Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WHSSC

Risk Management Strategy

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Contents

1 Introduction and Aims

WHSSC is committed to developing and implementing a Risk Management Strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives and delivering against its Integrated Commissioning Plan (ICP). It will be applied alongside other key management tools, such as performance, quality and financial reports, to give Joint Committee a comprehensive picture of the organisational risk profile.

The WHSSC Risk Management Strategy is based on the Risk Management Strategy agreed by Cwm Taf Morgannwg University Health Board (CTMUHB) (WHSSC's host organisation) so that there is alignment between approaches.

It aims to:

- set out respective responsibilities for strategic and -operational risk management for Joint Committee and staff throughout the organisation;
- set out responsibility for WHSSC sub-committees;
- set out WHSSC's relationship with the CTMUHB Audit and Risk Committee (as WHSSC's host organisation);
- describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives and delivering against its ICP.

The objectives of WHSSC's Risk Management Strategy are to:

- minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management;
- ensure that risk management is an integral part of WHSSC's culture;
- maintain a risk management framework, which provides assurance to Joint Committee that strategic and operational risks are being managed effectively;
- maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- minimise avoidable financial loss;
- ensure that WHSSC meets its obligations in respect of health and safety and quality and safety; and
- manage all potential risks WHSSC is exposed to.

2 Scope

The Risk Management Strategy covers the management of principal and organisational risks and the process for the escalation of risks for inclusion on the Corporate Risk Register.

A risk can be defined as: “the chance of suffering harm caused by a hazard, loss or damage or the possibility that the organisation will not achieve an objective”.
Risk is the uncertainty surrounding events and their outcomes that may have a significant effect, either enhancing or inhibiting:

- Achievement of aims and objectives
- Performance
- The meeting of stakeholder expectations

Principal Risks: are significant risks that have the potential to impact upon the delivery of strategic objectives and are raised and monitored by the WHSSC Corporate Directors Group and Joint Committee.

Organisational Risks: are key risks that affect individual directorates or commissioning teams (in relation to commissioned services) and are managed within individual directorates or commissioning teams and, if necessary, escalated through the risk reporting structure.

The Corporate Risk Assurance Framework (CRAF) is an integral part of the system of internal control and defines the extreme potential risks listed on the Corporate Risk Register (scored 15 or above) which may impact upon the delivery of strategic objectives. It also summarises the controls and assurances that are in place or plans to mitigate them. The CRAF aims to align principal risks, key controls and assurances on controls alongside each of WHSSC’s strategic objectives.

Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the development of an action plan for closing the gaps and mitigating the risks which is subsequently monitored by Joint Committee for implementation.

Levels of assurance are applied to each of the controls and the assurance on controls as follows:

(1) Management Reviewed Assurance
(2) Joint Committee or Sub Committee Reviewed Assurance
(3) External Reviewed Assurance

This provides an overall assurance level on each of the Principal Risks.

This Strategy applies to those members of staff that are employed by or on behalf of WHSSC. However, the culture of risk management and discussion of risk with partners and stakeholders, where appropriate should be encouraged.

The Risk Management Strategy is intended to cover all the potential risks that the organisation could be exposed to.

3 Risk Management Organisational Structure

WHSSC is a joint committee of each of the seven health boards in Wales and is hosted by CTMUHB.

3.1 Joint Committee

Members of the WHSSC Joint Committee share responsibility for the effective management of risk and compliance with relevant legislation. In relation to risk management, Joint Committee is responsible for:

- articulating the strategic objectives of WHSSC;
- articulating the Principal Risks of WHSSC;
- protecting the reputation of WHSSC;
- providing leadership on the management of risk;
- approving the risk appetite for WHSSC;
- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- reviewing risks scored 15 and above;
- endorsing risk related disclosure documents;

3.2 Integrated Governance Committee

The purpose of the Integrated Governance Committee (IGC), a sub-committee of the Joint Committee, is to scrutinise evidence and information brought before it in relation to activities and potential risks which impact on the services commissioned by the WHSSC and provide assurance to the Joint Committee that effective governance and scrutiny arrangements are in place across the organisation.

