STANDARD OPERATIONAL POLICY AND PROCEDURES

TOPIC	Risk Management – SOPP 74.01		
RESPONSIBILITY	All Areas		
AUTHORISATION	Director Development & Improvement		
SIGNED		**DATE**	31/10/2018
VERSION	2.1	**LAST REVIEWED**	August 2018
EFFECTIVE	November 2002	**NEXT REVIEW**	August 2021

1. PURPOSE

East Grampians Health Service (EGHS) recognises that effective risk management is an integral component of the delivery of safe and quality services and facilities for all stakeholders.

1.1 Organisation's Commitment to Risk Management

Annually EGHS provides resources for the management and mitigation of its strategic, financial, operational, clinical, cyber and communication risks. Sound governance processes have been established to enable the Board and Executive to minimise risks in the delivery of services and optimise available resources.

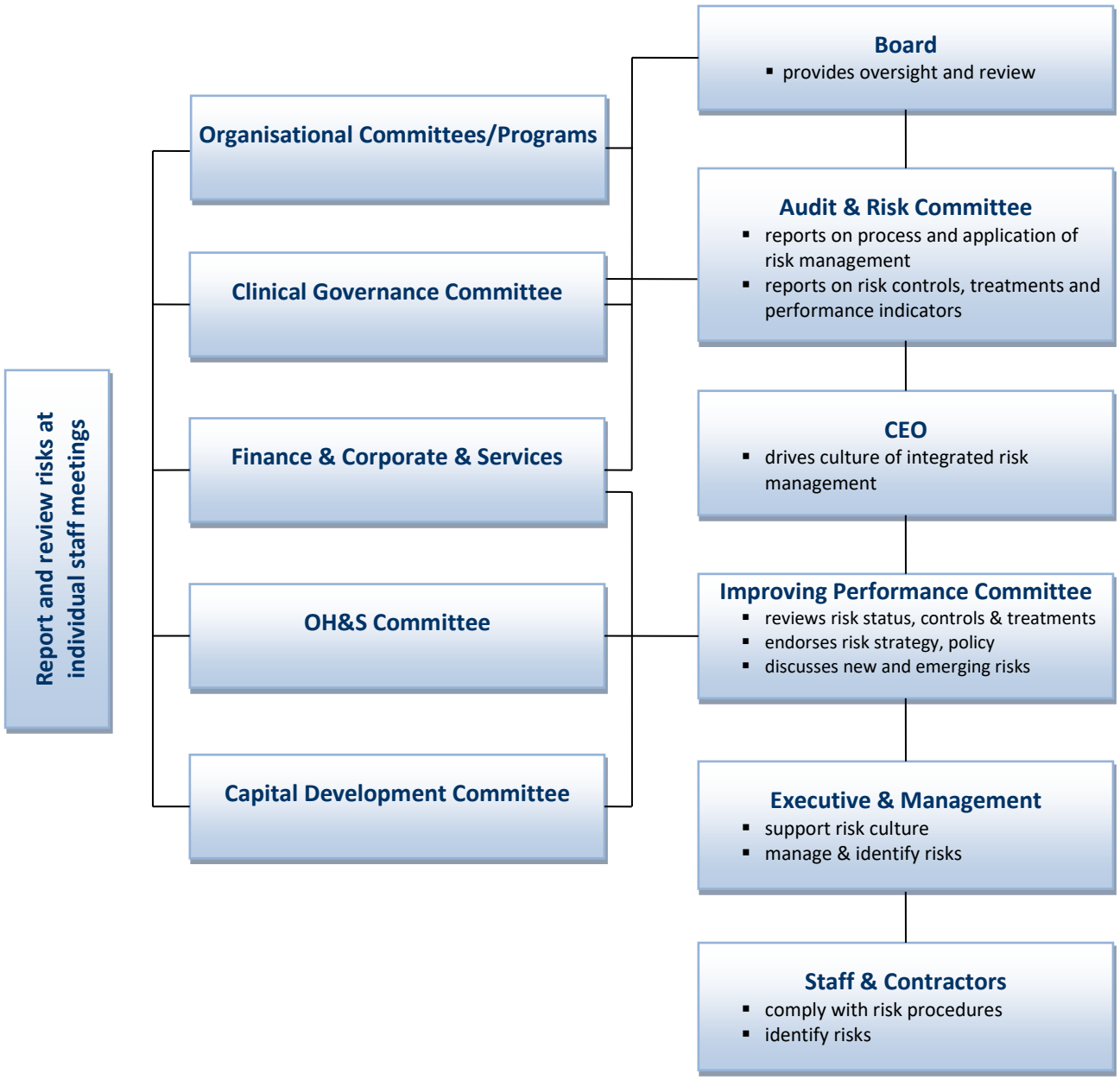
The EGHS Risk Management Framework provides for a minimum risk management standard across the organisation. An attestation by the Board Chair and the Chief Executive Officer in the annual report ensures that this requirement is built into annual planning and reporting processes.

