RISK MANAGEMENT STRATEGY 2026 - 2029

Version No: (Superseding 09.1)	10.0
Prepared By:	Debbie McCard, Risk Manager
Effective From :	10 August 2026
Review Date:	10 August 2029
Lead Reviewer:	Dr Crawford McGuffie, Executive Medical Director
Dissemination Arrangements:	

- Published via NHSAA public website and Intranet / AthenA

All of our publications are available in different languages, larger print, Braille (English only), audio tape or another format of your choice. Contact the Communications Department on 01563 826111 for further information.

Contents

Document Control Sheet

Title:	Risk Management Strategy
Document Status:	Draft
Document Type:	Strategy
Version Number:	09.2
Document location:	Intranet (internal) link: Policies and Guidelines
Authors:	Geraldine Jordan, Director of Clinical and Care Governance Debbie McCard, Risk Manager
Owner:	Dr Crawford McGuffie, Executive Medical Director
Approved By:	Risk and Resilience Scrutiny and Assurance Group
Date Effective From:	Approval date – June 2026 (Pending)
Review Frequency:	Every three years
Next Review Date:	June 2029

Revision History:

Version:	Date:	Summary of Changes:	Responsible Officer:
10.0	April 2026	• Section 1 – Statement of intent Revised objectives added and clear intent of what the strategy will achieve by the end of the strategy period.	Debbie McCard
10.0	April 2026	• Section 2 – Introduction Update added to describe the strategy reflects the principles in the following publications: ISO 31000, the HM Treasury Orange Book, the Blueprint for Good Governance, and the Scottish Public Finance Manual.	Debbie McCard
10.0	April 2026	• Section 2 – Introduction Updated to detail risk appetite as part of the introduction	Debbie McCard
10.0	April 2026	• Section 2.1 – What is risk? Updated to outline the impact of workforce risk on strategic risks. Updated to include the role of monitoring and analysis of trends of complaints and adverse events to identify potential risks.	
10.0	April 2026	• Section 3 – addition of alignment of risks to the corporate objectives and reporting aligned to this	Debbie McCard
10.0	April 2026	• Section 6.1 – Governance and Reporting – Governance Committees Updated to reflect the Audit and Risk Committee and Board receive the strategic risk register quarterly	Debbie McCard
10.0	April 2026	• Section 6.1 – Governance and Reporting – Governance Committees Updated to include the role of Corporate Management Team in oversight of the	Debbie McCard

		strategic risk register and provided a more specific description of report content/format	
10.0	April 2026	• Section 6.2 – Roles and Responsibilities – Medical Director Updated to more specific wording around responsibilities and linkage with fellow Directors	Debbie McCard
10.0	April 2026	• Section 7 – Risk Management Processes Updated to describe alignment of the strategy to the HM Treasury Orange Book	Debbie McCard
10.0	April 2026	• Section 7 – Risk Management Processes Updated to strengthen to role of Risk Appetite in decision making	Debbie McCard
10.0	April 2026	• Section 7 – Risk Management Processes Updated to include the role of Internal Audit in relation to risk.	Debbie McCard
10.0	April 2026	• Appendix 2 – NHSAA Risk Reporting and Assurance Updated to reflect reporting to Audit and Risk Committee and Board quarterly	Debbie McCard
10.0	April 2026	• Appendix 4 – Risk Management Quick Guide Risk matrix replaced with revised version as detailed in HIS National Framework for Reporting and Learning from Adverse Events in NHS Scotland (February 2025)	Debbie McCard
10.0	April 2026	• Appendix 4 – Risk Management Quick Guide Table 6 updated with revised timescales for review associated with risk appetite and risk tolerance	Debbie McCard
09.1	January 2025	• Section 8 - Information, Instruction and Training Table 2 added to describe training available and target audience	Debbie McCard
09.1	January 2025	• Appendix 2 – addition of NHS Ayrshire and Arran risk management governance structure and the risk management reporting and assurance framework	Debbie McCard
09.1	January 2025	• Appendix 4 – section 2 Current residual risk and target residual risk description added	Debbie McCard
09.1	January 2025	• Appendix 4 – section 3 Requirement that '*all actions must have an identified lead and expected completion date*' added	Debbie McCard
09.1	January 2025	• Appendix 4 – section 4	Debbie McCard

		Removal of contradictory advice regarding frequency of review of risks	
09.0	April 2023	• Statement of Intent: *Create a sense of urgency for completion of robust reviews of all adverse events to enhance timeous learning and outputs for those involved in the review;* to • *Ensure the completion of robust reviews of all adverse events to enhance timeous learning and outputs for those involved in the review* Reduction of the nine Objectives to seven, by combining three separate Objectives into one. They had a similar theme relating to organisational learning in relation to adverse events, risks and complaints and creating an integrated linkage between risk and resilience to encompass learning from adverse events and incidents Objective 2 relating to risk management training and support for colleagues, has been widened to include this being provided through a Human Factors approach	Kate Macdonald
09.0	April/May 2023	Section 6.1 Governance and Reporting – Board "The NHS Ayrshire & Arran Board has overall responsibility for NHS Ayrshire & Arran's Risk Management Strategy and for ensuring that significant risks are identified and controlled. <u>This is achieved through compliance with NHS Ayrshire & Arran's Code of Corporate Governance</u>." Removal of underlined section above. The Code is a suite of documents providing a framework for corporate governance across NHS Ayrshire & Arran. The Risk section has detail taken from the Strategy and therefore the Code does not require separate compliance. Replace "Integrated Governance Committee" with "individual governance committees" Replace "Corporate Risk Register" with "Strategic Risk Register"	Kate Macdonald

		Addition of approving the Risk Appetite Statement every two years, or sooner as appropriate.	
09.0	April/May 2023	Section 6.1 Governance and Reporting - Risk and Resilience Scrutiny and Assurance Group Addition that the RARSAG has responsibility …..for reporting the relevant Strategic risks to the assigned Governance Committees. Addition of the members not only considering risks regarding escalation and de-escalation of risk from one level of responsibility to the next, but also approving them.	Kate Macdonald
09.0	April/May 2023	Section 6.2 - Responsibility for Risk Management – Partnership Working Expansion of this section: *Working together with our Health and Social Care Partnerships and Local Authorities and their Integrated Joint Boards (IJBs) and constituent parties across North, South and East Ayrshire in terms of Risk Management plays a significant role in the success of the risk management agenda.* *The IJBs have their own Risk Management Strategies including a risk monitoring framework, and a Risk Register, which is maintained and shared between parties. Risks on delegated services which are shared between parties require to be communicated across partner organisations with clear responsibilities, ownership and timescales*	Kate Macdonald
09.0	April 2023	Section 6.3 – Responsibility for Risk Management – Partnership working Expansion of this section: *Working together with our Health and Social Care Partnerships and Local Authorities and their Integrated Joint Boards (IJBs) and constituent parties across North, South and East Ayrshire in terms of Risk Management plays a significant role in the success of the risk management agenda.* *The IJBs have their own Risk Management Strategies including a risk monitoring*	Kate Macdonald

		framework, and a Risk Register, which is maintained and shared between parties. Risks on delegated services which are shared between parties require to be communicated across partner organisations with clear responsibilities, ownership and timescales	
09.0	April 2023	Section 7 – Risk Management Process Review of Risk Appetite Statement from annually to every two years, or sooner as appropriate	Kate Macdonald

09.0	April 2023	Section 8 - Information, Instruction and Training
		More detailed description of what risk management related training is available:
		
		• Risk Management Training; Safety Action Notices, Risk Registers, Risk Grading,
		• Risk Management Awareness;
		  ○ What is Risk?
		  ○ Remit of the Risk Team,
		• Adverse Event Review Training: Reporting Training, Reviewer and Final Approver Training, Contributory Factors, Report Writing, Significant Adverse Event Review Team Pre-Meets, Completion of the Adverse Event Decision Making Form Training
		Risk System (Datix) Training: System Overview, Extracting Data for Reports
			Kate Macdonald

09.0	April 2023	Section 12 – Monitoring and Review Move from 2-yearly review to every three years and more frequently if the circumstances demand.	Kate Macdonald
09.0	May 2023	Appendix 1 - Definitions Updated the meaning of the Code of Corporate Governance to “(The Code) is a set of standards and policies which provide the overarching governance framework presented in a detailed document. The Code sets out how NHS Ayrshire & Arran will conduct its business” Definition of an ‘Issue’ added.	Kate Macdonald
09.0	May 2023	Appendix 2 – Risk Management Responsibilities The RARSAG, now has a standalone entry, separate from the Governance Committee entry.	Kate Macdonald

		Chief Executive responsibilities – removed reference to code of corporate governance and replaced with annual governance statement. Updating of the Board's responsibilities to "receive updates on Strategic Risks twice per year."	
09.0	April 2023	References to *Audit Committee* Replaced with *Audit and Risk Committee*	Kate Macdonald
09.0	April 2023	References to *Risk Committee* Replaced with *Risk and Resilience Scrutiny and Assurance Group*	Kate Macdonald
09.0	April 2023	References to *Director of O&HRD* Replaced with *HR Director*	Kate Macdonald

Approvals: this document was formally approved by:

Name & Title / Group:	Date:	Version:
Pending approval	January 2025	09.1
NHS Ayrshire & Arran Board	23 May 2023	09.0

Dissemination Arrangements:

Intended audience:	Method:	Date:	Version:
All Staff	Internal distribution via Chief Executive Note and Daily Digest	January 2025	09.1
All Staff	NHS Ayrshire & Arran internal and external web Health and Social Care Partnerships	January 2025	09.1
All Staff	Internal distribution via Chief Executive Note and Daily Digest	May 2023	09.0
All Staff	NHS Ayrshire & Arran internal and external web Health and Social Care Partnerships	May 2023	09.0

NB. This document is uncontrolled when printed. The contents of this document are subject to change, any paper copy is only valid on the day of printing. To ensure you have the most up to date version of this document please use the link to access the document directly from AthenA or contact the Author.

1. Statement of Intent

NHS Ayrshire & Arran believes that effective risk management will provide a safer environment and better care for patients and, will help the organisation to capitalise on opportunities and fulfil its corporate objectives in the short and longer term. The Board is committed to making risk management a core organisational process and ensuring that it becomes an integral part of our philosophy, practices and business planning and that responsibility for implementation is accepted at all levels of the organisation.

NHS Ayrshire & Arran acknowledges that providing health services is an inherently risky business and that risk can bring with it positive advantages, benefits and opportunities. The Board does not therefore aim to create a risk-free environment, but rather one in which risk is considered as a matter of course and appropriately identified and controlled.

We will ensure that risk management is embedded into NHS Ayrshire and Arran's vision and organisational culture; existing governance policies; and planning, reporting and decision-making structures at both the strategic and operational levels. We believe that organisations who integrate risk management have a greater likelihood of achieving strategic objectives and delivering services efficiently and effectively.

