Borders NHS Board

Meeting Date: 2 April 2020

Approved by:	*Tim Patterson, Joint Director for Public Health*
Author:	*Lettie Pringle, Risk Manager*

RISK MANAGEMENT POLICY

Purpose of Report:

The purpose of this report is to advise the Board of the updated risk management policy.

Recommendations:

The Board is asked to **approve** the risk management policy

Approval Pathways:

This report has been approved by the Clinical Executive and Strategy Group and the Audit Committee on 23 March 2020.

Executive Summary:

The Risk Management policy has been to Audit Committee and has been approved for dissemination following inclusion of additional appendices and adjustments in text surrounding the Audit Committees role.

The new approach to risk management through board governance groups has been reflected within the code of corporate governance.

Risk appetite has been updated and fed through the Risk Management Board following the updated policy publication.

The NHS Borders risk matrix has been updated to come in line with NHS Scotland risk matrix, specifically the financial section.

This is now for final approval by the Health Board.

Impact of item/issues on:

Strategic Context	*As part of the review process the Risk Management Policy has been reviewed to ensure it is still relevant and effective. This review is part of good governance systems.*
Patient Safety/Clinical Impact	*Reviewed policy does not affect any persons/groups adversely.*

Staffing/Workforce	*Risk management is included in existing managerial duties.*
Finance/Resources	*The Risk Management policy supports assessment to ensure safe, effective and affordable practices and systems are in place. Risk management policy allows the organisation to make informed decisions based on the impact to the organisation allowing a transparent process for decision making.*
Risk Implications	*Please identify any risks – has a risk assessment been undertaken – is the risk captured on the risk register.*
Equality and Diversity	*Please attach the EQIA as a separate Appendix to the paper.*
Consultation	*Staff consultation, topic specialists, Clinical Executive and Strategy Group, Audit Committee, Non-Executive members.*
Glossary	*Glossary included within the policy, appendix 2 .*

NHS Borders Risk Management Policy

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This policy has been approved for NHS Borders

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Chief Executive Employee Director

Approval date: 27.02.2020
Authorisation date: 26.03.2020

VERSION HISTORY

Release	Date	Author	Comments
Draft 1.0	31st October 2018	Risk and Safety Team	1st draft
Draft 1.2	07th February 2019	Risk and Safety Team	Following consultation
Draft 1.3	14th February 2019	Risk and Safety Team	Comments updated
Draft 1.4	28th February 2019	Risk and Safety Team	For agreement at CE-Ops
Draft 1.5	11th March 2019	Risk and Safety Team	Updated risk matrix
Draft 1.6	06th May 2019	Risk and Safety Team	Updated following health board comments
Draft 1.7	07th October 2019	Risk Team	Updated following review by CE-Ops
Draft 1.8	08th January 2020	Risk Team	Updated governance structure
Draft 1.9	27th January 2020	Risk Team	Updated adverse event policy reflected in risk management policy
Draft 1.10	17th February 2020	Risk Team	Add in appendix 8 following Audit Committee comments
Version 1.11	25th March 2020	Risk Team	Adjustments following comments from Board members at Audit Committee

AUTHORISING CONTROL

Document Control

Document Name:	NHS Borders Risk Management Policy
Version Number:	v1
Date Created:	31st October 2018
Date Last Amended:	25th March 2020
Approved By:	Clinical Executive and Strategy Group
Authorised By:	Audit Committee

Contents

1. Introduction

1.1 NHS Borders recognises that risk is inherent in the delivery of healthcare and that risk management should be part of an organisation's culture. The risk management policy explains how NHS Borders intends to deliver its risk management strategy by embedding processes and procedures into normal management practices.

1.2 The policy lays out how this will be achieved using a comprehensive and cohesive risk management framework, underpinned by clear accountability. These arrangements commit NHS Borders to an integrated risk management approach supported by a single risk management framework for all risks to be effectively managed.

1.3 Risk management is the responsibility of NHS Borders Health Board and requires staff to work in partnership to achieve best/good practice. Managing risks increases the likelihood of success and reduces the likelihood of failure. In essence, good risk management is good management.

1.4 This document is intended for use by all employees; temporary and permanent, including bank staff. Risk owners and senior management should familiarise themselves with this policy. All employees should ensure they read accompanying risk management guidance.

1.5 This policy is to implement aims and objectives of NHS Borders risk management strategy.

2. Context

2.1 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: *British 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 BS31000 Guidelines 2018*, and forms the basis of NHS Borders risk management framework and supporting arrangements.

2.2 Healthcare Improvement Scotland (HIS): A *national approach to learning from adverse events through reporting and review – December 2019* which commits to a national Scottish learning approach for adverse events. It has added the first principles of adverse event management; prevention based on risk assessment. The suggested prevention methodology is based on proactive risk management process, as is this policy, and is also reflected in the Adverse Event Management Policy.

3. Objectives of Policy

3.1 The objectives of the policy reflect the core business of the organisation which is the delivery of person centred, safe and effective healthcare. To ultimately encourage and support a positive safety culture: the prevention and mitigation of risk to acceptable levels is part of the organisations approach and attitude to all its activities. Decisions relating to the management of risk are based on informed and transparent decision making. This will be achieved by:

3.1.1 **Person centred:**

3.1.1.1 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.

3.1.1.2 Risk management training is available to the organisation to support a positive risk management culture
Ensure that all staff members have adequate training, information and support to fulfil their duties and responsibilities as described in this policy.

3.1.2 **Safe:**

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

3.1.2.2 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, are 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.

3.1.2.3 Risk management performance of very high and 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.

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

3.1.3 **Effective:**

3.1.3.1 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 consistently adhered to by risk owners.

3.1.3.2 Risks are escalated in accordance with the policy arrangements within this policy

3.1.3.3 The effective use of information management and technology to support the management of risk

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

4. Measurement of Objectives

4.1 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. Key performance indicators to reflect the objectives will be used to measure achievement of objectives. Focussed audits will be undertaken to establish the success of these objectives as deemed necessary. Objective outcomes will be reported to Clinical Executive and Strategy Group (quarterly) then to the Audit Committee and ultimately the Health Board through the annual report. See **Appendix 1** for Key Performance Indicators.

5. Glossary of Definitions

5.1 A glossary of definitions is included as **Appendix 2**.

A. Risk Management

6. Definitions

6.1 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.

6.2 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.

6.3 A full list of definitions for risk management used within NHS Borders is included as **Appendix 2**.

7. Risk Management Framework

7.1 The British Standards Institute (BSI) framework provides NHS Borders with a nationally recognised framework and 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.

7.2 For the framework to be optimal senior management/risk owners must ensure that risk management is integrated into all organisational activities. Achieving this through leadership and commitment ensures the risk management framework adds value to the organisation.

7.3 This Policy describes the framework that gives structures and practical means to deliver the strategic direction for risk management contained within the Risk Management Strategy, plus ensures that the corporate objectives are successfully delivered. Risk management is an integral part of the delivery of efficient and safe healthcare.

Diagram 1: BSI ISO 31000 Risk Management Framework

7.4 The diagram below describes how NHS Borders will implement each component part of the BSI ISO 31000 risk management framework.

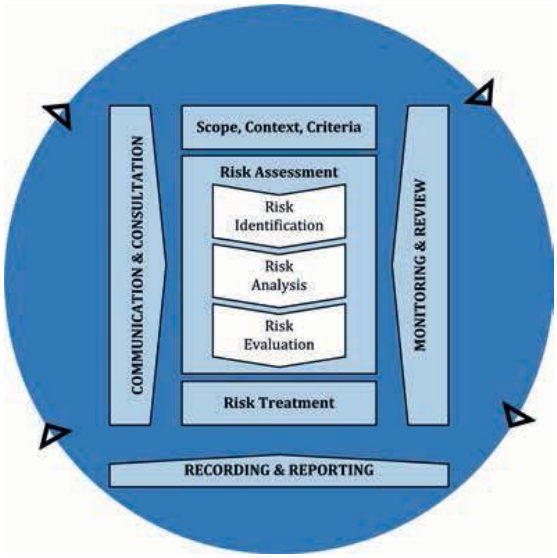
Diagram 2: NHS Borders Risk Management Framework

	Leadership and Commitment (How management is going to demonstrate leadership and commitment)	**Integration** (integrating risk into the organisational structures and context)	**Design** (understanding the organisation and its context/articulating risk management commitment, roles and responsibilities, resources and communication)	**Implementation** (Implementing the framework)	**Evaluation** (The effectiveness of the risk management framework)	**Improvement** (Adapting and continually improving)
Risk Management	-Supporting the implementation of all components of the framework -Ensuring that the necessary resources are allocated to managing risk -Supporting a risk culture that promotes the Quality Ambitions set out in the Healthcare Quality Strategy for NHS Scotland and supports the 2020 vision -Assigning authority, responsibility and accountability at appropriate levels within the organisation -Promote and support a positive risk management culture by embedding risk management through strategic and operational processes	- Through implementation of the Risk Management Strategy - Using a single approach to risk management -Inclusion of risk management in the Governance Statement - Code of Corporate Governance outlining risk management relationships within NHS Borders -Clinical Governance Strategy	Supporting documents and systems in communicating risk management commitment, responsibilities and resources to the organisation: - Refer to the NHS policy framework in **Appendix 3.**	-Adverse Event Management System -Risk Register -Claims Management System -Support and advice to risk owners, directors, managers, clinical leads, groups -Risk management process - proactive risk assessment and management -Education program through classroom learning, 1:1s and eLearning -Appraisal/ PDP/ Turas systems -Audit: Internal and external audit outcomes -all organisational papers require risk identification -NHS Borders Strategic risk register -Risk management embedded into local governance for clinical boards and directorates -Risk appetite of the organisation	-Measurement of Key Performance Indicators (KPIs) -Governance statement reflecting the performance of the organisation -Link risks identified to corporate objectives on the risk register -Performance review framework -Risk register health checks: periodic monitoring of risk registers – Reports and updates reported through operational and governance structures - Clinical Executive and Strategy Group assurance that the risk management framework is in place, is implemented and being used efficiently and effectively -Adverse Event Management systems lessons learnt - Data presented in quarterly reports - Data presented in Annual reports	-Review process for policies and arrangements -Clinical Board newsletters -Learning from application of risk controls and evaluating effectiveness -Benchmarking risk management framework to recognised standards -Network/ benchmark through the Datix Scottish User Group -Evaluations and continuous improvement plan -Updating adverse event and risk register systems -Implement lessons learnt from Adverse Events - Analysing data presented in the quarterly reports -Analysing data presented in the annual report -Review approach to risk management for Integrated Joint Board

8. Risk Management Process

8.1 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.

