COMMITTEE UPDATE REPORT / ADRODDIAD DIWEDDARU'R PWYLLGOR

AUDIT AND RISK ASSURANCE COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 18 June 2024

Quoracy/ Cworwm: Met

Report by/ Adroddiad gan: Councillor Rhodri Evans, Committee Chair

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KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

- The Audit and Risk Assurance Committee (ARAC) had no matters to alert the Board on this occasion.

Advise[2] (to monitor)/ **Cynghori** (i fonitro)

The Audit and Risk Assurance Committee wish to **advise** members of the Board that:

- **Escalation Status Update** due to financial targets not currently being met, the Committee determined that they could not provide overarching assurance to the Board.Assurance was taken in relation to the Health Board's responses and actions being taken to address Targeted Intervention status with a request future reports focus on outcomes and delivery rather than process.
- **Review of Operational Governance Arrangements across Service Directorates**The key recommendations of the report were regarding delays to the implementation of the operational governance structure and a lack of clarity around lines of accountability and reporting,. The Operations Directorate management team are working on addressing the recommendations of the report with it noted the new governance model needs to be aligned to the new operational structure. ARAC will be monitoring the implementation of the recommendations closely.
- **Bronglais General Hospital (BGH) Chemotherapy Day Unit Final Briefing Paper**The paper investigated the reasons for the discrepancy between the estimated costs and the final tender return relating to the redevelopment costs, as well as the process for escalating the funding shortfall. The briefing paper highlighted areas for improvement and the Project Manager for the BGH Chemotherapy Day Unit was tasked by ARAC to produce a formal management response which will be presented to the Committee on 13

[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*
[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern*.

August 2024 to provide assurance to the Committee that the areas for improvement will be addressed.

- The **Head of Internal Audit Opinion & Annual Report 2023/24** returned an overall opinion of **limited assurance**. The outcome of the report took into account the number of audits throughout the year which had a limited assurance rating, as well as the significance of the areas reviewed. It was noted that whilst this opinion was disappointing, it also illustrates that the Health Board is engaging with the process as intended, by demonstrating openness and honesty in our responses. The Head of Internal Audit advised that all limited assurance audits would be re-audited in the coming year.
- The **Audit Tracker** was presented to ARAC, as the need for recommendation owners to update their recommendations was highlighted as a concern to the Committee. ARAC therefore requested that an update on responses be presented at the 13 August 2024 meeting, to provide assurance; if the response was not deemed satisfactory the potential to escalate this matter was raised.

Assure[3] (to note)/ Sicrhau (i nodi)

The Audit and Risk Assurance Committee wish to **assure** members of the Board that:

- The Committee took assurance and approved the updated **Terms of Reference** which has incorporated changes in relation to the Committee's change of scope as a result of our escalation status under Targeted Intervention.
- **Audit Wales** provided assurance to the Committee in relation to their update report and the ongoing progress with their workplan.
- The **Internal Audit Plan Progress Report** was received by the Committee who were assured regarding the delivery of the Internal Audit plan for 2023/24 year.
- The Committee took assurance from a number of **Internal Audit** reports, of which the following all determined an overall opinion of **reasonable assurance**:
    - **Emergency Response Planning – Industrial Action report**
      The report made a number of recommendations as well as management actions, some of which have now been completed, and others which are in progress.
    - **Accelerated Cluster Development**
      This is a new area which is still under development and the draft Terms of Reference will be presented to the Strategic Developmental and Organisational Delivery Committee (SDODC) for their approval, which was one of the recommendations of the audit.
    - **Health & Care Quality Standards Final Report**
      The two main areas identified for improvement were to progress assurance reporting through the existing committee structures, and to

[3] *There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.*

embed the standards across operational and directorate levels. An action plan is now in place and a workshop is scheduled which will feed into the action plan.

- **Planning Maturity Matrix Draft Report**
  The report received reasonable assurance and will be shared with WG as part of the escalation status.

- **Reinforced Autoclaved Aerated Concrete (RAAC) Programme – Withybush General Hospital Final Internal Audit Report** which determined an overall opinion of **substantial assurance**. Internal Audit were satisfied by the actions undertaken to address RAAC at Withybush General Hospital.
- The **Financial Assurance Report** and the **Annual Summary of Single Tender Actions** presented to ARAC provided assurance on the actions undertaken by the Finance colleagues in these areas.
- The Committee received a brief summary report regarding **Counter Fraud** cases and were satisfied that the necessary policies and procedures were being carried out in relation to these.
- The **Clinical Audit Update and Forward Workplan** provided some assurance regarding the workplan, and the actions outlined in the update recognising further week needed to be undertaken.
- The **Risk Assessment Procedure** was also considered and approved.
- As part of the Committee's governance two reports are presented to the ARAC on a bi-annual basis; namely the **Post Payment Verification (PPV) Report** and the **Primary Care PPV Report** provided assurance regarding the contents of each report.

Review of Risks / Adolygiad o Risgiau

The Audit and Risk Assurance Committee will keep the Board updated on any developments regarding items flagged as 'to alert' and 'to advise' members as outlined above.