The Board also recognises the importance of involving local stakeholders in its risk management processes and of working in partnership to identify, prioritise and control shared risks.

By the end of the strategy period there will be improved Board insight to the organisations strategic risk, more consistent escalation, clearer linkage between learning and risk trends and a well embedded approach to risk appetite. This will be achieved through the implementation of the following objectives:

1. Ensure the Board has clear sight of the organisation's most significant risks and the effectiveness of controls
2. Clarify and strengthen risk ownership, escalation and accountability across all levels of the organisation.
3. Build risk management capability across the organisation, proportionate to role and responsibility.
4. Continual improvement and development of effective training and support for colleagues in relation to risk management activities, through a Human Factors approach;
5. Ensure that the risk appetite statement is embedded in risk management activities and clearly demonstrates application against the risk domains;
6. Continue to minimise the likelihood of adverse events, risks and complaints through effective risk identification, prioritisation, treatment and monitoring, to ensure integrated linage between risk and resilience to encompass learning;

Each objective will be developed further through the implementation of a Risk Management Improvement Plan.

2. Introduction

The Risk Management Strategy sets out the principles and approaches to risk management which are to be followed throughout NHS Ayrshire and Arran. Its objective is to achieve a consistent and effective application of risk management and enable it to be embedded into all core processes, forming part of the day-to-day management activity of the organisation.

This Strategy adopts a principles-based approach aligned to ISO 31000 and reflects public sector expectations set out in the HM Treasury Orange Book, the Blueprint for Good Governance, and the Scottish Public Finance Manual.

Primarily, risk management is about good governance and good risk management awareness and practice at all levels across the organisation is a critical success factor for NHS Ayrshire and Arran.

In order to be effective, Risk Management should be integrated into the way that NHS Ayrshire and Arran lead, direct, manage and operate. To support this there requires to be a Risk Appetite Statement, agreed by the NHS Ayrshire and Arran Board, which creates a framework for the risks that will be accepted in order to ensure the focus remains on the priorities to deliver the NHS Ayrshire and Arran Corporate Objectives.

NHS Ayrshire and Arran have clearly set out the levels of risk-taking that are acceptable within the risk appetite and tolerance statements detailed in the Risk Appetite Statement document. The levels are summarised below:

Risk Domain	Risk Appetite	Risk Tolerance
Injury/Illness	Cautious	Cautious
Healthcare Experience	Cautious	Moderate
Transformation & Innovation	Moderate	Open
Service Delivery / Business Interruption	Cautious	Moderate
Workforce	Cautious	Moderate
Financial	Cautious	Moderate
Compliance	Cautious	Moderate
Public Confidence	Cautious	Moderate
Health Inequalities	Cautious	Moderate

The Management of Health and Safety at Work Regulations 1999 require that as an organisation we should carry out assessments of the risks created by our activities, which may affect our patients, service users, employees, or anyone else who might be affected. Furthermore, the Corporate Homicide Act 2007 highlights the commitment required of senior management to take reasonable steps to protect employees, or anyone else that

may be affected where risks are created by their operations. As such the implementation of robust risk management systems is of paramount importance.

The Strategy supports NHS Ayrshire & Arran in the achievement of the Board's Purpose of '*Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran',* our Values of being **'***Caring, Safe and Respectful' and our objectives*.

2.1 What is risk?

A risk can be defined as 'the effect of uncertainty on objectives' (ISO31000). It is essentially any uncertain event which can have an impact upon the achievement of an organisation's objectives – either reducing the likelihood of achievement or stopping it altogether.

Not every perceived problem or adverse event is a risk. An important distinction must be made between what is a risk and what is an issue – or in other words, an uncertainty and a certainty. A risk is an event that may or may not happen. An issue or adverse event is something that is currently happening or has already happened. Issues and adverse events should therefore not be recorded and treated as risks.

Monitoring and analysis of trends of complaints and adverse events enables NHSAA to identify early warning signals, uncover systemic weaknesses, and protect patients, staff, and the organisation from avoidable harm. When done well, it shifts risk management from reactive to predictive.

Workforce sustainability is recognised as a principal strategic risk driver within NHS Scotland. Current recruitment, retention, capacity and wellbeing pressures underpin multiple strategic risks, including patient safety, service resilience, quality of care, and financial sustainability. Workforce risks are therefore considered in the identification, scoring and escalation of strategic risks across the organisation.

2.2 What is risk management?

Risk management is a systematic way of dealing with that uncertainty which involves the identification, analysis, control and monitoring of risk. Risk Management activities are designed to achieve the best possible outcomes and reduce the uncertainty. An effective system of risk management will draw together all types of risks and enable an interrelated view of the organisation's risk profile.

Risk Management may be defined as a proactive approach to the:

- Identification of risks;
- Analysis and assessment of the likelihood and potential impact of risks;
- Elimination of those risks that can be reasonably and practicably eliminated;
- Control of those risks that cannot be eliminated by reducing their effects to an acceptable level.

Additionally risk management is an integral part of the Code of Corporate Governance. Corporate assurance is a process designed to provide evidence that an NHS organisation is doing its "reasonable best" to meet objectives, protect patients, Board members, staff, the public and all stakeholders against risks of all kinds.

2.3 Why do we need Risk Management?

An effective system of risk management will deliver a range of outputs:

- Ensuring compliance with legislation, regulations and other mandatory obligations
- Providing assurance to internal and external governance groups that risks are being effectively controlled and further mitigations are being implemented
- Ensuring that decision making is informed and risk-based in order to mitigate threats to the achievement of key strategic objectives
- Supporting organisational resilience
- Raising awareness of the need for everyone to adopt consistent risk management behaviours and actions in our everyday business
- Empowering all staff to make sound judgements and decisions concerning the management of risk and risk taking
- Anticipating and responding to changing political, environmental, social, technology and legislative requirements and / or opportunities
- Preventing injury and / or harm, damage and losses.

2.4 Integration of Risk Management

Successful alignment of risk management and governance requires four key factors:

1) Organisation focus – where there is an identifiable source of risk management expertise within the organisation and senior managers come together on a regular basis to discuss risk management issues;

2) Organisation direction – where a clear direction and strategy is established for risk management, including articulating the organisation's risk appetite and giving a clear mandate for what constitutes effective risk management;

3) Decision-making structures – where risk management is not a separate process, but a key consideration at all parts of the decision-making chain: being factored into strategic and operational planning; included as a common component in all project proposals and business cases; and,

4) Capacity and capability – where the organisation's senior management invests time and resources to build momentum, capacity and capability, including: ensuring that there is a shared language of risk management; a common understanding of the principles; training and development to build expertise; and established tools and processes for risk management.

Integrated risk management requires an ongoing assessment of potential risks and opportunities for an organisation at every level. The results should inform all organisational level risks, facilitate priority setting and improve decision making.

3. Aims of the Strategy

The aims of this strategy is to establish and maintain a framework for risk management which will lead to:

- the Board being supported to achieve its corporate objectives and the delivery of high quality care and services that are safe, effective and focused on the patient experience;
- achieving a high standard of health, safety and wellbeing at work for all employees and others visiting, engaged in or affected by its activities and services of the NHS Board;
- processes that are based on best practice and national guidance and compliance with the relevant Legislation/Standards;
- risk treatment being monitored until risks are within acceptable risk scores;
- all risks being fully aligned and reported against the new corporate objectives around Better Workplace, Better Value, Better Care and Better Health;
- integrated risk management across NHS Ayrshire & Arran and supporting convergence of all aspects of Governance;
- risk management practice embedded into the day-to-day functions of NHS Ayrshire & Arran and within the role of every Board member and member of staff;
- assurance that appropriate management standards are robust and that controls and systems are defensible; and,
- a reduction in resource waste

4. Scope of the Strategy

This strategy is intended to provide an overarching framework for the management of risk within NHS Ayrshire & Arran and it will apply across all parts of the organisation. It applies to everyone employed by NHS Ayrshire & Arran and includes permanent, temporary, locum, contracted agency and bank staff.

5. Definitions

Definitions used throughout this strategy can be found at Appendix 1.

6. Risk Architecture

Clear responsibility and accountability needs to be in place otherwise risks may remain unidentified; causing loss that could be controlled or avoided. The strategy defines individual and organisation arrangements at local, system wide and Board levels

6.1 Governance and Reporting

NHS Ayrshire & Arran Board

The NHS Ayrshire & Arran Board has overall responsibility for NHS Ayrshire & Arran's Risk Management Strategy and for ensuring that significant risks are identified and controlled.

The Board is accountable and responsible for ensuring that an effective programme for managing all types of risk is in place. In order to verify that risks are being managed appropriately and that the Board can deliver its objectives, the Board receives and considers reports from the Standing Governance Committees. In particular, the Board will:

- receive annual assurance from individual governance committees and the Audit and Risk Committee that effective risk management is taking place
- consider the Strategic Risk Register quarterly
- consider mitigation status and receive assurance that progress is being made on further mitigation
- review and agree the Risk Appetite Statement every two years, or sooner as appropriate.

The NHS Ayrshire and Arran risk management governance structure and the risk management reporting and assurance framework are detailed in appendix 2.

Governance Committees

The NHS Board has delegated the function of risk governance to the governance committees. The Audit and Risk Committee has responsibility to review the effectiveness of the risk management system within the organisation.

Each committee has a responsibility to provide assurance to the NHS Board in respect of the risks that fall within their specific remit. Each committee has a further responsibility to encourage lead Directors and Senior Managers to ensure the dissemination of learning across NHS Ayrshire & Arran from adverse events, near misses, complaints and claims.

As part of the annual assurance process, the Audit and Risk Committee will receive the full strategic risk register quarterly utilising the following reporting approach:

- High Level Dashboard approach
- Reporting when new risks are accepted
- Reporting when there has been movement in risk level
- Risk within or out with agreed risk appetite/tolerance levels
- Reporting should be high level unless a “deep dive” or specific focus is required

Governance will be informed by RARSAG as described below:

Risk and Resilience Scrutiny Assurance Group

- Keeps the strategic risks and high/very high operational risks under regular review
- Has responsibility for monitoring the organisation’s risk profile and for reporting the relevant Strategic risks to the assigned Governance Committees of the NHS Board, namely the Integrated Governance Committee, Audit and Risk Committee, Healthcare Governance Committee, Information Governance Committee, Performance Governance Committee and the Staff Governance Committee.
- Considers and approves risks brought before members for decisions regarding escalation and de-escalation of risk from one level of responsibility to the next, or where it is deemed impossible or unpractical to manage certain risks within their current level and with the resources currently available.
- Receives assurance from Directors on the implementation of the risk management objectives at an operational level. This will be done on a cyclical basis and will include assurances on the management of very high and high operational risks.