Diagram 3: BSI ISO 31000 Risk Management Process



8.2 The above process has been broken down into a step by step process to assist staff in carrying out their duties as risk assessors/owners. This can be found in **Appendix 4**.

8.3 The process will also require the use of the NHS in Scotland (NHSiS) agreed risk matrix[1] for the measurement of risk levels for all types of risk (**Appendix 5**). 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. This also facilitates benchmarking like for like risk levels both internally and across NHS Scotland.

9. Risk Management Communication

9.1 The effective management of risk cannot be realised without a robust communication system with stakeholder involvement. The NHS Borders Communication Strategy[2] 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. The risk register requires the recording of stakeholders/stakeholder groups as a prompt to good communication.

10. Establishing Internal and External Communication

10.1 Establishing internal and external communication to support the risk management process is essential as part of the preparation and planning of the risk. Planning should take place to determine who the internal and external stakeholders are in the context of the risk and how they will be consulted. This planning will ensure that those accountable for implementing the risk management process engage and bring together differing areas of expertise for risk analysis. This will aid stakeholders to understand the basis on which decisions are made and the reason why particular actions are required.

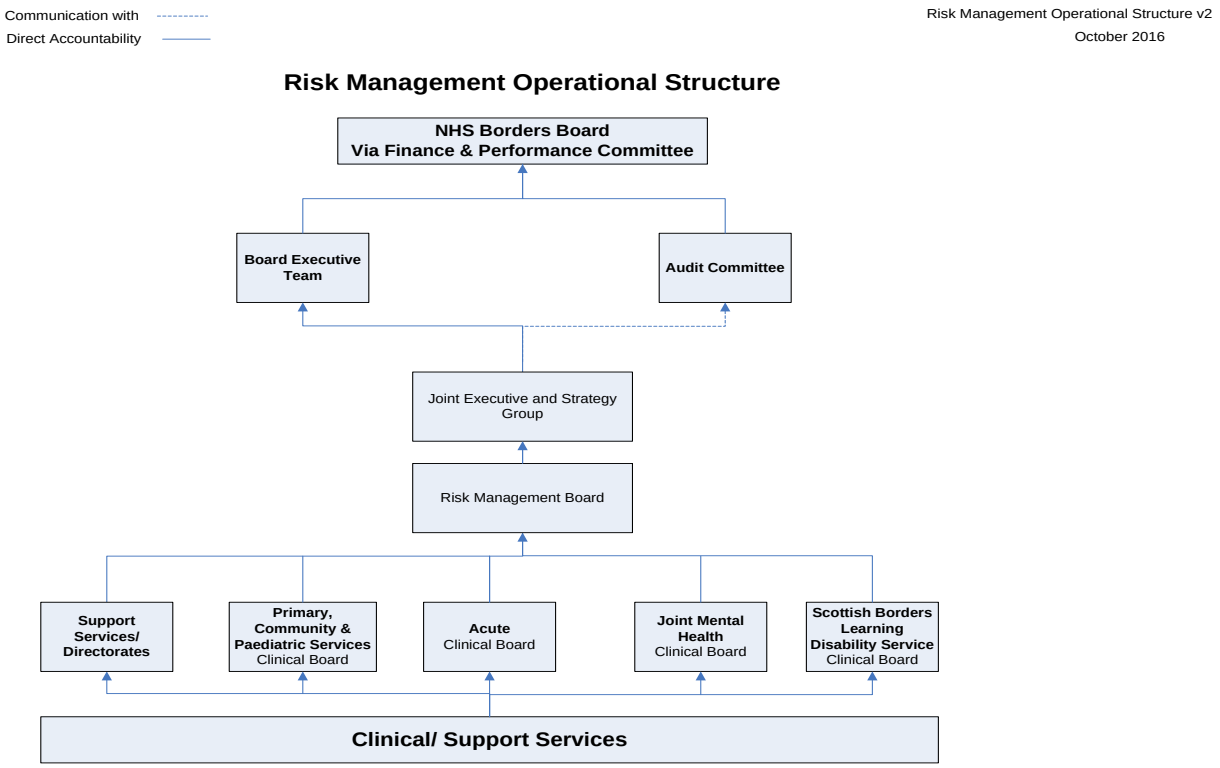
[1] NHS Quality Improvement Scotland (February 2008) sourced AUS/NZS 4360:2004 'Making it Work' (2004)
[2] NHS Borders Communication Strategy, http://intranet/resource.asp?uid=14732

B. Roles and Responsibilities – Committees and Groups

11. Operational Groups

Governance Roles can be found in section E.

Diagram 4: Risk Management Operational Structure



11.1 Health Board

11.1.1 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 provides leadership on the management of risk and ensuring the approach to risk management is consistently applied; determining the risk appetite for the organisation.

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

11.1.3 NHS Borders Health Board approves the Risk Management Policy.

11.2 Board Executive Team

11.2.1 The Chief Executive leading the directors share collective responsibility for the success of the Board Executive Team, including the effective management of risk and adherence to relevant legislation. The Board Executive Team has responsibility for risk management arrangements and ensures that the NHS Borders Health Board is kept fully informed of significant risks to the organisation.

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

11.2.3 The role of the Board Executive Team is to:

- Ensure that the strategic risk register is developed based on the organisation's overall strategic direction, working in partnership with the Clinical Executive and Strategy Group to oversee the risk register.
- Protect the reputation of NHS Borders against false or misleading information in the public domain, but not to the extent of failing to be as open as possible in reacting to adverse events, mistakes, failures or wrongdoing, in line with our legal duty of candour.
- Provide leadership on the management of risk and ensuring risk management is embedded into operational management and decision making.
- Support a positive risk management culture.

11.3 Clinical Executive and Strategy Group

11.3.1 The Clinical Executive and Strategy Group has a strategic role in ensuring that:

- A risk management strategy is developed and in place that is efficient and effective.
- Agrees a Risk Management Strategy that upholds the organisational vision and corporate objectives.
- This group works in partnership with the Board Executive Team to oversee the strategic risk register.
- To take financial responsibility and make decisions within delegated authority limits including making decisions regarding the allocation of resources for minimising risks to an acceptable level.

11.3.2 The group has an operational role in ensuring that a risk management framework is in place. Its operational role is to ensure that this risk management framework is being implemented and is used effectively and efficiently. Clinical Executive and Strategy Group approve the Risk Management Policy.

11.3.3 The Clinical Executive and Strategy Group have responsibility:

- To ensure the Risk Management Policy is in place and supports the implementation of the Risk Management Strategy.
- To approve all clinical, occupational health and safety, risk management and resilience policies.
- To promote the Corporate Objectives, Corporate Values and a culture of learning, openness and transparency encouraging staff, patients and the public to feedback and raise issues.
- To ensure that robust corporate systems are in place across the organisation to oversee, coordinate and assure activities centred on clinical effectiveness, patient safety, person centred care and research.
- To agree a robust risk management structure and process to fulfil the statutory and professional obligations of the organisation in relation to all types of risk. This has been delegated to the Risk Management Board.
- To manage key risks to the organisation, escalating significant risks to the Board Executive Team, Audit Committee, Strategy and Performance Committee or Clinical Executive Strategy Group as appropriate. This has been delegated to the Risk Management Board.
- To consider internal/external audit reports, agree the relevant organisational group to manage any issues arising and identify any risks to the organisation.
- To receive assurance from the Risk Management Board of the compliance with the organisational risk appetite by risk owners and as appropriate actions are taken to reduce very high and high risks.
- Ensure an agreed Quality and Audit process for risk regsister is in place and overseen by risk management specialists.
- Monitor risk arrangements, adherence to key priorities, key performance indicators and staff skills. This has been delegated to the Risk Management Board.

11.4 Supporting Groups to Clinical Executive

11.4.1 Supporting groups include:

- Infection Control Committee
- Occupational Health and Safety Forum
- Resilience Committee
- Research Governance Committee
- Information Governance Committee
- Risk Management Board
- Short life ad hoc working groups

11.4.2 These groups should bring risk management issues to the attention of the Clinical Executive and Strategy Group to provide assurance of actions being taken within their respective areas of responsibility.
Each group should:

- Consider the impact on the organisation of legislation, CEL, Scottish Executive directives and other relevant standards and report to the Clinical Executive and Strategy Group any weaknesses or deficiencies. Examples of these are HIS reviews, HEI standards, Clinical Governance standards, complaints, Health and Safety law, Environmental law, national security standards, external and internal audit.
- Bring to the attention of the Clinical Executive and Strategy Group risks that cannot be managed out through the risk assessment/ risk management process and which have significant risk levels or have a considerable impact on the organisation.
- Overseeing the implementation of the Adverse Event Management policy in relation to people safety/corporate adverse events. Ensure a culture of learning, openness and transparency, encouraging staff, patients and the public to feedback and raise issues
- The OH&S Forum will ensure the OH&S policy is implemented and effective. Monitoring the identification and management of OH&S risk as delegated by the Clinical Executive and Strategy Group.

11.5 Risk Management Board

11.5.1 The purpose of the Risk Management Board is to support the work of the Clinical Executive and Strategy Group (of which it is a sub-group) in promoting the development of effective risk management across NHS Borders. The Risk Management Board is responsible for establishing an operational approach to risk management across the organisation, ensuring the approach is proactive, integrated and standardised. The Board is also responsible for the overall co-ordination of risk management activity within NHS Borders. It ensures the necessary processes are in place to achieve the strategic and organisational objectives.