The IGC will, in respect of its provision of advice to the Joint Committee, ensure that:

- it maintains an oversight of the work of the Quality and Patient Safety Committee and CTMUHB Audit & Risk Committee. The Sub-committee will ensure integration of the governance work, addressing issues which fall outside or between the work of the these sub-committees, ensuring no duplication and coordinating those issues which need the attention of all three sub-committees;

- appropriate mechanisms are in place to manage risk issues, identifying and reviewing the top level risks and ensuring that plans are in place to manage those risks;
- it oversees the ICP, scrutinising the delivery and performance of the ICP; and it maintains an oversight of the work of the Welsh Renal Clinical Network addressing issues which fall outside or between the work of the network and the Welsh Health Specialised Services Team.

3.3 Quality and Patient Safety Committee

The purpose of the WHSSC Quality and Patient Safety Committee, a sub-committee of the Joint Committee, is to provide timely assurance to the Joint Committee that it is commissioning high quality and safe services. This will be achieved by:

- providing advice to the Joint Committee, including escalation of issues that require urgent consideration and action by the Joint Committee;
- addressing concerns delegated by the Joint Committee; and
- ensuring that local health board Quality and Patient Safety Committees are informed of any issues relating to their population recognising that concerns of specialised service may impact on primary and secondary and vice versa (whole pathway).

The sub-committee through its Chair and Members shall work closely with the Joint Committee's other joint sub-committees and groups to provide advice and assurance to the Joint Committee through the:

- joint planning and co-ordination of the Joint Committee and sub-committee business; and
- sharing of information.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Joint Committee's overall risk and assurance framework.

3.4 Corporate Directors Group Board

The Corporate Directors Group Board (CDGB) undertakes the following duties:

- promotes a culture within WHSSC which encourages open and honest reporting of risk with local responsibility and accountability;
- provides a forum for the discussion of key risk management issues within WHSSC;
- ensures appropriate actions are applied to commissioning risks;
- enables risks which cannot be dealt with locally to be escalated, discussed and prioritised;

- ensures Directorate and Commissioning Team risk registers are appropriately rated and action plans agreed to control them;
- reviews the risks on the Commissioning Team risk registers scored 15 or above to determine whether any of them will impact on the local health boards' strategic objectives;
- reviews the CRAF prior to its presentation to Joint Committee;
- advises Joint Committee of exceptional risks to WHSSC and any financial implications of these risks;
- reviews and monitors the implementation of the Risk Management Strategy; and
- provides assurance to Joint Committee that there is an effective system of risk management across the organisation.

3.5 Commissioning Teams

The Commissioning Teams are responsible for Organisational Risks within their areas of operation and providing assurance to CDGB on those risks and any support required in relation to the management of risk.

The Commissioning Teams will review and update existing risks, consider new risks for inclusion and escalate any extreme risks. These are presented to the CDGB by the relevant Commissioning Team representative.

3.6 CTMUHB Audit and Risk Committee

As a hosted organisation WHSSC has a governance relationship with the CTMUHB Audit and Risk Committee.

In relation to WHSSC, the CTMUHB Audit and Risk Committee's role is to review and receive assurance on the adequacy of an effective system of internal control and risk management at WHSSC.

WHSSC's risk reporting structure is attached at Appendix 3.

4 Duties

The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

4.1 All staff

All members of staff are accountable for maintaining risk awareness, and identifying and reporting risks as appropriate to their line manager.

In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for WHSSC and attend/complete risk management training as appropriate.

They will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by WHSSC's business;
- report all incidents/accidents and near misses;
- comply with WHSSC's incident and 'near miss' reporting procedures;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed; and
- be aware of WHSSC's Risk Management Strategy and processes and procedures and comply with them.

4.2 Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks, within a structured risk management framework.

Managers at all levels of the organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/area operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with WHSSC's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

Specifically they will:

- promote a culture which encourages open and honest reporting of risk with local responsibility and accountability;
- ensure a forum for discussing risk and risk management is maintained within their area which will encourage integration of risk management;
- co-ordinate the risk management processes which includes risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- update Corporate Directors Group Board on the management and mitigation of risk for their area;
- provide reports to the appropriate sub-committee of Joint Committee that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.

