Risk Management Policy

This document may be made available in alternative formats and other languages, on request, as is reasonably practicable to do so.

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:	Health Board
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High Level Summary of Key Changes in May 2025 version:

Risk Management Policy Statement – Refresh of content, update framework references.

Section 2 – Aim of the Policy – Refresh of content to align with wording within Risk Management Strategy.

Section 3 – Risk Management Roles and Responsibilities – Content refreshed to reflect and clarify elements of current roles and responsibilities, including job titles and the roles and relationships between committees. Also updated to include Strategic and Corporate Risk Registers.

Section 4 – Risk Management Reporting Structure – Content refreshed and updated to include: Strategic and Corporate Risk Registers, Population Health and Partnership and Digital, Data, Research and Innovation Committees.

Changes to Risk reporting structures (new Risk Management Group responsibilities, Risk Scrutiny Panel stood down) and removal of Quality and Safety reporting information (now available in other Health Board documentation).

Section 5 – Risk Management Process – Content refreshed and updated to include Strategic and Corporate Risk Registers and links to operational risk registers.

Section 6 – Risk Registers and Monitoring Risk - Content refreshed and updated to include the Strategic and Corporate Risk Registers, reporting arrangements and links to operational risk registers.

Appendix A – Schematic diagram to be refreshed

Appendix B – Updated Risk Management Group TOR included, plus additional adjustments made to reflect additions to membership to represent service groups and health & safety function, plus the role of Group in reviewing operational risks (as already reflected in work plan)

Former Appendix C – Risk Scrutiny Panel Terms of Reference removed (Panel disbanded and reformulated in to Risk Management Group)

Appendix E – Corporate Risk Register Template

Appendix F – Strategic Risk Register Template

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1 RISK MANAGEMENT POLICY STATEMENT

In Swansea Bay University Health Board (SBUHB), we are 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 risk, including the potential for harm to patients, which needs to be managed through a structured framework. This approach ensures that risks to patient and staff safety, and to delivery of organisational objectives, are identified, assessed, eliminated or minimised so far as is reasonably practicable with the aim being to minimise the chance of the risk being realised. Where this has not been possible, 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 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, and 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 Quality Standards 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 and impacting the organisation and its objectives, and its partnerships;
- 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 following objectives:

- Support the delivery of SBUHB's objectives;
- Strengthen and embed the system for risk management at all levels of the organisation, using a consistent framework;
- Create a culture which supports risk management;
- Provide the tools to support effective risk management;
- Provide the training to support risk management;
- Embed the Health Board's appetite for risk 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 support better decision making by contributing a greater insight into risks and their impacts. It is also a dynamic process requiring different groups and individuals to be involved at different times.

SBUHB recognises that risk management is an integral part of good management practice which, when successful, will lead to:

- Well defined, relevant strategies & policies being put into practice in all relevant parts of the organisation;
- 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 the delivery of its strategic, corporate and operational objectives, with risk management not being practiced as a separate programme. This is a key concept in risk management in that it becomes 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 in the AGS. The AGS 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;
- Produce and review the Risk Management Strategy and ensure its delivery and objectives are achieved;
- Ensure there is a robust risk management system in operation in the Health Board;
- Ensure, through the Risk Management Group (RMG) , that an effective process is in place to support the escalation and reporting of risks;
- Ensure, through the RMG; that an effective 'Gateway Review' process is in place to monitor and manage Service Group and Corporate Directorate operational risk registers;
- Draft the Risk Management section of the Annual Plan / Integrated Medium Term 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 Risk and Assurance Team

3.3 Executive Director of Nursing & Patient Experience and Executive Medical Director

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

In this role, they are 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 Strategy and 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 or untoward occurrences are reported and investigated promptly and effectively to ensure that lessons are learned and shared, that corrective action is taken where required, 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;
- Their Directorate Risk Registers are regularly reviewed and updated within the Health Board risk management system (currently DatixWeb Risk Module), and that risks requiring escalation are escalated via the Risk & Assurance Team to the RMG for consideration and inclusion on the Corporate Risk Register;
- Their Directorate risk registers are linked to the Health Board's objectives as set out in the Annual Plan and / or IMTP;
- Their Corporate risks are regularly reviewed and updated, with consideration to identification of themes and / or links between their Directorate Risk Registers, Corporate Risk Register (CRR) and the Strategic Risk Register (SRR);
- Their strategic risks, as captured within the SRR, are regularly reviewed and updated and linked to the Health Board's strategic objectives
- 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.

