Borders NHS Board

RISK MANAGEMENT POLICY

Aim

To update NHS Borders Board of the NHS Borders Risk Management Policy (November 2014) and its implementation.

Background

NHS Borders follows the national standard: BSI BS ISO 31000 Risk Management including BS 31100:2011 Risk Management-Code of Practice and Guidance for the implementation of BS ISO 31000.

The risk management framework within the NHS Borders has two distinctive parts: proactive risk management (risk information based on risk assessment flowing towards the risk register) and reactive risk management (risk information flowing towards the Adverse Event Management System). This Risk Management Policy describes the proactive risks management processes and supports risk owners in decision making when risk is identified. The policy objectives are to ensure the corporate objectives are achieved and any risks to the organisation are managed appropriately. Adverse event management and the risk register are now recorded/managed using the Datix risk management system to ensure the two systems are integrated. The organisation's risk appetite (risk tolerance level) is fully explained: for the events management this reflects the requirements of the HIS Health Improvement Scotland's (HIS): *Learning from adverse events through reporting and review: A national framework for NHSScotland Sept 2013.*

The Clinical Executive Operational Group, the Healthcare Governance Steering Group, Clinical Governance Committee, Audit Committee and BET all receive updates on significant risks.

Summary

The Risk Management Policy has been approved by the Clinical Executive Operational Group and is currently being implemented throughout the organisation.

Recommendation

The Board is asked to **note and ratify** the Risk Management Policy

Policy/Strategy Implications	Implementing of policies/strategies and risks arising would be included in risk management process
Consultation	Process inclusive of risk owners.
Consultation with Professional Committees	Clinical Executive Operational Group, Healthcare Governance Steering Group,

	APF, OH&S Forum
Risk Assessment	**Corporate Risk:** - The governance structure relies partly on the risk management framework to collect reliable risk information on organisational performance. Implementation is required for this information to be robust. **Operational risk:** - In discussion with clinical boards/directorates a greater demand for risk management training has been identified. Training needs to be based on relevant agreed systems. Without this training risk management may not necessary embed into operational systems. Risk in the organisation may be escalating. **Clinical risk:** - Clinical Boards require support to implement the risk management process to capture clinical risk. The risk management policy explains the framework and tools for this to happen but implementation may be varied across the organisation.
Compliance with Board Policy requirements on Equality and Diversity	As attached
Resource/Staffing Implications	Embedded into operational duties of risk owners

Approved by

Name	Designation	Name	Designation
Evelyn Rodger	Director of Nursing & Midwifery and Interim Director of Acute Services		

Author(s)

Name	Designation	Name	Designation
Sheila MacDougall	Risk and Safety Manager		

EQUALITY
IMPACT ASSESSMENT
(EIA)
Procedure and Toolkit
Version 2

You can get this document on tape, in large print, on disc and in various other formats. We can also provide information on language translations and extra copies. To arrange for an someone to meet with you to explain any parts of this document that may be unclear contact:

Equality and Diversity
Directorate of Public Health
NHS Borders
Newstead
MELROSE
TD6 9DB
Tel: 01896 826000

Annex A

NHS Borders
Equality and Diversity Impact Assessment Guidance

How to Complete the Equalities Scoping Template

Title: **Risk Management Policy**			
Which communities, groups of people, employees or thematic groups do you think will be, or potentially could be, impacted upon by the implementation of this policy? Please indicate whether these would be positive or negative impacts **Employees- positive** **Patient community- positive** **Borders Community – positive** **NHS Scotland- positive** **Healthcare partners- positive** **Independent contractors- positive** **Volunteers- positive**			
1. **Who does the proposed piece of work/policy/proposal affect?**			
Staff	**Patients/Service Users/Carers**	**Communities/Voluntary Groups**	**Public**
x	x	x	x
Tick all that apply. Note that a policy might be aimed at one particular group but still affect others			
2. **What are the aims and objectives of the work/policy/proposal being assessed?**			
Give a brief summary of the aims of the policy i.e. its purpose. This should include reference to other relevant documents such as the Delivery Plan and/or Directorate Plans. This policy is designed to aid the organisation deliver safe and effective healthcare to the Borders Community. The systems described are to support the achievement of the corporate objectives and minimise risks to acceptable			
		Yes	No
3.	**Will the proposal have any impact on equality of opportunity, discrimination between groups or relations between groups?** This policy will make progress towards reducing harm and ensuring risks are adequately managed.		X

4.	**Is the proposal controversial in any way in terms of equality and diversity (including media, academic, voluntary or sector specific interest)?** *Could the implications of the policy be seen as controversial in anyway e.g. a decision to remove funding, cut or change a service.*		X
5.	**Will the workforce or users of the service be disadvantaged as a result of the proposed work?** *Could this policy possibly have a negative impact on any of our workforce or patients/service users*		X
6.	**Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?** *If you are unsure of any of the answers tick yes and do a full impact assessment.*		X

If the answer to any of the above questions is yes or you are unsure of your answers to any of the above a full impact assessment is recommended.

7.	**Given the above statement, do you recommend a full impact assessment is completed?** *Simply indicate by selecting 'yes' or 'no' whether your assessment above indicates a need to conduct an equality impact assessment.*		X
8.	**If a full impact assessment is not required briefly explain why and provide evidence for the decision.** NHS Borders follows the national standard: BSI BS ISO 31000 Risk Management including BS 31100:2011 Risk Management-Code of Practice and Guidance for the implementation of BS ISO 31000. The risk management framework within the NHS Borders has two distinctive parts: proactive risk management (risk information based on risk assessment flowing towards the risk register) and reactive risk management (risk information flowing towards the Adverse Event Management System). This Risk Management Policy describes the proactive risks management processes and supports risk owners in decision making when risk is identified. The policy objectives are to ensure the corporate objectives are achieved and any risks to the organisation are managed appropriately. Adverse event management and the risk register are now recorded/managed using the Datix risk management system to ensure the two systems are integrated. The organisation's risk appetite (risk tolerance level) is fully explained: for the events management this reflects the requirements of the HIS Health Improvement Scotland's (HIS): *Learning from adverse events through reporting and review: A national framework for NHSScotland Sept 2013.*		

Completed By

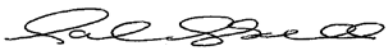
Name	Sheila MacDougall in partnership with	Dept.	Risk, Health and Safety Team
Post	Risk & Safety Manager	Date	11/02/2015

For your records, keep one copy of this Equality Scoping Assessment form and send an electronic copy plus any supporting documentation to evidence your decision to equality@borders.scot.nhs.uk

Risk Management Policy

Version number:	5.13
Prepared by	Risk Management Support Team
Distribution date:	10th November 2014
Review date:	23rd October 2017
Distribution arrangements:	Intranet

This policy has been approved for NHS Borders



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Chief Executive

……..
Employee Director

Approval date: 23rd Oct 2014

RM strategy review.pdrive.13/10/2014

Contents

1. Introduction

NHS Borders recognises that risk is inherent in the delivery of healthcare and that risk management should be part of an organisation's culture This Risk Management Policy explains how NHS Borders intends to deliver its risk management strategy (contained within Healthcare Governance Strategy) by embedding processes and structures into normal management practices. These management practices must ensure that risks are managed appropriately in line with statutory, mandatory and best and good practice requirements. The Policy lays out how this will be achieved using a comprehensive and cohesive risk management framework underpinned by clear accountability. These arrangements will commit to an integrated risk management approach supported by a single risk management framework for all risks to be effectively managed.

Risk Management is a responsibility of NHS Borders Health Board and ***all*** staff to work in partnership to achieve best practice.

Managing risks increases the likelihood of success and reduces the likelihood of failure. In essence, good risk management is good management.

The Healthcare Governance Strategy lays out the principal organisational strategies towards implementing effective risk management and as such this policy supports that strategy.

2. Context

NHS Borders moved towards integrating risk management and clinical governance into a cohesive health care governance approach March 2013. A new group was formed: Healthcare Governance Steering Group which draws together: clinical governance, risk management, infection control, resilience, research and occupational health and safety.

This policy will support the new Healthcare Governance Strategy as depicted below in figure 1 in partnership with the other specialist areas.

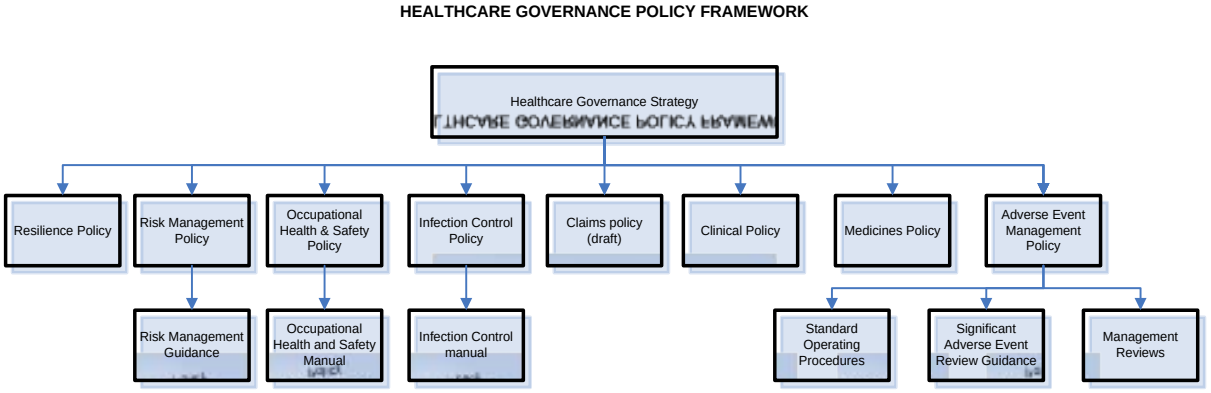


Figure 1- Policy structure

To ensure that NHS Border's corporate liabilities are managed to a sufficient standard reflecting good practice and robust governance, the current risk management framework follows the nationally recognised standard: *BS ISO 31000 Risk Management*. This standard is supported by *BS 31100:2011 Risk Management-Code of Practice and Guidance for the implementation of BS ISO 31000*, and forms the basis of NHS Borders risk management framework and supporting arrangements.
HIS: A *national approach to learning from adverse events through reporting and review – 2013* has the first indication of a national Scottish learning system for adverse events. It also added that one of the first principles of adverse event management is prevention based on risk assessment. The suggested prevention methodology is based on the proactive risk management process. This will be reflected in the Adverse Event Management Policy.

