NHS
Blood and Transplant

Board Meeting in Public

Monday, 18 May 2026

Title of Paper	Risk Management Policy (BLP5)	**Agenda No.**	4.3
Nature of Paper	☒ Official	☐ Official Sensitive	
Author(s)	Andrew Weal, Head of Compliance, Risk & Assurance		
Lead Executive	Helen Gillan, Director of Quality and Governance		
Non-Executive Director Sponsor	Ian Murphy		
Presenter(s) at Meeting	Helen Gillan, Director of Quality and Governance		
Presented for	☒ Approval ☐ Information ☐ Assurance ☐ Update		
Is there a plan to communicate this to the organisation?	☒ Yes ☐ No ☐ Yet to be determined		

Executive Summary

The Board Risk Policy requires an annual review and approval. The attached version includes recommendations, which include updated wording, a change to the appetite level for People related risk (affects P-07) and the addition of a new risk impact area. These amendments are coloured Purple.

Previously Considered by

BLP5 is reviewed annually by the RMC and ARGC. This document was reviewed and accepted at the 01 April 2026 Risk Management Committee meeting and the Audit, Risk and Governance Committee, 30 April 2026.

Recommendation

The Board is asked to to consider and approve this policy

Risk(s) identified (Link to Board Assurance Framework Risks)

This policy relates to, and informs all principal risks

Strategic Objective(s) this paper relates to:

☐ Collaborate with partners ☐ Invest in people and culture ☐ Drive innovation
☐ Modernise our operations ☐ Grow and diversify our donor base

Appendices:	

Changes in this version

Change to wording in sections 3 and 7.

Change to risk appetite for P-07 from Open to Cautious – Table in section 8

Addition of new impact area – Operational Capacity – Table in section 8

Board Level Policy

1. Policy Purpose

The purpose of the risk management policy is to provide guidance regarding the management of risk.

2. Scope of Application

This policy applies to all NHSBT activities. It forms part of the NHSBT governance framework and applies to all directors, chief officers, employees, contractors, volunteers and other individuals acting on behalf of NHSBT.

3. Policy statement and detail

NHS Blood and Transplant (NHSBT) recognises that it has a responsibility to manage risks effectively to deliver safe and effective products and services; to control its assets and liabilities; to protect its employees, stakeholders, customers, and patients against potential harm; to minimise uncertainty in achieving its obligations and objectives; and to maximise the opportunities to achieve its vision.

Risk management is an integral part of NHSBT's corporate governance arrangements and to ensure that confidence can be placed in risk management, **NHSBT shall comply** with the standards set in "Management of Risk – Principles and Concepts" (The Treasury Orange Book).

Risk management **shall** be factored into business planning, performance management, audit and assurance, business continuity management and project management.

4. Roles and responsibilities

- Board: Provides policy, agrees risk appetite, gives oversight and review of principal risks via the Board Assurance Framework. This policy, including the risk appetite statement must be considered and approved by Board annually.
- Audit, Risk and Governance Committee: Delegated authority from the Board to have regular in-depth risk review, allocating these to other Board Committees where they have the scope and expertise to better effect this review. Receives the annual report on risk activity.
- Board Committees: Provides in-depth risk review of risks within their scope, reporting this activity to the Audit, Risk and Governance Committee.
- Risk Management Committee: Oversees regular review of risk management activities, including initial deep dive reviews.
- Chief Executive Officer: Drives culture of risk management and signs off the Annual Report and Accounts, which contains the governance and risk statements.

- Chief Risk Officer (Assistant Director Governance and Resilience): A risk professional advising the Board on setting risk strategy, risk appetite and the architecture of the risk management framework.
- Risk Management Team: Continuous improvement of risk management policy, strategy and the supporting framework.
- Managers: Ensure staff in their business units comply with the risk management policy and foster a culture where risks can be identified and escalated.
- Staff and Contractors: Comply with risk management policies and procedures.

5. Training and awareness

Appropriate and proportionate training will be provided for all staff on risk awareness, and additional training will be provided to Risk Leads, Risk Owners, and those with governance responsibility for risk on the operation of the risk system. All such training will be mandatory.

6. Reporting in relation to policy

Risks scored within the Risk Limit will automatically be shared with the Risk Management Committee and the Board, via the Board Assurance Framework.