3.6 Assistant Head of Risk & Assurance

The Assistant Head of Risk & Assurance is the Health Board lead for all aspects of risk management. They 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 are 'fit for purpose' and meet the relevant statutory and regulatory requirements;
- Risk management is embedded across the organisation.

3.7 Assistant Director of Capital Planning and 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 Board Committee level in accordance with the SBU Health & Safety Policy.

3.8 Specialist Advisors

There are a number of specialist advisors 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.
- Economic Crime

3.9 Service Group Directors

The Service Group Directors (Service Director, Director of Nursing and the Medical Director/Dental Director) have devolved responsibilities for risk management, as outlined in Section 3.4 and as applicable to the Service Group.

3.10 Ward / (Departmental) Managers / Management Chain

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;
- Engaging with Service Group Risk Management Procedures and arrangements to ensure risks identified from risk assessments, rated 9 and above, are recorded 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 in a timely manner;
- Proactively inform their manager of risks which they have identified, in a timely manner;
- 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:

- Approve the Risk Management Policy and associated strategies for managing risk;
- Deliberate annual reports and annual assurance statements;
- 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 clinical/non-clinical incidents to foster continuous improvement;

Key approaches within the Health Board are summarised below.

The Health Board is responsible for the system of internal control, including risk management, and will delegate its responsibilities and functions in accordance with the arrangements set out in this document, and Standing Orders.

The Health Board will receive a report on Risk Management, the CRR and the SRR three times a year. Additionally, it will receive assurance on the effectiveness of implementation of the Risk Management Strategy and Risk Management Policy through the Audit Committee. The Audit Committee will provide assurance that risk management systems are in place and functioning properly to minimise risk.

The principal controls identified to manage risks to delivery of the Health Board's strategic objectives and plans will be captured within the SRR, with significant gaps in control and / or assurance identified.

The information captured within the SRR and CRR will be used to inform and formulate the Annual Plan and / or IMTP,

To support decision making, 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.

4.2 Committees of the Board

The Audit Committee oversees the overall operation of the system of risk management and will review arrangements for the oversight of risks by other Board Committees.

Each risk within the CRR and SRR will be assigned to a Committee of the Board for oversight. To accompany the specific risk register entries assigned to the Committees, reports will be submitted three times a year.

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

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 is maintained across the whole of the organisation's activities (clinical and non-clinical). This 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 CRR and SRR three times a year or as the Board determines;
- Ensure the presentation of the Board Assurance Framework 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. Where items are received that the Committee considers relevant to the work of other Committees it may refer these to those Committees for consideration also, and it may seek assurance from that Committee.

The Committee will bring to the board's specific attention any significant matters under consideration by the committee and ensure appropriate escalation arrangements are in place to alert the health board chair, chief executive or chairs of other relevant committees of any urgent/critical matters that may compromise patient care and affect the operation or public/stakeholder confidence in the health board.

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

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 CRR) and SRR 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 (this includes any urgent/critical matters that may compromise patient care and affect the operation or public/stakeholder confidence in the health board). Where items are received that the Committee considers relevant to the work of other Committees it may refer these to those Committees for consideration also.

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 CRR) and SRR 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 (this includes any urgent/critical matters that may compromise patient care and affect the operation or public/stakeholder confidence in the health board). Where items are received that the Committee considers relevant to the work of other Committees it may refer these to those Committees for consideration also.

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 Board's 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. The Committee will consider any relevant risks within the CRR) and SRR 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 (this includes any urgent/critical matters that may compromise patient care and affect the operation or public/stakeholder confidence in the health board). Where items are received that the Committee considers relevant to the work of other Committees it may refer these to those Committees for consideration also.