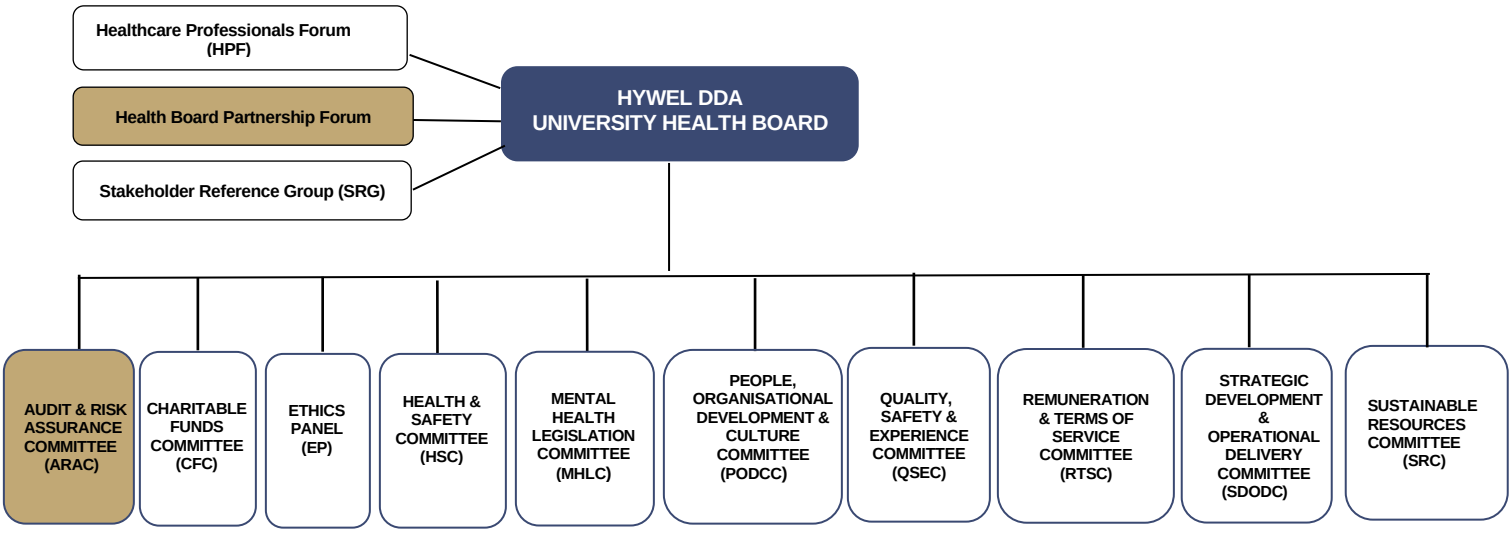
Sharing of learning / Rhannu dysgu

The need for timely Health Board responses to Internal and External Audit enquiries was stressed as being a priority and an area to improve upon in order to improve our overall annual assurance rating as well as individual report ratings.

Recommendation / Argymhelliad

The Board is asked to **NOTE** the report and **TAKE ASSURANCE** from the actions and oversight of the Committee. The Board is also asked to **APPROVE** the ARAC **Terms of Reference** and **Risk Assessment Procedure.**

Agenda, papers and minutes are available on our website / Mae agenda, papurau a chofnodion ar gael ar ein gwefan: [https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/audit-and-risk-assurance-committee-arac/]



AUDIT AND RISK ASSURANCE COMMITTEE

TERMS OF REFERENCE

Version	Issued To	Date	Comments
V1	Audit Committee Hywel Dda Health Board Hywel Dda Health Board	08.12.2009 28.01.2010 22.07.2010	Approved Approved Approved
V2	Audit Committee	07.06.2011	Approved
V3	Hywel Dda Health Board	29.09.2011	Approved
V4	Audit Committee	11.09.2012	Approved
V5	Audit Committee	11.08.2015	Approved
V6	Audit and Risk Assurance Committee	13.10.2015	Approved
V7	Hywel Dda University Health Board	26.11.2015	Approved
V8	Audit and Risk Assurance Committee	11.10.2016	Approved
V8	Hywel Dda University Health Board	26.01.2017	Approved
V9	Audit and Risk Assurance Committee	09.01.2018	Approved
V9	Hywel Dda University Health Board	29.03.2018	Approved
V.10	Audit and Risk Assurance Committee	19.02.2019	Approved
V.10	Hywel Dda University Health Board	28.03.2019	Approved
V.11	Audit and Risk Assurance Committee	25.02.2020	Approved

V.11	Hywel Dda University Health Board	26.03.2020	Approved
V.12	Audit and Risk Assurance Committee	23.02.2021	Approved
V.12	Hywel Dda University Health Board	25.03.2021	Approved
V.13	Hywel Dda University Health Board	29.07.2021	Approved
V.14	Audit and Risk Assurance Committee	21.06.2022	Approved
V.14	Hywel Dda University Health Board	28.07.2022	Approved
V.15	Audit and Risk Assurance Committee	18.04.2023	Approved
V.15	Hywel Dda University Health Board	25.05.2023	Approved
V.16	Audit and Risk Assurance Committee	20.02.2024	Approved
V.16	Hywel Dda University Health Board	28.03.2024	Approved
V.17	Audit and Risk Assurance Committee	18.06.2024	Approved
V.18	Hywel Dda University Health Board	25.07.2024	For approval

AUDIT & RISK ASSURANCE COMMITTEE

1. Constitution

1.1 The Audit Committee has been established as a Committee of the Hywel Dda University Health Board (HDdUHB) and constituted from 1 October 2009. The Committee is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. On 1 June 2015, the Committee took on an enhanced role and was re-named the Audit and Risk Assurance Committee (the Committee).

2. Purpose

2.1 The purpose of the Audit and Risk Assurance Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the UHB's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

2.3 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.4 The Committee's principal duties encompass the following:

2.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the

organisation's activities, both clinical and non-clinical.

2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.

2.4.3 Work with the Quality, Safety and Experience Committee, the People Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.

2.4.4 Receive an assurance on delivery against relevant Planning Objectives aligned to the Committee accordance with Board approved timescales, as set out in HDdUHB's Annual Plan.

2.5 Receive assurance, on behalf of the Board, of the Health Board's response to targeted intervention, including the systems and processes in place to oversee the timely delivery against the 6 domains, and assurance on the Health Board's progress towards de-escalation.

2.6 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, related to governance (see Appendix 1 for additional detail):

i. Observation and analysis
ii. Peer support
iii. Development of key frameworks
iv. Board Self-Assessment

3. Key Responsibilities

The Audit and Risk Assurance Committee shall provide advice, assurance and support to the Board in ensuring the provision of high quality, safe healthcare for its citizens, as follows:

Governance, Risk Management and Internal Control

3.1 The Committee shall review the adequacy of the UHB's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

3.2 In particular, the Committee will review the adequacy of:

3.2.1 all risk and control related disclosure statements (in particular the Accountability Report and the Performance Report), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

3.2.2 the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the

management of principal risks and the appropriateness of the above disclosure statements;

3.2.3 the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

3.2.4 the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.5 The Committee will seek assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address principal risks (those likely to directly impact on achieving strategic objectives), and that the effectiveness of that framework is regularly reviewed.

