GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Risk Management Policy

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Caring for each other, working together and always improving.

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

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

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1. Risk Management Policy Statement

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

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

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

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

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

- be proactive rather than reactive;
- identify and treat risks within the organisation;
- improve identification of opportunities and threats;
- comply with legislation and regulations.

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

2. Aim of the Policy

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

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

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

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

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

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

3. Significant Risks

The significant risks facing SBUHB are the risks linked to achieving the Health Board's objectives and the operational risks which have been escalated, in line with the risk management process, by the Service Groups (SG's). The organisational objectives are referred to in the Health Board's Annual Plan/ Integrated Medium Term Plan (IMTP) for 2020-2023. The objectives are:

- Together improve wellbeing and healthcare for all;
- Better health, better care, better lives;

- Support better health and wellbeing by actively promoting and empowering people to live well in resilient communities;
- Deliver better care through excellent health and care services achieving the outcomes that matter to people;
- Partnerships for improving health and wellbeing;
- Co-production and health literacy;
- Digitally enabled health and wellbeing;
- Best value outcomes from high quality care;
- Partnerships for care;
- Excellent staff
- Digitally enabled care;
- Outstanding research, innovation, education and learning.

The organisational priorities are monitored by the Board and the Boards Committees through assurance and exception reports. The Executive Team will use the IMTP as the basis for performance monitoring of Service Groups and Corporate Directorate priorities. Regular performance meetings will be held, with the Service Groups, aligned to the IMT, to monitor performance against the priorities and other key performance indicators.

4. Risk Management Roles and Responsibility

4.1 Chief Executive

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

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

The Medical Director and Director of Nursing and Patient Experience are responsible for Quality and Safety, and for ensuring that there are robust systems in place to deliver a quality service. They are supported to drive forward the patient safety agenda through their Assistant Directors who have roles in quality and safety, safeguarding, infection control and education.

4.2 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 Strategy and Risk Management Policy;
- Ensure there is a robust risk management system in operation in the Health Board;

- Ensure the Risk Scrutiny Panel, responsible for ensuring there is an appropriate process to support escalation and reporting of risks, is working throughout the Health Board;
- Draft the Risk Management section of the Annual Plan/IMTP;
- Ensure key risks are co-ordinated and reported to the Executive Board, Board Committees and Health Board;
- Produce the Annual Governance Statement and Accountability report, ensuring that high level risks are reported upon.

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

4.3 Executive Directors

Each Executive Director is responsible for managing risk within their area of responsibility. This means they will:

- Ensure staff are appropriately trained in risk assessment and management;
- Ensure 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 Senior Leadership Team/Executive Team, relevant Board Committees and the Board;
- Ensure there are mechanisms in place to learn lessons from any incidents or untoward occurrences and that corrective action is taken where required;
- Ensure their Directorate Risk Registers are regularly reviewed and updated within the RL Datix software system, and that risks requiring escalation are escalated to the Risk & Assurance Team for consideration for inclusion on the Health Board Risk Register;
- Ensure compliance with Health Board policies, legislation and regulations and professional standards for their functions.

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, and are supplemented by individual job descriptions.

4.4 Head of Patient Experience, Risk & Legal Services

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

4.5 Assistant Director & 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. Providing professional advice in respect of health and safety

management. Ensuring the Health Boards risk management methodology is applied to Health and Safety issues and reporting them to the Health & Safety Committee.

4.6 Specialist Advisors

There are a number of specialist advisers within the Health Board who provide advice on specific areas of risk management. These include: Safeguarding, Fire; Health & Safety; Infection Prevention & Control; Information Governance; Medical Devices; Radiation Protection; Resuscitation and Security Management.