3. Aims of Policy
The aims of the Policy are to:

- Encourage and develop risk management as an integral part of a positive culture towards risk.

- Build awareness, competence, knowledge and capability of the workforce in risk management.

- Support a work environment that instils confidence within staff to challenge and question without fear, enabling staff to be effective in managing risk.

- Ensure that NHS Borders' corporate liabilities are managed to a sufficient standard reflecting good practice and robust governance.

- Specify roles and responsibilities of risk owners and all staff members

- Set the parameters for risk appetite and tolerance of risk

- Support the achievement of corporate objectives and strategic goals

4. Objectives of Policy
The objectives of the policy reflect the core business of the organisation which is the delivery of person centred, safe and effective healthcare.

Person centred:

i. Inclusion of appropriate stakeholders in the risk management process: Risk owners must manage risk in partnership with staff, patients, the public and other organisations through inclusion and communication during the risk management process. **Every risk assessment will record stakeholder involvement**.

Safe:

ii. Key risks must be identified: Using the risk management process risk owners must identify and understand the key risks affecting NHS Borders, clearly identifying uncontrolled and tolerated risks. Each clinical board/directorate should have as **a minimum key risks identified in relation to implementing the corporate objectives.**

iii. Proactive risk assessment must be used to minimise occurrences of adverse events: Proactive risk assessment is required as a preventative action to minimise the risk of an adverse event occurring, managers must ensure that risks are minimised and where they continue to exist, managed appropriately.
Clinical boards/directorates must review their work activities/patient pathways/patient journeys to identify issues/problems/hazards that could lead to an adverse event using the risk assessment process to manage the risks.

iv. **Risk management performance of very high risks will be monitored through organisational performance review arrangements.** Establish systems of monitoring and evaluating risk management through clear accountability arrangements. All clinical boards are currently included in this system and Support Services are being included over time.

v. **Foster the development of a learning culture** that allows and encourages staff to raise issues and be supported in finding new ways to overcome and/or manage risks.

Effective:

vi. **The risk management framework and supporting processes are consistently used by risk owners**. An integrated risk management process exists that is efficient and promotes effective risk management decision making minimising risk and maximising good management practice, this requires to be uniformly implemented.

vii. **Risks are escalated in accordance with the policy arrangements within this policy**.

viii. **The effective use of information management and technology to support the management of risk.**

ix. **NHS Borders complies with national standards and guidance relating to risk management published by Healthcare Improvement Scotland.**

5. Measurement of objectives

Measuring the implementation of these objectives will be evidenced through the risk information on NHS Borders risk register and within the adverse event reporting system. Audit will be undertaken to establish the success of these objectives as deemed necessary. This will be reported to Clinical Exec Operational Group to the Audit Committee and ultimately the Health Board through the annual report.

6. Definitions

Risk is defined as:

- The chance of something happening that will have an impact on objectives; it is measured in terms of consequences and likelihood.

Hazards/problems/issues are defined as:

- Something with the potential to cause harm including injury and ill heath, damage to property, equipment, products or the environment, service losses and increased liabilities.

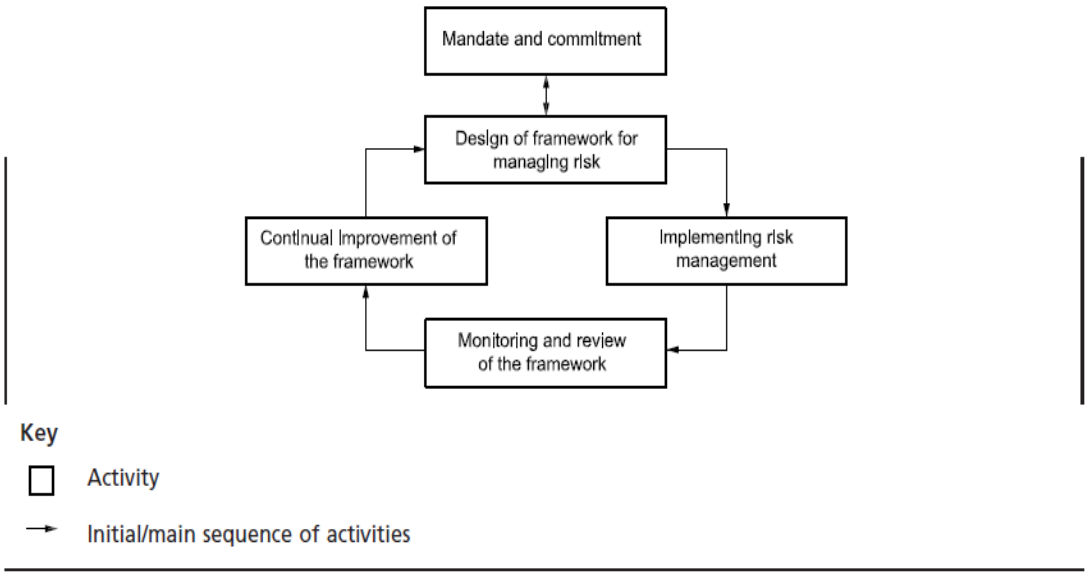
A full list of definitions for risk management used within NHS Borders is included in the appendices.

7. Risk Management Framework

BSI framework that provides NHS Borders with a nationally recognised framework is essential to a systematic and consistent approach to managing risk throughout the organisation. The framework will provide an infrastructure that will support the risk management activities of the organisation to attain the corporate objectives and ultimately the effective delivery of safe and effective healthcare.

Risk Management Framework-BSI National Framework

Figure 4 Development of components of the risk management framework



BSI 31100:2011- page 1

The framework consists of component parts that start with the commitment and mandate of the organisation to form a risk management strategy and framework.

	Mandate and Commitment	Framework design	Implementation	Monitoring and Review	Maintenance and continual improvement
Risk Management	Risk Management Strategy (Healthcare Governance Strategy) Governance Statement	Healthcare Governance Strategy Risk Management policy Risk Management guidance Review of Aspyre into RM Framework Adverse Event Policy Adverse Event Management Guidance Claims Policy (draft)	Adverse Event Management system- Datix Risk Register - Datix Support and advice to risk owners, directors, managers, clinical leads, groups. Risk management process -Proactive risk assessment and management Education programme Appraisal/PDP/eKSF systems Audit: NAO, Internal & External audit outcomes NHS Borders strategic risk register Risk management embedded into local healthcare governance for clinical boards and directorates Risk appetite	Governance Statement reflecting the performance of the organisation Link risks identified to corporate objective s on the risk register Performance review framework Work in specialist teams to review risk instances. Periodic monitoring of risk registers Healthcare Governance Steering Group – reports Staff Governance Committee- reports & updates Clinical Governance – reports & updates Adverse Event Management systems lessons learnt Risk dashboards Annual Report	Review process for policies & arrangements Internal audit outcomes HIS review outcomes & action plan Learning from application of risk controls & evaluating effectiveness Benchmarking risk mngt framework to recognised standards Network/benchmark @ Datix Scottish user group. Evaluation & continuous improvement plan Risk Management annual statement Updating electronic adverse event reporting & risk register systems Annual reports