11.5.2 The Risk Management Board will:

- Develop, manage and monitor the Risk Management Strategy and Risk Management Policy and supporting guidelines for consideration and approval by the Clinical Executive
- Ensure an effective strategic approach towards risk management is supported operationally by a robust risk management framework and process
- Underpin the corporate objectives and governance requirements of the organisation. Ensuring that statutory, professional and performance obligations are met. Establish systems of monitoring and evaluating risk management through clear accountability arrangements. Advise and report to the Clinical Executive and Strategy Group on performance, producing an annual report for the Clinical Executive and Strategy Group for presentation to the Health Board
- Facilitate the recognition of all risks – strategic and operational
- Oversee the flow of information derived from the risk management process, such as risk assessment, adverse event reporting, significant adverse event reviews, trend analysis, audit and others ensuring that risk owners use the risk management infrastructure to manage the risks

- Support the risk owners in identifying the organisations risks using the agreed process, specifically monitoring the key risks and effectiveness of action plans/risk controls. Ensure the efficient management of resources to control risks to acceptable levels
- All identified risks will have a risk owner appointed, where a risk has been identified as NHS Borders wide the RMB will collectively appoint a lead director for the purpose of being a team leader, individual accountability remains
- Gain assurances and evidence from risk owners that risks are being actively managed, with proportional and robust action plans in place
- Ensure a process is in place that minimises the number of very high risks
- Foster the development of a culture that allows and encourages staff to raise issues and be supported in finding new ways to overcome risks. Learn from experience and enhance the development of learning, supportive and open culture. Risk management is integrated into all NHS Borders systems and is owned by all
- Ensure the Clinical Executive and Strategy Group is informed of the adherence to fulfilling the risk management key performance indicators
- Work closely with the Resilience Group to support business continuity and taking advice to ensure best use of resources
- Allocate risk issues for further analysis to the sub groups of Clinical Executive and Strategy Group as required
- Receive reports from sub groups of the Clinical Executive and Strategy Group on any significant risks identified that have not been recorded on the organisational risk register

11.6 Clinical Boards

11.6.1 The Clinical Board, represented by the Associate Medical Directors/ Associate Directors of Nursing and General Managers (as the leads), will have responsibility to:

- Review identified risks within their area.
- Manage the risks to an acceptable level.
- Prioritise the risks and reporting to the relevant director or the Clinical Executive.
- Disseminate any relevant information relating to risks and their controls.

11.6.2 The Associate Medical Directors/Associate Directors of Nursing and General Managers of the Clinical Boards will be members of the Clinical Executive and Strategy Group and will exception report strategic risks, significant operational risks and risks out with organisational risk appetite to the Clinical Executive and Strategy Group as appropriate. Clinical Boards should have 'reviewing risks on the risk register' as a standing item on their agendas.

11.6.3 Each clinical board/ directorate should have recorded on their risk register key risks identified in implementing corporate objectives. Risks 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 and professional compliance

11.7 Integrated Joint Board

11.7.1 The Chief Officer will be a member of the Clinical Executive Strategy Group. Arrangements for the communication of risk are identified within the Scottish Borders Integrated Joint Board Risk Management Strategy.

11.8 Area Partnership Forum

11.8.1 The Area Partnership Forum is represented on the Clinical Executive Strategy Group and the Clinical Boards and Support Services groups. This ensures that partnership working and staff interests are considered, ensuring the involvement of all staff in the management of risk.

12. Individual Accountability of NHS Borders staff and management: Specific risk related duties/accountabilities

12.1 The management of risk is an integral part of leadership, operational delivery and clinical practice. Every individual within the health board is therefore responsible for identifying, reporting and managing risk.

12.2 It is important that managers at all levels in the organisation encourage, support and facilitate staff in the application of good risk management practice and that they ensure staff are provided with the education and training to enable them to do so.

12.1 Chief Executive

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

12.2 Medical Director, Chief Officer and Director of Nursing, Midwifery and Acute Services

12.2.1 Have the responsibility to ensure risk management is an integral part of 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.

12.3 Director of Public Health

12.3.1 The Director of Public Health has been delegated the responsibility from the Chief Executive for providing effective leadership on risk management and is responsible for risk management arrangements.
The Director of Public Health is responsible for:

- Ensuring 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.
- Promoting continuous quality improvement through performance review, which will address the adequacy of systems and processes for managing risk.
- Ensuring risks associated with the public health directorate are managed in accordance with risk management arrangements.
- Chairing the Risk Management Board.

12.4 Director of Nursing, Midwifery and Acute Services

12.4.1 The Director of Nursing, Midwifery and Acute services is the Chair for the Clinical Executive and Strategy Group.

12.4.2 The Director of Nursing, Midwifery and Acute Services is responsible for:

- Ensuring that controls are implemented through the Clinical Executive and Strategy Group to minimise the effects of identified significant risks.
- Supporting and promoting the risk management process and framework.

- Ensuring risks associated with acute services, spiritual care, infection control, nurse bank, clinical and professional development and quality improvement are managed in accordance with risk management arrangements.

12.5 Chief Officer

12.5.1 The Chief Officer is deputy Chair for the Clinical Executive and Strategy Group.

12.5.2 The Chief Officer is responsible for:

- Ensuring that controls are implemented through the Clinical Executive and Strategy Group to minimise the effects of identified significant risks.
- Ensuring that risk management activities within the integrated services are managed effectively.

12.5.3 It is the role of the Chief Officer to keep the Integrated Joint Board (IJB) informed. As described in the Scottish Borders Integration Joint Board Risk Management Strategy, the Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the services delivered under the direction of the IJB. The Chief Officer will be responsible for drawing to the attention of the IJB any new or escalating risks and associated mitigations to ensure appropriate oversight and action.

The Chief Officer will keep the IJB and the Chief Executives of the partner organisations informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes and objectives of the Strategic Plan or the reputation of the IJB or the partner organisations.

12.6 Medical Director

12.6.1 The Medical Director will be responsible for:

- Radiation protection issues and risks.
- Ensuring risks associated with clinical governance and quality and delivery of medical services and pharmacy are managed in accordance with risk management arrangements.

12.7 Director of Workforce

12.7.1 The Director of Workforce is 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.
- Chairing the Occupational Health and Safety Forum; ensuring that actions are put in place to ensure that the risk management responsibilities of the OH&S Forum are achieved.
- The risk management of human resource, workforce and planning issues arising from risk activities of NHS Borders including close liaison with staff governance arrangements.

12.8 Director of Finance

12.8.1 The Director of Finance is responsible for:

- The risk management of financial risks, advising on the financial implications of identified risks.
- Collating information and producing the annual governance statement to be submitted to the health board
- Advising 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 Audit Committee and the Clinical Executive and Strategy Group.
- Identifying and controlling all risks arising in NHS Borders premises supported by the Head of Estates and Facilities.
- Specific responsibilities relating to project planning and ensuring that adequate procedures exist for compliance with environmental and legal requirements.
- The risk management of financial, estates and facilities issues arising from the activities of NHS Borders.

12.9 Employee Director

12.9.1 The Employee Director is responsible for:

- Ensuring that risk associated with staff and workforce planning from a staff perspective is reported into the Clinical Executive and Strategy Group.
- In liaison with the Director of Workforce, the Employee Director ensures the staff survey results are analysed and risks associated with it are reported
- Ensuring that relevant staff risks are identified in the process of any project, management and organisational changes.

12.10 Director of Strategic Change & Performance

12.10.1 The Director of Strategic Change and Performance is responsible for:

- Ensuring that the performance review systems capture very high risks and management thereof and supports quality improvements for managing very high risk.
- The risk management of strategic change and Planning & Performance and Information Management and Technology issues arising from risk activities of NHS Borders including close liaison with staff governance arrangements.

12.11 Risk Manager

12.11.1 The Risk Manager is responsible for providing a risk management framework for NHS Borders.

12.12 Head of Clinical Governance and Quality

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

12.13 Resilience Manager

12.13.1 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.

12.14 Topic Specialists

12.14.1 Topic specialists including, but not limited to, Consultant Microbiologist, Infection Control Nurses, Occupational Health Specialists, Data Protection Officer, Fire advisor, Nurse Consultants, Nurse Specialists, Radiation Protection Adviser, Clinical & Professional Development and Physical Safety are available to provide specialist information and advice.

13. General Risk Management responsibilities/accountabilities

13.1 Directors/Managers

13.1.1 All directors and 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.

13.2 Risk Owners

13.2.1 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.
- Ensure local efforts taken to mitigate the risk have been exhausted prior to escalation.
- 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.

13.3 Staff

13.3.1 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 that exist or emerge within the area in which they work, and the escalation of these identified risks to managers as appropriate.
- Contributing to resolution of risk (s), including carrying out actions to mitigate or reduce the level of the overall risk as delegated by the risk owner.
- Identifying and reporting risks to line managers any hazardous situations and accidents/ near miss adverse events to the relevant manager as soon as possible and through NHS Borders adverse event recording system in line with the Adverse Event Management Policy.
- Taking part in risk assessment and the adverse event or near miss recording process following the policies, procedures and guidance.
- 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.

C. Risk Management Tools

14. Risk Register

14.1 A risk register is defined as **"**record of information about identified risks".
Risk registers are a key management tool that enables the organisation to understand its risk profile and log risks of all kinds that threaten the organisation's ability in achieving success in its aims/objectives by supporting the context, identification, assessment and monitoring of risk. Risk registers also provide useful information on risk trends and action planning and offer a means of sharing lessons learned and good practice across the organisation.

14.2 The risk register is facilitated using an electronic risk management system; this can be accessed through the intranet. 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.

14.3 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 status is determined (manage/ tolerate/ transfer/ terminate)
- A proportionate action plan developed
- Risk is on the risk register (i.e. finally approved)

14.4 Risk registers, if properly managed, can provide assurance information necessary to satisfy the organisations' governance arrangements.