4.3 Executive Directors

Executive Directors are accountable and responsible for ensuring that their areas of responsibility are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to WHSSC's strategic objectives.

Specifically they will:

- communicate to their staff WHSSC's strategic objectives and ensure that Directorate and Commissioning Team and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area which will encourage the proactive management of risk;
- co-ordinate the risk management processes which include: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- provide reports to the appropriate sub-committee of Joint Committee that will contribute to the monitoring and auditing of risk;

- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process; and
- ensure that the CRAF and the risk management reporting timetable are delivered to WHSSC processes**.**

4.4 Managing Director

The Managing Director is effectively the Accountable Officer of WHSSC and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of governance. This responsibility encompasses risk management, health and safety, finance, and organisational control and governance.

The Managing Director has overall accountability and responsibility for:

- ensuring WHSSC maintains an up-to-date Risk Management Strategy and CRAF endorsed by Joint Committee;
- promoting a risk management culture throughout WHSSC;
- ensuring that there is a framework in place which provides assurance to the Joint Committee in relation to the management of risk and internal control; and
- putting in place and maintaining an effective system of risk management and internal control.

4.5 Internal Audit

Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide WHSSC with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards and good practice contained within the NHS Internal Audit Manual. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the CTMUHB Audit and Risk Committee, as appropriate.

5 Risk Management Process

WHSSC is committed to developing a pro-active and systematic approach to risk management.

Appendix 2 sets out an outline of the risk management process.

A monthly reporting process is facilitated through the Corporate Risk Assurance Framework (CRAF), which comprises the Corporate Risk Assurance Report (CRAR), Corporate Risk Register (CRR) and Risks on a Page reports. Appendix 3 sets out the CRAF risk reporting structure.

5.1 Risk Assessment and Scoring

Each Directorate and Commissioning Team will identify organisational risks through the completion of risk assessments. Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and six, can be managed locally within the relevant Directorate and Commissioning Team. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each Directorate and Commissioning Team.

Appendix 1 sets out the risk register content and definitions.

Risk assessments should be completed by the Directorates and Commissioning Teams in line with the agreed approach to assessing risk (Appendix 5).

Risks scoring 8 or above are added to the Directorate and Commissioning Team risk register for monitoring of actions. Each Directorate and Commissioning Team will review its risk register on a monthly basis.

All types of risks are to be included i.e. financial, corporate, clinical, operational, commissioning and reputational risks.

All local risks should be reviewed and updated monthly at a minimum. This may need to be more frequently if circumstances require.

If it is felt that the risk can no longer be managed locally and requires more senior input and support then it will be escalated up through the Directorate and Commissioning Team to CDGB and all the way to Joint Committee if required.

A risk score is achieved by multiplying an individual likelihood (probability) score with an individual severity (impact) score:

Likelihood x Impact = Risk Score

The risk matrices for calculating an overall risk score can be found below and in further detail in Appendix 5.

Grade	Definition	Risk Score
Red	Extreme Risk	15-25
Amber	High Risk	8-12
Yellow	Moderate Risk	4-6
Green	Low Risk	1-3

Risks which attract the highest scores are therefore graded 'red' and warrant immediate attention by relevant personnel.

6 Joint Committee Assurance Framework (JAF)

WHSSC aspires to establish a JAF (often referred to in local health boards as a Board Assurance Framework or BAF), whilst not yet established the planned approach for developing the JAF is outlined in the following paragraphs.

The JAF will detail the principal risks faced by the organisation in meeting its strategic objectives and provides Joint Committee with a comprehensive method of describing its objectives, identifying key risks to their achievement and the gaps in assurances on which WHSSC relies.