4.2.5 Population Health and Partnerships Committee

The Population Health and Partnerships Committee provides the Board with advice and assurance on arrangements for: ensuring that strategic collaboration and effective partnership arrangements are in place; and that there are effective mechanisms in place for improving population health and reducing health inequalities. The Committee also provides the Board with advice and assurance on the robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership. The Committee will consider any relevant risks within the CRR) and SRR 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 (this includes any urgent/critical matters that may compromise patient care and affect the operation or public/stakeholder confidence in the health board). Where items are received that the Committee considers relevant to the work of other Committees it may refer these to those Committees for consideration also.

4.2.6 Digital, Data, Research and Innovation Committee

The Digital, Research and Innovation Committee provides the Board with advice and assurance that appropriate arrangements are in place for the successful delivery of current and future digital tools and services and that there are effective measures to drive the desired digital culture throughout the Health Board to enable the delivery of safe, high quality and efficient healthcare. The Committee will seek assurance that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the delivery of the digital agenda across the full range of the Health Board's services and oversee the delivery of agreed priorities. The Committee will consider any relevant risks within the CRR) and SRR 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 (this includes any urgent/critical matters that may compromise patient care and affect the operation or public/stakeholder confidence in the health board). Where items are received that the Committee considers relevant to the work of other Committees it may refer these to those Committees for consideration also.

4.3 Management Board & Executive Team

The Management Board, 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 CRRand SRR from the Corporate Governance team for review and endorsement, and exception reports from management highlighting organisational issues and risks, agreeing actions to address them and monitoring their delivery.

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 CRR and SRR as a standing agenda item at each meeting to ensure effective monitoring.

4.4 Risk Management Group (RMG)

The RMG is a formal sub-group of the Management Board, 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 risks are up to date by a 6 monthly gateway review of risks with service leads, and periodic review of operational risk registers;
- Consider escalated and deescalated risks and consider options to manage risks when Service Groups have identified a need to escalate for support / intervention;
- For escalated risks being managed on the CRR then the Executive lead will be responsible for agreeing with the Service Group Directors the level of risk score and where any discussion is required on this, the Risk Management Group will agree the current level of risk;
- 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.
- Consider and agree risks to be added / removed from the Strategic Risk Register and / or Corporate Risk Register as part of escalation and de-escalation of risks.

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

4.7 Health Board Specialist Groups

There are a number of specialist groups / committees (e.g. Patient Safety and Compliance Group, Patient and Stakeholder and Experience Group, the Infection Prevention & Control Committee, Health and Safety Operational Group, 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. 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.
The Service Group Board will ensure that risks that cannot be managed within the Service Group alone or are assessed as exceeding the Health Board's risk appetite, are escalated to the Risk & Assurance Team for consideration by the RMG.

The RMG 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 for their support for escalation to the CRR.

4.9 Corporate Directorates

There are eleven Corporate Directorates headed by the following Directors:

- Chief Operating Officer
- Director of Corporate Governance
- Executive Medical Director
- Executive Director of Nursing and Patient Experience
- Executive Director of Allied Health Professions & Health Science
- Director of Finance & Performance
- Director of Workforce & OD
- Executive Director of Planning and Partnerships
- Director of Digital
- Executive Director of Public Health
- Director of Insight, Engagement & Communication

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 its 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 /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**.** A risk assessment grading matrix is used to promote a consistent approach to risk assessment (See **Appendix C**).

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 CRR represents the Health Board's most significant operational risks, and the SRR its strategic risks. They are updated by Executive Directors bi-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

The context applicable to risk management processes should be established, and may 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, Local or National Partnerships and Networks, patients, staff and contractors.

Once the stakeholders / partners have been identified it is critical to consider their objectives, to take into account their perceptions, and to establish communication policies with these parties, including the definition of roles, responsibilities and accountabilities for managing risk. It is also important to consider these matters when considering relationships inside and outside the NHS, the behaviour of the “partners” and the organisation, and how this will affect any risks identified.

Criteria against which risk will be evaluated should also be established and the structure of the analysis defined.

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 the Health Board provides.

5.3.1 Strategic Risk and Integrated Medium Term Plan (IMPT)

Strategic risks are those risks associated with the achievement of aims and strategic objectives of the Health Board, in particular those set out in the 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 Strategic Risk Register**.** This will be a "top down" approach, undertaken collectively by the members of the Executive Team.

