NHS England and NHS Improvement Board meetings held in common

Paper Title: **Risk Appetite and Joint Corporate Risk Register (JCRR)**

Agenda item: 1 (Private session)

Report by: Emily Lawson, Chief Risk Officer and Executive Director of Transformation and Corporate Development (TCD)
Katherine Ibbotson, Director of Governance and Legal Services

Paper type: For decision

Summary/recommendation:
The purpose of this paper is to provide the NHS England (NHSE) and NHS Improvement (NHSI) Boards in common with an overview of the proposed approach to risk appetite for the joint organisation.

Members are asked to consider the recommended approach by reflecting on the case study provided and confirm whether the risk appetite statement, supported by the risk heatmap criteria, provides an appropriate guideline for assessing risks across the organisation i.e., whether it constitutes an appropriate framework for senior management and other employees to debate how much and what types of risk are acceptable, at any point in time, in order to make sound decisions on the balance between risk and reward.

Background - definition, context and purpose of risk appetite

1. The UK Corporate Governance Code states that 'the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'. This means that at least once a year, the NHSE and NHSI Boards, and/or our Boards in common should consider the types of risk they may wish to exploit and/or can tolerate in the pursuit of objectives.

2. NHSE and NHSI define risk appetite as **'the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives.'** It is key to achieving effective risk management and should be considered before risks are addressed.

3. NHSE and NHSI carry out analysis, make judgements, take decisions, develop and implement policy and run projects every day. We do not operate in a vacuum; equally risks are not static, nor are they mutually exclusive. We must therefore view risks holistically, assessing interdependencies across the system to provide a more rounded assessment of risk.

4. NHSE and NHSI recognise it is not possible to eliminate all risks which are inherent in achieving our corporate objectives and fulfilling our statutory duties,

and that we may need to consider and/or accept a certain degree of risk where it is in our and ultimately patients' best interests.

5. Risk appetite within NHSE and NHSI therefore aims to prevent failure caused as a consequence of reckless risk-taking and ensure that management and the Board are taking the right risks for success (e.g., to deliver improved impact and value for money). It should facilitate a forward-looking view of risk and be adaptable to local circumstances to help drive management action and facilitate informed decisions, and is:
    a. set by the Boards in common
    b. aligned with the joint organisations' strategy and corporate objectives and embedded into key business processes
    c. linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control
    d. not a single, fixed concept. There will be a range of appetites for different risks and these appetites may vary over time; in particular the Board will have freedom to vary the amount of risk which it is prepared to take as circumstances changes, for example, during periods of increased uncertainty or adverse changes in the operating environment
    e. reviewed once a year, or sooner if circumstances dictate.

6. The purpose of stating risk appetite within the joint organisation is therefore to:
    a. Provide awareness and an overall view of our risk profile, giving context to our risk position and exposure.
    b. Help steer decision making across the organisation by providing a position against which potential decisions can be tested and challenged.
    c. Provide guidance and an objective view on our ability to achieve longer term objectives; guides and monitors whether we are trending towards longer term objectives that the organisation is striving for – in particular the Long Term Plan.

Application and usage

7. When risk appetite is defined rigidly it can impede innovation and make an organisation overly cautious. It can also fail to reflect the complexity and diversity of decision making within an organisation such as NHSE and NHSI, and across the health and social care system as a whole.

8. Due to the nature of our organisations, and the duties we are mandated to perform, NHSE and NHSI acknowledge that a one-dimensional (and heavily quantitative and directive) approach to risk appetite would not drive the right results. Therefore, in keeping with our culture to empower and trust decision makers, to drive consistency and enable staff to take well calculated risks and make accurate risk trade-off decisions to improve delivery when opportunities arise (and identify when a more cautious approach should be taken to mitigate a threat), we propose that the NHSE and NHSI Boards adopt a **qualitative approach** to risk appetite.