4.7 Operational Risk Management Arrangements

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

- Staff are aware of the Risk Management Policy, are aware of their responsibilities, understand the extent to which they are empowered to take risk, and are appropriately trained in risk assessment and risk management;
- Service Groups adopt an open and fair culture;
- Hazards, incidents and risk are identified using a consistent approach to ensure that a learning approach results in continuous improvement;
- Risks are managed and high unresolved risks are reported to the appropriate Executive Director swiftly;
- Appropriate governance arrangements are established to manage risks, ensure action is taken and that lessons learned are shared;
- Staff are released to attend mandatory/statutory training;
- Staff receive regular PDR's/Appraisals;
- Service Group Risk registers are regularly revised and used as a tool to proactively manage risks and;
- Service Group Risk Registers are linked to the Integrated Medium Term Plan (IMTP).

4.8 Corporate Risk Management Arrangements

The Corporate Directors have devolved responsibilities for risk and are responsible for ensuring that:

- Staff are aware of the Risk Management Policy, are aware of their responsibilities, understand the extent to which they are empowered to take risk, and are appropriately trained in risk assessment and risk management;
- Directorates adopt an open and fair culture;
- Hazards, incidents and risk are identified using a consistent approach to ensure that a learning approach results in continuous improvement;
- Risks are managed and high unresolved risks are reported to the appropriate Executive Director swiftly;
- Appropriate governance arrangements are established to manage risks, ensure action is taken and that lessons learned are shared;
- Staff are released to attend mandatory/statutory training;

- Staff receive regular PDR's/Appraisals;
- Directorate Risk registers are regularly revised and used as a tool to proactively manage risks and;
- Directorate Risk Registers are linked to the Integrated Medium Term Plan (IMTP).

4.9 Ward / Departmental Managers

- Promote an open and fair culture for staff to report incidents;
- Promptly investigates incidents and supports staff through the process;
- Completes or ensures risk assessments are completed and, as a minimum, reviewed on an annual basis;
- Reports risks identified from risk assessments, rated 9 and above, into the Service Group's risk register and;
- Monitor staff attendance at mandatory/statutory training.

4.10 Independent Contractors

The Primary and Community Care Service Group is responsible for working with independent contractors and ensuring appropriate risk management arrangements and systems are in place to effectively manage risk. This is carried out through the review of the governance self-assessments for each profession.

4.11 All Employees

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

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

5. Risk Management Reporting Structure

The Risk Management Reporting structure is presented at **Appendix 1** 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.

5.1 Health Board

The SBUHB Board shall, in relation to risk management:

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

The Health Board will receive quarterly progress reports on the implementation of Risk Management through the Audit Committee.

Each Executive Director will ensure their Directorate/Service Group risk register is up to date and risks are regularly considered for inclusion on the Health Board Risk Register. The risk information will be used to formulate the Annual Plan/IMTP. The Plan would then be approved by the Executive Board, Audit Committee and Board. Alongside this, key principal risks will be highlighted through all main plans e.g. for service change proposals and in key reports to the Board, its Committees and the Executive Board as a key element to decision making through the Board Assurance Framework (BAF).

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

5.2 Sub Committees of the Board

Quarterly reports will be submitted to each of the sub Committees of the Board to accompany the specific Health Board Risk Register (HBRR) entries assigned to the Committees. The sub Committees will be requested to "note" and "endorse" any risks assigned to the Committee for review and scrutiny. A summary of the key risk areas is outlined in table 1 below:

Table 1 – Summary of Health Board Risk Register Entries to be Reported to Sub-Committees

Q&S Committee	Audit Committee	W&D Committee	Performance & Finance Committee	H&S Committee
Patient Safety Risks – inc falls and pressure ulcer risks.	Oversees all risks on HBRR	Workforce planning risks - Staff shortages	Performance risks e.g. Sustainable Services - Access	H&S Risks inc V&A, manual handling and Fire
Medical Device Risks	Compliance with Legislation/ Regulation	Legal compliance re employment law e.g. DBS	Financial planning risks	Estates Risks

Infection Control Risks	IT and Information Governance risks	Occupational Health & Wellbeing risks		Security Risks
Research & Development risks		Education, learning and development risks.		Emergency Planning risks

5.2.1 Audit Committee

The Audit Committee is responsible for providing assurance to the Board on the process for the Health Board's system for internal control by means of independent and objective reviews of corporate governance and risk management arrangements, including compliance with legislation, regulatory guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

- To maintain an oversight of the Health Board's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements;
- To review the Health Board Risk Register (HBRR) quarterly or as the Board determines;
- To monitor the Board Assurance Framework (BAF), and ensure its presentation to the Board at intervals that the Board determines;
- To assess the overall effectiveness of risk management and the system of internal control;
- To challenge on the effectiveness of controls, or approach to risks in the HBRR and specific risks assigned to the Committee to oversee on behalf of the Board.