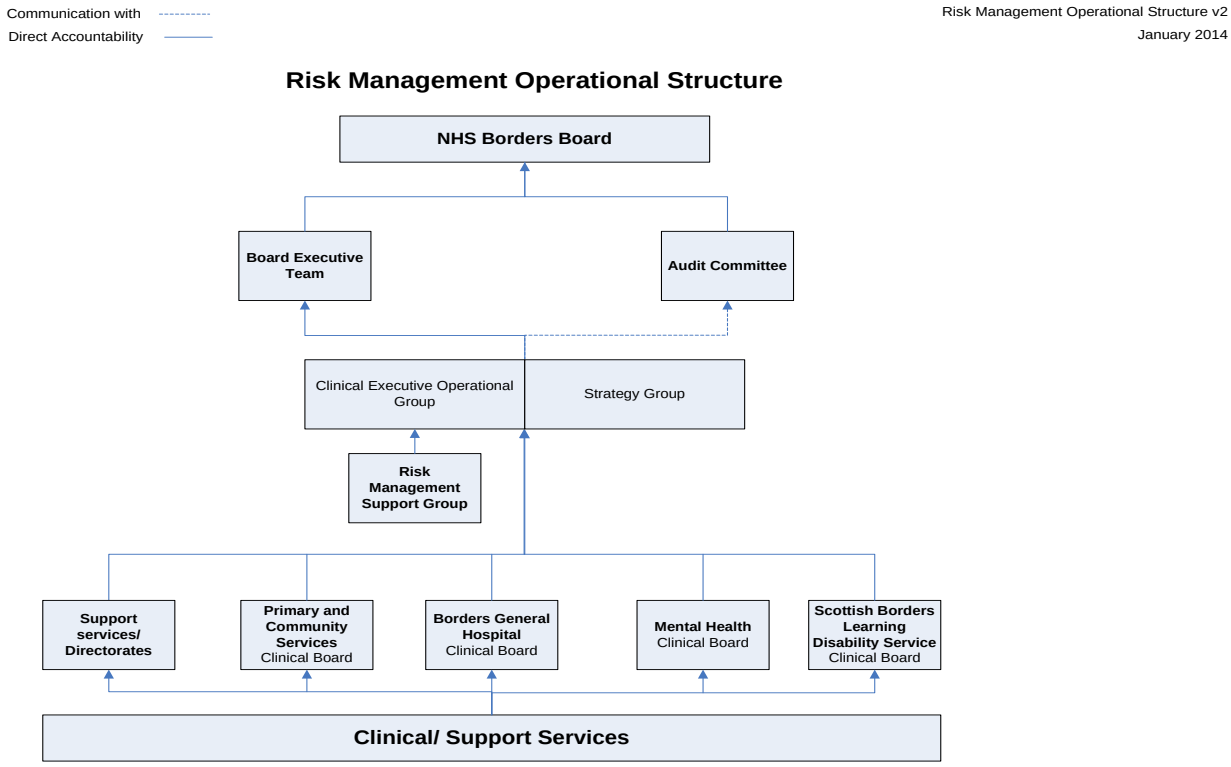
This Policy consists of the framework that gives structures and practical means to deliver the strategic direction and ensures that the corporate objectives are successfully delivered. Risk management is an integral part of the delivery of efficient and safe healthcare.

8. Risk Management Process

The risk management process is based on the BSI standards to achieve a consistent approach to risk identification and management of risks to acceptable levels (Appendix 1).
The process will also require the use of the NHS in Scotland (NHSiS) agreed risk matrix for the measurement of risk levels for all types of risk (Appendix 2). This facilitates the risk decision making process used by managers by ensuring that risks are managed through the same process and measured using the same tools and can be benchmarked internally and across NHSiS.

9. Roles and responsibilities: Risk management structure of committees and responsibilities

9.1 Organisational Arrangements



9.2 Borders Health Board has overall governance responsibility. Through the Board Executive Team and Clinical Executive, the Health Board has responsibility for risk management and its obligations to protect patients, staff and the public from risks related to the delivery of a healthcare service. Using a systematic and organised approach to risk management, the Board can lead and support the control of risk across the organisation.

The Borders Health Board reviews the Healthcare Governance Strategy on a 3 year cycle or as required and will receive a Risk Management Annual Report from the Clinical Executive Operational Group. The Health Board receives regular assurance that the arrangements to manage the organisation's risks have been implemented and are working efficiently.

9.3 The Board Executive Team (BET) has responsibility for risk management arrangements and ensures that the NHS Borders Health Board is kept fully informed of significant risks to the organisation.

9.4 Clinical Executive Operational Group has an operational role in ensuring that a risk management framework is in place that is efficient and effective. Its operational role is to ensure

that a risk management framework is being implemented and is used efficiently and effectively. Clinical Executive Operational Group agrees a Risk Management Policy that upholds the organisational vision and corporate objectives and that supporting guidelines and arrangements facilitate the management of risk. It has oversight of the risk register and effective management of all types of risk. Using the risk framework and the risk management process, the group fulfils the statutory and professional obligations of the organisation in relation to all types of risk.
It meets monthly and has responsibility for risk management delegated from NHS Borders' Health Board.

9.4.1 NHS Borders Strategy Group has a strategic role in ensuring that a risk management strategy is in place that is efficient and effective. The Strategy Group agrees a Healthcare Governance Strategy (incorporating the risk management strategy) that upholds the organisational vision and corporate objectives. Its role is to ensure that a strategic risk register is developed based on the organisation's overall strategic direction. It meets monthly and has responsibility for risk management delegated from NHS Borders' Health Board.

9.5 The Healthcare Governance Steering Group (HCGSG) has responsibility for seeking assurance from Clinical Boards and Support Directorates that they have effective local systems and procedures in place for healthcare governance including risk management.
The HCGSG promotes an active partnership approach within NHS Borders with staff, patients, key stakeholders and other organisations to enhance the quality of service provided and support the delivery of person centred, safe and effective healthcare. In addition the HCGSG monitors organisational wide learning relating to healthcare governance matters and fosters a culture of learning, openness and transparency encouraging staff, patients and the public to feedback and raise issues.

The HCGSG informs the healthcare governance agenda and supports the development of the organisations Governance Statement and other statutory requirements.

Through the performance review structure, the HCGSG monitors the performance of NHS Borders in relation to healthcare governance issues. As a core duty the HCGSG supports the governance requirements of the Local Delivery Plan and corporate objectives.

HCGSG reports to the Clinical Executive Operational/Strategic Group on performance, producing an annual report for the Clinical Executive Operational/Strategic Group for presentation to the Health Board.

9.6 Clinical Boards represented by Associate Medical Director/Associate Director of Nursing and General Manager (as the leads), have responsibility to review identified risks within their area, managing the risks to an acceptable level, prioritising the risks and reporting to the relevant director or the Clinical Executive. The Clinical Boards will disseminate any relevant information relating to risks and their controls. Associate Medical Director/Associate Director of Nursing and General Managers the Clinical Boards will be members of the HCGSG and will exception report strategic risks and significant operational risks to the HCGSG as appropriate. Clinical Boards should have 'reviewing risks on the risk register' as a standing item on their agendas.
Each clinical board/directorate should have recorded on their risk register **key risks identified in implementing the corporate objectives.** Risk should also be identified in relation to:

- Financial management and affordability
- Service redesign and sustainability
- Effective partnership working
- Patient safety and governance
- Performance management
- Capacity to deliver
- Statutory & professional compliance

9.7 Support Services Directors (as the lead), have responsibility to review identified risks within their area, assuring themselves through Heads of Service that risks are being managed to

acceptable levels, prioritised appropriately and escalated according to policy. The Director will disseminate any relevant information relating to risks and their controls. Directors will be members of the HCGSG and will exception report strategic risks and significant operational risks to the HCGSG as appropriate. Directors should ensure 'reviewing risks on the risk register' as a standing item on their Heads of Service meeting agendas.

9.8 Integration Board (shadow board)

Has responsibility to review identified risks within joint working areas, managing the risks to an acceptable level, prioritising the risks and reporting significant risks to the Chief Officer or the Clinical Executive. The Chief Officer will communicate any relevant information relating to risks and their controls. The Chief Officer will be a member of the HCGSG and will report on the Integration Board strategic risks and significant operational risks as appropriate. Work will be ongoing to harmonise the management of risk with our Healthcare Partner Scottish Borders Council.
April 2015 new arrangements will require further development of risk management arrangements as they apply to the evolving services.

9.9 Risk Management Support Team will fulfil an operational role in the development of a risk management framework with key objectives of:

- Developing the Risk Management Policy and supporting guidelines for consideration and approval by the Clinical Executive Operational Group. These are reviewed and maintained, alerting the Clinical Executive Operational Group of any issues.
- Develop systems to implement and monitor the Risk Management Policy.
- Support the Clinical Executive Operational Group on specific operational issues and take instruction regarding risk management systems.
- Promote an active partnership approach within NHS Borders, with staff, patients, key stakeholders and other organisations to enhance the quality of service and drive risk management effectively.
- Oversee the flow of information derived from risk management risk processes.
- Ensure a method for recording risks as a NHS Borders Risk Register exists.
- Facilitate the recognition of all risk - strategic and operational.
- Develop and maintain an education programme which supports managers and staff to take an active role in the risk management arrangements of NHS Borders

The Team reports to the Clinical Executive Operational Group with strong links to the Corporate Governance (Audit Committee) and HCGSG.

9.10 Local Clinical Board and Support Services Healthcare and Integrated Governance Groups review the risk register, highlighting any risks that may be significant/unacceptable across NHS Borders, ensuring necessary support for local managers in mitigating the risk through action planning, when necessary highlighting any risk issues to the HCGSG. Develop reports on trends identified through analysis of adverse event recording/investigation and risk assessments. Analyse the trends from complaints, claims, adverse events and risks to ensure all risks are being identified and managed according to policy. The organisation learns from the outcomes. Receive reports regarding legal actions and Fatal Accident Inquiries ensuring management actions are taking place and the organisation learns from outcomes.
These Groups report to the HCGSG with strong links to their respective clinical board/directorate leads.

9.11 Other Supporting Committees within the Healthcare Governance Structure are:

- Infection Control Committee
- Resilience Committee
- Occupational Health and Safety Forum
- Research Governance Committee
- Medicines Safety Action Committee

These committees/groups should bring risk management issues to the attention of the HCGSG to provide assurance of actions being taken within their respective areas of responsibility. Each committee should:

- Consider the impact on the organisation of legislation, CEL, Scottish Executive Directives and other relevant standards and report to the HCGSG any weakness or deficiencies. Examples HIS review, HEI standards, Clinical Governance standards, Complaints, Health and Safety Law, Environmental Law, External and Internal Audit.
- Bring to the attention of the HCGSG risks that cannot be managed out through the risk assessment/risk management process and which have significant risk levels or have considerable impact on the organisation.
- Ensure a culture of learning, openness and transparency encouraging staff, patients and the public to feedback and raise issues.