3.6 Monitor the assurance environment and challenge the build-up of assurance on the management of key risks across the year, and ensure that the Internal Audit plan is based on providing assurance that controls are in place and can be relied upon (particularly where there is a significant shift between the inherent and residual risk profile), and review the internal audit plan in year as the risk profile changes.

3.7 Seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the frameworks, charts/charters and action plans that are developed, supporting and endorsing these as appropriate.

3.8 Consider and recommend to the Board approval of any changes to the Risk Management Framework and oversee development of the Board Assurance Framework.

3.9 Provide assurance with regard to the systems and processes in place for clinical audit, and consider recommendations from the Effective Clinical Practice Working Group on suggested areas of activity for review by internal audit.

3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.

3.11 To receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by the UHB and report to the Board the adequacy of these arrangements.

3.12 To review and report to the Board annually the arrangements for declaring, registering, and handling interests.

3.13 Approve the writing-off of losses or the making of special payments within delegated limits.

3.14 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.

3.15 Receive a report on all Single Tender Actions and extensions of contracts.

Internal Audit and Capital/PFI

3.16 The Committee shall ensure that there is an effective internal audit and capital/PFI function established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- 3.16.1 review and approval of the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;
- 3.16.2 review of the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;
- 3.16.3 Regular consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- 3.16.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- 3.16.5 annual review of the effectiveness of internal audit.

External Audit

3.17 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- 3.17.1 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors and inspection bodies in the local health economy;
- 3.17.2 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Local Health Boards/NHS Trusts and associated impact on the audit fee;
- 3.17.3 review all External Audit reports, including agreement of the Annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses; and
- 3.17.4 review progress against the recommendations of the annual Structured Assessment.

Other Assurance Functions

3.18 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

3.19 The Committee's programme of work will be designed to provide assurance that the work carried out by the whole range of external review bodies is brought to the attention of the Board. This will ensure that the Health Board is aware of the need to comply with related standards and recommendations of these review bodies and the risks of failing to comply. These will include, but will not be limited to, any reviews by Inspectors and other bodies (e.g. Healthcare Inspectorate Wales, Welsh Risk Pool, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

3.20 The Audit and Risk Assurance Committee and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit and Risk Assurance Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.

3.21 The Audit and Risk Assurance Committee will also seek assurances where a significant activity is shared with another organisation and collaboratives, in particular the NHS Wales Shared Services Partnership, Welsh Health Specialised Services Committee, Emergency Ambulance Services Committee and other regional committees. The Audit and Risk Assurance Committee will expect to receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls.

Management

3.22 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.23 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

3.24 The Committee may also request or commission special investigations to be undertaken by Internal Audit, directors or managers to provide specific assurance on any areas of concern that come to its attention.

Financial Reporting

3.25 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on:

3.25.1 the ISA 260 report to those charged with governance;
3.25.2 changes in, and compliance with, accounting policies and practices;
3.25.3 unadjusted mis-statements in the financial statements;
3.25.4 major judgemental areas;
3.25.5 significant adjustments resulting from the audit;
3.25.6 other financial considerations include review of the Schedule of Losses and Compensation.

3.26 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

4. Membership

4.1 The membership of the Committee shall comprise of the following:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
3 ~~2~~ x Independent Members

4.2 The following should attend Committee meetings:

In Attendance
Director of Finance
Director of Corporate Governance/Board Secretary (Lead)
Representative of the Auditor General
Head of Internal Audit
Capital/Private Finance Initiative (PFI) Auditor
Local Counter Fraud Specialist
Assistant Director of Assurance and Risk
Head of Clinical Audit (as and when required)

4.3 Membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than three ~~two~~ of the membership and must include as a minimum the Chair or Vice Chair of the Committee, *together with a third of the In Attendance members*.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the University Health Board (UHB) Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

5.3 Any senior officer of the UHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any 'in attendance' officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Chief Executive, as the Accountable Officer, should be invited to attend, as a minimum when the Committee considers the draft internal audit plan, to present the draft Accountability Report and the annual accounts, and on request by the Committee.

5.7 The Chair of the UHB should not be a member of the Audit and Risk Assurance Committee and will not normally attend but may be invited by the Committee Chair to attend all or part of a meeting to assist with its discussions on any particular matter.

5.8 The Head of Internal Audit, Capital/PFI Auditor and the representative of the Auditor General shall have unrestricted and confidential access to the Chair of the Audit and Risk Assurance Committee at any time, and vice versa.

5.9 The Committee will meet with Internal, Capital/PFI and External Auditors and the Local Counter Fraud Specialist without the presence of officers on at least one occasion each year.

5.10 The Chair of the Audit and Risk Assurance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5.11 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Lead Director (Board Secretary), at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request of papers will be circulated to all Committee members.

6.3 All papers must be approved by the Lead/relevant Director.

6.4 The agenda and papers will be distributed **seven** days in advance of the meeting.

6.5 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and Table of Actions ~~action log~~ will be circulated to the Lead Director within **seven** days ~~members within **seven** days~~ to check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next **seven** days.

6.6 Members must forward amendments to the Committee Secretary within the next **seven** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Committee will meet bi-monthly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead (Board Secretary).

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8.3 The External Auditor, Head of Internal Audit and Capital/PFI Auditor may request a meeting if they consider one is necessary.

9. Accountability, Responsibility and Authority

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub committees and groups, to provide advice and assurance to the Board through the:

10.1.1 joint planning and co-ordination of Board and Committee business;

10.1.2 sharing of information.

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

10.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

10.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of the UHB's overall assurance framework.

10.5 The Committee Chair, supported by the Committee Secretary, shall:

10.5.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self assessment activity against relevant standards. The report will also record the results of the Committee's self assessment and evaluation.

10.5.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.

10.5.3 Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

10.6 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Board Secretary.