Internal Audit

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

5.2.2 Quality & Safety Committee

The Quality & Safety Committee is responsible for providing the Board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, corporate, workforce, information and research & development issues; and regulatory standards of quality and safety. The Committee will consider any relevant risks within the Health Board Risk Register (HBRR) and the Board Assurance Framework (BAF) as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.

5.2.3 The Performance & Finance Committee

The Performance & Finance Committee is responsible for providing information and making recommendations to the Board on financial performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Health Board Risk Register (HBRR) and the Board Assurance Framework (BAF) Board Assurance Framework as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate. The Terms of Reference of this Committee are set out in the Standing Orders approved by the Health Board and are available on the Intranet.

5.2.4 Workforce and Organisational Development (OD) Committee

The Workforce and OD Committee's focus is on all aspects of workforce as a resource aimed at ensuring the strategic and operational workforce agenda, priorities and work plan enables the delivery of the Health Boards objectives and supports quality and safety of healthcare and employment practice. The Committee provides assurance - in relation to the LHB's arrangements for workforce & OD ensuring they are in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

5.2.5 Health & Safety Committee

The Health & Safety Committee is chaired by a Non Officer Member and is supported by the Health & Safety Team. The Committee is a sub Committee of the Board. The Terms of Reference of this Committee are set out in the Standing Orders approved by the Health Board and are available on the Intranet. The Committee will receive and review the risks in the HBRR relating to health and safety.

The Assistant Director of Health & Safety and the Head of Health & Safety are members of the Quality and Safety Assurance Group ensuring there are strong links between quality assurance and health & safety agendas within the Health Board.

5.3 Executive Team

The Executive Team in its role as the Executive decision making forum of the Health Board maintains oversight of the operational risk and is responsible for the strategic and operational management and monitoring of risk, through the Health Board Risk Register (HBRR) and the Board Assurance Framework (BAF), and for agreeing resourced treatment plans and ensuring their delivery.

The Executive Team report to the Board through a formal written report to accompany the Health Board Risk Register (HBRR), requesting that the Board "note" any updates or changes to the Health Board Risk Register (HBRR);

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

5.4 Senior Leadership Team

The Senior Leadership Team (SLT) in its role as the senior decision making forum of the Health Board maintains oversight of the operational risk and is responsible for the operational management and monitoring of risk, through the Health Board Risk Register (HBRR) and the Board Assurance Framework (BAF), and for agreeing resourced treatment plans and ensuring their delivery.

A risk management report will be submitted to the Group shall report to the Executive Team and through a formal written report to accompany the Health Board Risk Register (HBRR), requesting that the Executive Team "approve" and "endorse" any updates or changes to the Health Board Risk Register (HBRR);

5.5 Risk Management Group

The Group reviews the Risk Management Policy and is responsible for overseeing the operational management of risk ensuring local systems and processes are in place and are operating effectively to ensure appropriate reporting and escalation. This is a Management Group which reports to the Audit Committee and Senior Leadership Team on a quarterly basis. The group receive reports on performance and assurance from:

5.5.1 Risk Management Scrutiny Panel

The Risk Scrutiny Panel is responsible for ensuring there is an appropriate and robust risk management system in place and working throughout the organisation. It is responsible for moderating new risks and escalated risks to the Health Board Risk Register (HBRR) and Board Assurance Framework (BAF) and recommending and advising the Senior Leadership Team (SLT) on the escalation and de-escalation of risks. The Panel meet on a monthly basis.