The JAF will be developed through the following key steps:

a. Joint Committee annually agree the Strategic Objectives as part of the business planning cycle (ICP process).

b. CDGB will identify the principal risks that may threaten the achievement of the WHSSC's strategic objectives; these risks will then be discussed and approved by Joint Committee.

c. For each principal risk the Executive Lead will:
   - give an initial (inherent) risk score, by determining the consequence and likelihood of the risk being realised; and
   - link the risk to the strategic objectives.

d. Risks from the previous year's JAF will be reviewed and a decision made whether to:
   - transfer the risk on to the JAF for the current year;
   - move the risk to the Corporate Risk Register and nominate a risk owner; or

- close the risk.

e. The Executive Lead will then:
   - identify the key controls in place to manage the risks and achieve delivery of the strategic objective;
   - identify the arrangements for obtaining assurance on the effectiveness of key controls across all the areas of principal risk;
   - evaluate the assurance across all areas of principal risk, i.e. identifying sources of assurance WHSSC is managing the risks to an acceptable level of tolerance;
   - identify how / where / when those assurances will be reported;
   - identify areas where there are gaps in controls (where WHSSC is failing to implement controls or failing to make them effective);
   - identify areas where there are gaps in assurances (where WHSSC does not have the evidence to assure that the controls are effective);
   - develop an action plan to mitigate the risk; and
   - agree a current (residual) risk rating for the first quarter of the financial year which is determined by the consequence and likelihood of the risks.

f. The JAF will be presented to the first meeting, in the financial year, of the Corporate Directors Group Board. It will moderate the risk scores and ensure there are appropriate controls and assurances, gaps in control and assurances with associated action plans in place for each risk.

g. Each month the Executive lead will for each of the risks for which they are responsible, review and monitor the controls and reported assurances and update the risk score and action plans.

h. The Executive will review and monitor all of the risks on the JAF each month prior to presentation to Joint Committee. In particular, the Corporate Directors Group Board will ensure that progress is being made to reduce or eliminate the impact of the risk.

i. Once agreed by Corporate Directors Group Board the completed JAF will be presented to Joint Committee for scrutiny and approval not less than twice a year.

The IGC, has oversight of the processes through which Joint Committee gains assurance in relation to the management of the JAF.

7 Risk Appetite

At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.

Decisions on accepting risks may be influenced by the following:

- the likely consequences are insignificant
- a higher risk consequence is outweighed by the chance of a much larger benefit
- occurrence is rare
- the potential financial costs of minimising the risk outweighs the cost consequences of the risk itself
- reducing the risk may lead to further unacceptable risks in other ways

Therefore a risk with a high numerical value may be acceptable to the organisation, but that decision would be taken at an appropriate level.

Joint Committee will assess its risk appetite using the Good Governance Institute Matrix for NHS Organisations (Appendix 4). Joint Committee will review its risk appetite on an annual basis to ensure that progress is being made toward the 'risk appetite' WHSSC wishes to achieve.

8 Information/Support

Support and guidance is available from the Corporate Governance Manager or Committee Secretary.

Risk Assessment templates and training information is available from the Corporate Governance Manager.