12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Appendix 1 - Targeted Intervention areas relating to governance

The **governance intervention and focus** whilst in targeted intervention covers the following areas and the health board will be required to action and demonstrate areas as highlighted below.

1. Observation and analysis
   - Respond to insight and feedback from observations in a positive and constructive manner, setting out how the feedback has had an impact.

2. Peer support
   - Respond to insight and feedback from peer support in a positive and constructive manner, setting out how the feedback has had an impact.

3. Development of key frameworks
   - Develop and implement core frameworks to include performance.

4. Board Self-Assessment
   - Review strategic risks and ensure that risk management is aligned with the health boards risk appetite.
   - Ensure an appropriate governance framework is in place, particularly with regards to providing appropriate scrutiny of performance, leadership style and practice.
   - Regular self-assessment against an agreed maturity matrix.
   - Responding to the outcome of self-assessments and external assessments and observations by setting objectives that will improve effectiveness.

De-escalation criteria for governance

1. Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee as demonstrated by Committee and Board papers.

2. Evidence of Board considering the Duty of Quality to inform their decision making and evaluating their compliance with the Duty.

3. Effective programme and performance management structure is in place, which defines objectives of the improvement work, has plans which show how the work is delivered and what barriers could impact on delivery of outcomes; structures have effective, open and transparent reporting, with effective Board oversight and a clear performance and delivery framework that drives improvement.

4. Risk management arrangements are in place for identifying, recording, managing risks across the organisation. Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny of fragile services provided by QSE and Board.

5. Clear governance and assurance systems in place with performance (quality, resource, activity/outcomes) issues escalated appropriately through clear structures and processes.

6. Self-assessment against an agreed governance maturity matrix with evidence the agreed level.

AUDIT AND RISK ASSURANCE COMMITTEE UPDATE REPORT

Date of last meeting: 09 July 2024

Quoracy: Met

Report by: Cllr Rhodri Evans, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert[1] (may require discussion)

- There are no mattes to **alert** members of the Board to.

Advise[2] (to monitor)

- There are no mattes to **advise** members of the Board to.

Assure[3] (to note)

The Audit and Risk Assurance Committee wish to assure members of the Board that:

- A robust governance process was enacted during the year, and recommend the approval of the Hywel Dda University Health Board (HDdUHB) Annual Report and Accounts 2023/24 to the Board, prior to its submission to the Welsh Government, via Audit Wales, by 15 July 2024, and its subsequent presentation at the Annual General Meeting on 26 September 2024.

Review of Risks

The Annual Report 2023/24 includes a section on the Health Board's capacity to manage risk, its significant risks during 2023/24, and the risk management systems and process that have been in place to manage risk during 2023/24.

Sharing of learning

Not applicable.

Recommendation

The Board is asked to:

- Be assured on the items that the Committee is providing assurance on.
- Approve the HDdUHB Annual Report and Accounts 2023/24 (approved at the Extraordinary Public Board meeting on 11 July 2024), prior to its submission to the Welsh Government, via Audit Wales, by 15 July 2024, and its subsequent presentation at the Annual General Meeting on 26 September 2024.

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[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*
[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.*
[3] *There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.*

Agenda, papers and minutes are available on our website: Audit and Risk Assurance Committee (ARAC) - Hywel Dda University Health Board (nhs.wales)

Risk Assessment Procedure

DRAFT

Procedure information

Procedure number: 674

Classification:
Corporate

Supersedes:
Previous versions

Version number:
3

Date of Equality Impact Assessment:
04/06/2024

Approval information

Approved by:
Detail which group/committee has approved this document
Date of approval:
Enter approval date
Date made active:
Enter date made active (completion by policy team)
Review date:
Enter review date (normally three years from approval date)

Summary of document:
This procedure explains the risk assessment process from identification to the treatment of risks and how to complete a risk assessment form.

Scope:
This procedure applies to all Executives, Directorate Risk Leads, Service Delivery Managers, General Managers and all staff who will be involved in the identification and management of risk.

To be read in conjunction with:
608 – Risk Management Framework – opens in a new tab
156 – Risk Management Strategy – opens in a new tab

DRAFT

Patient information:
Include links to Patient Information Library

Owning group:
Audit and Risk Assurance Committee Name the group with ongoing responsibility for this document Date signed off by owning group

Executive Director job title:
Phil Kloer – Interim Chief Executive

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1 – new procedure 14.2.2018
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2.1 - revised appendix
3 – full review

Keywords
Risk Assessment, Risk Assessment Form (RAF), Risk Matrix

Glossary of terms

Term	**Definition**
Risk	The effect of uncertainty on objectives. Note that an effect is may be positive, negative, or a deviation from the expected. Also, a risk is often described as an event, a change in circumstance or a consequence. (International Organisation for Standardisation (ISO) Guide 73, 2009)
Risk Assessment Form (RAF)	The means by which risks are evaluated and prioritised by undertaking risk identification, risk analysis and risk evaluation
Risk scoring matrix	Tool used in risk analysis to determine the likelihood and impact of the risk to understand the nature and level of risk
Risk appetite	The amount and type of risk that an organisation is willing to pursue or retain (ISO Guide 73, 2009)
Risk tolerance	The organisation's readiness to bear a risk after risk treatment in order to achieve its objectives. (ISO Guide 73, 2009)
Risk control	Mechanisms that are currently in place which make a risk less likely to happen, and include systems, processes, people, policies and procedures, inspection regimes, defined responsibilities and accountabilities of staff, monitoring and review processes

Contents

Aim

This procedure should be used for assessing all types of risks (noting that risk assessments relating to Health and Safety such as maternity should adhere to relevant Health and Safety guidance). Risk assessment is a proactive, systematic and effective method of identifying, analysing and evaluating risks to determine the significant risks facing the organisation, a project or strategy.

Although risk assessment is extremely important, it is only useful if the outcomes of the risk assessment are used to inform decisions and identify appropriate risk responses. It is the start of the risk management process, and should not be considered as an end in itself.

