management Group are added to the Service Group / Corporate Directorate lead governance/quality & safety group meetings (or another appropriate meeting).

8 FREQUENCY OF MEETINGS

8.1 The Group shall meet four times a year and at such other times as the Chair shall require.

9 REVIEW OF TERMS OF REFERENCE

9.1 At least once a year, the Group shall review its own performance, constitution and Terms of Reference to ensure it is operating effectively and recommend any changes it considers necessary to the Management Board for approval.

10 STANDING AGENDA ITEMS

The Secretariat will operate a forward planner to schedule agenda items during the year.

The following items shall be received and reviewed by the Risk Management Group:

10.1 Policies & Procedures

10.1.1 Risk Management Policy – annually

10.1.2 Risk Management Easy Read Guide – annually

10.2 Strategic Risk Matters

10.2.1 Health Board Risk Register – each meeting

10.2.2 Board Assurance Framework

10.3 Operational Risk Matters

10.3.1 Service Group and Corporate Directorate Risk Registers – rotational coverage, with a view to covering all service groups once during the year as a minimum.

Risk Scrutiny Panel
Terms of Reference

(DRAFT MARCH 2023)

1. PURPOSE, ROLE AND FUNCTION OF THE GROUP

1.1 The Health Board Risk Scrutiny Panel is a formal Executive group established by the Chief Executive to discharge the responsibility of the Executive Team for the consideration of operational risks escalated by services for inclusion within the Health Board Risk Register (the Role of the Group).

1.2 The Function of the Group is to:

1.2.1 Review risks escalated by Service Groups for inclusion in the Health Board Risk Register;

1.2.5 Review the arrangements in place for the management of the most significant risks within the Health Board Risk Register.

2 AUTHORITY AND ACCOUNTABILITY

2.1 The Group is authorised by the Executive Team, and by the authority delegated to the individual members of the Group, both in the Scheme of Delegation and Risk Management Policy, to undertake activities, and access staff and information required, to discharge its role as set out above.

2.2 The functions and actions of the Group do not replace the individual responsibilities of Executive Directors as set out in job descriptions and other forms of delegation of duties, including the health board's Risk Management Policy. Individual Directors remain accountable to the Chief Executive for the management of risk.

3 REPORTING

3.1 The Group shall summarise key decisions made and actions taken, via corporate Risk Reports, to the Management Board, membership of which ensures that Service Group Directors and Executive Directors have oversight of outcomes;

3.2 Additionally, the Group will provide feedback to Service Groups following meetings to share decisions and actions taken.

4 MEMBERSHIP

4.1 The following officers shall be members of the Risk Scrutiny Panel:

- Executive Director of Nursing (Chair)
- Executive Medical Director
- Director of Corporate Governance

4.2 The Assistant Head of Risk & Assurance, and members of the Risk & Assurance team, will attend to support the meeting.

4.3 Only members have the right to attend meetings. Other managers may be required to attend at the discretion of the Chair of the Group.

4.5 In the absence of the Chair of the Panel, the other clinical Executive Director will fulfil the role.

5 QUORUM

5.1 The quorum necessary for the transaction of business shall be one clinical Executive Director.

5.2 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the powers and discretions exercisable by the Group.

5.3 In exceptional circumstances, where a scheduled meeting is inquorate, decisions may be taken outside of the meeting by two members. These will be recorded.

6 DUTIES

The Health Board Risk Scrutiny Panel shall undertake the following duties:

6.1 Risk Escalation

6.1.1 Review risks escalated by service groups seeking their inclusion within the Health Board Risk Register; appraising the risk level assessments (considering from an organisational perspective the risks assessed within services), existing controls, planned actions and supporting information;

1.2.2 Agree the appropriateness of inclusion of escalated risks within the Health Board Risk Register, and nominating appropriate Executive leads when agreed;

1.2.3 Provide feedback to Service Groups on the outcome of considerations, or requesting further information / actions as may be required;

1.2.4 Provide assurance to the Management Board on decisions made, via the corporate Risk Reports submitted;

6.2 Risk Management Assurance

6.2.1 Appraise the arrangements in place to address the most significant risks on the Health Board Risk Register, with a view to ensuring appropriate action is taken to address high level risks within reasonable timeframes.

7 ADMINISTRATION

7.1 Director of Corporate Governance shall provide administrative support to the Group, via the Risk & Assurance team.

7.2 Notice and Conduct of Meetings

7.2.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Group and where appropriate, other persons required to attend, no later than two working days before the date of the meeting.