Appendix 1

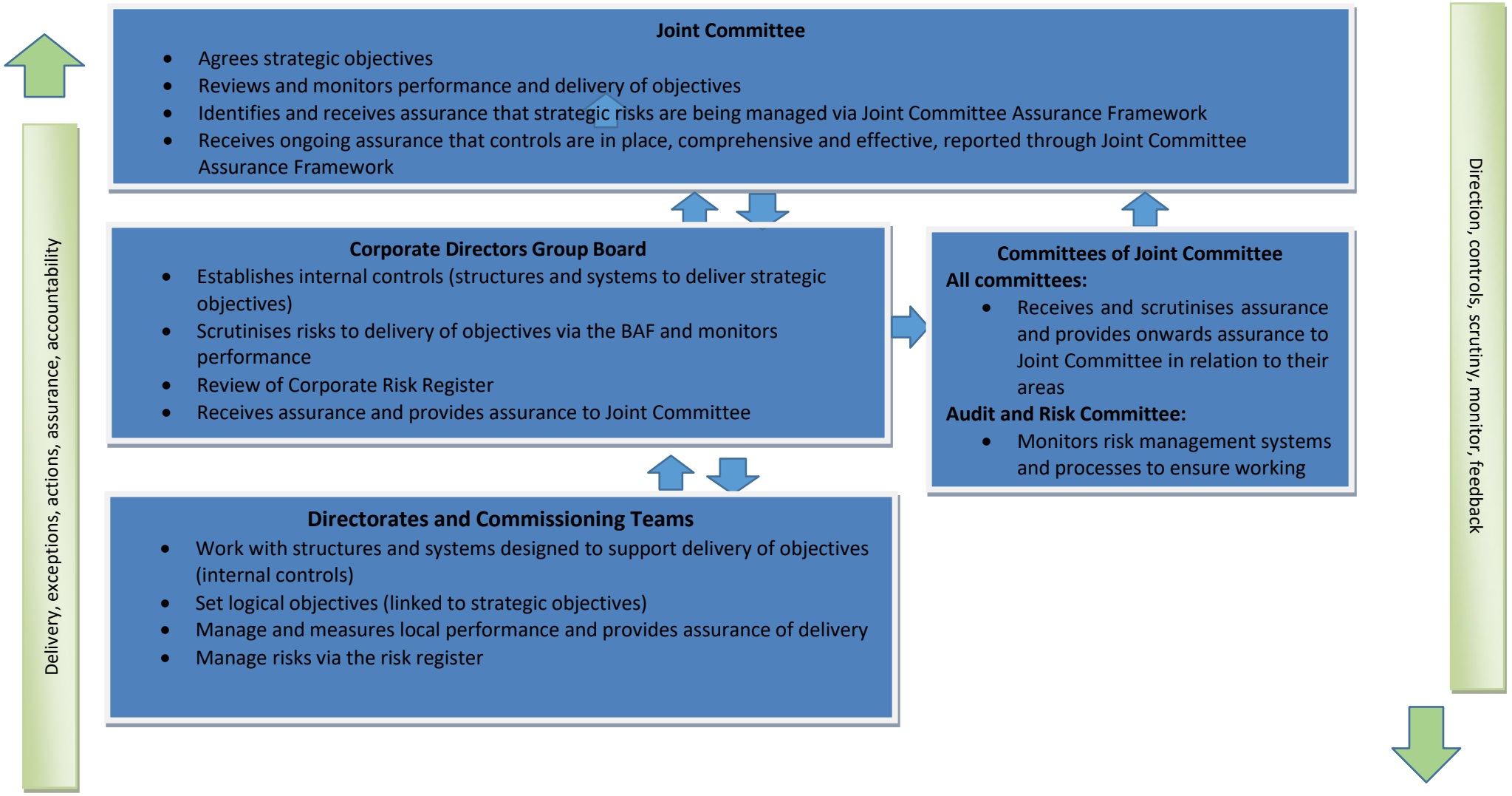
Risk Register Content and Definitions

Ref.	Column Heading	Information Required
1.	Date Opened	Date the risk was added to the Risk Register.
2.	Risk Description	A structured statement describing the risk usually containing the following elements: sources, events, causes and consequences / impact. A well-written risk statement contains three main parts; 1. **Explain risk-** Summarise the relevant background facts. These may include prior decisions, assumptions, dependencies and relevant objectives, i.e. introduce the area / topic. *Start by writing "There is a risk that……."* 2. **Source(s) of uncertainty / Cause / Event -** The conditions that currently exist that create the risk i.e. the factors that may cause the risk to occur and/or influence the extent of its effect. *Start by writing "Due to……."* 3. **Consequence / Impact -** The impact to the Programme / Organisation in the event of the risk occurring. Consequence could also result in opportunities that may surface in correcting the problems. *Start by writing "Resulting in …."*
3.	Risk Rating	This is calculated by multiplying consequence x likelihood (impact x probability).
4.	Impact / Consequence (see separate risk scoring matrix document)	This is the outcome of an event that has an effect on objectives. A single event can generate a range of consequences which can have both positive and negative effects on objectives. Initial consequences can also escalate through knock-on effects.
5.	Probability / Likelihood (see separate risk scoring matrix document)	This is the chance that something might happen. Likelihood can be defined, determined, or measured objectively or subjectively and can be expressed either qualitatively or quantitatively.
6.	Initial Risk Rating	The risk rating before any controls have been put in place.
7.	Current Risk Rating	The risk rating whilst risk responses are in the process of being implemented. Some controls are probably in place but others required are still being actioned & will be shown as gaps in control & actions until implemented.