Risk assessment is proactive; we are trying to stop an event from occurring. It includes the management of the business risks associated with running the Health Board or its hospitals, risks to delivering service objectives and plans, and risks to achieving and maintaining compliance, i.e. risks to business continuity, risk to patients, staff, etc. Once an event has occurred it is no longer a risk but becomes a management issue that needs action to be taken.

Objective

The procedure will explain the risk assessment process from identification to the treatment of risks and how to complete a risk assessment form.

Scope

This procedure applies to all UHB staff, contractors, other third parties working within the UHB and those who work in partnership with the UHB.

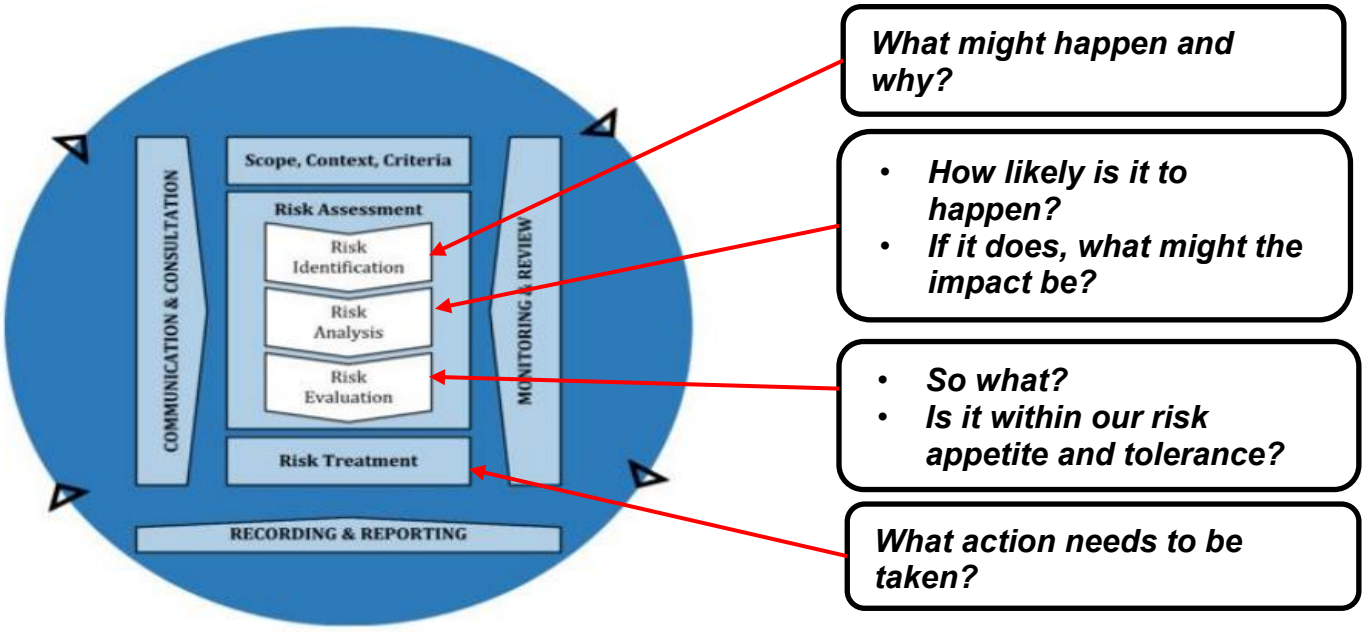
Risk Assessment Process

There should be a combined top down and bottom-up approach to risk assessment. Top-down risk assessment will enable the organisation to engage the top of the organisation with risk management and will tend to focus on strategic objectives and strategic risks, particularly external risks, whereas a bottom-up approach will focus on operational objectives and risks. It is important however to avoid a 'silo-based' approach and understand the interconnectivity of risks throughout the organisation.

Risk can be subjective, and it is likely that anyone involved in the risk management process will have different views or perceptions of risk. It is important that differing views are explored to reach a common position to ensure the right risk response is identified. Risks identified within services should be discussed with managers before a risk assessment is completed as they should not be done in isolation. A flowchart of the risk assessment process can be found at Appendix 1.

Risk assessment is part of the risk management process, and the following questions should be considered:

1. What could go wrong? *This is the 'event'*
2. What might lead to this event taking place? *This is the 'cause' of the risk*
3. How likely is this event?
4. What would be the impact of the event?
5. Is that outcome acceptable within the Health Board's stated risk appetite and tolerance?
6. Is there something the Health Board needs to do to reduce or mitigate the risk?



(ISO 31000, 2018)