5.5.2 NHS Redress

The NHS Redress legislation received Royal Assent in July 2008 and came into force in NHS Wales in April 2011. The Measure is intended to ensure that patients can seek Redress by means of treatment, support and compensation, if appropriate, for lower-value clinical negligence claims without the need to instigate legal action through the Courts.

Regulations setting out the detail of the new arrangements have been developed in close consultation with the NHS, patient groups and CommService Groupy Health Councils and the *Putting Things Right* Project. The previous Incident, Complaints and Claims policies and procedures have been reviewed in line with the Regulations and changes made to produce an integrated Putting Things Right Policy and Procedure.

5.5.3 Incidents

Incidents will be managed and reported in accordance with the SBUHB's "Putting Things Right" Policy & Procedure. Incidents are analysed for trends and to ensure action is taken and a Root Cause Analysis Investigation of serious

incidents. Guidance on Root Cause Analysis is contained within the “Putting Things Right” Policy as a supporting appendix document and can be access on the intranet.

Incident Reporting is not part of the SBUHB’s disciplinary process. However, examples of situations where disciplinary action may be necessary are as follows:

- Criminal Activity (e.g. theft, assault and fraud)
- Professional misconduct
- Acts of gross misconduct (e.g. treating patients under the influence of alcohol)
- Malicious activity (e.g. malicious reporting of untrue allegations against a colleague)
- Repeated unreported errors or violations of procedures

5.5.4 Complaints

Complaints are managed in accordance with the Health Board’s Policy covering the National Health Service (Concerns, Complaint’s and Redress Arrangements (Wales) Regulations 2011. Each complaint received is risk assessed in terms of the severity of the complaint and likelihood of the circumstances re occurring. The Corporate Concerns Assurance Team grade complaints and support Service Groups to investigate their complaints. In addition, analyses of serious complaints are presented to the Quality & Safety Governance Group for inclusion in the relevant Risk Register as appropriate. Action plans produced to reduce the risk of the complaint reoccurring are reviewed and monitored by the Group, with lessons learned from investigations shared throughout the Health Board.

5.10.5 Claims

Claims are managed in accordance with the Claims Policy & Procedure. Claims management and trend analysis are reviewed by the Quality & Safety Goverance Group. Lessons learned, where identified, are disseminated throughout SBUHB via the Quality and Safety Forum.

5.6 Health Board Specialist Groups

In addition to the above there are a number of specialist groups/committees (e.g. Infection Control & Prevention Committee, Medical Devices Group) in the Health Board which have specific responsibility for managing the risk associated to the specialty. These management Groups and Committees either report directly to a sub committee of the Board or to the Quality & Safety Assurance Group.

5.10.7 Service Group Governance Forums

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 Care and Community Services
- Singleton Hospital

Each Service Group has a Service Group Board, which is ultimately responsible for Risk Management, specifically operational risks. The Service Group Boards will ensure that risk management issues, which cannot be managed or are high level risks (16 and above), which may impact on strategic objectives, are escalated to the Risk Assurance Team for review and if appropriate advice sought from appropriate expertise in the Health Board and then escalated to an Executive Director lead who will consider the risk and whether to add to their Directorate risk register or recommend inclusion on the Health Board Risk Register to the Senior Leadership Team.

5.10.8 Corporate Directorates

There are nine Corporate Directorates:

- Chief Operating Officer
- Director of Corporate Governance
- Medical Director
- Director of Nursing and Patient Experience
- Director of Finance & Performance
- Director of Workforce & OD
- Director of Strategy
- Director of Public Health
- Director of Transformation

Each Executive Directorate is responsible for ensuring any risk management issue identified as a high risk is reported to the Senior Leadership Team and linked into the planning process, capital planning programme by identifying risks against the Board Objectives within the Annual Plan/IMTP.

6. 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 as these will change, as they are not single fixed concepts, and will vary over time, and current influential factors at a strategic, tactical and operational level.