14.5 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.

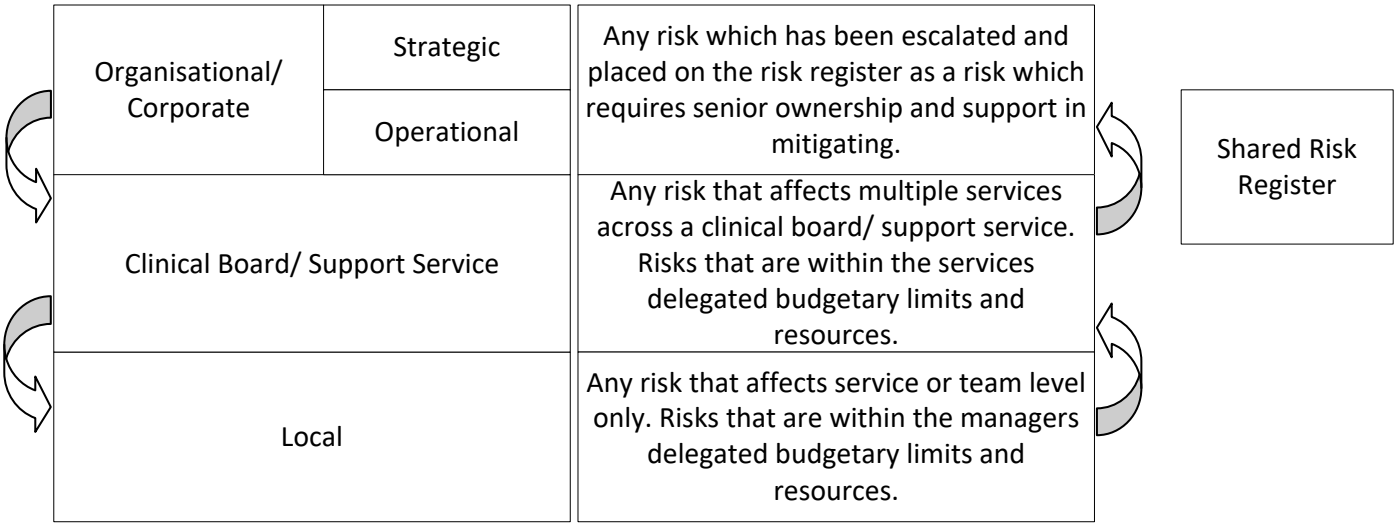
- **Operational risks** which have an organisational impact on the local delivery of healthcare services, the attainment of corporate objectives and compliance with statutory duties. This may be influenced by patient safety, staff safety, financial resources, workforce issues, patient pathways etc in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

14.6 ***Guidance on using the risk register is available of the Risk Team microsite.***

15. Risk Register Structure

15.1 To ensure we have a full understanding of the risks we face and their implications all risks are identified and assessed on 3 levels of management:

Diagram 5: Risk Register Structure



15.2 Some risks will have a direct impact on another clinical board/ support service and as such it is necessary for them to share the risk. The shared risk register sits alongside the risk registers. A Lead for a shared risk must be named before these are agreed onto the risk register.

15.3 Within NHS Borders short term project risks are entered into a separate IM&T system. Any risks that are deemed significant and require to be fed into the risk management framework are included within the quarterly risk management report.

16. Training and Support

16.1 The effective implementation of the Risk Management Policy will raise awareness on any areas that require training and support. Training and support will be offered to the organisation from the Risk and Safety Team.

16.2 **For further details on available courses please refer to LearnPro.**

D. Risk Appetite

17. Risk Appetite

17.1 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.

17.2 The parameters will include professional and managerial accountabilities, legal obligations and national/local standards.

18. Organisational Risks Statements for All Risks

18.1 All risks will be managed within statutory requirements.

18.2 Clinical risks will be managed in accordance with good clinical practice and clinical governance standards. Clinical risk owners should involve other stakeholders as appropriate.

18.3 Financial risk will be managed to corporate standards and financial policies.

18.4 All risks will be assessed using the electronic risk management system that informs the risk register. Any loss of service/resilience issues/ threats to corporate objectives must be proactively risk assessed and entered on the risk register.

19. Risk Appetite – Tolerance Levels

19.1 Target risk levels are used within NHS Borders to identify the tolerable level of risk that the organisation will aim to reduce a risk to.

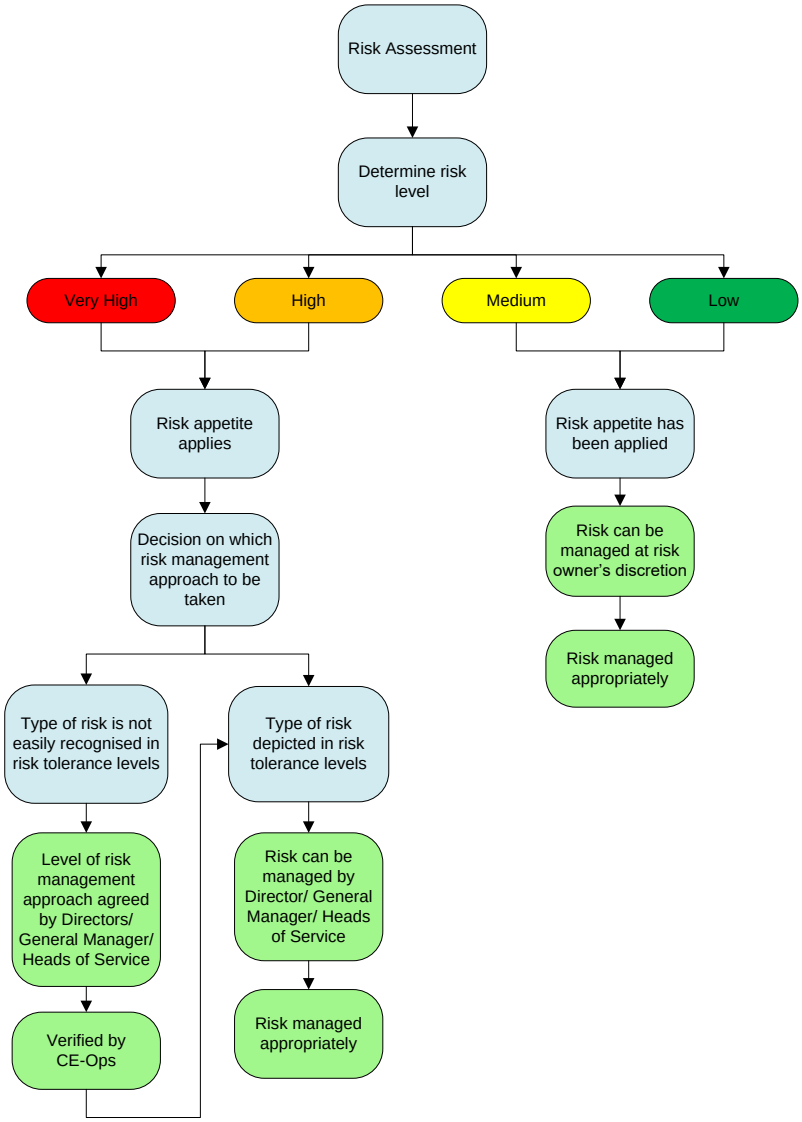
19.2 Risk appetite is a term that can be defined as the amount and type of risk that an organisation is willing to take, specifically what the organisation expects from risk owners in deciding what management actions are required at specified levels of risk to give a proportionate response.

19.3 The risk appetite process provides greater clarity of the risks NHS Borders wants to manage and those that are to be tolerated. It sets the tone from the top for the risk culture across the organisation ensuring there is a clear message that reflects NHS Borders visions and goals. It ensures that the actual risks are articulated to the organisation and informed decisions can be made.

19.4 All risks on the strategic risk register are overseen by the Board Executive Team.

19.5 To implement risk appetite and ensure consistency across the health board, NHS Borders follows the breakdown of risk tolerance as outlined in diagram 6.

Diagram 6: Risk Approach



19.6 Once risk assessment is completed, the first step is to benchmark the grade of the risk against the risk appetite.

Diagram 7: Risk appetite for risk level

Risk Rating	Risk Score	Risk Status	Decision to be made based on risk appetite parameters
Very High	20-25	Treat/Manage Terminate Transfer Tolerate	If a risk is graded as very high or high please refer to the risk management approach (Diagram 9). Using the guide to risk management approach, the risk owner must decide whether the risk is to be managed, tolerated, transferred or terminated. Level of risk management approach must be agreed by one of the following: General Manager/Head of Service/Director.
High	10-16	Treat/Manage Terminate Transfer Tolerate	
Medium	4 -9	Treat/Manage Terminate Transfer Tolerate	Risk can be managed at risk owner's discretion.
Low	1-3	Tolerate	

19.7 Each risk requires a level of response in how the risk owner is to address the risk. This is done through identifying which risk status will be most appropriate for the risk. There are four options:

Diagram 8: Risk status

Manage (Treat)	Resources are being put into the risk to reduce the risk level. An action plan is in place to identify how the risk level is going to be reduced in specified timescales.
Tolerate	The risk is getting minimal or no resource to reduce the risk level. In some cases it is not necessary to take action to reduce a risk, but to have an action plan in place to ensure that the control measures are still working efficiently and the risk level is not escalating.
Terminate	In this situation the risk is terminated at the source of the risk. For example, the risk owner/approver may decide that an activity is not going to go ahead due to the amount of risk associated with this and these outweigh the potential benefits.
Transfer	A risk is transferred if it is moved to a third party e.g. contractor.

19.7.1 Risk treatment is another term for managing risk. Treatment/management of risk is ensuring appropriate control measures are implemented and that an action plan is in place to reduce the risk, mitigate the risk or stop the risk level from escalating.

19.7.2 The response given to the risk will incorporate policies, procedures, processes, business continuity plans, systems, clinical pathways and other aspects of NHS Borders operations. The control measures put in place should:

- Enable NHS Borders to respond appropriately and proportionately to risks.
- Help ensure the quality of internal and external reporting.
- Help ensure compliance with applicable laws and regulations, and also NHS Borders policies.