9.12 Working Groups are set up as required by the risk management process through the Clinical Executive Operational Group, HCGSG or Risk Management Support Team. They may be long-term committees or short life groups and their remits reflect the duty of NHS Borders to determine risk levels, controls and remedial actions.

9.13 Area Partnership Forum is represented on the HCGSG, Risk Management Support Team and the Local Clinical Board and Support Services Healthcare and Integrated Governance Groups. This ensures that staff interests are considered and supports the involvement of all staff in the management of risk.

10. Roles and Responsibilities: Individual accountability of NHS Borders staff and management.

Specific risk related duties/accountabilities:

10.1 Chief Executive is NHS Borders' accountable officer and has overall executive responsibility for risk management arrangements. This responsibility is discharged by providing effective leadership on risk management and by delegating specific responsibilities as below.

10.2 Medical Director, Chief Operating Officer and Director of Nursing and Midwifery promote risk management as an integral part of all clinical activity. They provide assurance to the Chief Executive that clinical risk management and patient safety systems reflect the explicit arrangements for integrated risk management.

10.3 Director of Nursing and Midwifery has been delegated responsibility from the Chief Executive for providing effective leadership on risk management, is responsible for risk management arrangements and is Joint Chair of the HCGSG. The Director of Nursing and Midwifery:

- Ensures that a risk management framework exists that identifies risks to the achievement of the corporate objectives. Risk mitigation plans are in place to ensure the success of corporate objectives.
- Promotes continuous quality improvement through performance review, which will address the adequacy of systems and processes for managing risk.

10.4 The Chief Operating Officer chairs the Clinical Executive Operational Group and ensures that controls are implemented through the Clinical Executive to minimise the effects of identified risks. The Officer has responsibility for ensuring that risk management activities within CHCP, Community Dental Service, Managed Clinical Network Office and the Clinical Executive are managed effectively within the integrated risk management arrangements.

10.5 Medical Director will be responsible for ensuring risks associated with Information Management and Technology is managed in accordance with risk management arrangements. They will also be responsible for radiation protection issues and risks.

10.6 Joint Director of Public Health and the Director of Workforce and Planning are jointly responsible for Occupational Health and Safety risk including the development of an Occupational

Health and Safety Policy and supporting policies that reflect the process of good risk management. Joint Director of Public Health is Chair of the OH&S Forum.

10.7 Director of Workforce & Planning is responsible for the risk management of human resource/workforce planning issues arising from the activities of NHS Borders including close liaison with staff governance arrangements. Ensures that the performance review systems capture very high risks and management thereof with support quality improvements for managing very high risk.

10.8 Director of Finance has responsibility for management of financial risks, advising on the financial implications of identified risks and overseeing the statement of internal control. The Director of Finance advises the Chief Executive on the risk considerations relevant to the agreement of strategic objectives ensuring that investment priorities are reflected in the local Health Plan and provides the link between the Audit Committee and HCGSG.

10.9 Director of Estates and Facilities is responsible for identifying and controlling all risks arising in NHS Borders premises as well as the Estates and Facilities Department. There are specific responsibilities relating to project planning and ensuring that adequate procedures exist for compliance with environmental and legal requirements.

10.10 Employee Director is responsible for ensuring that risk associated with staff and workforce planning from a staff perspective is reported into the Clinical Executive Operational Group. In liaison with Director of Workforce the Employee Director ensures the Staff Survey results are analysed and risks associated with it are reported. The Employee Director will ensure that relevant staff risks are identified in the process of any project, management and organisational changes.

10.11 Risk and Safety Manager is the chair of the Risk Management Support Team. The Risk and Safety Manager acts as the named competent person within health and safety, advising on the statutory requirements for safety and the development of the Health and Safety Policy and is the Claims Manager. The Risk, Health and Safety Team oversee the Datix system for reporting and risk registers.

10.12 Head of Clinical Governance and Quality has responsibility to ensure patients safety systems are in place and follow the integrated risk management framework.

10.13 The Resilience Manager is responsible for ensuring that NHS Borders is prepared for any major incident. This might include road or air accident, infectious disease or chemical spillage. The Resilience Manager supports the development of contingency plans, which will allow services to be maintained or re-established with minimal disruption following any unexpected event such as loss of premises or utilities.

10.14 Topic Specialists including Consultant Microbiologist, Control of Infection Nurses, Occupational Health Specialists, Data Protection Officer, Fire Officers, Nurse Consultants, Nurse Specialists, Radiation Protection Adviser, Education Training Professional Development Staff and Moving and Handling co-ordinators are available to provide specialist information and advice.

11. General Risk Management responsibilities/accountabilities

11.1 All Directors/Managers are responsible for effective risk management within their own area (**note: Directors/Managers *accountability* cannot be delegated**). Specific duties in addition to the responsibilities of all staff include:

- Risk ownership and accountability
- Implementation of Risk Management Policy and associated Policies and Procedures.
- Implementation of risk identification processes for all types of risk: workforce, clinical, health and safety, finance, operational, corporate as examples.
- Raising awareness of risk.

- Ensuring staff, through annual appraisal and personal development planning, maintain knowledge and skills in the management of all risk.
- Carrying out a training needs analysis of their area, ensuring staff attendance at statutory/mandatory/appropriate training sessions as dictated by risk;
- Encouraging staff to identify and report hazards/problems/clinical issues/risks and responding positively when they do so;
- Prioritising and controlling risks;
- Ensuring that all adverse events and near misses are recorded;
- Reviewing identified trends and implementing change as a consequence.

11.2 Risk Owners identified within the risk register will have responsibility for:

- Being accountable for identified risk.
- Ensuring the risk information and risk levels are correct.
- Monitoring the action plan.
- Identifying resources where required.
- Escalating the risk through line management structure.
- Reporting risk through the risk management structure as appropriate.
- Involvement in decision making process of tolerated/to be managed/transferred or terminated risks.

11.3 All Staff are responsible for:

- Maintaining general risk awareness.
- Participating in risk management training.
- Co-operating with NHS Borders in managing risk, including complying with policies and procedures.
- Identifying risks.
- Contributing to resolution of risk (s).
- Identifying and reporting risks to line managers.
- Taking part in risk assessment and the adverse event or near miss recording process.
- Taking reasonable care for the health, safety and welfare of themselves and others.
- Using equipment and substances safely.
- Demonstrating good infection control prevention and control.
- Undertaking infection control audits as per agreement.

12. Organisational parameters

To gain consistency in the risk management decisions taken across NHS Borders the organisation will use the following risk statements to aid managers to understand what the organisation requires in terms of risk management decision making.
The parameters will include professional and managerial accountabilities, legal obligations and national/local standards.

12.1 Organisational Risks Statements:

1. All risks will be managed within statutory requirements.
2. Clinical risks will be managed in accordance with good clinical practice and clinical governance standards. Clinical risk owners should involve other stakeholders as appropriate.
3. Financial risk will be managed to corporate standards and financial policies.
4. Very High risks that are to be managed will have a target set of high, medium or low and must be at target level within 1 year. Exception reporting will be required to the HCGSG by risk owners of risks out with this parameter including evidence of risk controls taken and pending.
5. Very high risks that are to be tolerated that remain tolerated after 1 year will require exception reporting by risk owner to the HCGSG with evidence of risk review annually.

6. Very High and High risks that are to be terminated or transferred must have this action completed within 1 year. Exception reporting will be required to the HCGSG by risk owners of risks out with this parameter.
7. High risks that are to be managed will have a target set of medium or low and must be at target level within 1 year. Exception reporting will be required to the HCGSG by risk owners of risks out with this parameter.
8. High risks that are to be tolerated that remain tolerated after 1 year will require exception reporting by risk owner to the HCGSG with evidence of risk review annually.
9. Medium and low risks can be managed by local risk owners as per good risk management practice but must be reviewed 2 yearly to determine that risk remain as per risk analysis.
10. All risks will be recorded on the risk register and evidence of risk analysis in the form of a risk assessment will be attached. Any loss of service/resilience issues must be proactively risk assessed and entered on the risk register.
11. All risks controls should have a monitoring mechanism for effectiveness e.g. audit, review, outcome benchmarking, and recurrence rates as examples.
12. Adverse events that are graded as major/extreme outcome will be classified as a significant adverse event and will result in a significant adverse event review and be subject to risk analysis.
13. Adverse events that are categorised as per Adverse Event Management Policy section 7 i.e. never events, unexpected clinical incidents, unexpected environmental events, RIDDOR or other types of events and are deemed a significant adverse event (SAE) must have a significant adverse event review (SAER).
14. Events will be managed as per Adverse Event Policy Management Policy; focus will be on minimisation of recurrence, reduction in harmful outcomes and organisational learning. Managerial monitoring of remedial action must be undertaken within 14 working days of adverse event being reported i.e. approval process.

12.2 Risk appetite

Risk appetite is a term used to explain what amount and type of risk the organisation is willing to accept or tolerate. Specifically what the organisation expects from risk owners in deciding what management actions are required at specified levels of risk.

Risk appetite as follows:
Reactive risk management is concerned with the management of adverse events i.e. risks have been realised and harm occurred or had the potential to occur.