Risk Identification

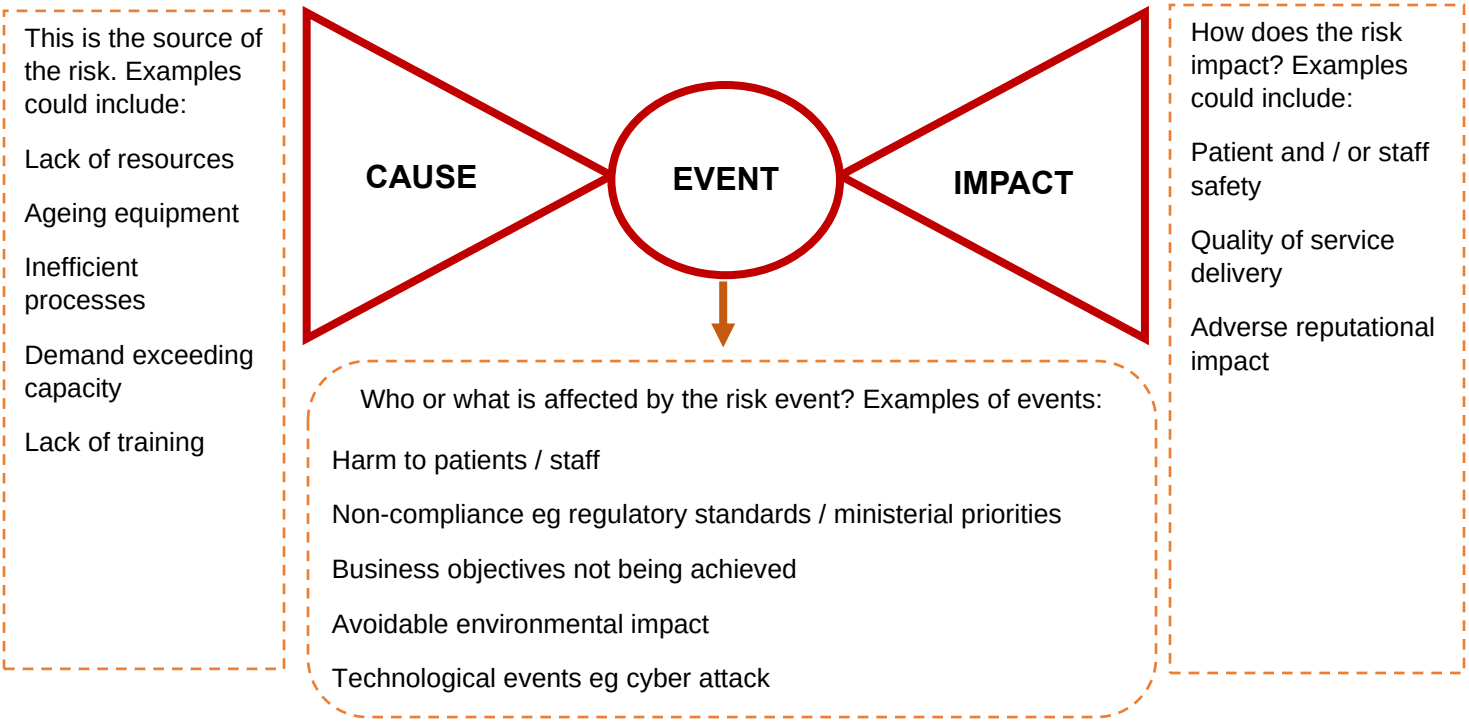
Identification of a risk will tell you what could go wrong. Understanding why, how, when and where things go wrong is also important to ensure the right risk response. The better you can define the risk, the more precise you can be in describing the impact and determining the proper controls needed.

Identifying possible scenarios where risks could occur helps the organisation to understand its most vulnerable areas of impact and where actions need to be taken to protect them.

The risk should be thought about in three parts using the following phrase:

- There is a risk that ....*(this is the ' future event'*).
- This is caused by.....
- This would lead to an impact/effect on....

The bow-tie diagram below can be a useful way of representing the three components needed in risk description.



Risks can be identified by anyone in the organisation, however risk assessments should be discussed and completed with the line manager to ensure the right controls and actions are identified, and this is communicated to everyone who needs to know or is involved in the activity giving rise to the risk.

Sources of risk can include the following:

Proactive	Risk assessments, hazard reporting, workshops, surveys, horizon scanning, SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis, PESTLE (Political, Economic, Social, Technological, Legal, Environmental/Ethical) analysis, committees
Reactive	External reviews and inspections, incident investigations, claims, customer and staff satisfaction measures

Risk is not just about threats and negative impacts, managing risk can also bring about opportunities and enhance positive outcomes.

The risk assessment form in Appendix 2, and available via the Assurance and Risk Sharepoint page, must be completed when a risk has been identified. The person identifying the risk should complete it with their manager.

Risk Analysis

Once a risk has been identified, the next step is to analyse the risk. ISO 31000 (2018) states:
This step involves analysing the positive and negative consequences of the risk (i.e. its impact or magnitude of effect), and the likelihood that those consequences may occur (i.e. its frequency or probability). The consequence and likelihood are rated against established criteria which are on the Risk Scoring Matrix (Appendix 3).

It is essential that the 'domain' is chosen based on the consequence/impact already identified in risk description (previous step). Where a number of impacts have been identified, the domain selection should be based on the impact with the severest consequence/impact. Whilst in the majority of risks, the consequence/impact score will remain the same for the inherent, current and target score, as actions will generally be taken to reduce the likelihood of the risk occurring, risk owners should also consider whether actions can be taken to reduce the impact of the risk. This will help to reduce harm, minimise costs and limit damage should the risk materialise.

Using the Risk Scoring Matrix will help to enable a level of consistency on the approach to scoring risk across the Health Board. Risk scoring can be very subjective and is often based on personal values and attitudes, therefore it is always better to score with colleagues who have the relevant experience and knowledge to gain a different perspective. To help determine the impact and likelihood of a risk, it might be helpful to consider:

- Historical or past data;
- Personal relevant experience;
- Industry-relevant experience of the risk;
- Published literature on the risk;
- Market research;
- Economic/statistical models to base forecasts; and
- Expert information specific to the risk to make judgements.

The risk score is one way the Health Board will rank risks by significance, therefore it is important not to inflate or deflate scores. Risk scores must be an honest reflection of the risk to Health Board to aid it in its decision making and prioritisation of resources.

This step involves considering the controls or mitigating activities already in place that reduce the level of risk. These controls or mitigating activities, and their effectiveness, should be identified in the risk assessment form.

Controls are mechanisms that are currently in place which make a risk less likely to happen, and include systems, processes, people, policies and procedures, inspection regimes, defined responsibilities and accountabilities of staff, monitoring and review processes.

Risk Evaluation

The next step in the process is to evaluate the risk. This is the decision point after analysing the risk, whether the risk can be tolerated (accept the risk and do nothing further) or treated (further action to be taken).

In order to have a consistent approach to risk management within the organisation, it is important that those who manage risk understand the trigger point, above which, they should respond or tolerate a risk. If they do not, it will lead to an inconsistent management of risk based on personal attitudes rather than organisational objectives and priorities. Risk appetite represents the organisation's willingness to undertake an activity that involves risk (see the UHB's risk appetite statement here - opens in a new tab). It can also be used in decision making in areas such as allocating resources and project approval.