7.2.4 Supporting papers shall be provided to members and to other attendees as appropriate, at the same time.

7.3 Records of Meetings

The Risk & Assurance Team will provide administrative support to the meetings, which will include:

- Brief meeting notes will record members present at meetings and key outcomes of risks considered;
- Feedback will be provided to Service Groups following meetings on the outcomes of considerations or actions taken.

8 FREQUENCY OF MEETINGS

8.1 The Group shall meet monthly.

9 REVIEW OF TERMS OF REFERENCE

9.1 At least once a year, the Group shall review its own performance, constitution and Terms of Reference to ensure it is operating effectively and recommend any changes it considers necessary to the Management Board for approval.

RISK ASSESSMENT GRADING MATRIX

Appendix D

For each risk identified, the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the risks and attempts to assess the likelihood/probability of the event occurring and the effect/impact it could have on the Health Board. This process ensures that the Health Board assesses its risks in a structured way, and prioritises the allocation of its resources towards managing those risks with the greatest potential impact on the organisation.

The risk grading matrix is set out as below:

RISK MATRIX	LIKELIHOOD				
CONSEQUENCE	**1 - Rare**	**2 - Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

Additional guidance is presented to support the assessment of Consequence and Likelihood scores, and to promote consistency in how this is performed across the organisation:

LIKELIHOOD

LIKELIHOOD SCORE	1	2	3	4	5
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it / does it happen?	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	0.1-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

CONSEQUENCE

RISK DOMAINS	CONSEQUENCE SCORE & DESCRIPTOR				
	1	2	3	4	5
	NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
Patient Safety	Minimal injury requiring no/minimal intervention or treatment. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Increase in length of hospital stay for 1-3 days. Category 2 pressure ulcer.	Moderate injury requiring professional intervention. Increase in length of stay by 4-15 days. Category 3 pressure ulcer. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/ disability. Fall requiring surgical intervention. Category 4 pressure ulcer. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of people.
Health and Safety	No obvious injury. No time off work.	An injury sustained at work requiring time off or reduced duties up to 7 days.	RIDDOR Reportable 7 Days or more off due to work related injury or reduced duties. Any Reportable Occupational Disease.	RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. (Formally classified as major injuries).	RIDDOR Reportable. Incident leading to death. An event which impacts on a large number of staff.
Governance and Assurance	Peripheral element of treatment or service suboptimal. Informal inquiry.	Overall treatment or service suboptimal. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low performance rating. Critical report.	Totally unacceptable level or quality of treatment/ service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman/ inquiry. Gross failure to meet national standards.
Workforce and Organisational Development	Lower than expected staffing level that temporarily reduces service quality for 1 day or less.	Lower than expected staffing level that temporarily reduces service quality for 1 day or more.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level or skill mix (1 - 5 days). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or skill mix (5 days or more). Loss of key staff. Very low staff morale.	Non-delivery of key objective/service due to lack of staff. Ongoing unsafe staffing levels or skill mix. Loss of several key staff. No staff attending mandatory training/ key training on an ongoing basis.
Compliance with Legislation and Statutory / Regulatory Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendations/ improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices/ Critical report.	Multiple breaches in statutory duty or prosecution. Complete systems change required.

RISK DOMAINS	CONSEQUENCE SCORE & DESCRIPTOR				
	1	2	3	4	5
	NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
				Low performance rating.	Zero performance rating. Severely critical report.
Information Governance	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 additional suffering. It may also include possible inconvenience 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 or it prevents someone from doing their job such as a cancelled procedure that has the potential of prolonging suffering but does not lead to a decline in health.	There has been reported suffering and decline in health arising from the breach or there has been some financial detriment occurred. Loss of bank details leading to loss of funds. There is a loss of employment.	A person dies or suffers a catastrophic occurrence.
Sustainable Services / Project Delivery	Insignificant cost increase/ schedule slippage.	<5% over project budget. Minor schedule slippage <1 month.	5-10% over project budget. Schedule slippage <2 months.	10-25% over project budget. Schedule slippage <3 months.	>25% over project budget. Schedule slippage >3 months. Key objectives not met.
Service / business interruption	Loss/interruption of service >1 hour	Loss/interruption of service >8 hours.	Loss/interruption of service >1 day	Loss/interruption of service >1 week	Permanent loss of service or facility
Financial Management	Small loss.	Loss of 0.1 - 0.25% of budget*	Loss of 0.25 - 0.5% of budget*	Loss of 0.5 - 1.0% of budget* Uncertain delivery of key objective.	Loss of >1% of budget* Non-delivery of key objective.
Environment, Estates and Infrastructure	Minimal or no impact.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic impact on environment.
Medical Devices, Equipment and Supplies	Minimal injury requiring no/minimal intervention or treatment. Negligible disruption to a clinical service.	Minor injury or illness, requiring minor intervention. Minor short term disruption to a clinical service.	Moderate injury requiring professional intervention. Re-scheduling of a clinical service.	Major injury leading to long-term incapacity/ disability. Cancellation of a clinical service.	Incident leading to death or permanent irreversible health effects. Cessation or closure of a clinical service.