In order to provide the foundation and framework for the work of the Risk and Resilience Scrutiny Assurance Group, NHS Ayrshire & Arran will ensure that a Risk Management Strategy Implementation Plan will be in place clearly detailing the direction for medium to long term objectives. The Implementation Plan will be led by this Group and will be realistic, achievable and allow the Group to focus on strategic issues whilst enabling a focus on continually developing operational improvements and programmes to deliver objectives.

Corporate Management Team

Although the NHS Board has delegated the function of risk governance to the governance committees via RARSAG, regular oversight of the strategic risk register will be provided to the Corporate Management Team for discussion.

6.2 Responsibility for Risk Management

The following sections provide detailed information in relation to responsibilities for risk management and a summary matrix highlighting key responsibilities for specific areas is contained at Appendix 3.

The Ayrshire and Arran NHS Board

Executive and Non-Executive Board Members share a responsibility for ensuring the success of the NHS Ayrshire & Arran activities, including the effective management of risk and compliance with relevant legislation. In relation to risk management the Board is responsible for:

- articulating the critical success factors for the organisation;
- protecting the reputation of NHS Ayrshire & Arran;
- providing leadership on the management of risk;
- determining the risk appetite for NHS Ayrshire & Arran;
- ensuring the approach to risk management is consistently applied; and
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps are taken to manage it effectively and appropriately.

Chief Executive

As the Accountable Officer, the Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's objectives. To fulfil this responsibility the Chief Executive will:

- ensure that management processes fulfil the responsibilities for risk management as set out in this strategy;
- ensure that full support and commitment is provided and maintained in every activity relating to risk management;
- plan for adequate resources to ensure that priority areas such as people, services, finance and quality are effective, ensuring a positive impact on the management of risk within the organisation;
- ensure an appropriate Code of Corporate Governance is prepared and regularly updated and receives appropriate consideration; and

- ensure that an Annual Governance Statement, adequately reflecting the risk management issues within the NHS Ayrshire and Arran, is prepared and signed off each year.

Executive Directors

Directors will act as responsible officers for their respective areas and will ensure that within their directorates all risk management issues are coordinated, managed, monitored and reviewed including:

- notifying their directorate senior management team of any strategic risks to the delivery of defined objectives or escalating operational problems for onward reporting to the Corporate Management Team;
- leading the management of risk by devising short, medium and long-term strategies to tackle identified risk, including the production of any action plans:
- ensuring that all activities undertaken within their directorate are consistent with the safe operation of the NHS Ayrshire & Arran Board expectation;
- ensuring risk management / health, safety and wellbeing objectives are considered in individual's personal objectives;
- ensuring staff comply with all organisational policies and procedures;
- ensuring that appropriate operational risk registers are maintained and actively managed within their directorate or programme area; and
- making recommendations to the Risk and Resilience Scrutiny Assurance Group in relation to directorate high level risks.

Medical Director

While the Chief Executive holds overall accountability for risk management across NHS Ayrshire and Arran, the Medical Director is directly accountable to the Chief Executive and acts as the executive lead for the Risk Management Strategy, associated processes and systems. The Medical Director provides overall leadership and coordination of the risk management agenda across all categories of risk, working in partnership with fellow Directors, and is supported in this role by the Risk Manager.

Human Resource Director

The Human Resource (HR) Director is accountable to Chief Executive for leadership and co-ordination of the staff governance agenda and staff risk (including management of staff and occupational health and safety risks). The HR Director works in partnership with the Medical Director to ensure that there is continued focus on an integrated risk management agenda and is supported in this process by the Competent Person –Occupational Health and Safety.

General Managers, Heads of Service, Senior Managers and Clinical Leads

All General Managers, Senior Managers and Clinical Leads are responsible for ensuring:

- that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility including;
- that all their staff are made aware of the risks within their work environment and of their personal responsibilities, and that all their staff receive appropriate information, instruction and training to enable them to work safely. This responsibility extends to anyone affected by the Board's operations, including patients, contractors, members of the public and visitors; and,
- that all necessary risk assessments are carried out within their directorate/department in liaison with relevant advisors where necessary, e.g. Risk Management, Health and Safety, Infection Prevention and Control, etc.

Directorate/Department Risk Officers

Responsible within an individual speciality, department or Directorate area for maintaining lines of communication with the risk function, administering the risk register and coordinating all risk activities

All Staff

All staff have a responsibility for contributing to the management of risk and are therefore responsible for:

- familiarising themselves and complying with this strategy and any relevant departmental risk management procedures;
- complying with all Board policies, procedures and guidance for the protection of the health, safety and wellbeing of themselves and others;
- being aware of their duty under legislation and Staff Governance Standards to take reasonable care of their own safety and the safety of others;
- identifying risks within their area of work and taking appropriate action to assess and manage such risks and/or report them to their line manager;
- being aware of any emergency procedures relevant to their role and place of work, e.g. resuscitation, evacuation and fire precaution procedures;
- attending training and development events to ensure a full understanding of their risk management responsibilities; and,
- reporting adverse events and near misses using the Adverse Event Reporting System (Datix).

Partnership Working

Working together with our Health and Social Care Partnerships and Local Authorities and their Integrated Joint Boards (IJBs) and constituent parties across North, South and East Ayrshire in terms of Risk Management plays a significant role in the success of the risk management agenda.

The IJBs have their own Risk Management Strategies including a risk monitoring framework, and a Risk Register, which is maintained and shared between parties. Risks on delegated services which are shared between parties require to be communicated across partner organisations with clear responsibilities, ownership and timescales

Our approach to risk management recognises the importance of working in partnership with all relevant stakeholders including:

- Patients and the Public;
- Staff; and
- Partner Agencies, Contractors and the Voluntary Sector.

7. Risk Management Process

Overview
The Board has adopted the risk management model described in the HM Treasury Orange Book. This provides a generic model for identifying, prioritising and dealing with risks in any situation – whether at local or corporate level. The process is shown at Figure 1.

Each stage of the risk management process should be documented in order to:

- demonstrate the process is conducted properly;
- provide evidence of systematic approach;
- provide a record of risk and to develop the Board's knowledge of risk;
- provide relevant decision makers with a risk management plan for approval etc.,
- provide an accountability mechanism and tool;
- facilitate review and monitoring;
- provide an audit trail; and,
- share and communicate information.

Figure 1 – Risk Management Process

This process has been simplified into four stages covering the identification, assessment, management and treatment of risk. This four stage approach along with a brief management of risk guide is contained at Appendix 4. The risk monitoring and reporting elements are described in Appendix 2.

Rating of Risks
The rating of risk is useful as a guide for prioritising risks and in ensuring that risks are brought to the attention of the most appropriate staff, i.e. the highest risks are notified to the most senior management level.

Risk is measured in two dimensions: the *consequence* (what the outcome would be should the risk occur) and the *likelihood* (how probable it is that the risk will occur). The matrix that the Board use for rating risks is contained within the Risk Management – Quick Guide Appendix 4 and will result in risks being rated in one of the following four categories as shown in Table 1:

Very High Risk	Red
High Risk	Orange
Moderate Risk	Yellow
Low Risk	Green

Table 1 – Risk Categories

In many cases, there will be existing controls already in place to reduce the consequence and likelihood of risks, e.g. policies and procedures, monitoring and reporting mechanisms, audits, etc., The effectiveness of these controls will be mapped against identified risks and the current residual risk assessed using the same categories as above.

The risk management process specifies risks that need to be actively managed. These are assigned a risk owner who is accountable for:

- owning the risk;
- overseeing the development and maintenance of appropriate control measures;
- monitoring the risk where there is material change in its status; and
- reporting on the risk.

While the risk owner has overall accountability for the management of the risk, they might not own or operate the control(s) which relates to the risk. In this case, the role of the risk owner is to oversee that the control(s) is / are owned, are fit for purpose and operate effectively.

Prioritisation of Risks

Risk prioritisation involves agreeing the order in which risks need to be addressed. Generally, risks will be prioritised according to their rating, i.e. the higher the rating, the higher the priority afforded to the risk. However, some minor risks may be easy to address and tackled sooner rather than later for that reason. Some very high risks may be part of the nature of care given itself and difficult, impractical and even inappropriate to reduce. Reducing a risk may have an adverse impact on another aspect of the Board's business, prevent the taking up of an important opportunity or stifle innovation. The risk prioritisation must consider these broader considerations. For this reason, the Integrated Governance Committee in conjunction with the Corporate Management Team will have final responsibility for prioritising risks.

Risk Appetite

Risk appetite is the amount of risk which is judged tolerable and justifiable. It is the amount of risk that any organisation is prepared to accept, tolerate, or be exposed to at any one point in time. A formal risk appetite statement is in place; it will be agreed every two years, or sooner as appropriate, by the Board and included within the Code of Corporate Governance.

The Orange Book emphasises that risk management should be embedded in both day-to-day operations and strategic decision-making, rather than treated as a separate or

purely compliance-driven activity. Understanding risk should actively inform choices about service change and transformation programmes by clarifying trade-offs, prioritising resources, and improving the quality and transparency of decisions.

Effective use of risk information enables leaders to judge where risks should be mitigated, where they can be tolerated or accepted, and where they must be avoided, in line with the organisation's objectives and risk appetite. By integrating risk considerations into planning, investment decisions and performance management, NHSAA will be better placed to deliver outcomes while managing uncertainty in a controlled and proportionate way.

Treatment of Risks – 4Ts
The following options required to be assessed and the most appropriate option selected for the management of each risk:

Tolerate the risk (accept) – means the risk is known and accepted by the organisation. In instances such as high/very high risk the Risk and Resilience Scrutiny and Assurance Group should formally sign off that this course of action has been taken;

Treat the risk (manage) – means we aim to reduce the likelihood of the threat materialising or else reduce the resultant impact through introducing relevant controls and continuity strategies;

Terminate the risk – do things different therefore removing the risk; and

Transfer the risk – arranging for another party to bear or share some part of the risk, through contracts, partnerships, joint working, Insurance, etc., although this does not eliminate the risk.

Further information on the treatment of risk can be found within the "Managing and Controlling Risks" section of Appendix 4.

Monitoring and Review of Risks
Progress in implementing the Board's risk action plans will be monitored on at least a quarterly basis to enable the underlying risks to be re-assessed. This monitoring will be carried out by the respective Governance Committee and overseen by the Integrated Governance Committee.

Where the target residual risk remains in the moderate to very high, the risk management process will be repeated until the risk is either eliminated or reduced to an acceptable level so far as is reasonably practicable.