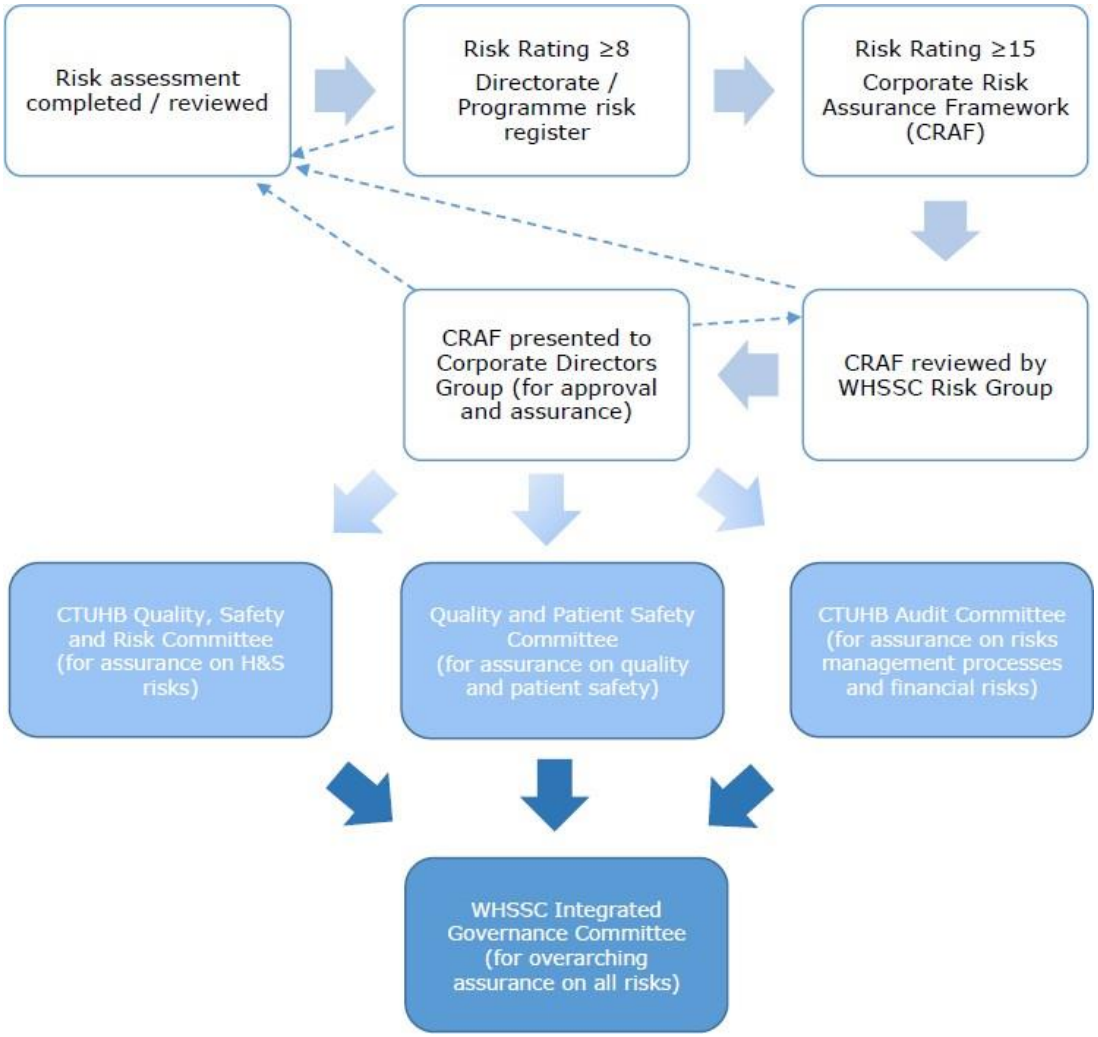
8.	Target risk rating / Residual Risk	When action is taken to treat risks, it may eradicate the possibility of the risk occurring. However, actions are often more likely to reduce the probability of the risk occurring, leaving the residual risk. The remaining level of risk after all treatment plans have been implemented is the residual risk. Generally the target level is the level at which the organisation is saying it's happy to live with. All agreed controls are in place & assurance is being provided that controls are working as planned. At this point the risk should be closed unless further actions are deemed required.
9.	Controls	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method, or device that modifies or manages risk. Risk treatments become controls, or modify existing controls, once they have been implemented.
10.	Gaps in Controls	A gap in control implies a measure or action that would help modify or control the risk is missing / yet to be implemented. Gaps result from failure to put in place sufficiently effective policies, procedures, practices or organisational structures to manage risks and achieve objectives
11.	Assurance	Confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved. Sources of assurance include; reviews, audits, inspections both internal & external.
12.	Gaps in assurance	Gaps in assurance imply that insufficient evidence is available that controls are in place & operating effectively & that the risk is being actively managed & controlled. Work is required to fill gaps & enable assurance to be obtained.
13.	Actions	Actions required to mitigate the risk. Actions should be SMART & have clear owners assigned. This will allow action progress to be tracked & monitored & issues with action completion to be visible & dealt with.
14.	Risk Owner	Senior person best placed to keep an eye on the risk with decision making authority. This person is accountable for the Risk & should be aware of its current status.
15.	Action Owner	Person responsible for implementing the risk response / actions, providing updates on action progress & flagging issues relating to action completion.