Risk Treatment

If a decision is made to treat the risk, existing controls should be reviewed in terms of their efficiency and effectiveness and whether there are any gaps. The aim of risk treatment is to develop and implement further actions to reduce the likelihood of the risk occurring and minimise the impact if the risk does materialises. It will help reduce prevent loss, limit further damage and contain costs. The options for risk treatment are identified in the 4Ts:

Tolerate	i.e., accept the risk. Risk exposure may be tolerated without any further action being taken, even if it is higher than the level the organisation would choose to accept. Where the ability to do anything about certain risks may be limited or the cost of taking any further action may be disproportionate to the potential benefit gained, the response should be to manage the risk to as low as reasonably practicable (ALARP), then tolerate the risk. This option can also be supplemented by contingency planning for handling the consequences that may arise if the risk is realised. By tolerating the risk, this demonstrates the organisations' readiness to bear the risk after treatment. Where the status of the risk is to tolerate, the risk must be monitored and reviewed by the risk owner as per Health Board review guidance. The Executive Risk Owner must approve the tolerance of risks within their area of responsibility, and these will be reported to the Executive Risk Group and through the Board and its Committees.
Treat	i.e, reduce or remove the risk The purpose of treating a risk, is that whilst continuing the activity giving rise to the risk, action is taken to reduce the risk to an acceptable level. The Health Board has acceptable risk tolerance levels for different types of risks and these are determined by the Board. Risk owners should continue to treat the risk to bring within tolerance where possible. If the target risk score exceeds the tolerance level, then this will need to be agreed by the relevant Executive Risk Owner. Most risks should be addressed in this way before any other course of action should be considered.
Transfer	i.e., transfer responsibility. It may be possible to transfer the risk to another party either by insurance or contractual agreement, or some other means of sharing the risk. It is worth noting that a risk can never be fully transferred, and whatever the intention of the parties, the risk to the Health Board of any transfer arrangement should be risk assessed. This option is rarely possible in the NHS. The Executive Risk Owner must approve the transfer of risks within their area of responsibility and these will be reported to the Executive Risk Group and through the Board and its Committees.
Terminate	i.e., Suspend the risk situation/activity. Some risks will only be treatable, or containable to acceptable levels, by stopping the activity. It should be noted that this option is severely limited in the public sector as

	the activity may be a statutory requirement or stopping the activity would give rise to a higher risk. The Executive Risk Owner must approve the termination of risks within their area of responsibility and these will be reported to the Executive Risk Group and through the Board and its Committees.

Monitoring and Review

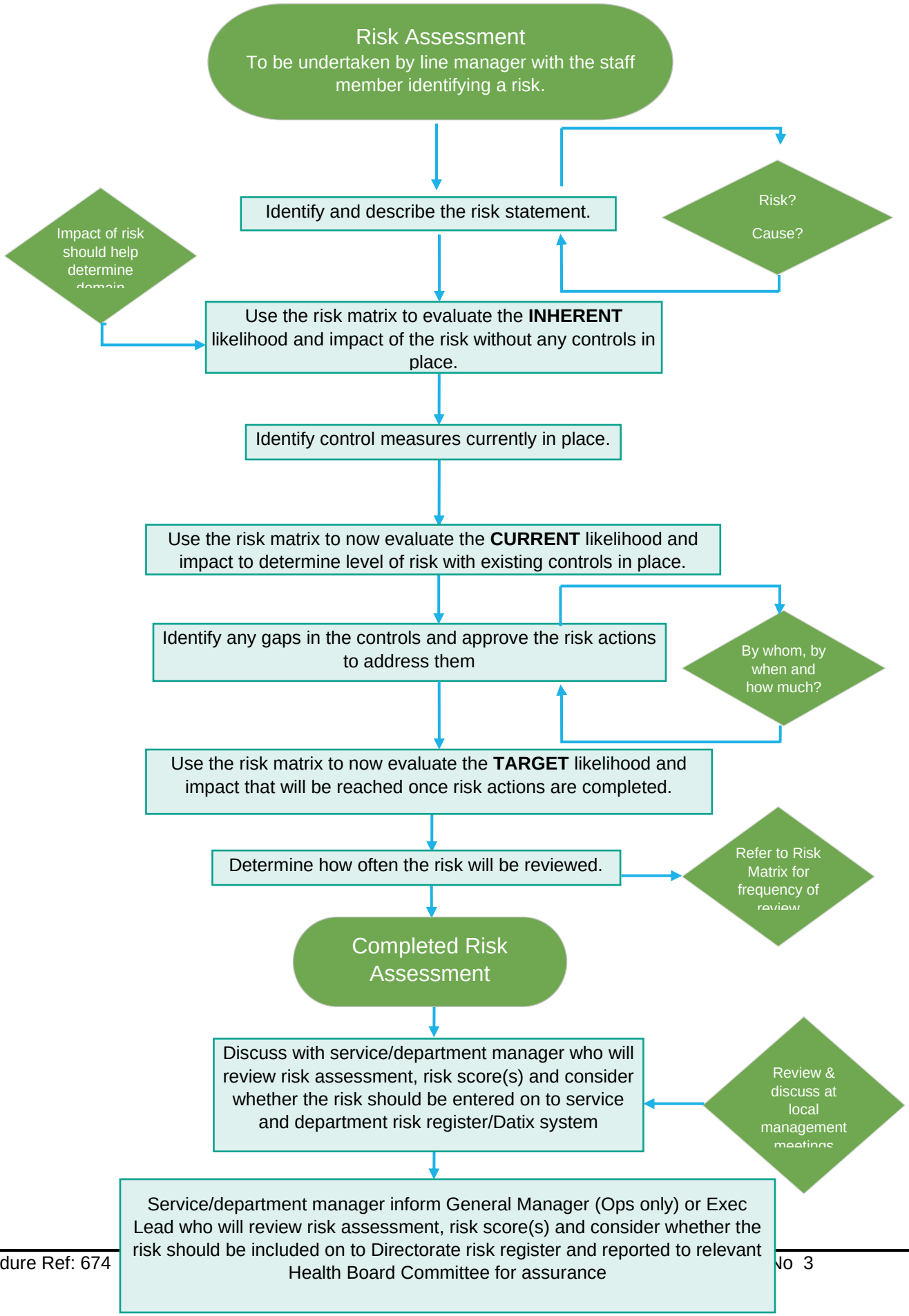
Once a risk assessment form has been completed, it must be reviewed and approved in line with Health Board guidance and local management arrangements prior to addition to the risk register.