12.2.1 Reactive risk management: Adverse Event Management

	CATEGORY 1 ADVERSE EVENT	CATEGORY 2 ADVERSE EVENT	CATEGORY 3 ADVERSE EVENT
Level of Review	**Significant Adverse Event Review** All events graded as having an outcome of major or extreme or are deemed significant enough to review through the SAER process. Other events that have a lower graded outcome may warrant a review due to significant issues being identified that can impact on corporate objectives	**Management Review** Adverse events that have significant impacts at local level/ clinical board level should be considered for a management review. Likely to be graded moderate or minor but not exclusively. All RIDDOR reports will have a management review (unless it is deemed an SAE)	**Further Inquiry** All events will have contributing factors determined and recorded on Datix. This is a minimal review in which managers are satisfying themselves they know why an event happened
Level of authority ***(Decision making)***	**BET/ Associate Medical Director/ Associate Director of Nursing or General Manager or Head of Service** will authorise exceptions. Risk, Health and Safety Team will co-ordinate appointment of a Sponsor and Reviewers in accordance with SAER process	**Associate Medical Director/ Associate Director of Nursing/General Manager/Clinical Service lead/Clinical Service Manager** may decide a management review is required and who will lead.	All Approvers and Deputies will undertake as part of normal Datix management
Review process	**Initial Review** will be undertaken to determine whether adverse event requires a **comprehensive review** (all lapses investigated), a **concise review** (focus on identified significant lapses) or a management review (local managers take ownership of review process).	**Initial Review** will be undertaken to determine whether event requires a **comprehensive review** (all lapses investigated) or a **concise review** (focus on identified significant lapses). Appointed manager takes ownership of review process.	Approvers will satisfy themselves that contributing factors have been identified by staff discussion, observations, looking at policies/practices, circumstances
Review Team	Sponsor agree terms of reference and supported by Reviewer/s will determine whether they will suffice as the Review Team or whether other stakeholders are required. Review Team conduct the review as agreed.	Lead Reviewer will decide on team members based on the type of adverse event and potential risks associated with it.	A Team is not necessary however if the Approver feels that there is benefit then they make arrangements as required on a short life basis
Review undertaken	All reviews must result in a Review Report. Complete review documentation as per SAE Review Protocol. Review Report submitted to Clinical Board/Support Directorate	All reviews must result in a Review Report. Complete review documentation as per Management Review Protocol	Recorded on Datix.
Improvement Action Plan	Clinical Board/Directorate develop Improvement Plan and identify Lessons Learnt see Appendices in the Significant Adverse Event Review Process)	Complete improvement /Action plan (see Appendices in the Significant Adverse Event Review Process)	Notes may be entered into Datix
Time-scale / Key Performance	• Sponsors/Reviewers appointed within 24 hrs • Initial review completed 1 week • Comprehensive/Concise review completed , report with recommendation within 8 weeks • Clinical Board/Directorate develop improvement plan &lesson learnt within 2 weeks • Improvement plan timescales set as appropriate	• Manager appointed to oversee review process – 24hrs • Lead reviewer appointed if required within 48hrs • Initial review completed 1 week • Comprehensive/Concise review completed, action plan & lessons learnt developed within 5 weeks • Improvement plan timescales set as appropriate	Operational Manager to have monitored event details and improvement actions approving within 10 days of being reported. Initiate a risk assessment if appropriate

Escalation of adverse events reports:
Significant Adverse Event Review (SAER) will be reported by the Clinical Board/Directorate to HCGSG/Clinical Executive Operational Group (CEOps). Onward escalation to the Board Executive Team (BET) will be dependent on adverse event outcomes and risk impacts. Specific RIDDOR/OH&S related SAER reports will be reported to OH&S Forum. **Learning outcomes** will be reported centrally to Clinical Governance & Quality Team/Risk, Health and Safety Team for collation and dissemination throughout the organisation.

Local Management Review will be reported to local Healthcare Governance Group, escalated to Clinical Board/Director. When appropriate further escalation to HCGSG/ Clinical Executive Operational Group. Onward escalation to the BET will be dependent on adverse event outcomes and risk impacts. **If learning outcomes** have organisational wide value these will be reported centrally to Clinical Governance & Quality Team/Risk, Health and Safety Team for collation and dissemination throughout the organisation

Further Inquiries will be reported to local area/local directorate as necessary.

Escalation to the Health Board will be determined by the relevant Governance Committee/ BET.

12.2.2 Proactive risk management: risk assessment/ risk register

The process by which risk is identified and managed proactively rather than waiting for an adverse event and analysing/reviewing root causes. Triggers for risk assessment and how the process works is explained within the risk management guidance.

Risk level	Manage	Tolerate	Terminate	Transfer
Low	Local Risk owner may decide	Local Risk owner may decide	Local Risk owner may decide	Local Risk owner may decide
Medium	Operational Manager/Head of Service must decide	Operational Manager/Head of Service must decide	Operational Manager/Head of Service must decide	Operational Manager/Head of Service must decide
High	General Manager/Director must decide	General Manager/Director must decide	General Manager/Director must decide	General Manager/Director must decide
Mngt Action ↓	*Must have target medium/low and this must be reached <1 year. Qtr report to HCGSG Annual report to HCGSG, escalated to CEOps Group*	*Qtr review of risk to ensure nothing has worsened/improved, report change to HCGSG. Risk must have yearly review. Annual report to HCGSG, escalated to CEOps Group*	*Must have been terminated <1 year. Qtr report to HCGSG, >1year exception report required for HCGSG, escalated to CEOps Group*	*Must have been transferred <1 year. Qtr report to HCGSG, >1year exception report required for HCGSG, escalated to CEOps Group*
Very High	General Manager/Director must decide	General Manager/Director must decide	General Manager/Director must decide	General Manager/Director must decide
Mngt Action ↓↑	*Must have target high/medium/low and this must be reached <1 year. Qtr report to HCGSG, if not on trajectory then escalated to CEOps Group*	*6 monthly review with report to HCGSG, Annual review of resources to prioritise. >1 year on register escalate to CEOps Group /Health Board.*	*Must have been terminated <1 year. Qtr report to HCGSG, >1year exception report required for HGSG. If not on trajectory then escalated to CEOps Group.*	*Must have been transferred <1 year. Qtr report to HCGSG, >1year exception report required for HCGSG. if not on trajectory then escalated to CEOps Group*

Escalation/reporting of key risks:

Very High risks with unacceptable corporate risk or poor remedial actions will be escalated to HCGSG/ Clinical Executive Operational Group as appropriate and then by Clinical Executive Operational Group to BET/Audit Committee/Clinical Governance Committee/Staff Governance Committee/Public Governance Committee.

High risks with unacceptable corporate risk, poor remedial actions and a high probability of escalating into very high risk will be escalated by HCGSG/Clinical Executive Operational Group as appropriate and then by the Clinical Executive Operational Group to BET/Audit Committee/ Clinical Governance Committee Staff Governance Committee/Public Governance Committee.

13. Risk Register
A risk register is defined as:

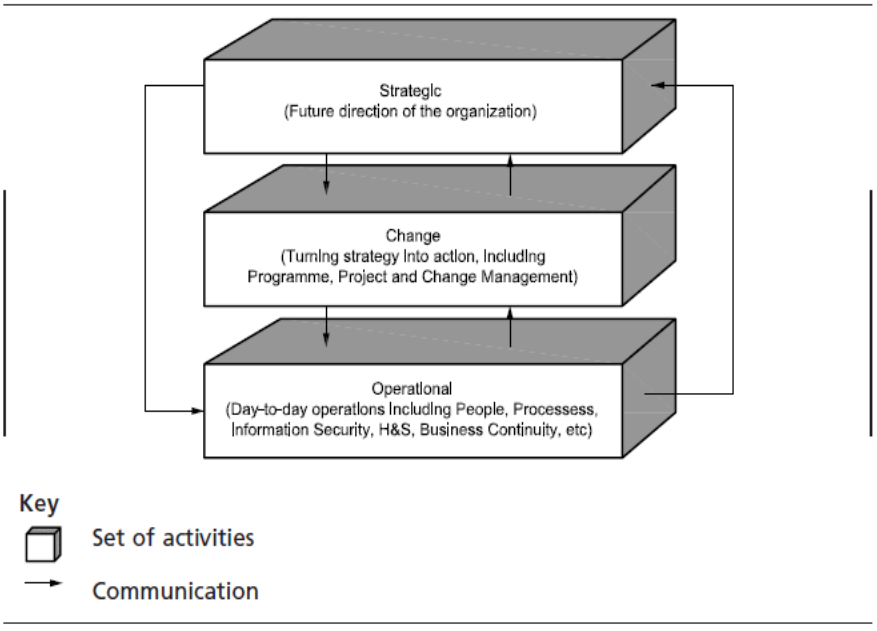
"record of information about identified risks"
NOTE: The term "risk log" is sometimes used instead of "risk register".
Ref: [ISO Guide 73]: **BS 31100:2011**

The risk register is a management tool that enables the organisation to understand its risk profile, log risks of all kinds that threaten the organisation's ability in achieving success in its aims/objectives and provides assurance information necessary to satisfy the organisations' governance arrangements.
NHS Borders Corporate Risk Register is made up of the following:

- Strategic risks linked to corporate objectives, local delivery plan and Clinical Strategy. Strategic risk is concerned with threats and opportunities that potentially affect the long-term aims of the organisation, its plans to achieve these aims and how these aims once achieved will be sustained. This may be influenced by government policy, legal decisions, changes in stakeholder requirements etc

- Operational risks which have an organisational impact on the local delivery of healthcare services, the attainment of corporate objectives and compliance with statutory duties. This may be influenced by patient safety, staff safety, financial resources, workforce issues, patient pathways etc in the delivery of local services.