RISK APPETITE STATEMENT

Executive Sponsor: Executive Director of Nursing & Patient Experience

Document Author: Director of Corporate Governance

Approved by: Health Board

Approval Date: 24/11/2022

Review Date: 30/11/2023

Version: Final

This document should be read in conjunction with Swansea Bay University Health Board's Risk Management Policy and Board Assurance Framework (BAF)

Table of contents

1. Introduction

The UK Corporate Governance Code states that '**the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'**. This means that at least once a year, Swansea Bay University Health Board should consider the types of risk it may wish to exploit and/or can tolerate in the pursuit of objectives. This helps demonstrate to our service users, regulators and other stakeholders that there are clear and effective processes for managing risks, issues and performance across the Health Board.

Swansea Bay University Health Board define risk appetite as **'the amount of risk we are willing to seek or accept in the pursuit of long-term / strategic objectives.'** It is key to achieving effective risk management and should be considered before risks are addressed.

It is not possible to eliminate all risks which are inherent in achieving our objectives and fulfilling our statutory obligations, and so we may need to consider and/or accept a certain degree of risk where it is in our, patients' or staffs' best interests i.e., where taking managed risk (in keeping with our statements of risk appetite) may result in positive benefits for our patients, service users, staff and visitors.

We carry out analysis, make judgements, take decisions, provide services and run projects every day. We do not operate in a vacuum; equally risks are not static, nor are they mutually exclusive. We must therefore view risks holistically, assessing interdependencies to provide a more rounded assessment of risk, finding a better balance between the potential benefits of managed risk taking and avoidance of risk.

Risk management within the Health Board aims to achieve the optimum balance between quality of care, treatment and rehabilitation of patients, and the provision of services which are safe by optimising use of resources and identifying prioritised risk control action plans. Therefore, an approach to risk appetite which puts the quality of care and the safety of patients and staff at the centre but recognises the requirement for efficiency, especially in today's climate, has been considered to support clear decision making and accountability for our Health Board.

In conclusion, risk appetite within the Health Board aims to prevent failure caused as a consequence of excessive risk-taking and ensure that Management Board and the Board are taking the right risks for success (e.g., to maintain or enhance patient safety and experience to maintain performance within an appropriate use of resources, and to deliver improved outcomes for patients and deliver value for money). It should facilitate a forward-looking view of risk and be adaptable to local circumstances across our Health Board to help drive management action and facilitate informed decisions. Risk appetite provides freedom for prudent decision-making within agreed risk boundaries by:

- Providing early warning where risks are outside of limits (yet still within risk capacity and well within legal requirements);
- Creating a "freedom" that promotes flexibility and accountability to management and operations;
- Making sure a breach triggers internal actions designed to escalate and respond before it threatens the reputation and viability of the Health Board;
- Eliminates excessive risk aversion by articulating preference for risk taking;
- Defines thresholds for risk taking that optimise risk and reward;

- Helps integrate risk taking and performance management;
- Assists with the definition of risk metrics that support day-to-day business operations;
- Defining escalation and reporting procedures related to pre-set levels.

Risk appetite in Swansea Bay University Health Board is:

a) set by the Board;
b) aligned with our corporate and recovery & sustainability priorities and embedded into key business processes;
c) linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control;
d) not a single, fixed concept. There will be a range of appetites for different risks and these appetites may vary over time; in particular, the Board will have freedom to vary the amount of risk which it is prepared to take as circumstances change, such as, periods of increased uncertainty or adverse changes eg in response to COVID-19; and
e) reviewed once a year, or sooner if circumstances dictate.

2. What is Risk Appetite and Risk Tolerance?

Risk Appetite and Risk Tolerance set boundaries for the level of risk that Swansea Bay University Health Board, and the Service Groups, Divisions and departments, are prepared to accept throughout the course of ongoing operations. Establishing these parameters should facilitate the ability to set a proportional response to risk in the context of business objectives.

Having a defined risk appetite strategy helps to consider how much risk is appropriate in the course of performing activities, and it can be used to assess and prioritise the management of risks that are determined to be outside of the agreed appetite and tolerance set by the Board.