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 Corporate Risk Register.

5.3.2 Corporate Risk

Those risks that cannot be managed within the Service Group or individual Corporate Directorates alone and / or are assessed as exceeding the Health Board's risk appetite yet are not considered to be a strategic level risk will be captured in the CRR.

The CRR will create a link between the SRR and the Operational Risk Registers.

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.

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, which enables risk to be ranked to allow identification of management priorities. For example, if the levels of risk established are low, then risks may be tolerable, and treatment of the risk may not be required. Consideration should also 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. Discussion of the risk 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	SRR/CRR 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

The organisation will agree actions to manage and control identified 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 the Health Board's 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 the Health Board, and its 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 D**). 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 Health Board's 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 may be reactive, proactive, preventative or corrective.

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 altogether (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's 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 CRR.

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,

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 RMG. To support effective review, the Group 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 Group evaluates escalated risks from the Service Groups, 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 CRR. Executive Directors may also identify and escalate risks directly for inclusion within the CRR.

In addition to the above, individual risks which are thematically connected may be considered for escalation to the CRR. These may be identified from reports & discussions at corporate management groups or from thematic reviews of the risk register. The RMG 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. 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 Health & Care Quality 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 and Directorates 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 Corporate Risk Register (CRR)

The Health Board's CRR can be described as *"a log of all the significant operational risks that may threaten the success of the Health Board*." The Board-level CCRR represents the Health Board's most significant operational risks. The template for presentation of the CRR at Board and Committees is attached at **Appendix E**.

6.3 Strategic Risk Register (SRR)

The Health Board's SRR sits above the CRR. It is a log of all the risks that may threaten the success of the Health Board in achieving its objectives, at a strategic level. The Board-level SRR represents the strategic risks of the organisation, as aligned to its strategic objectives and in support of the BAF. The template for presentation of the SRR at Board and Committees is attached at **Appendix F**.

The Risk and Assurance Team will coordinate the CRR and the SRR to produce a 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 CRR and SRR 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

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 AS / NZS 4360:2004

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)

Appendix A

RISK REGISTER MANAGEMENT & REPORTING

The Board's Assurance Framework (BAF) and Strategic Risk Register (SRR) provides the organisation with a structured approach to effectively managing the principal risks to achieving its strategic objectives.

Health Board will receive the SRR and CRR periodically enable oversight of the risks and the actions being taken to mitigate.

Risks within the SRR are identified, reviewed and refreshed by Executive Directors in a top-down process as part of the annual strategic and operational planning between October and March. The aim is to identify the high-level strategic risks that have the potential to impact on the Health Board's delivery of its strategic objectives.

Audit Committee reviews the effectiveness of the overall risk management framework. The Audit Committee will receive the SRR and CRR periodically to inform its oversight of risk management arrangements. The Committee also oversees the allocation of risks to other Committees for scrutiny.

The Strategic Risk Register is informed by risks captured within the Corporate Risk Register (CRR). Significant risks in the CRR may have potential to impact on strategic risks – where this is the case, they are cross-referenced in the SRR.

Committees receive extracts of the SRR and CRR for risks assigned to them.

Other committees of the Board will review extracts of the SRR and CRR assigned to them.

As part of bi-monthly update process, Executive Directors review risks assigned to them within the CRR and SRR and update accordingly. Final risk registers are returned to Execs for approval. These are reported periodically to Management Board, ahead of reporting to Audit Committee and the Board.

Following the addition of risks to the CRR, risks are assigned Executive Director owners and monitored as part of the bi-monthly update process. Where CRR risks are reduced to the point whereby an Executive Director considers they can be de-escalated, these proposals are taken to the RMG for approval.

The Management Board will periodically receive the SRR and CRR for review and endorsement. Risk Reports will include summarised outcomes of Risk Management Group meetings.

The CRR provides a dynamic picture of the Health Board 's most significant operational risks. It comprises the most significant risks within service groups and corporate directorates, together with complex risks that may span services, and Board Director oversight.