Figure 1 **Risk management perspectives**



British Standards Institute Risk Management BS 31100:2011

The change process including Productivity and Benchmarking activities feed into these two risk registers through the risk assessment process.
The risk register is facilitated using the Datix system; this can be accessed through the intranet portal. This allows the risk assessment process to be electronically recorded by risk assessors/owners, the risk owners must then ensure all aspects of the risk assessment process have been completed and that risks and risk levels are correct. A decision is taken as to how the risk owner intends to manage the risks and a proportionate action plan is devised. This is then passed to the line manager for agreement (final approval).
Risk on the risk register will only be considered as being reported to the organisation once the risk owner has fully developed the risk assessment, risk decisions made (manage/tolerate/transfer/terminate), and a proportionate action plan developed i.e. the risk is 'awaiting final approval'.
Line managers will have a maximum of 14 days to agree the risk including any modification they wish the risk owner to make (i.e. they have rejected the risk assessment).
Once the line manager is satisfied with the risk assessment, agrees with the risk decision and action plans then the risk will be finally approved and considered to be appropriately placed within the corporate risk register.
Risk registers will be presented to Healthcare Governance Steering Group/Audit Committee/Staff & Clinical Governance Committees as required and will only include the agreed risks on the corporate risk register.

Please refer to the Risk, Health and Safety Team microsite for more detailed guidance on using the Datix risk register.

14. Escalation of risks
Risk requires to be escalated through the organisational structure to ensure that every level of management has an opportunity to make management decisions: manage risk to acceptable levels, tolerate the risk, transfer it to another organisation or terminate the risk through complete removal. The risk register will effectively ensure that all managers/directors will have access to information about risks directly under their control. All risks will need to be agreed (approved) by the line manager above the initial risk owner. In agreement with the line manager risks can be escalated using the risk register by changing the risk owners name to the next responsible manager. Risks must be escalated through line management to a General Manager or Director prior to being fed into the Clinical Executive Operational Group or HCGSG. Reporting risks to the relevant committee/board/group will also escalate the importance of the risk to the organisation as a whole.

Escalation to the Health Board will be determined by the relevant Governance Committee/ BET.
For escalation process please refer to appendix 3.

15. Risk Management Communication
The effective management of risk cannot be realised without a robust communication system with stakeholder involvement. The Communication Strategy should be utilised where appropriate. Communicating risks and remedial actions to those affected by risks is an essential element to involving people and organisations in the risk management systems, in gaining ownership of the risks and in managing risk.

15.1 Establishing internal and external communication to support the risk management process is essential. A plan to communicate and consult with both internal and external stakeholders should be developed at an early stage in the risk management process. This plan will ensure that those accountable for implementing the risk management process and those with a vested interest engage to bring together differing areas of expertise for risk analysis. These will aid stakeholders to understand the basis on which decisions are made and the reason why particular actions are required.

16. Training
A training programme has been devised to help managers/risk owners implement the risk management policy and develop knowledge and skills in risk management techniques. The

organisation will be required to undertake a training needs analysis of its risk management training requirements which will inform and update the training programme as required.

17. Monitoring and Audit arrangements

Monitoring should enable the organisation to:

- Identify new risks and prioritise the focus on patient safety issues.
- Ensure risks are being managed in accordance with risk appetite, policy and processes.
- Evaluate the effectiveness of the risk management framework.
- Highlight common risk issues and ensure wherever relevant that a common solution is developed and learning/intelligence is cascaded throughout the organisation.
- Escalate and prioritise risks and resources.
- Intervene and take any necessary actions where necessary.
- Identify significant internal & external changes, issues and events that might impact on risk profile of organisation.

Monitoring will be in two forms:

17.1 Monitoring and evaluating the framework

The component parts of the framework will be monitored for effectiveness and reported to the organisation as per an agreed timetable. Evaluation of the component parts will use benchmarking and auditing techniques to ascertain its effectiveness.

17.2 Monitoring the risks identified and potential future risks

Risks will be monitored by the HCGSG to ensure that they are being managed in accordance with the risk appetite and good practice. Clinical Boards/Support Directors as risk owners will report progress on risk management and controls on a quarterly basis with exception reporting to the HCGSG as required and annually. The progress in managing risk to target levels and the effectiveness of controls will be monitored by Clinical Boards/Support Directors and reported through the risk management structures. ***For governance structure refer to appendix 4.***

Horizon scanning will take place to ensure internal and external risk issues or events are used to foresee potential future corporate risk and possible risk impacts.

Monitoring the effectiveness of risk management arrangements is essential to determine any areas of weakness and possible risk areas not identified.

The Clinical Executive Operational Group will:

- Review risk management arrangements and report to the NHS Borders Health Board on an annual basis.
- Consider the corporate objectives on an annual basis, changing future risk management priorities as required.
- Monitor the risk register and the performance of the organisation to implement the risk management objectives.
- Determine whether staff/managers have sufficient risk management skills, knowledge and competence in line with the risk responsibilities.
- Ensure that risk owners are receiving adequate support to enable them to meet their roles and responsibilities.
- Determine one audit a year in liaison with the Audit Committee regarding the risk management performance of the organisation.

18. Governance structure

See appendix 5 for Governance & Risk Management process

The Audit Committee will act as the governance body overseeing risk management reporting to the NHS Borders Health Board. The purpose of the Audit Committee is to assist the Board to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Board that an appropriate system of internal control is in place. The framework for risk assurance will keep the Audit Committee and ultimately the Health Board informed (Appendix 4).

Risk management governance is based on:

1. Risks are recognised
2. Risks are acted upon
3. Risks are reported
4. Assurance that risk management framework is working

Risk management information and dashboards form part of the performance information for all of the governance committees to enable the organisation to gain assurance in all corporate aspects:

- Business is conducted in accordance with the law and proper standards.
- Public money is safeguarded and properly accounted for.
- Financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question.
- Affairs are managed to secure economic, efficient and effective use of resources.
- Reasonable steps are taken to prevent and detect fraud and other irregularities.
- Effective systems of Risk Management are in place.
- Effective systems of Information Governance are in place.

The Governance structure includes:

- Public Governance
- Clinical Governance
- Staff Governance
- Corporate Governance (Audit Committee) with sub committee: Information Governance

Weaknesses identified may form the basis of an entry into the Governance Statement.

19. Freedom of Information (FOI)

FOI requests can be made to obtain information regarding risks; these requests must be managed through the Communications Team with all disclosed information conforming to data protection requirements.

20. Policy Review

The policy will be reviewed on a 3 year cycle or when any relevant significant organisational changes occur.

21. References

1. *BS ISO 31000 Risk Management*. *& BS 31100:2011 Risk Management-Code of Practice and Guidance for the implementation of BS ISO 31000*

2. Healthcare Quality Strategy (2010)
http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf

3. Health and Safety Legislation , Health and Safety Executive
http://www.hse.gov.uk/legislation/enforced.htm

4. National Patient Safety Agency, 2012 [Online], *http://www.npsa.nhs.uk/*

5. Healthcare Improvement Scotland, 2013, *"Learning from adverse events through reporting and review: A national framework for Scotland"*

6. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
http://www.legislation.gov.uk/uksi/1995/3163/contents/made

7. Health and Safety at Work Act 1974
http://www.legislation.gov.uk/ukpga/1974/37

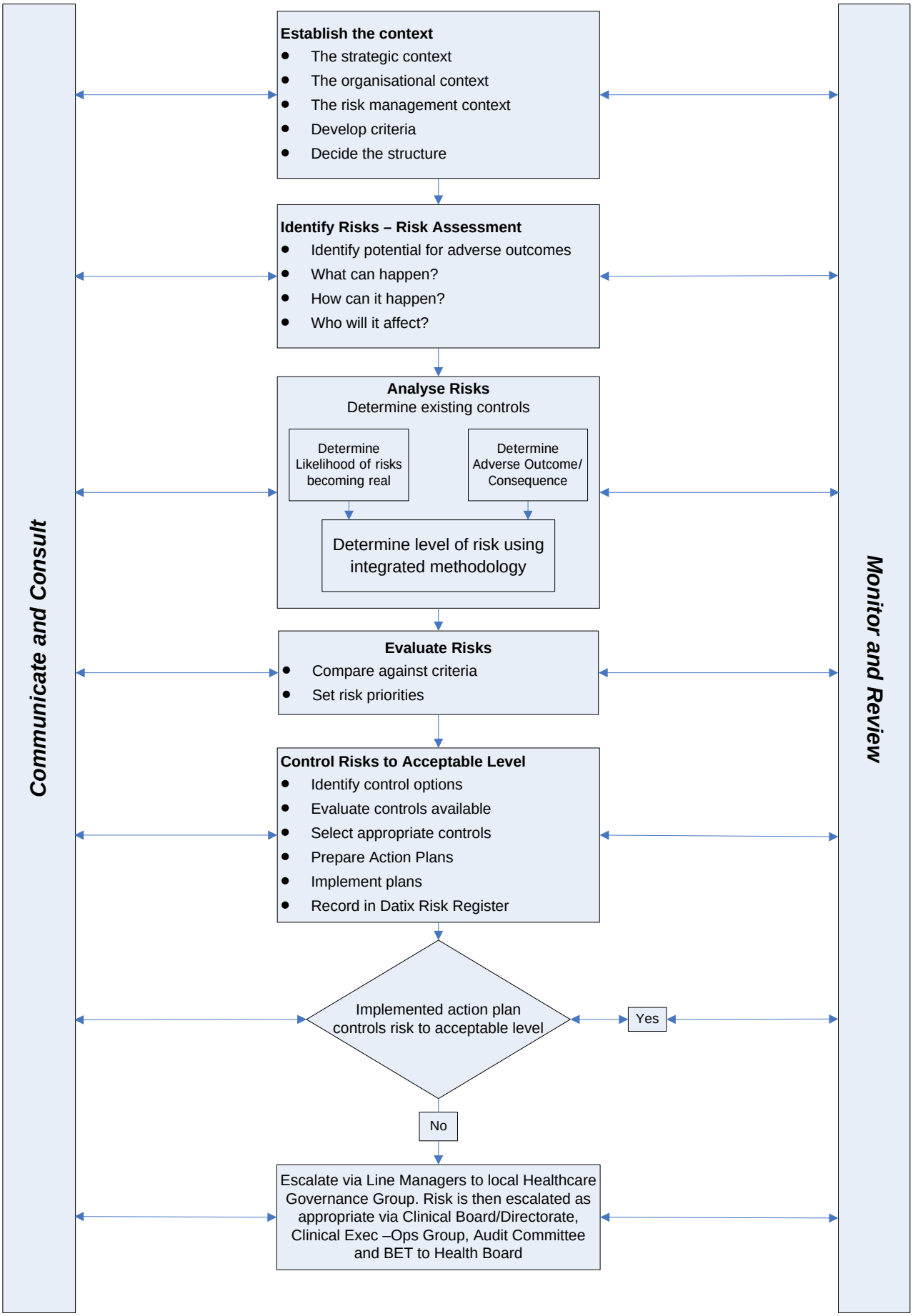
8. Management of Health and Safety at Work Regulations 1999
http://www.hse.gov.uk/pubns/books/l21.htm