9. The aim is to make risk appetite considerations an **intrinsic part of our risk management and business processes**, not seen as something separate or extra, achieved as follows:

Business processes:

a. To ensure that the organisations' day-to-day operations are well managed and that decisions are well controlled within local circumstances, we aim to ensure risk appetite considerations are an intrinsic part of how we do business; with the aim of improving organisational performance. Therefore, in some instances, for example from an operational perspective, risk appetite reflects the constraints that are already placed on staff in the organisation. For example, risk-reward trade-off discussions and/or appetite/tolerance limits are:

   i. Embedded within operating limits, delivery targets/KPIs, standing financial instructions (SFIs) and/or delegation of authority arrangements.
   ii. An integral part of strategic and financial planning. For example, the annual budget prioritisation process is linked to our business planning cycle which allows an overview of financial and other types of risk.
   iii. Built into impact assessment processes and considered within programmes and projects (at the very outset of project conception, within the formal decision-making process and throughout delivery) actively guiding management to assess the level of risk beyond which programmes and projects would not be considered viable.

Risk processes:

b. A high-level **qualitative risk appetite statement** is proposed, structured around the joint organisations' seven key or principal risk types (see Appendix 2).

c. As a guide for setting risk appetite/to find out if individual risks fall within an acceptable tolerance range, the risk appetite statement corresponds with **risk heat map criterion** (see Appendix 3).

d. **Target risk levels** (i.e., the risk level that the affected risk owner, region or national directorate believe is best for meeting its objectives / the level of risk we would like to drive towards over time needed to achieve target level) are also assigned to each risk to ensure they are managed within set appetite.

e. The Joint Executive Risk Management Group (JERMG) and/or NHS Executive Group, as appropriate, will continue to monitor corporate risks **top down** to ensure appetite is within tolerance range, that actions taken to reach target levels of risk are achievable and met, and/or that changes in one risk category do not unwittingly compound others. A high-level overview of the current draft of the joint NHSE and

NHSI Corporate Risk Register (JCRR) is attached at appendix 4 (see separate PowerPoint document).

f. The approach to risk appetite also provides a way of steering risk appetite/tolerance discussions **bottom up** and should ensure consistency of approach for the enterprise as a whole, including in the day-to-day delivery of programmes and projects.

Next Steps

10. Consideration of risks falling outside of appetite will be considered and reported within the joint organisation's risk reporting schedule as follows. N.B., Frequency of Audit and Risk Assurance Committee (ARAC) and Board risk reporting will be reassessed as our risk management maturity increases:

- Quarterly to Joint Executive Risk Management Group (JERMG);
- As required to the NHS Executive Group;
- Quarterly to ARACs; and
- Quarterly to the Boards

11. Following agreement at Board, the risk appetite component will be added to the risk management framework (RMF) and communicated across the organisation.

Recommendation

12. The Boards are invited to review and comment upon the proposed approach to risk appetite articulated within this paper, and using the scenario proposed in Appendix 1, consider:

a. whether the **qualitative** risk appetite approach works culturally/allows enough flexibility operationally?

b. what trade-offs would be acceptable in certain categories; where our tipping points would be, and whether the approach facilitates such an approach?

c. whether the draft risk appetite statement captures the joint organisation's approach sufficiently.