The Risk Management Group (RMG) receives escalated operational risks. It reviews the risk, the controls in place, the risk level assessment (in the context of the Health Board's wider business objectives) and the further actions being taken/planned and determines whether an additional risk or link to a pre-existing risk on the CRR is appropriate. Feedback is provided to the originating service following its consideration.

The Risk Management Group will review the management of the SRR, CRR and ORR (with a focus on high scoring risks) advising on areas for improvement and reporting to Management Board. In doing so it may seek specialist/expert advice as required.

Service Group Directors and Executive Directors monitor their operational risks and where they are judged to exceed the Board's risk appetite and/or require support beyond the service to address (eg cross-cutting risks) escalate these to the Risk Management Group for consideration.

Services and corporate functions identify, describe and assess risks related to their functions within their operational risk registers (ORR). New operational risks are reviewed and accepted within their local governance arrangements. Service Group Management Boards / Executive Directors implement systems to consider their risk registers with a focus on those most significant.

Each risk on the SRR and CRR is owned by a lead Board Director. They are responsible for ensuring the effective management of these risks and ensuring that the register entries remain relevant and up to date.

Risk Management Group
Terms of Reference

(MARCH 2025)

1. PURPOSE, ROLE AND FUNCTION OF THE GROUP

The Health Board Risk Management Group (the "Group") is a formal sub-group of the Management Board 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).

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 strategic and 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 risks are up to date by a 6 monthly gateway review of risks;
- Consider escalated and deescalated risks and consider options to manage risks when Service Groups have identified a need to escalate for support/intervention.
- For escalated risks being managed on the Corporate Risk Register then the Executive lead will be responsible for agreeing with the Service Group Directors the level of risk score and where any discussion is required on this the Risk Management Group will agree the current level of risk.
- 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.
- Consider and agree risks to be added/removed from the Strategic Risk Register and or Corporate Risk Register as part of escalation and de-escalation of risks.

2. AUTHORITY AND ACCOUNTABILITY

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.

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

The Group will report to the Management Board following each meetings.

4. MEMBERSHIP

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

- Executive Medical Director & Deputy Chief Executive Officer (Chair)
- Executive Director of Nursing (Vice Chair)
- Executive Director of Allied Health Professions and Health Science
- 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 Digital Services
- Assistant Director of Estates
- Assistant Director of Capital Planning and Health & Safety
- Head of Compliance
- Assistant Head of Risk & Assurance
- Service Group Representative

Specialist advisors in the Health Board will be co-opted to attend meetings when risks linked to their specialties are scheduled to be discussed e.g: infection control; medicines management; health & safety; estates.

Only members have the right to attend meetings unless they are on leave – then a nominated deputy with appropriate knowledge and expertise may attend by exception on their behalf.

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

5. QUORUM

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

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.

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.

Urgent decisions required to be made outside of the routine meeting arrangements will be by Chair's action.

6. DUTIES

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

- Risk Management Policy

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.

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

  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.

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

- Review of key Risk documents:
  The Group will support the ongoing review of the:

  - Board Assurance Framework;
  - Strategic Risk Register;
  - Corporate Risk Register; and
  - Operational Risk Register.

7. ADMINISTRATION

The Corporate Governance Directorate shall provide administrative support to the Group.

The meetings will be minuted and action logs maintained by the Corporate Governance Directorate and issued 5 working days after the meeting.

8. FREQUENCY OF MEETINGS

The Group will meet monthly and the Chair may request additional meetings.

9. REVIEW OF TERMS OF REFERENCE

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 C

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 D

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.

STRATEGIC RISK REGISTER TEMPLATE **Appendix F**

To follow		

STRATEGIC RISK REGISTER TEMPLATE **Appendix F**

Risk ID Number Allocated by R&A	**Risk Title** – To be created/completed by the Lead Director and/or nominated representative. Risk Description – To be created/completed by the Lead Director and/or nominated representative.