19.8 Once the risk appetite for the risk grading of very high and high risks is applied, the following risk management approach should be followed.

Diagram 9: Risk Management Approach

Risk management approach	**Innovative**	**Eager to be innovative and to take opportunities offering potentially higher benefits despite greater risks**	**Risk managed with a robust action plan in place to ensure success and some risks may be tolerated.**
	Open	**Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of benefit**	**Risk managed with a robust action plan. If risk controls cannot be introduced due to lack of resource and are dependent on external factors the risk may be tolerated.**
	Cautious	**Preference for safe options where the level of benefit is limited**	**Risk managed with a robust action plan. Will tolerate risks whilst risk is being mitigated/ reduced to an acceptable level.**
	Averse	**Avoidance of risk and uncertainty is a key objective**	**Risk managed with a robust action plan. No tolerance to risk with a very high or high risk level.**

19.9 The organisation has defined its risk management approach to specific types of risks as follows:

Diagram 10: Risk Management Approach Types of Risks

	Types of Risk	**Risk Management Decision**
Clinical	**Inequalities** NHS Borders has an innovative risk appetite to ensure that all patients receive the same quality with correct care, at the correct time, in the correct manner.	Innovative
	Patient Safety/ Clinical Risk/ Clinical Activity We are cautious to risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.	Cautious
	We are open to risks which allow us the opportunity to receive a better patient outcome in terms of clinical care.	Open
Financial	NHS Borders will manage and will not tolerate any financial risks that exceed £300,000.	Cautious
	NHS Borders has a cautious risk appetite for financial risks. Whilst NHS Borders strives to deliver services within financial budgets, the health board seeks the best possible return on the investment of public money and will accept the risk of limited financial loss, in order to achieve long term financial and service quality gains.	Cautious

	Types of Risk	Risk Management Decision
Corporate	**Adverse Publicity/ Reputation** NHS Borders will maintain high standards of conduct, ethics and professionalism at all times and has an open risk appetite for risks or circumstances that could cause adverse publicity or reputational damage to the health board or a loss in public confidence, but not to the extent of failing to meet our responsibilities to be open and transparent.	Open
	Information Security/ Information Governance We have a cautious appetite for risks that may result in a breach of patient confidentiality and non compliance with the UK Information Governance requirements.	Cautious
	NHS Borders has a cautious appetite to threats to its assets arising from internal and external malicious attacks.	Cautious
	Legal NHS Borders is averse to risks that could result in the health board being non-compliant with legislation, or any of the applicable regulatory frameworks in which we operate.	Averse
	We have an averse risk appetite to any parts of the Health and Safety at Work legislation and any regulatory frameworks not being adhered to. For example, data protection, human resources and occupational and health and safety.	Averse
	NHS Borders has a cautious risk appetite for risks that could result in avoidable harm to patients, staff or the public.	Cautious
	Staffing/ Competence NHS Borders is committed to recruit and retain staff that meets the high quality standards of the organisation. We have an averse risk appetite to unprofessional conduct or an individual's competence to perform roles or tasks safely or that contradict NHS Borders values.	Averse
	Technological NHS Borders has an open appetite for risks associated with new technologies if this enables us to ensure that we can provide efficient and safe care and provide innovative solutions to new technology and infrastructure. However we will only take risks when we have the capacity and resources to manage them and there will be no adverse impact on the safety and quality of services NHS Borders provides.	Open
	NHS Borders has an open risk appetite for updating outdated technologies to ensure that all clinical and non-clinical systems are working correctly.	Open

19.10 If a risk within risk appetite does not meet the above statements, the ownership of the risk must be escalated to the line manager of the current risk owner as per the escalation protocol (appendix 6)
If after escalation the risk is still not managed to an acceptable level this must be reported to the Clinical Executive Strategy Group via the Risk Management Board, with recommendations to the Finance and Performance Committee.

19.11 If the risk does not fall into the defined risk tolerance levels, a decision by the risk owner on how to manage the risk is to be taken. If the decision is to tolerate a very high/high risk then the Risk Management Board must agree this approach.

20. Adverse Events

20.1 'Learning from adverse events through reporting and review' published by Health Improvement Scotland in December 2019[3], highlights that:

- Adverse events are a key source of intelligence about how safe care has been in the past and so have a clear place in understanding and improving safety.
- As well as learning when things go wrong, there needs to be a clear focus on anticipating future risks and preventing safety problems occurring in the first place
- Learning from when things go well should also be considered.
- To get the most benefit, adverse events should be considered alongside rather than separately from other sources of data/ intelligence. To illustrate, this could include information on/from: feedback, safety huddles, staffing levels, reliability of key clinical processes, team/ organisation scorecards, local quality improvement work and mortality and morbidity reviews.
- It is important to have mechanisms in place to ensure that the learning from these different sources is integrated and acted upon.

20.2 Escalation of adverse events reports:

20.2.1 **Significant Adverse Events (SAE)** will be shared by the Commissioning Manager to the local governance groups. The Commissioning Manager will be held accountable by groups for implementation of improvement plans. Themes of any Significant Adverse Event Reviews (SAERs) undertaken are reported to the Clinical Governance Committee. Onward escalation to the Board Executive Team (BET) will be dependent on adverse event outcomes and risk impacts. Specific RIDDOR/OH&S related significant adverse event reviews will be reported to the OH&S Forum.

Learning outcomes will be reported centrally to Clinical Governance & Quality Team/ Safety Team for collation and dissemination throughout the organisation.

20.2.3 **Management Reviews**

General Managers/ Head of Service for the Clinical Board/ Support Services, where the significant adverse event occurred, will be part of a shared decision making process to determine the level and type of review required. Management reviews of a clinical nature are reported into the Clinical Governance Committee. RIDDOR/OH&S related reviews will be reported into the OH&S Forum and when appropriate further escalation to the Clinical Executive and Strategy Group. Onward escalation to the BET, from either clinical or RIDDOR/OH&S related reviews, 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/ Safety Team for collation and dissemination throughout the organisation.

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

20.2.5 **Escalation to the Health Board** will be determined by the relevant Governance Committee/ BET.
For escalation process, please refer to Appendix 6.

[3] Learning from adverse events through reporting and review: A national framework for Scotland, December 2019

Diagram 11: Reactive Risk Management: Adverse Event Management

Adverse Event Category	Suggested Level of Review	Lead Reviewer & Peer Reviewers	Type of report, approval process and timescales
Category 1 Major & Extreme outcomes* & unacceptable and preventable events (appendix 7)	**Level 1:** Significant Adverse Event Review (SAER)	The Commissioning Manager will appoint a Lead Reviewer who should be sufficiently removed from the event and have no conflict of interest to be able to provide an objective view. The Commissioning Manager will determine the scope of the review. A Co-Reviewer may be appointed. The Peer Review Team will comprise of: – An Associate Director of Nursing – An Associate Medical Director – General/Service/Operational Manager – Subject Matter Expert	Commission review within 10 working days of the adverse event being reported on electronic adverse event system** Commence and close review (SAER report submitted for approval) within 90 days of the commissioning date Final approval by: Medical Director and Director of Nursing, Midwifery & Acute Services should take no longer than 30 days from report submission Develop an improvement plan within 10 days from report approval.
	Level 2: Management Review / Safety Management Review	The Commissioning Manager will appoint a Lead Reviewer who may be a Clinical/General/Operational Manager. This review will be competed with multidisciplinary input. There is no Peer Review Process.	Commission review within 10 working days of the adverse event being reported on electronic adverse event system** Commence and close Management Review (report submitted for approval) within 30 days of the commissioning date Final approval by: An Associate Director of Nursing or an Associate Medical Director should take no longer than 30 days from report submission. Develop an improvement plan within 10 days from report approval
	Level 2: Patient Fall Review	This will be completed by a manager or registered practitioner within the area in which the Fall event occurred. There is no Peer Review Process.	Fall Review Tool Commence, close and submit review tool within 30 days of the adverse event Final approval by: Clinical/Service/Operational Manager within 30 days of receiving review tool.
	Level 2: Pressure Ulcer Investigation	This will be completed by a manager or registered practitioner within the area in which the (developed) pressure damage event occurred. There is no Peer Review Process.	Pressure Ulcer Investigation Tool Commence, close and submit review tool within 30 days of the adverse event Final approval by: Clinical/Service/Operational Manager within 30 days of receiving review tool.
Category 2 Moderate & Minor outcomes	**Level 3:** Initial / Management Review	This will be completed by a manager or registered practitioner within the area in which the event occurred.	Recorded on the electronic adverse event recording system Finally approved within 10 days of being reported.
Category 3 Negligible outcomes & Near Misses	**Level 3:** Initial Review	This will be completed by a manager or registered practitioner within the area in which the event occurred.	Recorded on the electronic adverse event recording system Finally approved within 10 days of being reported.

E. Governance

21. Governance structure

21.1 See **Appendix 7** for Governance & Operational structure.

21.2 The Audit Committee will act as the governance body aiming to give assurance to the NHS Borders Health Board that there is an appropriate risk management system and processes in place and that this is being implemented. 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 7**).

21.3 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

21.4 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.

21.5 The Governance structure includes:

- Corporate Governance (Audit Committee)
- Staff Governance
- Clinical Governance
- Public Governance

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

22. Roles and Responsibilities – Committees and Groups - Governance Groups

Strategic risks will be fed into the governance group that is most appropriate depending on the risk subject.

22.1 Borders Health Board

22.1.1 The health Board has overall governance responsibility, ensuring an annual governance statement that confirms the adequacy of controls is in place to manage risk.