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

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

6.1. Methodology

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

For each issue/risk identified the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the issues and attempts to assess the likelihood of the event occurring (PROBABILITY) and the effect it could have on the Health Board (IMPACT). This process ensures that the Health Board will be focusing on those risks which require immediate attention, rather than spending time on areas which are, relatively, a lower priority. The prioritising of risk using this mechanism is detailed in ***Appendix 2*.**

The Health Board uses the risk module of RL Datix to record and monitor all risks. Ideally all should be recorded on RL Datix and as a minimum all risks rated 9 and above must be report the risk management database. The Health Board Risk Register can be accessed throug Health Boards intranet and internet and is updated, as a minimum, on a quarterly basis.

6.2 Establish the context

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

The context can include the financial, operational, competitive, political (public perceptions/image), social, client, cultural and legal aspects of the Health Board's functions. Within these areas it is critical to identify the internal and external stakeholders/partners which may include any of the following: Welsh Government, patients, staff and contractors. Once the stakeholders/partners have been identified it is important to consider their objectives, take into account their perceptions, and establish communication policies with these parties. It is also important to consider these issues when considering relationships inside and outside the NHS the behaviour of the "partners" and the organisation and how this will affect any risks identified.

6. 3 Risk Identification

Risk identification can be undertaken on an individual basis or as part of a multidisciplinary team and can be reactive or proactive and linked to strategic objectives, underpinning the assurance framework, or operational services we provide. Details of how to identify risks are provided within the "Simple Guide for Risk Management" which provides guidance on how to complete a Risk Assessment which supports the implementation of the Risk Management Policy. The "Simple Guide for Risk Management" is presented at ***Appendix 3*** for information.

6.3.1 Strategic Risk and IMTP Plan (associated with the achievement of aims and objectives of the HB).

The IMTP Plan sets out the organisational objectives for 2020-2023, the achievement of these objectives will ensure the Health Board effectively manages key organisational risks. This will be a "top down" approach, undertaken collectively by the members of the Executive Board. The risk of not achieving the objective and the risks to that objective will be highlighted, as appropriate, to the Health Board, Stakeholders and partners.

6.3.2 Operational Risk (associated with the direct delivery of services by the organisation area i.e. risks arising from operational activities).

This will be a "bottom up" approach undertaken by the staff within individual Service Groups overseen by the Service Group Management Boards. Where "operational" issues raise questions over the strategic objectives of the Health Board, these will be considered in detail by the Service Group's Governance Groups.

6.3.3 Patient/Health & Safety Management

Patient and Health & Safety assessment involves identifying the significant risk areas in Service Groups, prioritising them and deciding what action to take. Significant patient/Health & Safety risks are classified as those:

- that could lead to death, disability or severe distress to patients/staff/visitors;
- that are less serious but could occur more frequently or affect large numbers of patients/staff/visitors should also be included
- that could impact on the finances or reputation of the Health Board.

6.4. Analyse/Evaluate risks

Determine the existing controls and analyse risks in terms of consequence and likelihood in the context of those controls. The analysis should consider the range of potential consequences and how likely those consequences are to occur. This enables risk to be ranked so as to identify management priorities. If the levels of risk established are low, then risks may fall into an acceptable category and treatment may not be required. Consideration should be given to the balance between potential benefits and adverse outcomes of managing these risks.

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

6.4.1. Acceptable Risk: Risk Score of 1 – 4 (Green)

Realistically it is never possible to eliminate all risks, and there will be a range of risks identified within the Health Board that would require us to go beyond 'reasonable action', if any, required to eliminate or reduce them, i.e. the cost in time or resources required to reduce the risks would outweigh the potential for harm. These risks would be considered 'acceptable' by the Health Board. Examples are frequent, low consequence events such

as minor property loss or damage, injuries requiring first aid only, or potentially serious events that are unlikely to occur and for which reasonable preventative measures are already in place.

6.4.2. Manageable Risk: Risk Score of 5 – 9 (Yellow)

The risk can be realistically reduced, within a reasonable time scale, through cost effective measures through the purchase of new equipment and or training. Examples are manual handling injury, malicious damage, and injury to staff or patients. Action would normally be the responsibility of the Service Group.