Risk Score	**Consequence**	**Likelihood**	**Overall Score**	**Trend**	**Strategic Objective**	The Strategic Objective(s) impacted by this risk. Taken from the HB Annual Plan / IMTP
Inherent Score	Lead Directors and/or nominated representative assessment of the risk score if no controls were applied.			Lead Directors and/or nominated representative assessment of progress made in managing the risk since the last report. Convention supplied.	**Lead Director / Risk Owner**	Identifies the Director responsible/accountable for managing the risk
Current Score	Lead Directors and/or nominated representative assessment of the current risk score, taking into account the controls in place.				**Monitoring Committee**	Identifies the Committee with delegated responsibility for overseeing the management of this risk.
Target Score	Lead Directors and/or nominated representative assessment of the risk score attainable if all currently identified actions were completed, and gaps addressed			**Improving Stable Deteriorating**	**Risk Appetite**	As set by the Board.

Risk Score Over Time	**March 2024**	**July 2024**	**Nov 2024**	**March 2025**	**July 2025**	**Nov 2025**	**March 2026**	**July 2026**	**Nov 2026**	**March 2027**	**July 2027**	**Nov 2027**
	Historical risk scores reported to the Board (To assist in demonstrating progress)											

Related Risk on Corporate Risk Register
Linked or associated risks which sit in the register immediately below the Strategic Risk Register

Risk ID	**Short Name**	**Description**	**Score**
Risk ID Number Allocated by R&A	Risk Title – To be created/completed by the Lead Director and/or nominated representative*	Risk Description – To be created/completed by the Lead Director and/or nominated representative*	Lead Directors and/or nominated representative assessment of the current risk score, taking into account the controls in place*

*Where this information has already been created/updated by the Lead Directors as part of our established HBRR process, it can be populated by the R&A Team.

Key Controls ***What key controls/systems/processes/governance mechanisms do we already have in place to manage this risk?***	
Control Ref	**Control**
1	
2	
3	
4	
5	
6	
7	
8	
9	

Assurance on Control ***What information do we have about the adequacy, effectiveness and application of each of our controls, where is it coming from, and what is it telling us?***				
Control Ref	**1st Line Assurance**	**2nd Line Assurance**	**3rd Line Assurance**	**Strength of Control**
1	This should be completed by the Lead Director and/or nominated representative **for each of the controls listed above,** detailing the source(s) of assurance they have regarding the adequacy, completeness and application of that control, and an assessment of the control strength (A convention is provided). Where there is more than one source of assurance, all should be listed. Where there is currently no source of assurance for a given control, or where the assurance available indicates that the control is insufficient or ineffective, this should be recorded as a gap in the table below together with the agreed action to address it.			Substantial Reasonable Limited Unsatisfactory
2				
3				
4				
5				
6				
7				
8				
9				
	Current Overall Assurance Rating The Lead Director and/or nominated representative should state the overall level of assurance that can be taken and given regarding the effective management of this risk, having considered all of the information available regarding the adequacy, effectiveness and application of each of the controls in place, and any gaps identified. A convention is provided.			**Significant** **Good** **Moderate** **Weak**

STRATEGIC RISK REGISTER TEMPLATE **Appendix F**

	Gaps in Control and/or Assurance *Do we require further assurance that the key controls/systems/processes/governance mechanisms we have in place are working effectively?* *What more do we need to do to control this risk, that we are not already doing?*	Actions to Address Gaps in Control and/or Assurance *What are we going to do, by when, to further manage and mitigate this risk?*	Lead Director	Due Date	Progress
1	This section should detail all identified gaps in control and/or assurance. Such gaps can be identified in a number of ways: • By the Lead Director and/or nominated representative as part of their review and update process • By the Board or its committees during the discharge of their oversite role • By an assurance provider as part of their assessment process (e.g., NWSSP Audit & Assurance, Audit Wales)	For every gap in control or assurance identified, the Lead Director and/or nominated representative must detail the agreed action which will be taken to address it. There can be more than one agreed action to address each gap.	Lead Director responsible for delivering the agreed action	Deadline for action completion	Current status of action
2					Complete
3					On Track
4					Off Track
5					Not Started

Additional Comments
To be completed by the Lead Director and/or nominated representative, detailing any additional information they would like to bring to the attention of the Board. This may be particularly relevant where action to address a gap is being reported as ‘Off Track’ or ‘Not Commenced’