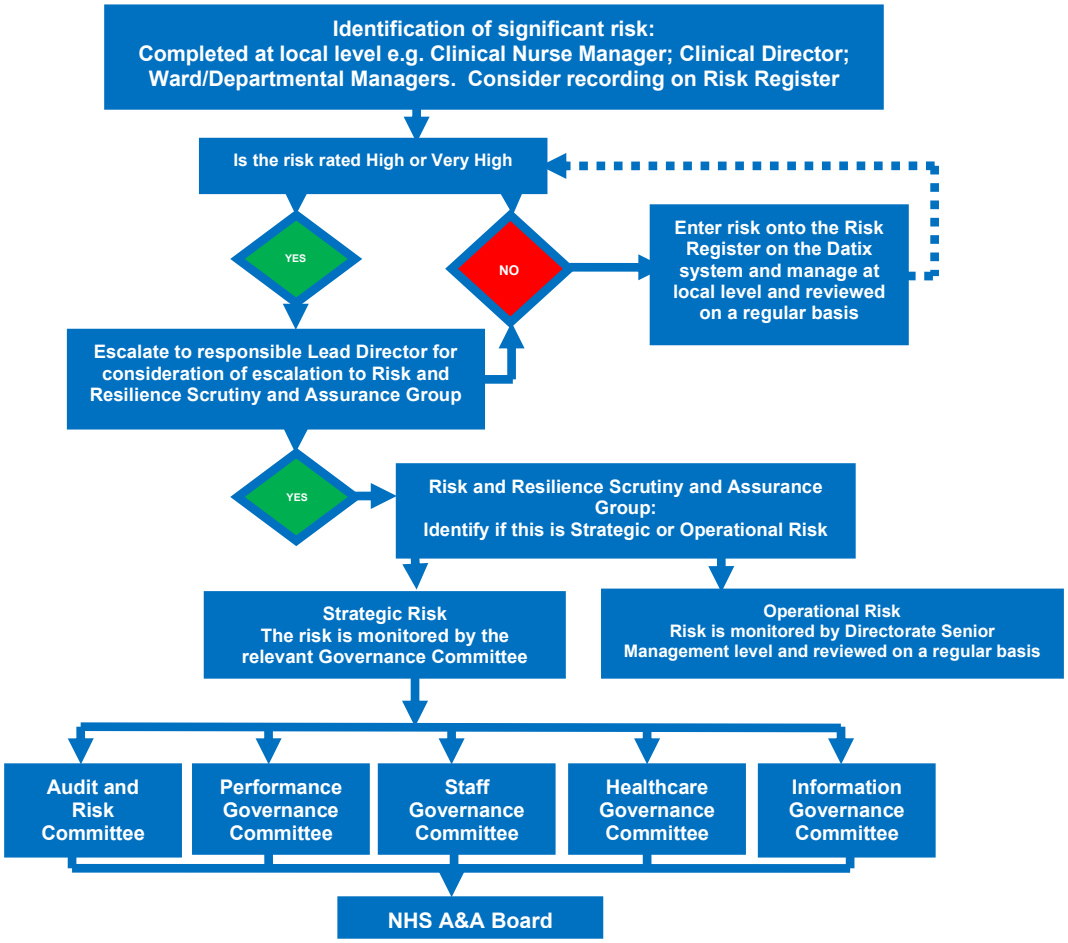
Risk Registers
The risks faced by the organisation are many and varied, ranging from health and safety risks to its employees, clinical risk to patients, to the potential failure to balance the books or achieve the corporate objectives.

At the heart of the risk management process outlined above is the risk register, a management tool that enables the organisation to understand its comprehensive risk profile. It is a repository for all risk information. The related risk action plan provides the

priority given to managing the risk by the organisation together with the actions needed to address the risk in question.

A tiered process involving local directorate based registers and a corporate register has therefore been implemented to reflect this risk profile. The aim of this approach is to ensure that the higher risk picture does not become clouded by the day to day risk management issues that can be and are dealt with as a matter of course at local level, whilst still providing a clear route for significant local issues to influence the strategic risk profile. Figure 2 below demonstrates the process of escalation for risks, commencing with activity based risk assessments, escalating to recording on local directorate based registers and finally escalation to recording on the strategic risk register.

Figure 2: Risk Escalation Process



Annual Governance Statement

As Accountable Officer, the Chief Executive is responsible for maintaining sound systems of internal control. The Governance Statement is part of the overall assurance process and will include a section on how NHS Ayrshire & Arran provides assurance that an effective risk management process is in place and risk are identified, assessed and reviewed accordingly.

Internal Audit

Internal Audit provides independent assurance on the effectiveness of risk management and internal controls. As part of audit planning and assurance work, Internal Audit may

review key risks and associated controls to inform the audit programme and provide risk-based assurance to the Audit Committee. Responsibility for risk identification, ownership and management remains with management.

8. Information, Instruction and Training

To implement this strategy effectively, it is essential to achieve:

- a workforce with the competence and capacity to manage risk and handle risk judgements with confidence;
- an organisational focus on identifying malfunctioning systems rather than people; and,
- organisational learning from events.

Training is an essential element in supporting and embedding risk management throughout NHS Ayrshire & Arran and the development of the organisation's risk management service.

To meet organisational requirements, training will be delivered which is dependent upon departmental training needs analysis and risk. Whilst there are many subjects which will fall under the description of risk management, table 2 below outlines the courses/tutorials available:

Training Event	Purpose of Training	Method	Staff Group
Adverse Event Reporting	Why and how to effectively report adverse events via the electronic system (Datix)	LearnPro Module	Open to all staff – not mandatory prior to reporting an adverse event however beneficial to understand the process and system.
Adverse Event Reviewer and Final Approver	Methodology around effectively reviewing and finally approving an adverse event, escalation or significant adverse event process and associate timescales	Microsoft Teams session	Staff responsible for reviewing and approving adverse events. Staff must complete this training prior to permissions granted to adverse events.
Electronic system (Datix) Administration	Guidance on system and dashboard navigation including retrieval of data / reports etc.	Microsoft Teams session	Staff responsible for oversight, interrogation and presentation of data. Staff must complete this training prior to permissions granted to adverse event data and/or dashboards.
Significant Adverse Event and Local Management Team Review Reports	Guidance on population of the report template, designed to improve the recording and	Video Presentation on Athena	Open to staff involved in Local Team Management Reviews and

Training Event	Purpose of Training	Method	Staff Group
	standardisation of reports		Significant Adverse Event Reviews.
Significant Adverse Event Review Pre-Meeting	Overview of the significant adverse event review process including the roles and responsibilities of the review team	Face to Face / Microsoft Teams session	Open to staff leading Significant Adverse Event Reviews
Risk Register	Overview of risk management and guidance on how to develop a risk assessment template	Microsoft Teams session & workshops	Open to staff nominated as Risk Managers/Risk Owners/Designated Risk Management Officers. Staff must complete this training prior to permissions granted to risks.
Non Executive Induction	Overview of Risk Management Team remit, risk register process, Significant Adverse Event Review process.	Face to Face / Microsoft Teams session	Provided to each Non Executive as part of organisational induction.
Safety Action Notice Process	Overview of Safety Action Notice Distribution process.	Microsoft Teams session	Open to NHSAA assigned Technical Specialists, Responsible Managers and delegated deputies.

Table 2 - Training

9. Key Performance Indicators

Each part of the organisation is responsible for developing appropriate measures to monitor risk management performance.

The Risk and Resilience Scrutiny and Assurance Group is responsible for developing organisational Key Performance Indicators in line with their approved improvement plan.

10. Links to other Policies/Procedures and Guidance

The Risk Management Strategy should be read in conjunction with the following Corporate Policies:

- Code of Corporate Governance;
- Risk Appetite Statement;
- Health, Safety and Wellbeing Strategy and Policy;
- Health and Safety Manual Procedure No 4 General Risk Assessment Procedure; and
- Adverse Events Policy and Application guidance.

11. Implementation of Strategy

Support and guidance will be given to all staff to implement the strategy. To support the implementation of the strategy, risk management must be incorporated into the performance objectives for all staff on an annual basis and be part of the induction programme for all new staff.

It is important that all staff understand their roles and responsibilities in relation to Risk Management. These responsibilities are detailed within section 6.2 of this strategy.

Risk Management will work within the remit of the Risk and Resilience Scrutiny and Assurance Group in identifying appropriate training levels commensurate with the requirements of specific job roles.

12. Monitoring and Review

The following reports and information will be provided in support of this strategy:

- the Board will receive an annual assessment of the Risk Management function
- the Audit and Risk Committee and the Board will receive the Strategic Risk Register quarterly for review and assurance
- A measuring performance programme will be developed to measure the implementation of the risk management strategy at all levels of the organisation

The strategy will be reviewed every three years and more frequently if the circumstances demand.

Definitions

A risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives of a programme area (critical success factors). It is measured in terms of consequence/impact and likelihood. It consists of a combination of the probability of a perceived threat or opportunity occurring, and the magnitude of its impact on the objectives, where:

- threat is an uncertain event that could have a negative impact on objectives.
- opportunity is an uncertain event that could have a favourable impact on objectives.

An **issue** is a challenging event which has already occurred or currently occurring

The **Code of Corporate Governance** (The Code) is a set of standards and policies which provide the overarching governance framework presented in a detailed document. The Code sets out how NHS Ayrshire & Arran will conduct its business.

Consequence/Impact is a measure of the effect that the predicted harm, loss or damage would have on the people, property or objectives affected.

The **control** of risk involves taking steps to reduce the risk from occurring such as application of policies or procedures.

Critical Success Factor (CSF) is a measure used by NHS Ayrshire & Arran to ensure that the key programme objectives are being met.

Gaps in controls or assurance are where an additional system or process is needed, or evidence of effective management of the risk is lacking.

Independent assurance is external evidence that risks are being effectively managed (e.g. planned or received audit reviews).

Key control mechanisms are the systems and processes in place that mitigate this risk

Likelihood is a measure of the probability that the predicted harm, loss or damage will occur.

Management assurance/actions are what we are doing to manage the risk and how this is evidenced – how and when will this be reported to the Board.

Operational risk is a key risk, which impacts on a programme's operational achievement.