Risk assessments require to be reviewed regularly by management, to ensure the risk is managed to an acceptable level and actions are being implemented. Guidance on frequency of review can be found on the Risk Scoring Matrix at Appendix 3.

Communication and Consultation

Effective communication is essential to ensure that those responsible for implementing risk management, and those with a vested interest or may be affected by the risk, understand the basis on which risk management decisions are made and why particular actions are required. It is also essential that those with actions are informed of their responsibilities and provide updates on progress when required.

Appendix 1 – Risk Assessment Flowchart



Appendix 2 - Risk Assessment Form

For guidance on completing this form please click on the following link: Risk-Assessment-Guidance-Form sharepoint.com)

Risk Ownership

Executive Director:	
Directorate lead:	
Management or service lead:	

Directorate:	Choose your Directorate.	**Service or Department:**	Choose your Service or Department.

Risk Details

Title of risk: **Maximum characters: 128**	Risk of	due to
Date risk identified:	Select date.	
Domains of Quality (select all that are applicable):	Select Domain. Select Domain. Select Domain.	Select Domain. Select Domain. Select Domain.

Other risks you would like to link to on Datix:	

Risk Statement

Please describe your risk clearly and concisely - who/what is at risk?	
There is a risk… **Maximum characters: 200**	
List all the causes of this risk	
This is caused by… **Maximum characters: 400**	
List all potential consequences of the risk	
This will lead to an impact/effect on… **Maximum characters: 450**	
Location of the risk:	
Select the DOMAIN of the risk:	Choose one DOMAIN. **This should be based on the Impact of the risk**

Inherent Risk Score (Impact x Likelihood = Risk Score)

Using the risk scoring matrix, evaluate the **inherent** risk rating. This is the risk score **WITHOUT** control measures in place.					
Inherent impact score	Impact	**Inherent** likelihood score	Likelihood	**Inherent** risk score	Score (I x L)

Control Measures

List all completed actions and ongoing activities that are in place to successfully mitigate the risk

Gap in Controls

List any shortfalls in your control measures and unsuccessful actions (these should be addressed in your Action Plan)

Current Risk Score (Impact x Likelihood = Risk Score)

Using the risk scoring matrix, identify the **current** risk rating. This is the risk score **WITH** control measures in place.					
Current impact score	Impact	**Current** likelihood score	Likelihood	**Current** risk score	Score (I x L)

Rationale of Current Risk Score

Please provide the reason/justification for the **current** risk score chosen above, taking into account the control measures in place and actions yet to be completed. **This section should be updated at each risk review and include any performance metrics that show progress to date that will inform the relevant committee/sub committee on the current position of the risk.**

Risk Decision

Tolerate, Treat, Transfer or Terminate (Full definitions available here)	Choose 1 option

Target Risk Score (Impact x Likelihood = Risk Score)

Using the risk scoring matrix, identify the **target** risk rating. This is the risk score you are trying to achieve when **all actions are complete**.					
Target Impact score	Impact	**Target likelihood score**	Likelihood	**Target risk score**	Score (I x L)

Risk themes (select all that are applicable): For theme definitions click here.	Select theme. Select theme. Select theme.	Select theme. Select theme. Select theme.

Risk Review & Monitoring

Identify the Lead Assurance Committee or Sub-Committee this risk should be reported to:	Choose a Committee or Sub Committee.		
Identify the local management group this risk should be monitored at:			
Is this risk to be entered onto your service risk register in Datix?	Y/N.	**Frequency of review (based on Current Risk Score):**	Choose frequency of review.

Risk Action Plan - **Please note, this section is not visible until your risk has been saved to Datix.**

Please specify actions that address the cause of the risk**. Actions must be SMART: Specific, Measurable, Achievable, Relevant/Realistic and Time-bound.** Add as many actions as necessary to achieve your target risk score.	**By whom** **Name 1 owner per action**	**By when** **Future dates only**
ACTION 1:		
PROGRESS UPDATE:		
ACTION 2:		
PROGRESS UPDATE:		
ACTION 3:		
PROGRESS UPDATE:		
Add as many actions as needed		

Status of Risk

All risks are automatically added at **Service Level**. **Directorate Level** risks must be approved by your Directorate lead. If you would like to add/escalate a risk to **Corporate Level** please contact the Head of Assurance & Risk.	Service/Department Level

Appendix 3 - Risk Scoring Matrix

Likelihood x Impact = Risk Score

Likelihood	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**Will probably happen/recur, but it is not a persisting issue/ circumstances.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for 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.***
* time-framed descriptors of frequency					
Probability - Will it happen or not? *(what is the chance the adverse consequence will occur in a given reference period?)*	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
*used to assign a probability score for risks related to time-limited or one off projects or business objectives.					

Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	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. 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.
Quality, Complaints or **Audit**	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint - Escalation. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low achievement of performance/delivery requirements. 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 / performance requirements.

Workforce & OD	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 or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/ improvement notice.	Enforcement action Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/delivery requirements. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Low achievement of performance/delivery requirements. Severely critical report.
Adverse Publicity or 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. AMs concerned (questions in the Assembly). Total loss of public confidence.
Business Objectives or 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	Small loss. Risk of claim remote.	Loss of 0.1–0.25 per cent of budget. Claim less than £10,000.	Loss of 0.25–0.5 per cent of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget. Claim(s) between £100,000 and £1 million.	Non-delivery of key objective/ Loss of >1 per cent of budget. Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day. Disruption to a number of operational areas within a	Loss/interruption of >1 week.	Permanent loss of service or facility.

		Some disruption manageable by altered operational routine.	location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	**Extreme**	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	**High**	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	**Moderate**	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	**Low**	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5	**5**	**10**	**15**	**20**	**25**
MAJOR 4	**4**	**8**	**12**	**16**	**20**
MODERATE 3	**3**	**6**	**9**	**12**	**15**
MINOR 2	**2**	**4**	**6**	**8**	**10**
NEGLIGIBLE	**1**	**2**	**3**	**4**	**5**