6.4.3 Moderate Risk: Risk Score 9 – 15 (Amber)

The risk will need to be reduced within 6 months, given that it is a moderate risk, action would normally be the responsibility of the Service Groups.

6.4.4 High Risk: Risk Score of 16 – 25 (Red)

Significant risks are where the consequences of the event could seriously impact on the organisation and threaten its objectives. As examples accidental death, major fire, and major disruption of services. This category might include risks that are individually manageable but cumulatively serious, such as a series of similar injuries. Risks identified as being serious should be reported to the relevant Executive Director and to the monthly performance review meeting.

6.5. Risk Management and Control

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

6.5.1 Risk Appetite and Tolerance

The Chief Executive and the Board encourage the taking of controlled risks, the grasping of new opportunities and the use of innovative approaches to further the interests of the organisation and achieve its objectives, provided the resultant exposures are understood and acceptable.

When deciding if a risk should be tolerated it is necessary to consider a number of factors, e.g. legislation, clinical governance, patient experience, requirements of commissioners and the appetite for these risks. Risk appetite and tolerance considers what risks the Health Board is prepared to take in pursuit of achieving its objectives. This document sets out levels of risks and within these levels there is a management structure which supports decision making in terms of risk appetite and tolerance. Risks rated up to 15 can be managed including determining the risk appetite and tolerance within Service Groups. Risks rated 16 and above will need to be considered at Executive level

in terms of the risk appetite and tolerance levels. Each risk must be considered individually to determine the level of risk appetite and tolerance.

Organisational policies and written control documents define where there are mandatory processes and procedures, e.g. the Equality and Human Rights Policy. Non-compliance with prescribed policies and procedures constitutes an unacceptable risk and possibly a contravention of legislation.

Some risks are tolerable provided the prescribed organisational process is followed, e.g. expenditure proposals, staff recruitment, and designated responsibilities/ authorities are adhered to.

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

6.5.2 Treat the Risk

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

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

6.5.3 Terminate the Risk

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

6.5.4 Transfer the Risk

Transfer – 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. In addition, many areas of business and reputational risk cannot be transferred at all.

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.

6.5.5 Escalation of Risks

On a monthly basis the Service Groups and Corporate Directorates are requested to escalate risks for consideration for entry on the HBRR, Risks of 16 and above trigger escalation by the Service Group, or corporate directorate to escalate the risk for consideration for inclusion on the HBRR.

When escalating risks, a summary in terms of the adequacy of controls and actions being taken to manage the risk should be provided for consideration by the Risk Scrutiny Panel.

In addition, risks can be escalated in terms of themes of risks across the organisation or sensitive risks which need to be escalated to the Risk Management Group/Senior Leadership Team and sub Committees of the Board. The Risk Scrutiny Panel will oversee the escalation and reporting of these risks.

Risk registers, risk of 12 and above trigger consideration by the Service/Corporate Departmental risk registers to escalate on to the Service Group/Corporate Directorate risk register. Risks less than 12 to be managed by the Service/Corporate departments.

The triggers for escalation and de-escalation are outlined in ***Appendix 1.***

6.6 Communicate and Consult

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

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

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

7. Health Board Risk Register (HBRR)

Once the risk has been identified and analysed the next stage is to ensure the risk is recorded within RL Datix software system Web Risk Register Module which will form the Service Group's Risk Register. The principal tool that the organisation will use for managing the risk assessment systems and processes will be the Health Board's Risk Register (HBRR), template presented at Appendix **4** for information. The Health Board's Risk Register can be described as:

"a log of all the risks that may threaten the success of the Health Board in achieving its declared aims and objectives."

Identifying and logging the risk will ensure that the Service Groups are aware of the risk and, following consideration of any existing controls in place, whether other options exist to further reduce or eliminate the risk.