9. Freedom of Information Act (Scotland) 2002
http://www.legislation.gov.uk/asp/2002/13/contents

10. NHSScotland Resilience – Preparing for Emergencies Guidance, 2013

11. *Business Continuity-A Framework for NHS Scotland:* Scottish Government, NHSScotland Resilience, 2009

Appendix 1 - Risk Management Process



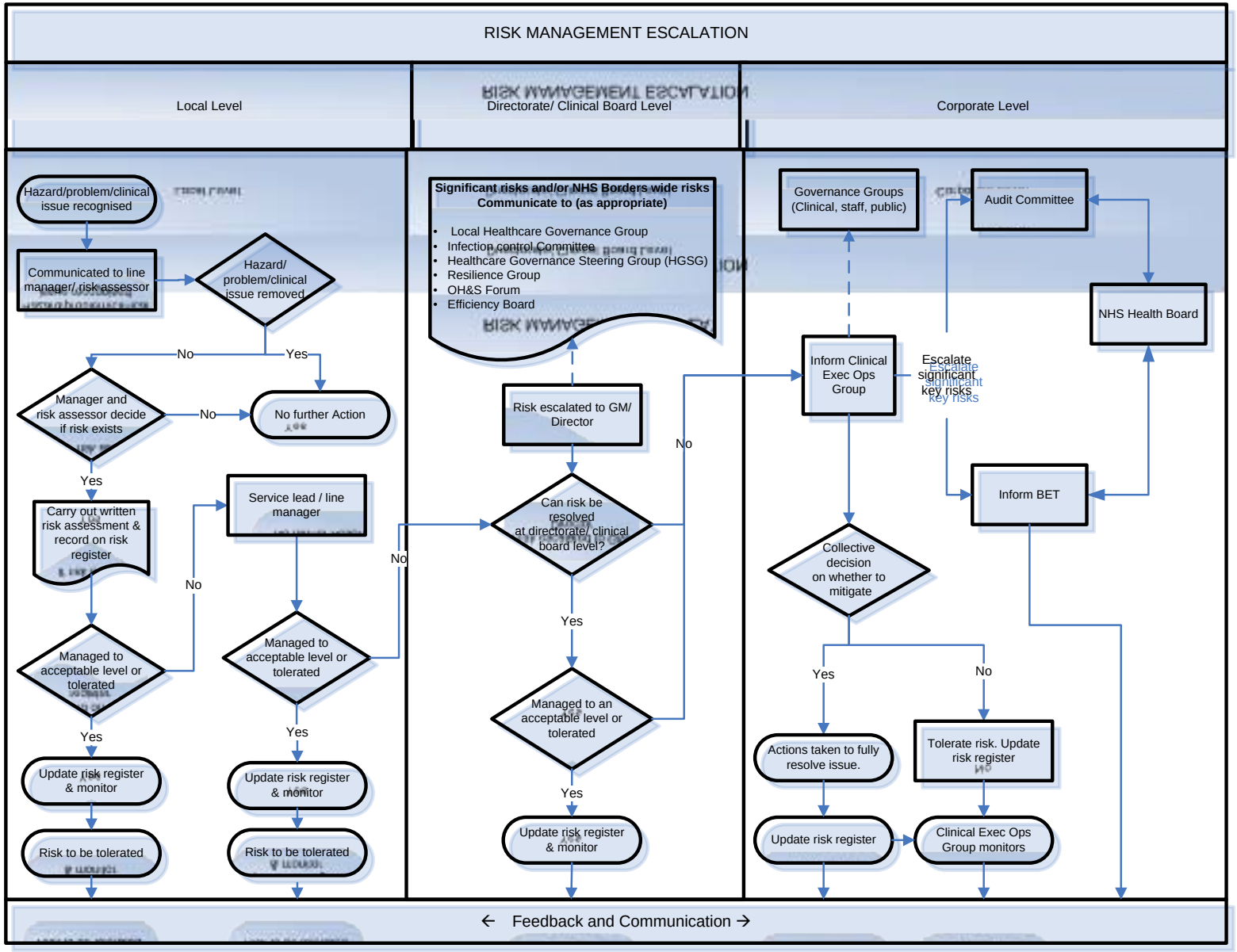
Appendix 2 - Risk Matrix

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Injury (physical and psychological) to patient/visitor/ staff.	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. RIDDOR, Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling. Broken bone.	Incident leading to death or major permanent incapacity.
Patient Experience	Reduced quality of patient experience/clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/ clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/ clinical outcome; short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome; long term effects – expect recovery >1wk.	Unsatisfactory patient experience/ clinical outcome; continued ongoing long term effects
Staffing and Competence	Short-term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. Minor error due to ineffective training/implementation of training.	Late delivery of key objective / service due to lack of staff. Moderate error due to ineffective training/implementation of training. Ongoing problems with staffing levels.	Uncertain delivery of key objective/ service due to lack of staff. Major error due to ineffective training/ implementation of training.	Non-delivery of key objective/service due to lack of staff. Loss of key staff. Critical error due to ineffective training/ implementation of training.
Objectives / Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule	Reduction in scope or quality of project; project objectives or schedule.	Significant project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint-involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim Complex justified complaint
Service / Business Interruption	Interruption in a service that does not impact on the delivery of patient care or the ability to continue to provide service.	Short-term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant “knock on” effect
Financial (including damage / loss / fraud)	Negligible organisational/ personal financial loss. (£<1k). (NB. Please adjust for context)	Minor organisational/personal financial loss (£1-5k).	Significant organisational/personal financial loss (£5-50k).	Major organisational/personal financial loss (£50k-300k).	Severe organisational/personal financial loss (£>300k).
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.	National/international media/adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Inquiry/ FAI.
Emergency planning/ Region wide	Insignificant numbers of injuries or impact on health.	Small number of people affected no fatalities, and a small number of minor injuries with first aid treatment.	Limited number of people affected, no fatalities, some hospitalisation and medical treatment. Localised displacement of small number of people for 6-24 hrs.	Significant number of people in affected area, with multiple fatalities, multiple serious or extensive injuries, significant hospitalization. Large number of people displaced 6-24 hrs or possibly beyond.	Very large number of people (100s) in affected area impacted, significant numbers of fatalities, large number of people requiring hospitalization with serious injuries with longer-term effects.