This document creates a common language and understanding with regards to Swansea Bay University Health Board's attitude to risk. Relevant definitions for Risk Appetite and Risk Tolerance, and other related terminologies, are defined in **Appendix 1**:

3. Risk Appetite Statement

The Health Board has developed the principles of the Good Governance Institute Risk Appetite for NHS Organisations Matrix, **Appendix 2**, in terms of the levels of risk appetite:

0 – averse
1 – minimal
2 – cautious
3 – open
4 – seeking
5 – significant

The Board has developed several risk appetite statements and indicative tolerance limits. Following engagement with Executive Directors, it has been recognised that

current levels of service demand, staffing availability and financial constraints create a high risk environment. The relatively high appetite levels currently proposed reflecting this context in order to focus effort on the management of the most significant of risks – however, it is the health board's aspiration to reduce these as soon as practicable. These risk appetite statements and indicative limits are provided against nine risk types and will be reviewed annually by the Board set out in Table 2 below.:

Table 2:

	Risk Type	Risk Appetite
1	**Quality** The provision of high-quality services is of the utmost importance for Swansea Bay University Health Board. The Health Board acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. In the current context, the Board accepts a 'seeking' appetite in relation to quality risks, though it aspires to adopting a 'cautious' appetite in the medium term and indicates that wherever possible currently, action should be taken to address risks which could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions.	Seeking
2.	**Workforce** Swansea Bay University Health Board is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximize the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. We have a 'seeking' risk appetite for decisions taken in relation to workforce given the recognised workforce shortages. However, we will not accept workforce risks where they contradict our Values (eg unprofessional conduct, underperformance, bullying), or present risk to the safety of patients or staff, as described in our risk approaches to Quality and Health & Safety.	Seeking
3.	**Financial sustainability** Swansea Bay University Health Board is entrusted with public funds and must remain financially viable while safeguarding the public purse. We strive to deliver our services within the budgets our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or	Seeking

	Risk Type	Risk Appetite
	quality of care according to a 'seeking' risk appetite. We will ensure that all such financial responses deliver optimal value for money. While this is the case, the Health Board has a highly risk-averse appetite for accepting or pursuing risks that would leave the organisation at risk of fraud or breaches of Standing Financial Instructions.	
4.	**Compliance** While the board has an 'open' appetite in relation to compliance risk in the current context, where the risk relates to laws, regulations and standards about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them. The health board aims to reduce this appetite to a 'cautious' level in the medium term.	Open
5.	**Reputation** The Health Board will maintain high standards of conduct, ethics and professionalism at all times and is 'cautious' in its approach to managing risks to these. However, the board has a 'seeking' risk appetite where actions and decisions taken in the interest of ensuring quality and sustainability may affect the reputation of the organisation.	Seeking
6.	**Health & Safety** The Health Board holds staff safety in the highest regard. In the current context, the Board accepts a 'seeking' appetite in relation to health & safety risk, but aspires to adopting a 'cautious' appetite in the medium term and indicates that wherever possible currently, we will support our staff to work in collaboration with partners to develop appropriate and safe plans based on assessment of risk.	Seeking
7.	**Estates Management** Key to keeping patients and staff safe is the condition of the estate. We are committed to ensuring that our services are provided in buildings that are fit for purpose, are compliant with legislation and do not represent a health and safety risk. In the current context, the Board accepts a 'seeking' appetite in relation to estates management risk, but aspires to adopting an 'open' appetite in the medium term.	Seeking
8.	**Digital & Informatics** While the health board wishes to minimise risks arising from technology not delivering the expected services due to inadequate or deficient system/process development and performance or	Seeking

	Risk Type	Risk Appetite
	inadequate resilience, while this is the case, it has a risk-seeking appetite to the development of new systems and managing system changes that are aimed at improving service delivery.	
9.	**Business Continuity** The Health Board wishes to limit disruption or compromise to services in operational areas as much as reasonably possible, with few exceptions. There must be business continuity plans and disaster recovery plans in place to ensure that if identified risks materialise, the damage is limited, ie, the scale of disruption is minimum, and costs are contained. It currently has a 'seeking' appetite towards risks of this nature, but aims to reduce this to an 'open' appetite in the medium term.	Seeking

Table 3 summarises the health boards **risk appetite statement** structured around the Health Board's key risk types and also include risk tolerance levels and the assuring committees for the risks.