16.	Risk treatment / Risk response	This is a risk modification process. It involves selecting & implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls. Treatment options include; • Avoidance / Remove the source of the risk • Reduction • Transference • Retain / Accept the risk • Also known as the four T's – Treat, Transfer, Tolerate & Terminate
17.	Assurance rating	This is the rating which has been given regarding the level of assurance: • (1) = CDGB Reviewed Assurance • (2)= Joint Committee Reviewed Assurance • (3)= External Reviewed Assurance

Appendix 2 Risk Management Process



Appendix 3 Risk Reporting Structure



Matrix to support better risk sensitivity in decision taking

Appendix 4

Risk levels ▶ Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix 5

Approach to assessing Risk

Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days 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 patients
Population Health	Managed according to standard response protocols, routine control programmes, and regulation (e.g. monitoring through routine surveillance systems	Managed according to standard response protocols, routine control programmes, and regulation (e.g. monitoring through routine surveillance systems	Roles and responsibility for the response must be specified. Specific monitoring or control measures required. (e.g. enhanced surveillance additional vaccination campaigns)	Senior Trust Officers Attention needed. There may be a need to establish command and control structures; a range of additional control measures will be required some of which may have significant consequences	Immediate response required even if reported out of normal working hours. Immediate Senior Trust Officer attention needed. (e.g. the command and control structure should be established within hours); the implementation of control measures with serious consequences is highly likely.
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on

		Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Multiple complaints/ independent review Low performance rating Critical report	Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) 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 competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Finance including claims	Unplanned financial impact under 0.1% of budget Risk of claim remote	Unplanned financial impact between 0.1% and 0.25% of budget Claim less than £10,000	Unplanned financial impact between 0.25% and 0.5% of budget Claim(s) between £10,000 and £100,000 Purchasers failing to pay on time	Unplanned financial impact between 0.5% and 1% of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Unplanned financial impact > 1% of budget Failure to meet specification/ slippage Claim(s) >£1 million Purchasers failing to pay on time
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence × likelihood (C × L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

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

1–3	Low risk
4–6	Moderate risk
8–12	High risk
15–25	Extreme risk

Instructions for use

Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

Determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

Determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score the risk multiplying the consequence by the likelihood:

C (consequence) × L (likelihood) = R (risk score)

Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.