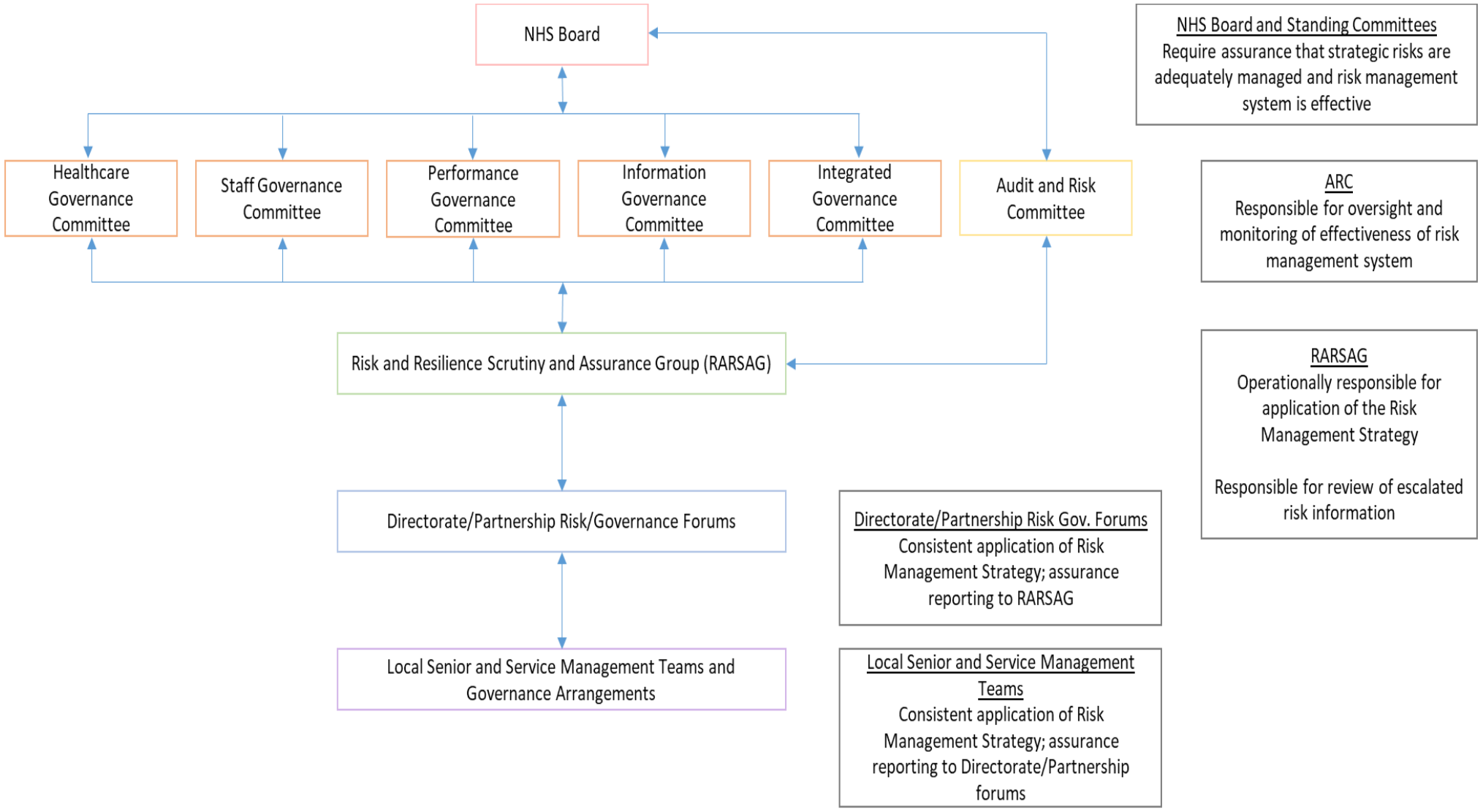
Risk assessment is the process used to evaluate the risk and to determine whether precautions are adequate or more should be done. The risk is compared against predetermined acceptable levels of risk.

Risk management is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk.

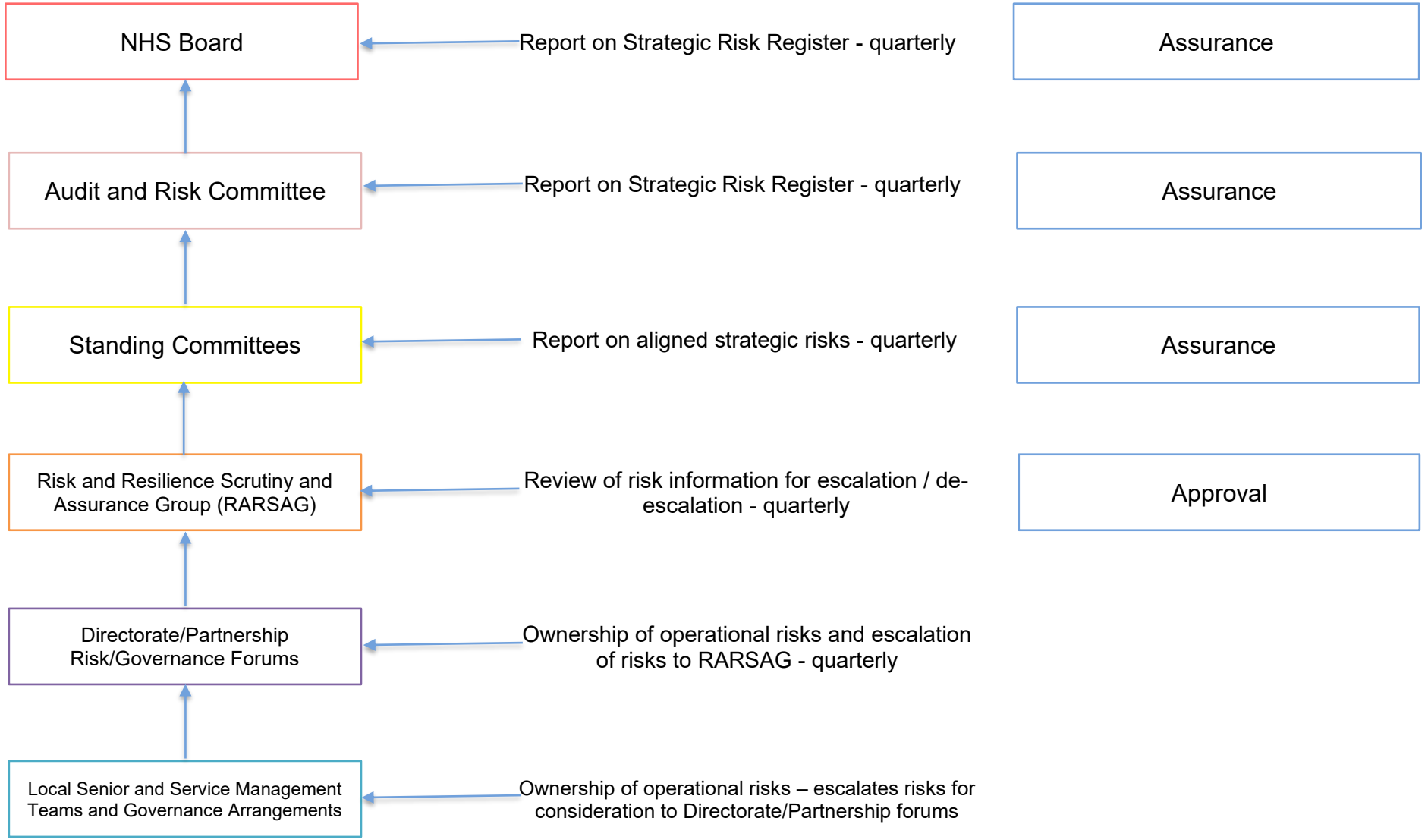
Strategic risk is a significant risk that will have an impact across the organisation and not just a specific directorate.

Appendix 2

NHSAA Risk Management Structure



NHSAA Risk Reporting and Assurance



Appendix 3

Risk Management Responsibilities – Quick Reference Guide

	Departmental Risk Registers	Operational Risk Registers	Strategic Risk Registers
All Staff	To identify and report risks for Departmental Risk Registers	N/A	N/A
Competent Person(s)	To provide guidance and support to Directors and Heads of Services as appropriate	To provide guidance and support to Directors and Heads of Services as appropriate	To support and assist the Risk and Resilience Scrutiny and Assurance Group in the development and review of Strategic Risks
General Managers, Heads of Service, Senior Managers and Clinical Leads	To prepare, at least twice per year and in consultation with appropriate colleagues, a 'local' Risk Register for their Departments	To provide assurance to Directors that robust Risk Management Procedures are in place and being monitored	To highlight risks within Department for the attention of the Risk and Resilience Scrutiny and Assurance Group and decision making in relation to addition to Strategic Risk Register
HR Director	Ensure competent support and guidance is available to Directors and Heads of Service in relation to Staff Governance Risks	Ensure competent support and guidance is available to Directors and Heads of Service in relation to Staff Governance Risks	Ensure competent support and guidance is available to Directors and Heads of Service in relation to Staff Governance Risks
Medical Director	Ensure competent support, guidance and systems are in place to enable the management of risk at a Directorate level.	Ensure competent support, guidance and systems are in place to enable the effective reviews of risk registers at a Directorate level	Management of the Strategic risk register process ensuring agreed reporting structures and submission dates are met
All Directors	Ensure suitable arrangements are in place for the management of risk within their Directorate	To receive assurance that Directorate robust Risk Management Procedures are in place and being monitored	To review their Strategic Risks in accordance with time-scale for risk category i.e. very High quarterly, High Six monthly, etc.
Chief Executive	Receiving assurances that all Directors have suitable and sufficient risk management process in place	Receiving assurance that Directorate risk register are reviewed	Receiving assurance that management of the strategic risk register process is in place and included in the Annual Governance Statement
Governance Committees	N/A	N/A	Each committee has a responsibility to provide assurance to the NHS Board in respect of the strategic risks that fall within their specific remit. Strategic risk registers relating to each committee will be provided on a quarterly basis following approval at RARSAG

	Departmental Risk Registers	Operational Risk Registers	Strategic Risk Registers
Risk and Resilience Scrutiny and Assurance Group	Develops, reviews and monitors implementation of NHS Ayrshire & Arran's Risk Management Strategy and assuring operational delivery. Embeds risk management and organisational resilience wherever possible into the organisation's existing philosophy, practices and business processes. Develops, reviews and monitors implementation of NHS Ayrshire & Arran's Organisational Resilience Strategy.		
The Board	N/A	N/A	To receive updates on Strategic Risks twice per year. To receive annual assurance from the Board's Governance Committees that effective Risk Management is taking place.

Table 3 – Roles and responsibilities summary

Risk Management – A Quick Guide

What is Risk Management and why do we have to do it?

Risk is something that may have an impact on the achievement of our objectives. This could be an opportunity as well as a threat. Good risk management means that we have a better understanding of what risks and opportunities NHS Ayrshire & Arran faces and how it can best manage them.

This quick guide provides basic details on the risk management process more detailed information in relation to using the Risk Management System (Datix) risk register, directorate risk registers, peer review process, etc. can be found in the supporting Management of Risk Guidance document.

Understanding and managing threats or risks comes down to four very simple questions:

1. What are the worst things that could happen to us?
2. What is the likelihood of them happening?
3. What would be the impact?
4. What can we do about it? (how can we prevent it from happening, or what can we put in place to manage it if it should?)