The role of the Health Board is to:

- Provide strategic leadership and direction for risk management
- Review and ensure the efficient, effective and accountable governance of NHS Borders, including risk management
- Focus on agreed outcomes

22.2 Audit Committee

22.2.1 The Audit Committee will act as the governance body overseeing risk management processes and systems 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 public funds. In particular, the Committee will seek to provide assurance to the Board that:

- An appropriate system of internal control is in place
- Effective systems of risk management are in place
- Assurance from risk owners that review and mitigation is undertaken for very high risks

22.3 Clinical Governance Committee

22.3.1 The Clinical Governance Committee will ensure an appropriate approach is in place to deal with clinical risk management, including patient safety, across NHS Borders and review performance in the management of clinical risk.

22.3.2 The Clinical Governance Committee will seek assurance from risk owners that clinical strategic risks are being managed proportionally in line with the risk management process and systems.

22.3.3 The Committee shall receive reports on very high operational risks from relevant risk owners. As a result of these reports, the Clinical Governance Committee may investigate further.

22.4 Staff Governance Committee

22.4.1 The Staff Governance Committee has a responsibility to highlight any risks to the board in implementing the staff governance standards.

22.4.2 The Staff Governance Committee will seek assurance from risk owners that strategic risks relating to workforce are being managed proportionally in line with the risk management process and systems.

22.5 Public Governance Committee

22.5.1 The public governance committee shall receive quarterly reports from relevant service leads. As a result of these reports, any areas of risks shall be highlighted and reported.

22.5.2 An action tracker arising from Committee business should be kept to record, to identify and ensure all actions have been carried out.

22.5.3 The Public Governance Committee will seek assurance from risk owners that strategic risks relating to public communication and engagement are being managed proportionally in line with the risk management process and systems.

22.6 Finance and Resource Committee

22.6.1 The Finance and Resource Committee has a responsibility to highlight any risks to the Board in regard to financial performance and organisational performance.

22.6.2 The Finance and Resource Committee will seek assurance from risk owners that strategic risks relating to finance are being managed proportionally in line with the risk management process and systems.

F. Monitoring and Audit Arrangements

23. Monitoring

23.1 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.

23.2 **Monitoring will be in two forms:**

23.2.1 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.

23.2.2 Monitoring the risks identified and potential future risks

Risks will be monitored by the Risk Management Board as delegated by the Clinical Executive Strategy Group 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 Risk Management Board 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 7.**

23.2.3 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.

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

23.2.5 As part of the monitoring function, the Risk Management Board, as delegated by the Clinical Executive and Strategy Group, will be responsible for:

- Reviewing risk management arrangements and report to the NHS Borders Health Board on an annual basis.
- Considering the corporate objectives on an annual basis, changing future risk management priorities as required.
- Monitoring the risk register and the performance of the organisation to implement the management objectives.
- Determining whether staff/managers have sufficient risk management skills, knowledge and competence in line with the risk responsibilities.
- Ensuring that risk owners are receiving adequate support to enable them to meet their roles and responsibilities.

24. Key Performance Indicators

24.1 The Key Performance indicators (KPIs) are a quantifiable measure used to evaluate the success of risk management in NHS Borders.

24.2 The key performance indicators for risk management require action by the risk owner. The key performance indicators are monitored by the Risk Management Board through quarterly risk management reports.

25. Audit

25.1 External Audit

25.1.1 The role of External Audit is to provide an independent evaluation to inform the organisation's Governance Statement.

25.2 Internal Audit

25.2.1 The role of internal audit is to provide an objective evaluation and opinion on the adequacy and effectiveness of governance, risk and control.

25.3 Local Audit

25.3.1 The Risk Management Board will ensure an agreed Quality and Audit process is in place and overseen by risk management specialists.

26. Freedom of Information (FOI)

26.1 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.

27. Policy Review

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

28. Supporting Documents

- Risk Management Strategy
- Risk Management Protocol
- Risk Register Guidance
- Corporate Code of Governance
- Adverse Event Management Policy
- General Risk Assessment Guidance
- Information Governance Policy
- GDPR Regulation
- Clinical Governance Strategy
- Resilience Policy

References

BS ISO 31000:2018 Risk Management & BS 31100:2011 Risk Management-Code of Practice and Guidance for the implementation of BS ISO 31000

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NHS Southern Health; Risk Management Strategy and Policy; 2018

NHS Avon and Wiltshire; Risk Management and Assurance Strategy; 2018

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Institute of Risk Management, Standard Deviations: A risk practitioner's guide to ISO31000, 2018

Appendix 1 – Key Performance Indicators

Performance Tool			
R	Under Performing	Current performance is significantly outwith the trajectory set.	Under the target by 11% or greater
A	Slightly Below Trajectory	Current performance is moderately out with the trajectory set.	Under the target by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory set	Matches or exceeds the target.

Target Indicator	Policy objective	Target Descriptor	Target	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Performance compared to previous quarter	Status	Comments
Person centred	Inclusion of the appropriate stakeholders in the risk management process	Every agreed risk assessment will record stakeholder involvement	100%										R	
	To support a positive risk management culture Risk management training is being attended as per training plans	All statutory/ mandatory risk management training is undertaken	100%										R	

Target Indicator	Policy objective	Target Descriptor	Target	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21		Status	Comments
Safe	Key risks must be identified	Agreed risk must name the corporate objectives affected	100%										A	
	Proactive risk assessment must be used to minimise occurrences of adverse events	Risk action plans are attached to every agreed risk assessment	95%										R	
	Risk management performance is monitored through organisational performance review arrangements	Monitor target date in regards to averse risk management approach	100%										A	
	Establish the development of a learning culture	Attendance level at risk management training courses/ eLearning	100%											

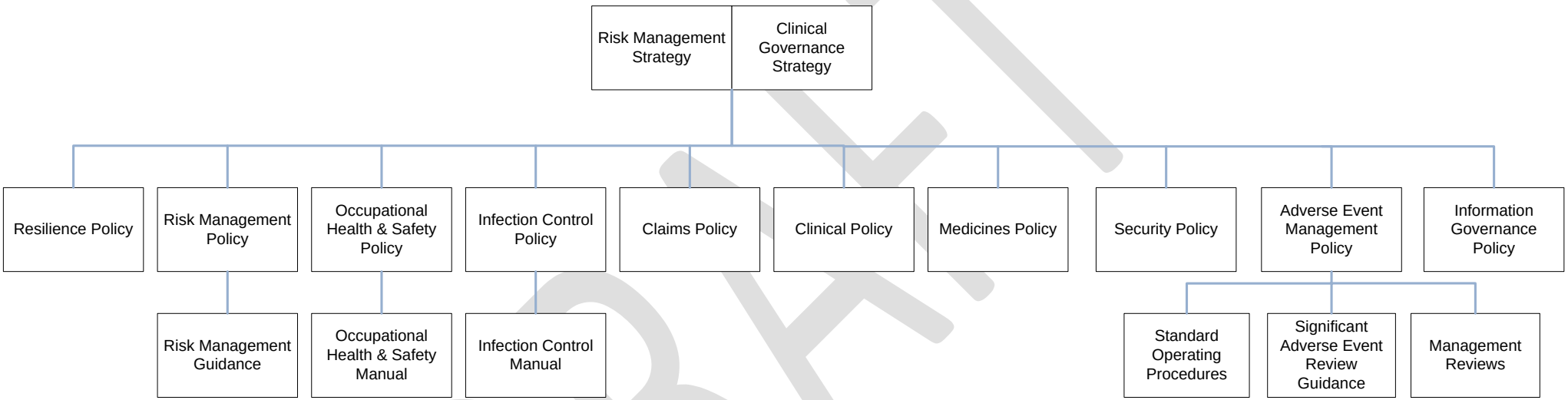
Target Indicator	Policy objective	Target Descriptor	Target	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Performance compared to previous quarter	Status	Comments				
														Quarter	Primary, Acute and Community Services	Learning disability Service	Mental Health	Support Services
														Q1 18-19				
	The risk management framework and supporting process is used by risk owners	Risks are agreed by risk approvers within 14 day timescale	100%											**Q2 18-19**				
														Q3 18-19				
														Q4 18-19				
Effective	Risks are escalated in accordance with the policy arrangements	Sample audit carried out by Risk Management team on quarterly basis	100%															
	The effective use of information management and technology to support the management of risk	Risk management system to review annually by the Risk Management Team	100%															
	NHS complies with national standards and guidance relating to risk management published by Healthcare Improvement Scotland	In line with the publication of the national standards, Risk Management policies are reviewed by Clinical Governance & Quality/ Risk Management Team	100%															