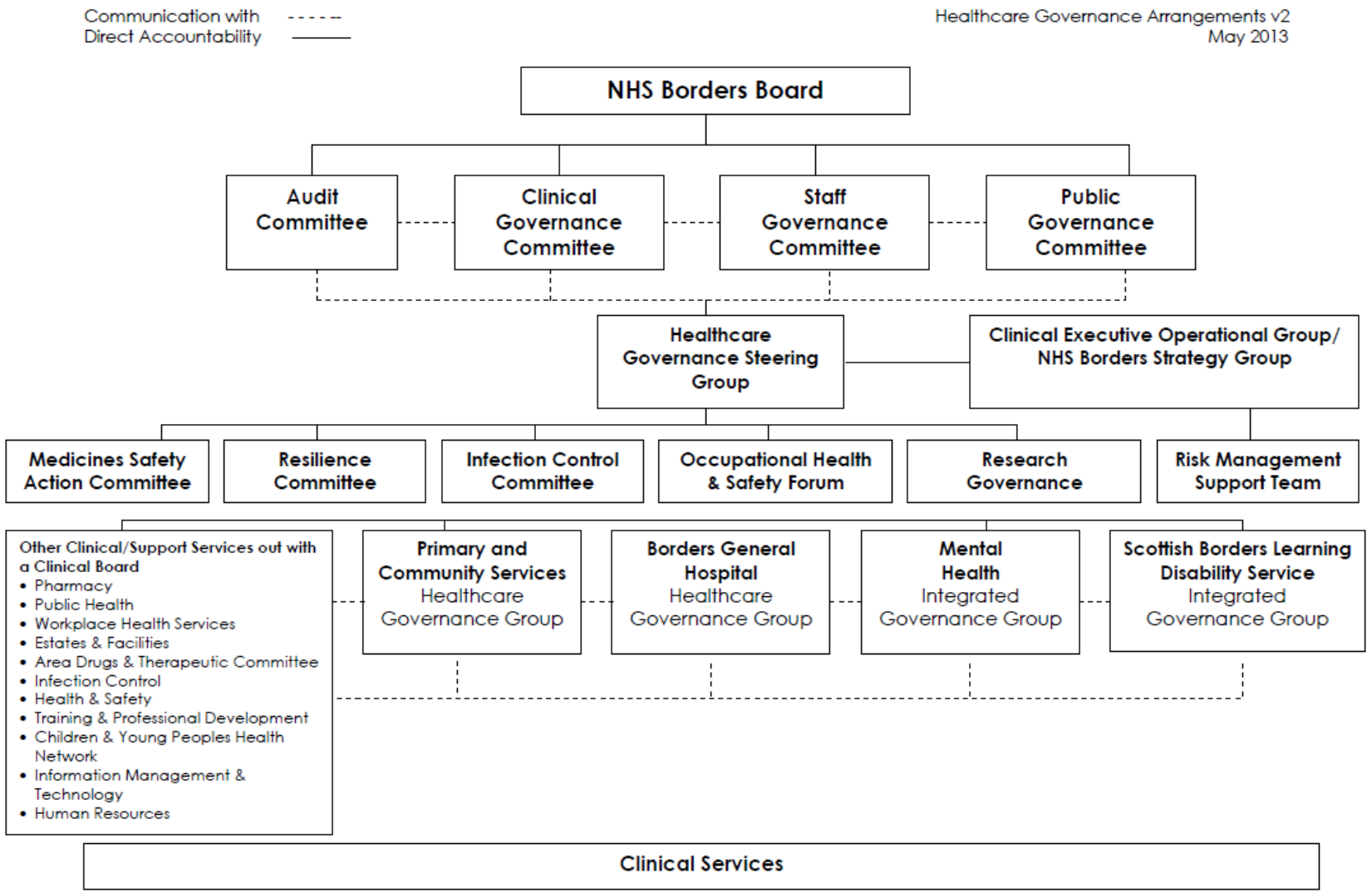
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	Can't believe this event would happen – will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists – unlikely to occur.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	Strong possibility that this could occur – likely to occur. Not persistent.	This is expected to occur frequently / in most circumstances – more likely to occur than not. Persistent

Likelihood	Consequences / Impact				
	Negligible (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Almost Certain (5)	Medium (5)	High (10)	High (15)	V High (20)	V High (25)
Likely (4)	Medium (4)	Medium (8)	High (12)	High (16)	V High (20)
Possible (3)	Low (3)	Medium (6)	Medium (9)	High (12)	High (15)
Unlikely (2)	Low (2)	Medium (4)	Medium (6)	Medium (8)	High (10)
Rare (1)	Low (1)	Low (2)	Low (3)	Medium (4)	Medium (5)

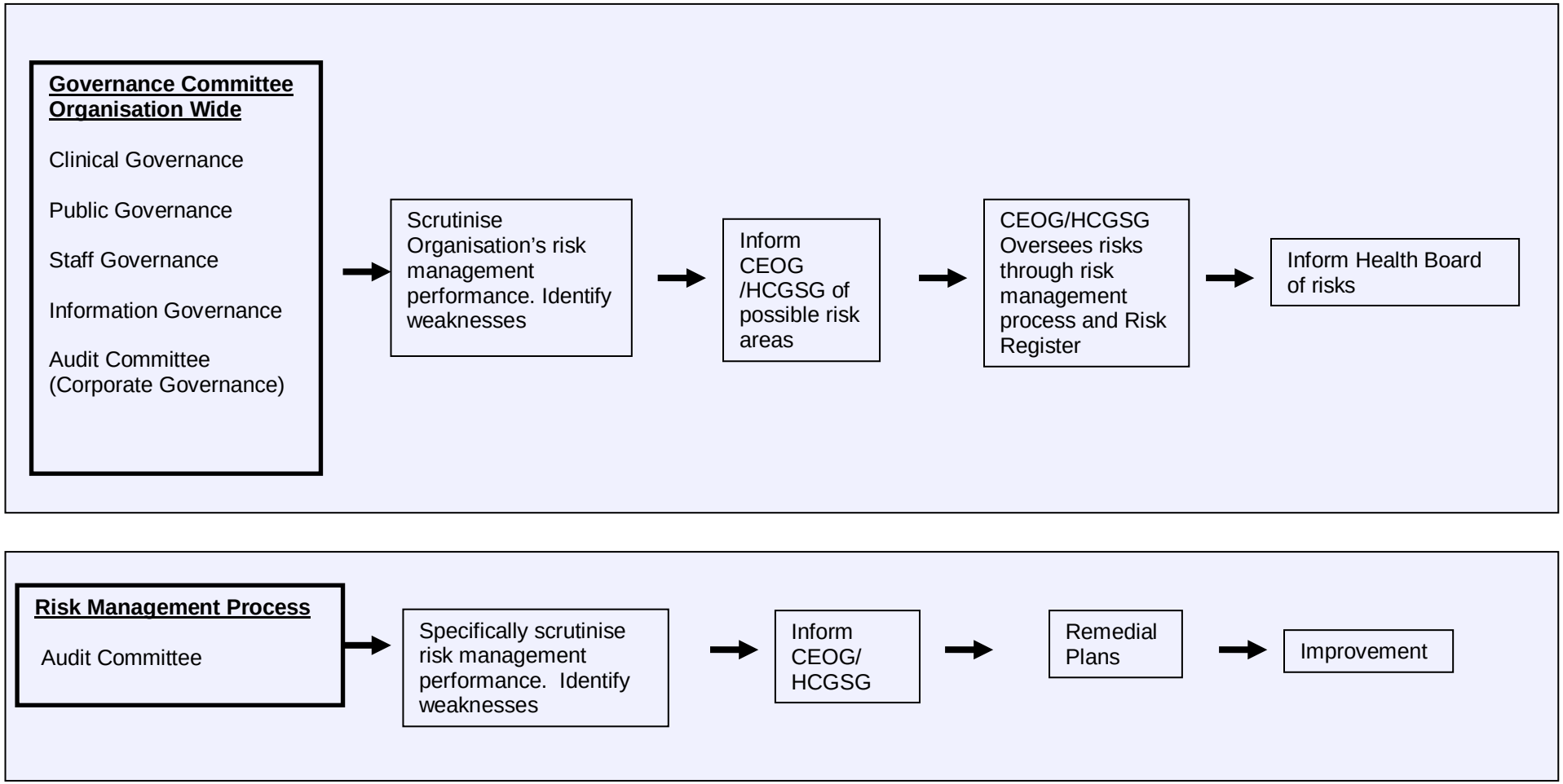
Appendix 3 - Risk Management Escalation Flowchart



Appendix 4 - Healthcare Governance Arrangements



Appendix 5 - Governance & Risk Management Process



Glossary of Definitions

Consequence	The outcome of an event expressed qualitatively or quantitatively, being loss, injury, ill health, disadvantage or gain.
Cost	Of activities, both direct and indirect, involving any negative impact, including money, time, labour, disruption, goodwill, political and intangible losses.
Frequency	The rate of occurrence of an outcome, expressed as the number of occurrences of that outcome over a specified period of time.
Hazard	A source of potential harm or a situation with a potential to cause loss.
Likelihood	Used as a qualitative description of probability or frequency.
Loss	Any negative consequence, financial or otherwise.
Residual Risk	The remaining level of risk after risk treatment measures have been taken.
Risk	The chance of something happening (an opportunity or hazard) that will have an impact (good or bad) upon objectives. Risk is measured in terms of its consequences and likelihood.
Risk Acceptance (tolerated risk)	An informed decision to accept the consequences and likelihood of a particular risk.
Risk Analysis	A systematic use of available information to determine how often specified events may occur and the magnitude of their consequences.
Risk Assessment	A systematic process to determine risk management priorities through finding out the frequency of an outcome and its consequences.
Risk Control	That part of risk management, which involves the implementation of policies, standards, procedures and physical changes to minimise adverse risk.
Risk Evaluation	The process used to determine risk management priorities by comparing the level of risk against predetermined standards, target risk levels or other criteria.

Risk Management Framework	Set of elements of an organisations management system concerned with managing risk. Components that provide foundations and arrangements for risk management to be implemented within the organisation i.e. strategy, policy, accountability, escalation process etc
Risk Identification	A process for finding out what outcomes are possible and how they occur.
Risk Level	The level of risk calculated as a function of likelihood and consequence.
Risk Management	A systematic approach to the management of risk, staff and patient/client/user safety, to reducing loss of life, financial loss, loss of staff availability, loss of availability of buildings or equipment, or loss of reputation. Risk management involves identifying, assessing, controlling, monitoring, reviewing and auditing risk.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	A tool used to calculate the level of risk based on likelihood and consequences
Risk Reduction	A selective application of appropriate techniques and management principles to reduce either likelihood of an occurrence or its consequences, or both.
Risk Retention	Intentionally or unintentionally retaining the responsibility for loss or financial burden of loss within the organisation.
Stakeholders	Those people and organisations who may affect, be affected by or perceive themselves to be affected by a decision or activity.