Appendix 1: Risk Appetite Scenario / Case Study

Case Study: X CCG	
Risk Category:	Innovation, Performance and Patient Safety and Quality of Care
Present Risk Appetite Level / Threshold:	Innovation - Moderate to High; Performance - moderate
Activity:	The Long Term Plan sets out a vision for a future integrated model of care, changing how we and the system work and how care is delivered. Proposals for New models of care at X CCG entail a novel contracting proposal, major transfer of services between providers and overhaul of the governance arrangements at a local FT/Trust to widen system participation.
Debate:	How much risk should we take when we approve novel clinical, contractual and organisational models under the integrated support and assurance process (ISAP) framework? Given that the burden of ISAP largely flows from the transaction review requirements, are those still fit for purpose. Should we take risk (operational/financial/reputational) to deliberately disrupt the status quo compared to making incremental change? If not, do we risk the inertia and our assurance processes tending to stymy innovation. Specifically: 1. Should we be i) assessing and ii) approving the risks attached to the shift to new clinical, contractual and organisational models at the centre or within and between ICS partners. What factors determine our approach in individual cases? 2. Specifically, should we maintain our published approvals thresholds for patient benefits and financial improvement (or should we rely on a lower evidence base for patient benefits and/or financial improvement (higher appetite for risk) in order to reach clinical, contractual and organisational arrangements which can encourage integrated care pathways and whole system governance participation? 3. Should we accept a higher degree of risk in limited circumstances in order to test concepts (for example the ICP contract, new governance arrangements, new clinical models) within a clear evaluation framework to broaden the investment and innovation pipeline and test/prove improvements? Might we accept some element of risk in order to secure significant improvements? 4. What is the trade-off and how could we manage this appetite across the sector?
Key risk(s):	• Disruption (to organisations and people) and financial cost • Uncertain whether benefits (improved pathways, healthier population) will materialise • Personal risk of senior leaders • Legal challenge leading to disruption

Appendix 2: Draft risk appetite statement

NHSE and NHSI Risk Appetite Strategy (Qualitative Statement)

The risk appetite of NHS England and NHS Improvement is grounded in the NHS Constitution. The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively.

NHSE and NHSI believe that no risk exists in isolation from others and that risk management is about **finding the right balance** between risks and opportunities to act in the best interests of patients and tax payers. Our approach to risk appetite inevitably involves risk trade-off conversations and a consideration of the counterfactual - giving us a flexible framework within which we can try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour.

When balancing risks, NHSE and NSHI will tolerate some more than others. For example: NHS England and NHS Improvement will seek to minimise avoidable risks to patient safety in the delivery of quality care and has a very low appetite for risk in this area. In the case of innovation or proof of concept we are prepared to take managed "moderate to high risk" on the proviso that the following has been undertaken:

- An assessment of what and where the current risks are;
- That the potential future impact has been understood and agreed;
- Rapid cycle monitoring is in place to enable swift corrective action should things go wrong;
- Consideration of the system's ability to respond i.e., different regions face different circumstances and some areas are very challenged;
- Trade-off between risks is understood / assessment of unintended impacts on other risks undertaken (i.e., whether it will lead to an increase or reduction in other categories of risk);
- Cost–benefit analysis and stated preference is undertaken;
- Reliability and validity of data used to make the assessment has been considered;
- Counterfactual risks have been considered to ensure management apply any learning before taking the risk;
- We can demonstrate significant and measurable potential benefits (i.e., enhanced efficiency and/or value-for-money delivery).

Ranges to guide these trade-off discussions are provided in Figure 1 below:

Figure 1: Range of Risk Appetite Levels

	Risk Category	Risk Appetite Level
1	Patient Safety and Quality of Care	Very Low
2	Performance (operational and financial)	Moderate
3	Innovation / opportunistic risk (e.g. identification of new ways of working, to integrate services and develop new models of care)	Moderate to High
4	Financial risk and Value for Money (VfM)	Low
5	Compliance and Regulatory risk	Moderate
6	Reputational risk	Low to Moderate
7	Operational risk (including underperformance / delivery risk, internal capacity/capability and other people risks, information technology/data risks, and external event risk)	Moderate

Appendix 3: Risk Heatmap Criterion – overview of the organisations 5 X 5 risk scoring matrix

Heatmap/RAG

Likelihood	Impact				
	1 - Very Low	2 - Low	3 - Moderate	4 - High	5 - Very High
5 – Very Likely	5	10	15	20	25
4 – Likely	4	8	12	16	20
3 – Possible	3	6	9	12	15
2 – Unlikely	2	4	6	8	10
1 – Rare	1	2	3	4	5

	Low Risk (1-6)
	Moderate Risk (8-10)
	High Risk (12-16)
	Extreme Risk (20-25)

Appendix 4: Joint Corporate Risk Register

Please refer to separate Microsoft PowerPoint document for details of the organisations joint corporate risk register (JCRR).