An Action Plan will be approved and monitored by the Service Group Boards setting out action to be taken and priorities within their Service Groups. The Head of Patient Experience, Risk and Legal Services will coordinate the Health Board Risk Register (HBRR) and produce a SBUHB Risk Register Report and action plan, for risks with a risk rating of 16 and above. The Executive Team will oversee and approve the Health Board Risk Register (HBRR) which will then be reported to the Audit Committee.

Risk Registers will continue to be developed to include risks identified from:

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

8. Risk Management Training

The Risk Management Policy will be supported by training to ensure staff are trained in the assessment and management of risks and 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 the importance of following them;

- Risk register and;
- Risk identification and assessment.

All training provided to staff (of whatever grade) is to be recorded centrally using the Electronic Staff Record (ESR) and training will be provided 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.

9. 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 opportService Groupies 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 (opportService Groupies 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 in a position to ensure a risk is managed and controlled.

Risk rating

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).

Significant risk
Those risks assessed to have an overall rating of 16 or above (using risk management matrix).

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 or doing things differently.

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

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

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

10. 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)

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

6. Audit Committee Handbook June 2012

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

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

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

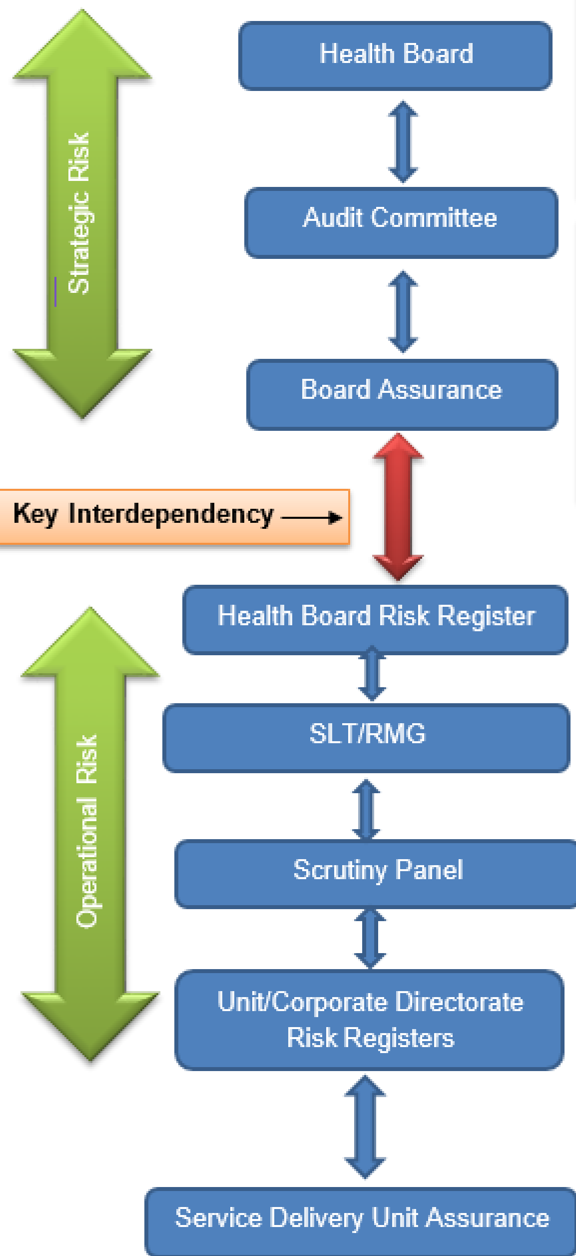
10. Risk Management in the NHS (NHS Management Executive, December 1993)

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

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

Appendix 1

Flow of Risks – Escalation & De-Escalation



Triggers for Escalation & De-Escalation

The Board's Assurance Framework (BAF) provides the organisation with a structured approach to effectively managing the principal risks to achieving its strategic objectives. The Health Board promotes an open culture and encourages staff to operate in a transparent manner when identifying, understanding, responding and escalating risks.