There are several tools which can be used to answer these questions. For simplicity and ease of understanding our approach is to use a simple 4 stage process of identification, assessment, management and review to ensure our risks are recorded and effectively managed. This approach is shown in Figure 3 and described in the four sections below.

Figure 3 – Four Steps to Managing Risk

1. Identifying risks

To identify risks think through the things that could prevent or hinder your team from achieving its business objectives. There are three parts to a risk – an event that has a consequence that leads to an impact on our objectives. Typical risk phrasing could be:

loss of…
failure of…..
failure to… } ***leads to ……*** ***resulting in……***
lack of…
development of…

You will also need to identify whether the risk is:

- Strategic: risks that are significant in size and duration and will impact on the reputation and performance of NHS Ayrshire & Arran as a whole and in particular on its ability to deliver its four Board objectives;
- Operational: risks specific to the delivery of individual services/service performance/project.

2. Assessing risks

Residual = the level of risk remaining after managing it through treatment and/or control measures.

To identify the residual risk we simply identify the consequence score from the appropriate domain listed in Table 4 after we have identified the control measure. We then multiple the consequence score by the likelihood of the event occurring. The likelihood score is taken from the matrix at Table 5.

Multiplying the consequence x likelihood then provides us with the Residual Risk. The Residual risk score helps to make decisions about the significance of risks to the NHS Ayrshire and Arran, and how they will be managed, the controls required and the treatment of the risk. This can be found in Table 6.

There are two opportunities to score the residual risk;

- the current residual risk is the level of risk remaining following controls that are currently in place
- the target residual risk is the level of risk expected upon implementation of any further controls when treating a risk.

SEVERITY CONSEQUENCE MATRIX

Domain	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Injury/Illness **(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.	Injury requiring medical treatment. Injury (RIDDOR reportable) that results in >7 days incapacitation for routine work. Consideration of Organisational Duty of Candour.	Long term incapacity/disability requiring medical treatment. Specified RIDDOR injury; occupational disease or dangerous occurrences with/without a ≥7 day incapacitation for routine work e.g. fractures, amputation, crush, serious burns. Consideration of Organisational Duty of Candour.	Any adverse event lead to death(s). Major permanent physical incapacity. RIDDOR reportable work-related fatality. Consideration of Organisational Duty of Candour
	Psychological impact with no wellbeing support required.	Psychological impact with signposting to wellbeing support.	Psychological impact requiring short term wellbeing support.	Psychological impact requiring medium term wellbeing support.	Long term psychological impact. Critical impact on wellbeing, co-ordinated response and referral to support services.
Healthcare Experience (Impact on how our stakeholders experience our organisation)	Reduced quality experience.	Unsatisfactory experience – readily resolvable.	Unsatisfactory experience/clinical outcome with potential for short term effects.	Unsatisfactory experience/clinical outcome with potential for long term effects.	Unsatisfactory experience/clinical outcome continued permanent' effects.
	Locally resolved verbal complaint or observations.	Justified written complaint.	Multiple justified written complaints.	Multiple justified complaints with problem themes emerging, informed from more than one source.	Complex justified complaints with serious problem themes from more than one source.
Transformation & Innovation (Impact on our ability to deliver change & innovation	Barely noticeable reduction in scope, quality or schedule of change programme or project.	Minor reduction in scope, quality or schedule of change programme or project.	Moderate reduction in scope, quality or schedule of change programme or project.	Significant change to scope, quality or schedule of change programme or project, resulting in significant changes to projected outcomes.	Inability to meet scope, quality or schedule of change programme or project.

Domain	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
across our organisation)					
Service Delivery / Business Interruption (Impact on our ability to deliver efficient and effective services)	Interruption to service/process that does not impact on delivery of services.	Short term disruption to service/process with minor impact on services.	Medium term disruption to service/process with unacceptable impact on services, impacting on departmental business continuity plans being enacted.	Long-term/sustained loss of service/process which has serious impact on delivery of services, resulting in major service wide continuity plans being enacted.	Permanent loss of core service/facility/process resulting in significant knock-on effect to other services. Major organisation wide contingency planning enacted.
Workforce (Impact on our staff wellbeing, competency & levels)	Temporary reduction in staffing levels/skill mix or any escalations fully mitigated with no impact on service delivery or care quality.	Short term reduction in staffing levels/skill mix (1 week) or escalations mitigated with no impact on service delivery or care quality due to work prioritisation/delay.	Medium term reduction in staffing levels/skill mix (1 month) or escalations unable to mitigate resulting in missed care.	Long term reduction in staffing levels/skill mix (>1 month) or multiple escalations unable to mitigate resulting in missed care and patient harm.	Loss of key/high volumes of staff or, system wide escalations unable to mitigate resulting in patient harm and impacting care standards.
	Staff unable to network with other professionals.	Staff unable to carry out complementary/non-essential training.	Staff unable to carry out training required by the organisation (including training that improves the function of the organisation).	Staff unable to carry out statutory/mandatory/role specific training or maintain competency levels.	Staff are unable to carry out any training/maintain competency levels which impact on the function of the organisation.
	No use of supplementary staffing.	Increased usage of supplementary staff.	Reliance of supplementary staff in a few areas.	Reliance on supplementary staff in multiple areas,	Unsustainable reliance on supplementary staff across the organisation.
	Negligible impact on staff wellbeing.	Minor impact on staff wellbeing, requiring peer support.	Moderate impact on staff wellbeing, requiring line manager support in a few areas.	Major impact on staff wellbeing, requiring referral to support services in multiple areas.	Extreme impact on staff wellbeing, requiring coordinated response and referral to support service across the organisation.
Financial (Impact through unplanned	Some adverse financial impact but not sufficient to affect the ability of the	Adverse financial impact affecting the ability of one or more	Significant adverse financial impact affecting the ability of one or more	Unable to achieve annual financial balance given scale of funding gap and savings	Significant aggregated financial impact affecting the long-term financial

Domain	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
cost/reduction of available finances) *%'s used may vary depending on size of Board and are to act as a guide.	service/department to operate within its annual budget. Scale of impact experienced is ≤1% of Directorate Impact or 0.1% of Board Annual Budget.	services/departments to achieve their annual financial balance. Scale of impact experienced is 2-5% of Directorate Impact and/or multiple Directorates OR 0.2-0.5% of Board Annual Budget.	services/departments to achieve their annual financial balance. Scale of impact experienced is 6-10% of Directorate Impact and/or multiple Directorates OR 0.6-1% of Board Annual Budget.	requirements across the full Board. Scale of impact experienced is 11-20% of Directorate Impact and/or multiple Directorates OR 1.1 to 2% of Board Annual Budget across Full Board Impact in year. Potential for Scottish Government involvement/escalation.	sustainability of the organisation. Scale of impact is experienced is >2% of Board Annual Budget. Potential for Scottish Government escalation.
Compliance (Impact on business controls to comply with industry rules, regulations and sustainability)	Report/Audit that identifies minor compliance/quality issues. No change to level of Board Assurance.	Report/Audit that identifies a small number of compliance/quality issues. No change to level of Board Assurance.	Report/Audit that identifies a challenging number of compliance/quality issues. Minimal disruption on Board Assurance.	Report/Audit that identifies a significant number of compliance/quality issues stating a low compliance rating/critical rating. Reduced level of Board Assurance.	Report/Audit that identifies a significant Zero/Severely critical rating in relation to Compliance/Quality. Significant reduction in level of Board Assurance.
	No compliance/permit impact. No regulatory involvement.	Minor noncompliance/permit impact (Regulatory advisory letter).	Moderate noncompliance/permit impact that results in Regulator involvement. (Notice of Contravention issued).	Major noncompliance/permit impact that results in Regulator Enforcement action and/or fines. (Improvement Notice).	Major noncompliance/permit impact that results in Regulator Enforcement action and/or fines. (Prohibition Notice/Prosecution/Public Register).
Public Confidence (Impact on public confidence of the organisation)	Some concerns from individuals, local community groups and media (including social media) – short term (<1 day).	Ongoing concerns raised by individuals, local media, social media, local communities and their representatives – long term (≤1 week).	Ongoing concerns raised by individuals, local media, social media, local communities and their representatives – long term (>1 week).	Significant impact on public confidence in the organisation that either results in a decline in uptake/use of services, or from concerns raised by national organisations/scrutiny bodies and short term (<1 week) national media coverage.	Critical impact on staff, public and stakeholder confidence in the organisation resulting from an external investigation/public enquiry or through prolonged (>1 week) national/international concerns and media coverage or being scrutinised by parliament.
Health Inequalities (Impact could	Negligible impact on health inequalities as measured by patient	Minor impact on health inequalities as measured	Moderate impact on health inequalities as measured	Serious exacerbation of health inequalities as	Critical exacerbation of health inequalities as measured by

Domain	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
create/increase Health Inequalities across the Population)	access and patient outcomes.	by patient access and patient outcomes.	by patient access and patient outcomes.	measured by patient access and patient outcomes.	patient access and patient outcomes.
	No issues with access to service or differential/inequitable outcomes across the population.	Some differences in service access and/or outcomes for different population groups identified.	Restricted access and/or differential health outcomes for different population groups identified.	Significant access and/or differential health outcomes for different population groups identified.	Extensive access and/or differential health outcomes for different population groups identified.
	Compliance with equalities legislation.	Unlikely to result in inequity of access/outcomes.	May result in inequity of outcome or legislation non-compliance.	Likely to result in impact on equity of outcome and/or legislation no-compliance.	Will result in failure to comply with equalities legislation.

Table 4 – Consequence matrix

Likelihood – What is the likelihood of the risk occurring? *

*There is no need to use all sections of each descriptor below, these are for a guide only.

Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
It is assessed that the risk is very unlikely to happen. Will only occur in exceptional circumstances.	It is assessed that the risk is not likely to happen. Unlikely to occur but potential exists.	It is assessed that the risk may happen. Reasonable chance of occurring – has happened before on occasions.	It is assessed that the risk is likely to happen. Likely to occur – strong possibility.	It is assessed that the risk is very likely to happen. The event will occur in most circumstances.
≤10% chance that the risk may occur.	11-37% chance that the risk may occur.	38-64% chance that the risk may occur.	65-89% chance that the risk may occur.	>90% chance that the risk may occur.
A potential for a 5-10 year event.	A potential for a 2-5 year event.	A potential for an annual event.	A potential for a quarterly event.	A potential for frequent occurrence e.g. daily/weekly/monthly.