Appendix 2– Glossary of Definition

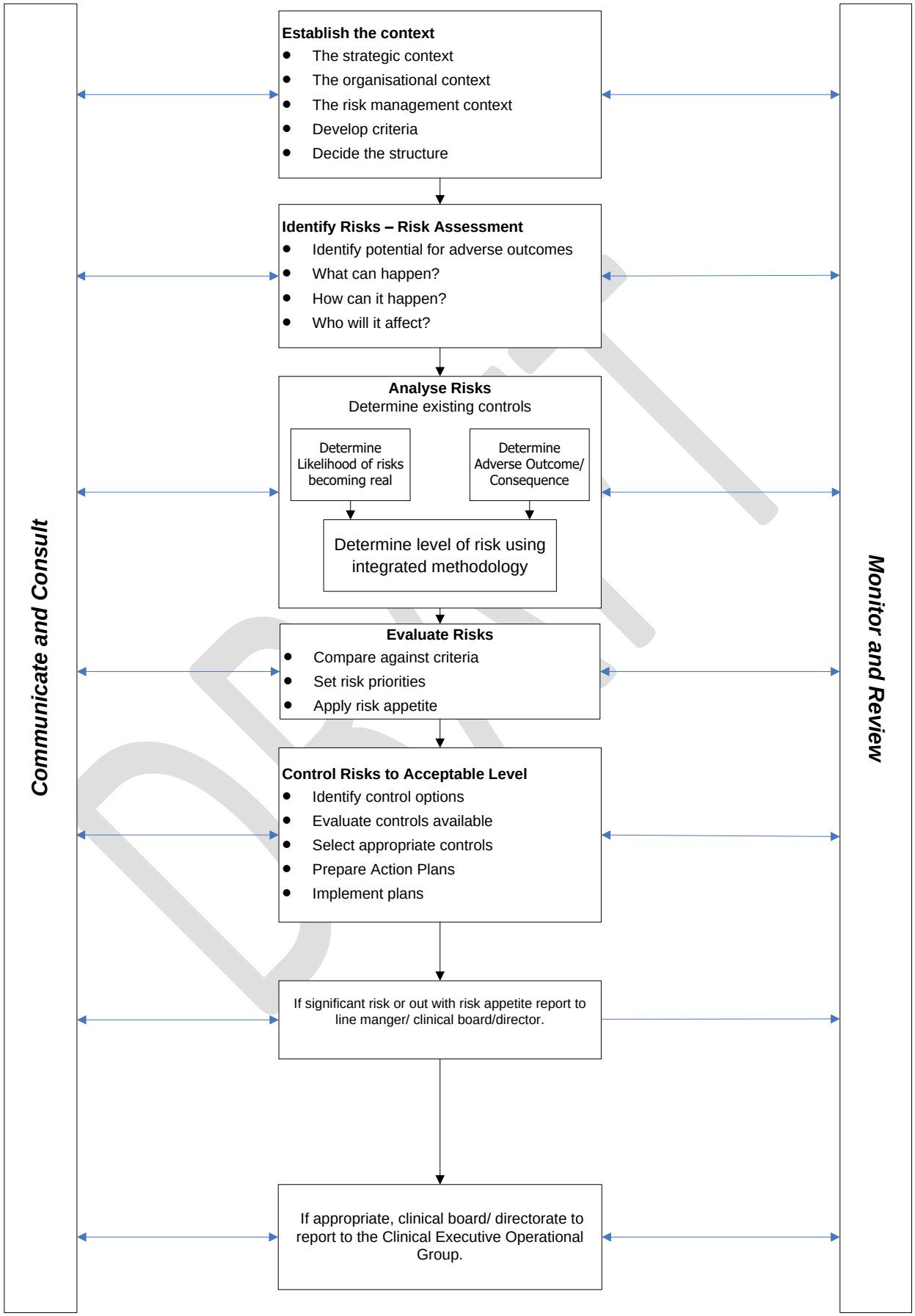
Consequence	The outcome of an event being loss, injury, ill health, disadvantage or gain.
Cost	Of activities, both direct and indirect, involving any negative impact, including money, time, labour, disruption, good will, political and intangible losses.
Frequency	The number of occurrences of that outcome 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, clinical, corporate or otherwise.
Operational Risk	Risk of loss or gain resulting from inadequate or failed internal processes, people and systems or from external events.
Residual Risk	The remaining level of risk after the risk has been managed/ treated.
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 Analysis	A systematic use of available information to determine how often specified events may occur and the severity of their consequences.
Risk Appetite	Risk appetite is a term used to explain what amount and type of risk the organisation is willing to accept or tolerate.
Risk Assessment	A systematic process of evaluating the potential risks that may involve a project activity or undertaking.
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.
Risk Tolerance	An informed decision to accept the consequences and likelihood of a particular risk.
Stakeholders	Those people and organisations who may affect, be affected by or perceive themselves to be affected by a decision or activity.
Strategic Risk	Risk concerned with where the organisation wants to go, how it plans to get there and how it sustains this. Long term risks.

Appendix 3 – Policy Framework

POLICY FRAMEWORK



Appendix 4 – Risk Management Process



Appendix 5 - Risk Matrix

Impact/Consequence Definitions

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 (£1-10k).	Significant organisational/personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/personal financial loss (£>1m).
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 6-14 hrs.	Significant number of people in affected area, with multiple fatalities, multiple serious or extensive injuries, significant hospitalization. Large number of people displaced 6-14 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.

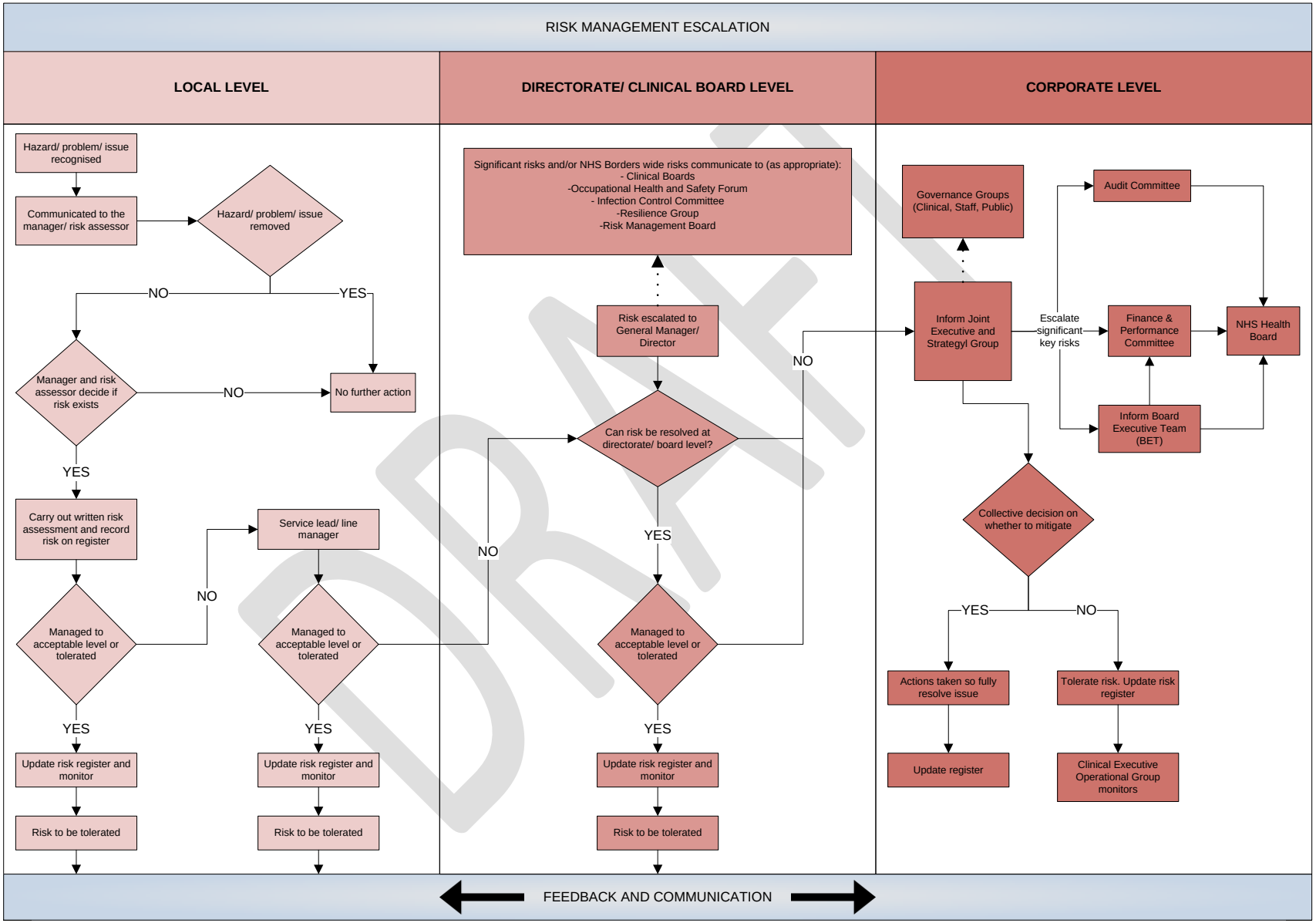
Likelihood Definitions

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.	This is expected to occur frequently / in most circumstances – more likely to occur than not.