Risks scored in the Judgement Zone will be managed by the responsible Senior Management Team meeting, with the Chairperson responsible for any escalation requirements. Risk in the appetite range for a period of six months or more, will be reported by the Risk Management Team to the Risk Management Committee.

Visibility of risk appetite levels, against each Principal Risk, will be presented monthly in the risk section of the Board Performance Report, via the Board Assurance Framework and available to users in the landing pages of the Risk Management System.

7. Related policies and procedures

All risk management processes within NHSBT shall be compliant with the Treasury Orange Book processes which are set out in the Risk Manual (MPD1336).

8. Risk Appetite

NHSBT's Board and Executive Directors accept that:

NHSBT as a provider of healthcare related services and products, operates in an environment where there are risks associated with the processes and activities required to deliver products and services. Risks will be consistently managed in a considered and controlled manner

NHSBT must take risks to successfully deliver its strategic priorities, as part of the commitment to fulfil the organisations ambition

NHSBT will strive to ensure risks are managed within the agreed appetite levels confirmed by the Board, with any risk exceeding agreed tolerances prioritised and managed accordingly

In certain circumstances risks which exceed the agreed tolerance level and fall within the judgement zone, may be tolerated, if they result in a recognised benefit. This will be by exception, with this risk treatment approved and monitored by the Risk Management Committee

Risks will not be considered acceptable and will always be actively managed if they have the potential to:

- Expose donors, patients, staff and the public to avoidable harm
- Compromise NHSBT's ability to deliver key products and services within specifications and terms of agreements to hospitals, the NHS or other customers
- Breach statute, regulatory, mandatory or professional standard requirements
- Adversely impact the reputation of NHSBT

Individual risk appetite levels and the appetite statement will be monitored by the Risk Management Committee, signed by the Chair and CEO after approval by the Board as an element of this policy, and will be updated as legislation or the operating environment changes.

Risk Appetite Statements for Specific Impact Areas

Risk Impact Area	Level
Donor & Patient Safety	Minimal
Avoid risk, except in very exceptional circumstances, that may result in injury or harm to donors or patients	
Staff & Public safety and wellbeing	Minimal
Avoid risk, except in very exceptional circumstances, that may result in injury or harm to staff or members of the public	
Legal, Regulatory & Compliance	Cautious
Want to be reasonably sure we would win any challenge	
Governance	Minimal
Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions	
Financial	Open
Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels	
People	Cautious
Seek safe and standard People Policy, decision making authority generally held by senior management	
Innovation & Development	Open
Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance	
Service Disruption	Minimal
Avoid risk, except in very exceptional circumstances, that may result in minimal or short-term disruptions to service or product delivery, taking into consideration mitigating controls in place	
Commercial	Open
Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved	

Risk Impact Area	Level
Data & Technology	Open
Systems / technology developments considered to enable improved delivery. Agile principles may be followed. *Accept need for operational effectiveness in distribution and information sharing.*	
Reputation	Open
Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	
Operational capacity	Minimal
Operational delivery is a priority and other organisational responsibilities are secondary unless essential. Disruption to operational delivery is avoided. Decision making authority held by the Executive	

9. Policy Review and Compliance Monitoring

Element/Activity being monitored	Lead/roles	Reporting arrangements and frequency	Recommendations/actions
Policy review	Head of Compliance, Risk and Assurance	Annually	Policy review and consideration of any proposed amendments
Assurance on Compliance	Assistant Director Governance and Resilience	At each ARGC using BAF and Deep Dives. Also at RMC by routine agenda.	Regular review of risks.
Policy/process effectiveness	Assistant Director Governance and Resilience	Quarterly reports at RMC, Annual report at ARGC	Consideration of effectiveness of risk management
Breaches	Assistant Director Governance and Resilience	Quarterly reports at RMC, Annual report at ARGC	Consideration of any failures or breaches of risk management

10. Version Control and RACI view

Version	Owner	Approved by and basis of changes	Approved Date	Effective Date	Date of Next Review
1.0	Richard Rackham	Board of Directors	24/09/2024	24/09/2024	Within one year

(R) Responsible	Richard Rackham, Assistant Director Governance and Resilience
(A) Accountable	Helen Gillan, Director of Quality
(C) Consultees	Board and Executive Team
(I) Informed	Board, Members of Risk Management Committee.