The Audit Committee has a key risk assurance role within the governance framework. All sub-Committees within the framework review the relevant BAF risks allocated against their remit as well as the 16 and above risks that have a key interdependency with the BAF risks. The Risk Management Group (RMG) will review all BAF risks and all 16 and above Health Board Risks on a quarterly basis, prior to reporting to the Senior Leadership Team (SLT), Audit Committee and Health Board.

BAF risks are reviewed and refreshed as part of the annual strategic and operational planning process between October and March. The principle should be that this process informs the identification of high level strategic risks which have the potential to impact on the Health Board's delivery of its strategic objectives.

The Board Assurance Framework has a key interdependency with the Health Board Risk Register which contains dynamic risks rated 16 or above. HBRR risks rated 16 and above are considered for escalation to the BAF/HBRR by the Risk Scrutiny Panel (RSP) and reported to RMG/SLT. Each HBRR entry is owned by an Executive Director. The risks at this level have the potential to impact on the relevant BAF Risk scoring. The HBRR provides a dynamic risk profile of the Health Board's operational risks.

Operational Risk Management Thresholds of Escalation and De-escalation triggers. Risk of 16 and above trigger consideration by the Unit, Corporate Directorate to escalate to HBRR. Risk registers risk of 12 and above trigger consideration by the Service/Directorate to escalate to the Unit/Corporate Directorate Risk Registers. Risks less than 12 to be managed by the Service/Directorate.

Assurance Role

Health Board will receive the BAF and HBRR on a 6 monthly basis and endorse the risks and the actions being taken to mitigate.

Audit Committee will scrutinise and challenge the BAF and HBRR in terms of ensuring that documents reflect the principal and high level operational risks of the Health Board and are satisfied with the action being taken to investigate the mitigate the risk decisions to manage the risk.

Sub committees of the Board will scrutinise and challenge the BAF and HBRR risks assigned to them by the RMG/SLT.

SLT/RMG will consider recommendations made from the RSP and collectively challenge or endorse the BAF/HBRR and Board Sub Committees to oversee them and receive assurance on behalf of the Board.

RSP will consider all risks of 16 and above and will take advice from Executive Management Specialised Groups/Committees and management and Lead Specialist managers in relation to the level of risk, controls in place, planned mitigating action to reduce the risk and will then recommend to the RMG/SLT the risks to be included on the BAF and HBRR.

The RSP will consider themes of risks emerging from Units/Service/Department level which are below 16 although collectively could require escalation to the RMG/SLT for the HBRR.

Specialist Groups and Committees will provide expert advice on themes of risks and risks rated 16 and above in terms of the adequacy of the controls in place. Further action to be taken to mitigate the risks and endorse or challenge the risk entries.

Appendix 2

For each risk identified, the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the risks and attempts to assess the likelihood of the event occurring (PROBABILITY) and the effect it could have on the Health Board (IMPACT). This process ensures that the Health Board will be focusing on those risks which, require immediate attention, rather than spending time on areas which are, relatively, a lower priority.

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 (**) - Severity of Harm					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DOMAINS	**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 serivce 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 unresoved. 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. Low performance rating.	Multiple breaches in statutory duty or prosecution. Complete systems change required. 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 ot it prevents someone from doing their job such as a cancelled procedure that has the potential of prolonging suffering but does no 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	Insignificant cost increase/ shcedule slippage. Loss/interruption of service >1 hour	<5% over project budget. Minor schedule slippage <1 month. Loss/interruption of service >8 hours.	5-10% over project budget. Schedule slippage <2 months. Loss/interruption of service >1 day	10-25% over project budget. Schedule slippage <3 months. Loss/interruption of service >1 week	>25% over project budget. Schedule slippage >3 months. Key objectives not met. 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 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

Appendix 3

"A Simple Guide to Risk Management"

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Appendix 4

Risk Register Template

Risk Ref	Strategic Aim	Date of Entry	Service Group	Type of Risk/ Specific Risk	Current Context	Controls in Place	Consequence	Likelihood	Current Risk Rate	Action Plan	Action Lead	Board/ Committee	Progress