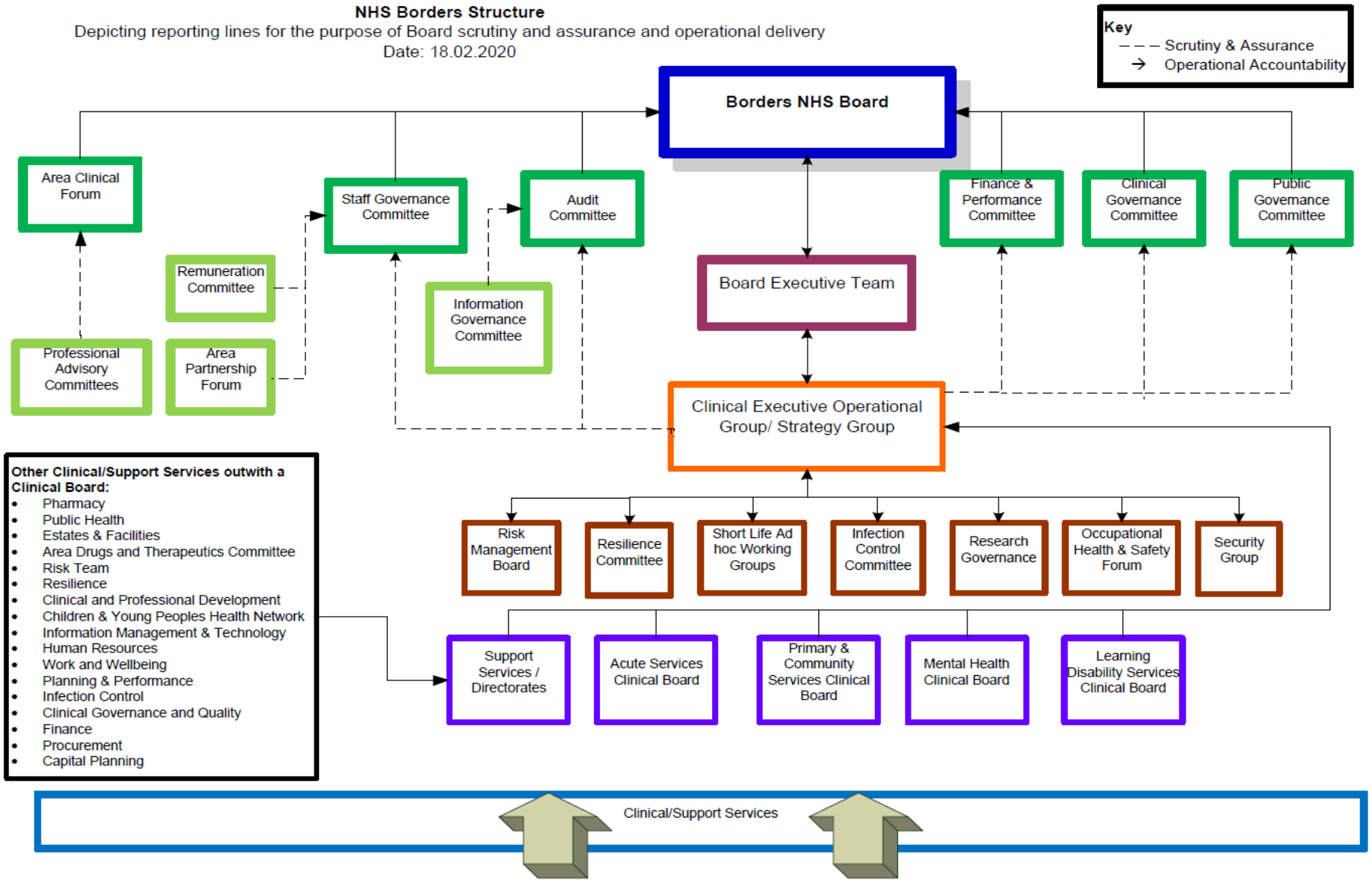
Risk Levels

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 (15)
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)

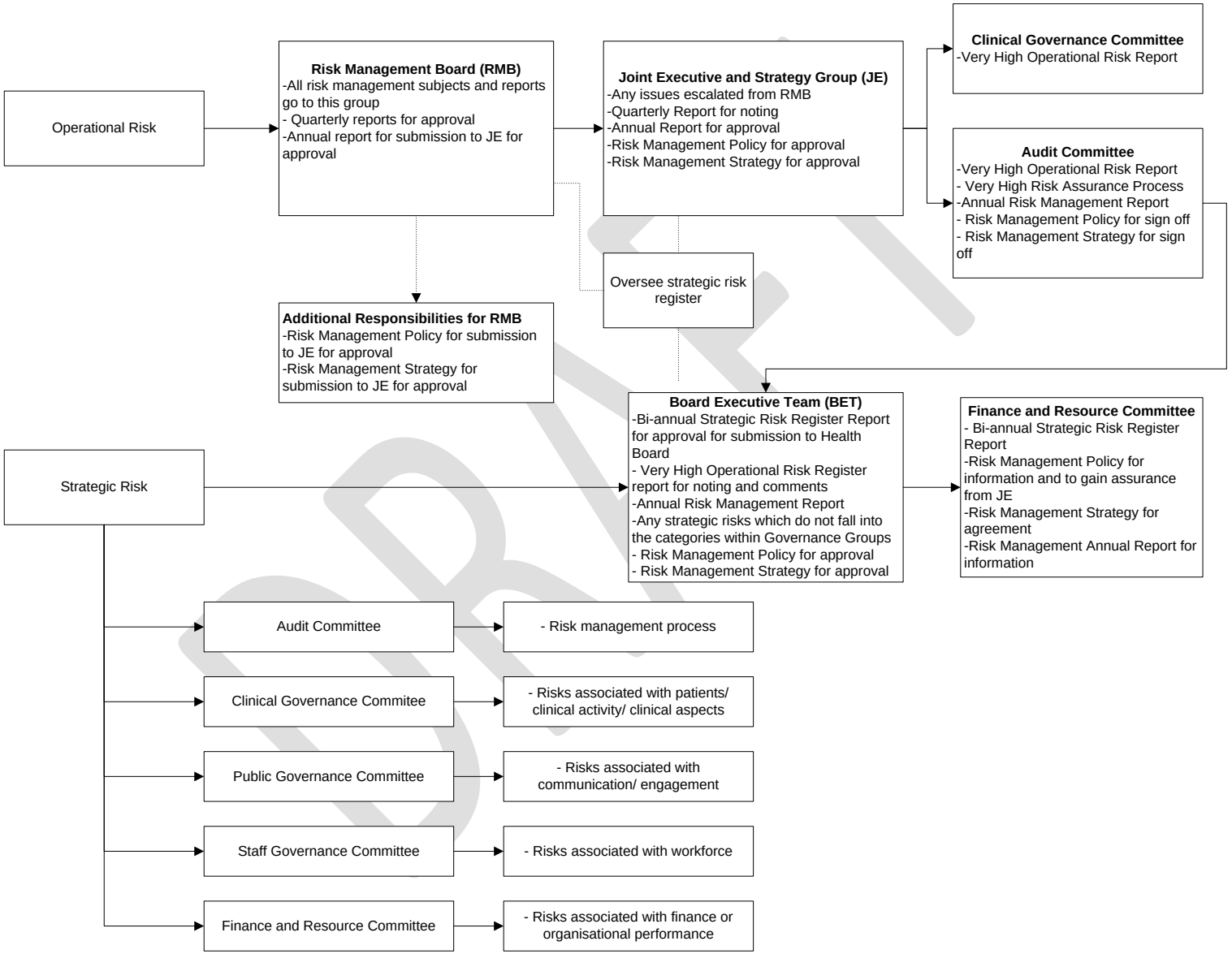
Appendix 6 – Risk Management Escalation



Appendix 7 – Operational and Governance Structure

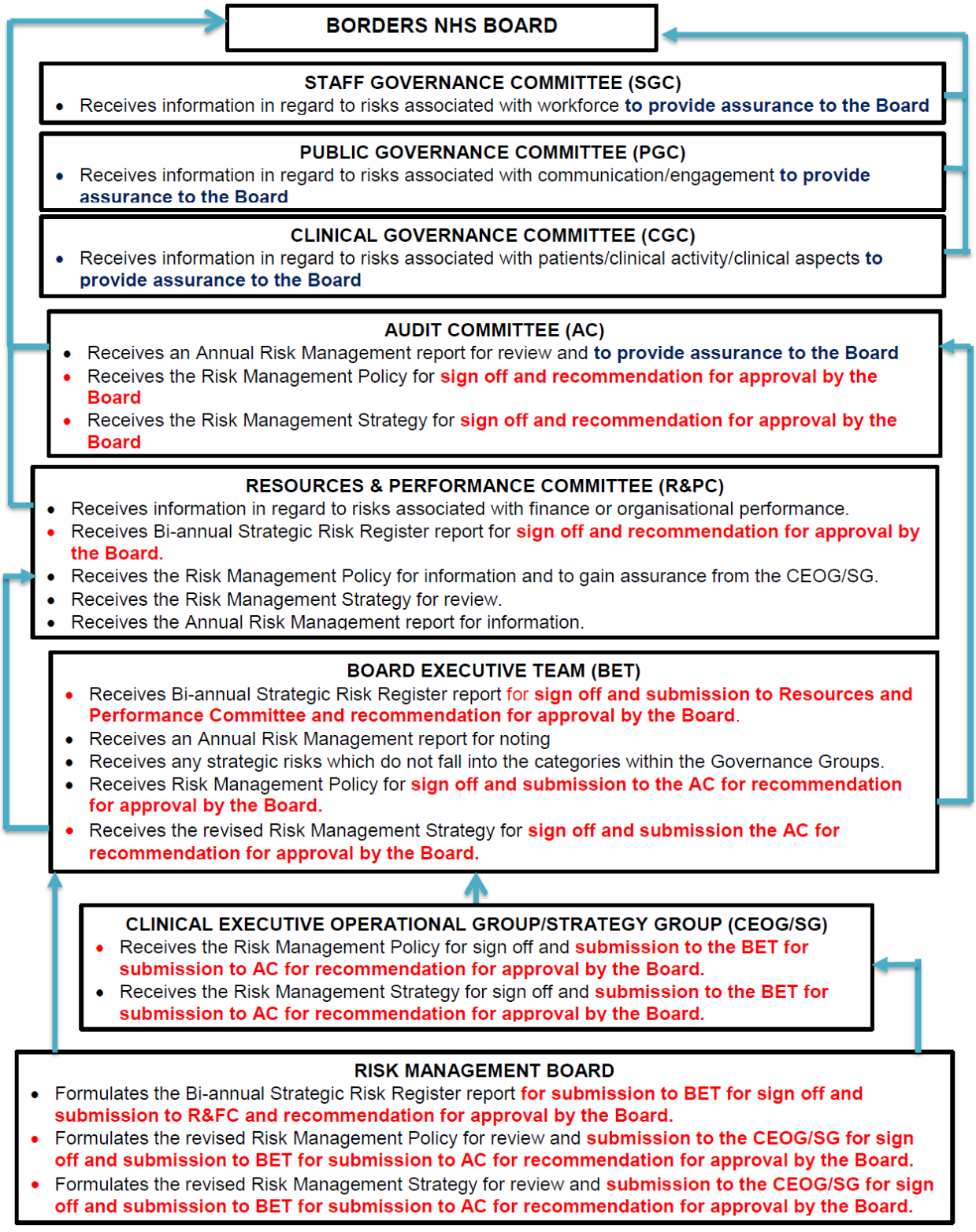


Appendix 8 – Operational and Strategic Responsibilities



STRATEGIC RISK

ASSURANCE IS PROVIDED TO THE BOARD THROUGH THE BOARD SUB COMMITTEES (AUDIT, CLINICAL GOVERNANCE, STAFF GOVERANNCE, PUBLIC GOVERNANCE, RESOURCES AND PERFORMANCE COMMITTEE) FOR STRATEGIC RISK



OPERATIONAL RISK

ASSURANCE IS PROVIDED TO THE BOARD THROUGH THE AUDIT COMMITTEE AND CLINICAL GOVERNANCE COMMITTEE FOR OPERATIONAL RISK