Table 5 – Likelihood

LIKELIHOOD						
	5	Moderate 5	High 10	High 15	Very High 20	Very High 25
	4	Moderate 4	Moderate 8	High 12	High 16	Very High 20
	3	Low 3	Moderate 6	Moderate 9	High 12	High 15
	2	Low 2	Moderate 4	Moderate 6	Moderate 8	High 10
	1	Low 1	Low 2	Low 3	Moderate 4	Moderate 5
		1	2	3	4	5
IMPACT						

Table 6 – Risk matrix

3. Managing and controlling risks

Level of Risk	Risk	How the risk should be managed
Out with Risk Tolerance	Immediate Action Required Intolerable	Requires active management to manage down and bring the risk within agreed tolerance level for the risk domain. Review monthly.
Out with Risk Appetite	Immediate Action Required Intolerable	Requires active management to manage down and bring the risk within agreed tolerance level for the risk domain. Review every 3 months (minimum)
Risk is within appetite		**Review according to risk level detailed below:**
Very High (20-25)	Immediate Action Required Intolerable	Requires active management to manage down and maintain the exposure at an acceptable level. Escalate upwards. The activity or process should not be started or allowed to continue until the risk level has been reduced. While the control measures selected should be cost-effective, legally there is an absolute duty to reduce the risk. Review every 3 months (minimum).
High (10-16)	Immediate Action Required Unacceptable	Contingency plans may suffice together with early warning mechanisms to detect any deviation from the profile. Escalate upwards. If a new activity or process, it should not be started until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk. Where the risk involves an existing activity or process, the problem should normally be remedied within one to three months. Review every 6 months (minimum).
Moderate (4-9)	Action Required	Efforts should be made to reduce the risk, but the cost of reduction should be carefully measured and limited. Risk reduction measures should normally be implemented within three to six months. Once every year or sooner if appropriate.
Low (1-3)	Acceptable	No further preventative action is necessary, but consideration should be given to more cost-effective solutions or improvements that impose no additional cost burden. Monitoring is required to ensure that the controls are maintained. Once every year or sooner if appropriate.to ensure conditions have not changed.

Table 6 – How Risks should be managed

THE FOUR Ts

The level of the inherent risk will help determine the best treatment for a risk, whether strategic, corporate, partnership or operational. Once the type of risk has been determined, consideration must be given to the most appropriate to treat the risk, action plan will be require to be drawn up and implemented. The rating and prioritisation of the risk will determine the speed with which the risk action plan should be implemented and at which level of the organisation the risk needs to be reported.

Tolerating	NHS Ayrshire & Arran may tolerate a risk where: • the risk is effectively mitigated by internal controls, even if it is a high risk • the risk cannot be mitigated cost effectively • the risk opens up greater benefits These risks must be monitored and contingency plans should be put in place in case the risks occur.
Treating	This is the most widely used approach. The purpose of treating a risk is to continue with the activity which gives rise to the risk, but to bring the risk to an acceptable level by taking action to control it in some way through either: • containment actions (these lessen the likelihood or consequences of a risk and are applied before the risk materialises) or • contingency actions (these are put into action after the risk has happened, thus reducing the impact. These must be pre-planned) • all actions must have an identified lead and expected completion date noted
Terminating	Doing things differently and therefore removing the risk. This is particularly important in terms of project risk, but is often severely limited in terms of the strategic risks of an organisation.
Transfer	Transferring some aspects of the risk to a third party, e.g. via insurance, or by paying a third party to take the risk in another way. This option is particularly good for mitigating financial risks, or risks to assets. However it is a limited option.

Table 7 – The Four Ts

CONTROLS

Any action, procedure or operation undertaken to either contain a risk to an acceptable level (the impact), or to reduce the likelihood. Where future actions are planned these should have a date by which they will be implemented.

4. Monitor and Review Risks

REPORTING RISK

Nothing stays the same forever. By talking to your staff and monitoring incident rates and control measures, you will be able to judge whether your risk control measures are effective. Managers and staff must be given responsibility to oversee the process and develop reporting procedures, discussing and helping to implement solutions, as well as monitoring the solutions for effectiveness.

Your risks should be reviewed regularly to ensure that the risk has not changed and that no further control measures are needed. A risk should also be reviewed if any changes occur that may increase the risk of an adverse event occurring.

There is no legal time frame for when you should review your risk assessment. However, NHS Ayrshire & Arran has adopted a review timeframe linked to the current risk level as detailed in table 6 (how risks should be managed), however these timeframes are the minimum a risk should be reviewed. Risks are, by nature, dynamic and should be updated as the risk and controls change.

Equality Impact Assessment including Fairer Scotland Duty and Children's Rights and Wellbeing Impact Assessment

Discrimination is usually unintended, for example, in the design of a new policy a one size fits all approach may be applied with the intention to be fair to everyone but what this actually does in practice is apply differential impacts on different groups of people.

The **Equality Impact Assessment (EQIA)** process is an evidence based approach designed to help organisations ensure that policies, practices, procedures, service change or redesign and decision-making processes are fair, equitable and that they don't present barriers to participation or disadvantage to any protected groups. The equality impact assessment is used to identify any disadvantage and take appropriate steps to mitigate, or at least minimise, this. You should start the EQIA process at the outset and continue throughout the process; don't wait until the end when a decision has been made. Below are steps to consider to support filling in your EQIA.

Step 1 - Identify what is being assessed. You need to be clear what is being assessed and consider what impact this will have and on which groups.

Step 2 - Give details about the policy. You need to be clear of the purpose at this stage, what are the benefits and who are the stakeholders.

Step 3 - Gather and analyse data and information and engagement. You will need to gather evidence to inform your Equality Impact Assessment. This may come from your stakeholder group(s).

Step 4 – Assess Impact. You need to think about what impact it will have on different groups in our community/workforce. Continue to work with your stakeholders to gain 'lived experience' impacts.

Step 5 – Have you identified any adverse impacts. You need to think about what can be done to mitigate or minimise the adverse impacts.

Step 6 – Send EQIA to Equality and Diversity Adviser for publication. NHS Ayrshire & Arran has an obligation to publish the results of all our equality impact assessments.

In 2018, the **Fairer Scotland Duty** became law and this looks at the impact of socio-economic disadvantage. NHS Ayrshire & Arran have incorporated this into our equality impact assessment process. It should be borne in mind that some minority groups, such as disabled people, ethnic minority people, women, are at a higher risk of facing socio-economic disadvantage and this should be considered when completing the equality impact assessment. This should be considered under each of the area in section 2 with a specific section at 2.16.

In March 2021, the Scottish Parliament unanimously passed the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill. This incorporates children's rights into law and places a duty on us as a public authority to ensure children's rights are protected and promoted in all areas of their life. NHS Ayrshire & Arran are building the **Children's Rights and Wellbeing Impact Assessment** into our existing EQIA process. This is woven through the document with a specific section at 2.17.

EQUALITY IMPACT ASSESSMENT

This is a legal document stating you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission

If you require advice on the completion of this EQIA, contact elaine.savory@aapct.scot.nhs.uk

'Policy' is used as a generic term covering policies, strategies, functions, service changes, guidance documents, other

Name of Policy	Risk Management Strategy		
Names and role of Review Team:	Risk Management Team	**Date(s) of assessment:**	17/04/2026

SECTION ONE AIMS OF THE POLICY

1.1. Is this a new or existing Policy : Existing

Please state which: **Policy** ☐ **Strategy** ☒ **Function** ☐ **Service Change** ☐ **Guidance** ☐ **Other** ☐

1.2 What is the scope of this EQIA?

NHS A&A wide ☒ **Service specific** ☐ **Discipline specific** ☐ **Other (please detail)** _____

1.3a. What is the aim?

Update of existing Risk Management Strategy.

1.3b. What is the objectives?

NHS Ayrshire & Arran believes that effective risk management will provide a safer environment and better care for patients and, will help the organisation to capitalise on opportunities and fulfil its corporate objectives in the short and longer term. The Board is committed to making risk management a core organisational process and ensuring that it becomes an integral part of our philosophy, practices and business planning and that responsibility for implementation is accepted at all levels of the organisation.

NHS Ayrshire & Arran acknowledges that providing health services is an inherently risky business and that risk can bring with it positive advantages, benefits and opportunities. The Board does not therefore aim to create a risk-free environment, but rather one in which risk is considered as a matter of course and appropriately identified and controlled.

We will ensure that risk management is embedded into NHS Ayrshire and Arran's vision and organisational culture; existing governance policies; and planning, reporting and decision-making structures at both the strategic and operational levels. We believe that organisations who integrate risk management have a greater likelihood of achieving strategic objectives and delivering services efficiently and effectively.

The Board also recognises the importance of involving local stakeholders in its risk management processes and of working in partnership to identify, prioritise and control shared risks.

1.3c. What is the intended outcomes?

Through implementation of the Strategy, the organisation intends to provide high quality and substantial patient safety benefits, including improved governance and performance in the short and long term and an environment that is safe for the staff it employs or contracts with to provide services.

1.4. Who are the stakeholders?
All staff in particular those responsible for managing risk at an operational and strategic level.

1.5. How have the stakeholders been involved in the development of this policy (this should include children and young people where appropriate)?
Consulted with Directors and Health and Social Care Partnership Directors, General Managers, Associate Medical Directors, Senior Nursing Managers and Clinical Nurse Managers, Head of Occupational Health & Safety.

1.6 Examination of Available Data and Consultation - Data could include: consultations, surveys, databases, focus groups, in-depth interviews, pilot projects, reviews of complaints made, user feedback, academic or professional publications, reports etc)

Engagement with stakeholders was undertaken through ongoing discussion at risk and governance forums regarding upcoming review and also virtually upon development of the strategy.

The following publications were reviewed in the development of this strategy:

- HIS National Framework for Reporting and Learning from Adverse Events (February 2025)
- HM Treasury Orange Book
- ISO 31000
- The Blueprint for Good Governance
- Scottish Public Finance Manual

Name any experts or relevant groups / bodies you should approach (or have approached) to explore their views on the issues.

Benchmarking with other risk management professionals in NHS Scotland.

What do we know from existing in-house quantitative and qualitative data, research, consultations, focus groups and analysis?

The Risk Management Strategy is an organisational requirement, and revision was required to bring the strategy in alignment with national guidance and best practice guidance. Through consultation, we know that the Strategy is in accordance with staff expectations, and we know from feedback from Governance Committees that the roles, responsibilities and reporting arrangements set out within the Strategy meet organisational requirements.

What do we know from existing external quantitative and qualitative data, research, consultations, focus groups and analysis?

The previous strategy referenced the Australia/New Zealand risk management standards which have been superseded by other publications that the organisation should align to.

1.7. What resource implications are linked to this policy?

There are no resource implications linked to the Risk Management Strategy out with the resource to raise awareness and ensure the strategy is implemented in accordance with the implementation plan.

SECTION TWO	IMPACT ASSESSMENT

Complete the following table, giving reasons or comments where:

The Programme could have a positive impact by contributing to the general duty by –

- Eliminating unlawful discrimination
- Promoting equal opportunities
- Promoting relations within the equality group

The Programme could have an adverse impact by disadvantaging any of the equality groups. Particular attention should be given to unlawful direct and indirect discrimination.