Table 3:

Type of Risk	Risk Appetite	Risk Tolerance Levels*	Assuring Committee
Quality	Seeking	20	Quality & Safety
Workforce	Seeking	20	Workforce & OD
Financial	Seeking	20	Performance & Finance
Regulatory Compliance	Open	16	Audit
Reputational	Seeking	20	Audit
Health & Safety	Seeking	20	Health & Safety
Estates management	Seeking	20	Health & Safety
Digital & Informatics	Seeking	20	Performance & Finance
Business Continuity	Seeking	20	Audit

* Risks below these levels will be tolerated, but action would be expected to reduce those risks achieving or exceeding these levels.

Risk Appetite levels have been aligned to risk tolerance levels as set out in Table 4 overleaf:

Table 4

Risk Appetite Levels	Risk Tolerance Levels
0 – Averse	4
1 – Minimal	9
2 – Cautious	<15
3 – Open	<16
4 – Seeking	<20
5 – Significant	25

When a risk reaches the tolerance level then it is escalated and reported to a nominated committee of the Board to oversee, scrutinise and receive a deep dive report as appropriate to ensure appropriate assurance is provided in terms of the plans to manage the risk to within the tolerance levels set.

In drafting the Health Board's risk appetite across these nine domains, reference has been made to the Good Governance Institute's Risk Appetite for NHS Organisations Matrix (see **Appendix 2**) as a guide.

Appendix E

Risk Appetite Appendix 1: Risk Definitions

Key Term	Definition
Risk Capacity	The maximum amount and type of risk an organisation can assume / is *able* to support in pursuit of its objectives given its resources, operational environment and obligation.
Risk Appetite	The amount and type of risk an organisation is willing to accept in the pursuit of objectives. Risk appetite is the aggregate level and types of risk that Swansea Bay University Health Board executive management and Board is willing to assume *within its risk capacity* to achieve business objectives. Risk appetite is usually encompassed in practice through standard operating procedures, policy and guidelines.
Risk Tolerance	The acceptable level of deviation from a standard or objective delineated through the use of limits, policies, and delegation of authorities. Swansea Bay University Health Board's tolerance for risk relates to the degree to which performance can deviate from expected outcome and still be considered within an acceptable range from a risk perspective. Risk tolerance determines the **maximum** risk Swansea Bay University Health Board is willing to take for a particular activity / objective, or category of risk. Exceeding a risk tolerance will typically act as a trigger for corrective action at the executive level, immediate notification to the board, and a fulsome review of the underlying causes of the high-risk exposure or significant variation from expected performance.
Risk targets	The **optimal** level of risk that an organisation wants to take in pursuit of a specific business goal. This is usually based on the desired return or outcome, the risks implicit in trying to achieve the organisations' strategy and related returns and the ability to manage the related risks.
Risk limits (or indicators)	The **thresholds** to monitor for the risk exposure or performance deviating from the target i.e., that actual risk exposure does not deviate too much from the risk target and stays within Swansea Bay University Health Board defined risk tolerance. Exceeding a risk limit will typically act as a trigger for corrective action at the process level, immediate notification at management level, and reporting at a governance level.
Principal Risks	Principle risks are significant risks or combinations of risks that can threaten the delivery of our strategy / can affect the strategic performance, reputation, or prospects of the organisation. These include those risks that would threaten the business model, future performance or financial sustainability of Swansea Bay University Health Board. Principal risks may be identified by Board members when considering risks to strategic objectives & plans. They may also be identified through analysis and/or consolidation of operational risks reported by different functions and/or identified by key stakeholders (such as member of the Executive/Service Groups).

Risk Appetite: Appendix 2 – Good Governance Institute Risk Appetite Matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

RISK REGISTER TEMPLATE **Appendix F**

<table>
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Health Care Standards:</td><td colspan="2">HBR Ref Number:
Risk Target Date:</td><td>Current Risk Rating
C x L = R</td></tr>
<tr><td colspan="2">Objective:</td><td colspan="3">Director Lead:
Assuring Committee:</td></tr>
<tr><td colspan="2">Risk: [Title]
[Description]</td><td colspan="3">Date last reviewed:</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: C x L = R
Current: C x L = R
Target: C x L = R</td><td rowspan="2">[GRAPH – RISK TREND]</td><td colspan="3">Rationale for current score:</td></tr>
<tr><td>Date added to the risk register
00/00/00</td><td colspan="3">Rationale for target score:</td></tr>
<tr><td colspan="2">Controls (What are we currently doing about the risk?)</td><td colspan="3">Mitigating actions (What more should we do?)</td></tr>
<tr><td colspan="2" rowspan="4"></td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Assurances (How do we know if the things we are doing are having an impact?)</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)</td></tr>
<tr><td colspan="5">Additional Comments / Progress Notes</td></tr>
</table>