If any potential impact on any of these groups has been identified, please give details - including if impact is anticipated to be positive or negative.

If negative impacts are identified, the action plan template in Appendix C must be completed.

Equality Target Groups – please note, this could also refer to staff

	Positive impact	Adverse impact	Neutral impact	Reason or comment for impact rating
2.0 All			✓	Through implementation of the Risk Strategy, the organisation aims to deliver high-quality patient safety benefits, including improved governance and performance in both the short and long term, while ensuring a safe environment for staff and those contracted to provide services. The strategy establishes a framework for staff to identify and manage risks effectively. By setting clear governance and performance standards, it supports the delivery of consistently high-quality care for all patients, regardless of protected characteristics.

2.1. Age • **Infants, children and young people (IC&YP)** Any impact on IC&YP requires additional completion of section 2.17 below.			✓	See section 2.0 All
• Adults			✓	See section 2.0 All
• Older People (also consider impact on IC&YP such as kinship care)			✓	See section 2.0 All
2.2. Disability (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health)			✓	See section 2.0 All The impact of the strategy should have no differential impact on disability compared to other characteristics.
2.3. Gender Reassignment			✓	See section 2.0 All The impact of the strategy should have no differential impact on gender reassignment compared to other characteristics.
2.4 Marriage and Civil partnership			✓	See section 2.0 All The impact of the strategy should have no differential impact on marital or civil partnership status compared to other characteristics.

2.5 Pregnancy and Maternity			✓	See section 2.0 All The impact of the strategy should have no differential impact on pregnancy and maternity status compared to other characteristics. Any risk related to patients or staff who are pregnant should be considered and addressed.
2.6 Race/Ethnicity			✓	See section 2.0 All The impact of the strategy should have no differential impact on race or ethnicity compared to other characteristics. Where language is a barrier to communication, existing organistional processes will be implemented to ensure clear communication between clinician and patient, thus reducing any risk of miscommunication.
2.7 Religion/Faith			✓	See section 2.0 All The impact of the strategy should have no differential impact on religion or faith status compared to other characteristics.
2.8 Sex (male/female)			✓	See section 2.0 All The impact of the strategy should have no differential impact on sex compared to other characteristics.
2.9 Sexual Orientation • Lesbians • Gay men • Bisexuals			✓	See section 2.0 All The impact of the strategy should have no differential impact on sexual orientation compared to other characteristics.
2.10 Carers including young carers			✓	See section 2.0 All The impact of the strategy should have no differential impact on carers compared to other characteristics.

2.11 Homeless			✓	See section 2.0 All The impact of the strategy should have no differential impact on homeless individuals compared to other characteristics.
2.12 Involved in criminal justice system including youth justice			✓	See section 2.0 All The impact of the strategy should have no differential impact on those involved in the criminal justice system compared to other characteristics. The strategy sets out a process within which staff can identify and manage any risk.
2.13 Literacy			✓	See section 2.0 All The impact of the strategy should have no differential impact on literacy compared to other characteristics. Where staff have literacy concerns, alternative ways of communicating this will be implemented.
2.14 Rural Areas			✓	See section 2.0 All The impact of the strategy should have no differential impact on staff working or patients living in rural areas compared to other characteristics.
2.15 Staff • Working conditions • Knowledge, skills and learning required • Location • Any other relevant factors	✓		✓ ✓ ✓	The Risk Management Strategy sets out a process within which staff can identify and manage risk.

2.16. What is the socio-economic impact of this policy / service change? (The Fairer Scotland Duty places responsibility on Health Boards to actively consider how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions)				
	Positive	**Adverse**	**Neutral**	**Rationale/Evidence**
Low income / poverty			✓	The risk strategy will have no differential impact on the socio-economic status of staff or patients.
Living in deprived areas			✓	
Living in deprived communities of interest			✓	
Employment (paid or unpaid)			✓	

2.17. What is the impact of this policy / service change on infants, children and young people (IC&YP)? (The United Nations Convention on the Rights of the Child (UNCRC) places a compatibility duty on public authorities to ensure the rights of children are protected and promoted in all areas of their life).				
	Yes	**No**	**Not applicable**	**Rationale/Evidence**
Will this policy impact on the best interests of IC&YP?			✓	Through implementation of the Risk Management Strategy, the organisation intends to provide high quality and substantial patient safety benefits, including improved governance and performance in the short and long term and an environment that is safe for the staff it employs or contracts with to provide services.
Will this policy impact on the developmental needs of the IC&YP?			✓	

Will this policy impact on IC&YP being able to express their views in relation to the service and have that view taken into account?			✓	The Strategy sets out a process within which staff can identify and manage risk. The provision of clear governance and performance standards should ultimately improve care for all patients regardless of protected characteristic.
Will the policy have any direct or indirect impacts on IC&YP?			✓	
Have you considered the impact of the policy across the wide range of IC&YP, e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?			✓	

SECTION THREE CROSSCUTTING ISSUES				
What impact will the proposal have on lifestyles? For example, will the changes affect:				
	Positive impact	**Adverse impact**	**No impact**	**Reason or comment for impact rating**
3.1 Diet and nutrition?			✓	The risk strategy will have no differential impact on diet and nutrition.

3.2 Exercise and physical activity?			✓	The risk strategy will have no differential impact on exercise and physiclal activity.
3.3 Substance use: tobacco, alcohol or drugs?			✓	The risk strategy will have no differential impact on substance use.
3.4 Risk taking behaviour?	✓			The Risk Management Strategy does not encourage risk-taking or risk-aversion, but rather, effective risk management based on nationally agreed standards and guidance.

SECTION FOUR	**CROSSCUTTING ISSUES**			
Will the proposal have an impact on the physical environment? For example, will there be impacts on:				
	Positive impact	**Adverse impact**	**No impact**	**Reason or comment for impact rating**
4.1 Living conditions?			✓	The risk strategy will have no differential impact on living conditions.
4.2 Working conditions?	✓			The Risk Management Strategy supports an environment that is safe for the staff it employs or contracts with to provide services.
4.3 Pollution or climate change?	✓			The Strategy encourages the identification and management of all kinds of risk including environmental factors and highlights the organisation's Corporate Social Responsibility in this respect.
Will the proposal affect access to and experience of services? For example:				
	Positive impact	**Adverse impact**	**No impact**	**Reason or comment for impact rating**

Health care	✓			The Risk Management Strategy supports all aspects and areas of service delivery. The Strategy promotes quality improvement based on risk management methodologies; “Maximising opportunity whilst managing potential adverse events”
Social Services			✓	There is no impact on social services of the NHS risk management strategy.
Education			✓	There is no impact on education services of the NHS risk management strategy.
Transport			✓	There is no impact on transport services of the NHS risk management strategy.
Housing			✓	There is no impact on housing services of the NHS risk management strategy.

SECTION FIVE MONITORING

How will the outcomes be monitored?

The outcome of this document is to ensure that there is a formalised, clearly understandable, equitable and transparent process that allows the robust identification, assessment, management and review risks at operational and strategic levels. Regular review and reporting on risks will be shared on a quarterly basis with Directorates for consideration via local governance structures.

What monitoring arrangements are in place?

Quarterly reporting and assurance provided via Risk and Resilience Scrutiny and Assurance Group (RARSAG) and the aligned committees of the Board. Monthly monitoring of risks is also being introduced at Corporate Management Team meetings.

Who will monitor?

Members of Risk and Resilience Scrutiny and Assurance Group (RARSAG) and the Corporate Management Team

What criteria will you use to measure progress towards the outcomes?

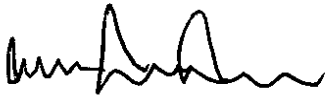
Key Performance Indicators relating to:

- timely review of risks in accordance with their evaluation
- implementation of further mitigations in relation to risks being treated
- action being taken to bring risks within appetite levels

PUBLICATION

Public bodies covered by equalities legislation must be able to show that they have paid due regard to meeting the Public Sector Equality Duty (PSED). This should be set out clearly and accessibly and signed off by an appropriate member of the organisation.

Once completed, send this completed EQIA to the **Equality & Inclusion Manager**

Authorised by	Dr Crawford McGuffie	**Title**	Executive Medical Director
Signature		**Date**	12th June 2026

Identified Negative Impact Assessment Action Plan

Name of EQIA:	

Date	**Issue**	**Action Required**	**Lead (Name, title, and contact details)**	**Timescale**	**Resource Implications**	**Comments**

Further Notes:

Signed: Date:

Appendix 3

Risk Management Strategy Implementation Plan

	Objective	Action	Action owner
1.	Ensure the Board has clear sight of the organisation's most significant risks and the effectiveness of controls	Review reporting mechanism to the committees of the Board and the Board to ensure presentation of a clear, concise and dynamic Strategic Risk Register	Risk Manager
		Undertake education and awareness to improve risk content – particularly around key controls and impact of key controls and the future ambition of the risk	Risk Manager
2.	Clarify and strengthen risk ownership, escalation and accountability across all levels of the organisation.	Ensure risk managers and risk owners review and update risks in accordance with the Risk Management Strategy	Risk Team Lead
		Further embed the risk escalation and de-escalation process detailed in the NHSAA Risk Register User Guide	Risk Team Lead
3.	Build risk management capability across the organisation, proportionate to role and responsibility.	Undertake Risk Management Training for new risk managers	Risk Team Lead
		Provide ongoing risk management support workshops for existing risk managers to ensure all staff are aware of and adhering to the current Risk Management Strategy	Risk Team Lead
4.	Continual improvement and development of effective training and support for colleagues in relation to risk management activities, through a Human Factors approach	Review risk management training to include Risk Appetite application.	Risk Manager
		Undertake awareness sessions to implement the revised Risk Matrix	Risk Team Lead
		Review Significant Adverse Event training to focus on a Human Factors approach to reviews as described in HIS National Framework for	Risk Team Lead

	Objective	Action	Action owner
		Reporting and Learning from Adverse Events.	
5.	Ensure that the risk appetite statement is embedded in risk management activities and clearly demonstrates application against the risk domains	Review the Risk Management System to ensure the revised Risk Appetite Statement is recorded and reportable	Risk Team Lead
		Revise risk reports to ensure performance against the Risk Appetite Statement is measured and appropriately escalated where necessary	Risk Manager
6.	Continue to minimise the likelihood of adverse events, risks and complaints through effective risk identification, prioritisation, treatment and monitoring, to ensure integrated linage between risk and resilience to encompass learning	Deliver Risk Management Awareness sessions to ensure staff are appropriately equipped to undertake the risk management process	Risk Team Lead
		Develop closer linkage between risk, adverse events and resilience through collaboration and review of the functionality of the Risk Management System.	Risk Manager/Head of Resilience