EGHS sets strategic objectives which support the organisations future direction. These objectives and associated policies, guidelines and actions are assessed for the management of risk with a view to minimising adverse events and maximising opportunities within the accepted risk tolerance for each defined activity.

The Board and Executive define the level of risk tolerance based on best available information including the context in which the service operates.

1.2 Governance Framework

Set out below is the EGHS risk management governance structure. This structure illustrates that risk management is not the sole responsibility of one individual, but rather occurs and is supported at all organisational levels.



1.3 Roles and Responsibilities

Roles of those involved in the risk governance structure.

Board

- EGHS Board review the strategic risks of the organisation monthly and the high priority risks quarterly through the Audit & Risk committee.
- EGHS Board set the Risk appetite and tolerance to pursuing strategic objectives.

Clinical Governance Committee

- This Committee is responsible for the review of EGHS processes and structures for the management of clinical risk.

Improving Performance Committee

- The Improving Performance Committee is responsible for the reviewing and monitoring of risk. This group, through the CEO, reports to the Board on current new and emerging issues including strength of controls to mitigate risk.

Chief Executive Officer

- The CEO is responsible for the governance of all risk procedures for EGHS.

Audit & Risk Committee

- This committee is responsible for review of the EGHS processes and structures for the management of risk. This committee reports to the Board regarding the degree of appropriateness and satisfaction with the functioning of risk management procedures.

Director of Development and Improvement

- This role is responsible for the implementation, review, auditing and reporting of risk throughout the organisation. The Director of Development and Improvement provides education for staff in systems for the management of risk.

Managers

- Managers are responsible and accountable for the management of risk in line with their delegation of authority. They are required to report, discuss and document risk and any treatments applied. They are responsible for the management of their staff in relation to risk identification and control. They are also responsible for the escalation of risk as described through the risk assessment process.

Staff and Contractors

- All staff and contractors are responsible for their safe work practice and the identification and management of risk in their environment. They are required to be familiar with and practice risk reporting.

1.4 Context

EGHS must review its internal and external context on an annual basis. This will be a task of the Improving Performance Committee and key stakeholders. It will be reported to the Board annually when it reviews the strategic plan.

1.5 Conflict

In setting of EGHS objectives, plans, actions and the associated assessment of risk and the defining of risk tolerance, conflict may occur. This conflict will be referred to the CEO who will provide mediation between the parties. Advice will be sought and decisions made either by the conflicting parties or the CEO in accordance with EGHS governance policies.

1.6 Resourcing

Where EGHS strategic objectives and action plans have been risk assessed and approved, appropriate resources will be made available (controls) to mitigate risks. These controls will be reviewed at a minimum of 12 monthly.

2. POLICY OUTCOMES

- The risk management system will assist EGHS achieve efficient, effective and safe operations, protecting all persons, assets, information, reputation and property.
- Risks are identified, assessed and prioritised within recognised areas.
- Responsibility for review of strategic risks is undertaken by the Improving Performance Committee who then generate monitoring and rating reports for the Board via the Board subcommittee.
- Maintenance of comprehensive and current policies and protocols are recognised as part of the risk management system.

- Activities for the monitoring and evaluation of risk in all areas are undertaken.
- Identified risk areas are registered on the strategic risk register with risk controls/mitigating practices and treatment/plans documented to eliminate or minimise risk. Risks are reviewed on a regular basis.
- Operational risk reporting and monitoring is maintained as detailed in the risk management framework.
- Staff are encouraged to actively participate in the reporting of risks, and monitor, where necessary, appropriate controls and mitigation risk.
- Staff will receive information and education related to Risk Management at orientation and at least annually.
- The Risk Management System will demonstrate compliance with legislation, regulations, government recommendations and all accreditation standards

3. PROTOCOLS

3.1 Risk Identification

Risk identification is the process used to identify all possible situations within EGHS where people may be exposed to injury, illness or disease or the organisation is exposed to loss of assets, information, reputation or property.

With respect to patients/residents/clients, risk identification is used to identify all possible situations where they may be exposed to additional or unexpected injury, illness or disease.

Risks are identified through relevant industry literature and information, such as clinical risk management reporting, sentinel event and quality and safety reports and by reporting and monitoring systems and audit results. EGHS has developed and implemented tools which identify and determine risk: incident reports, compliments and concerns forms, patient/client/carer surveys, manual handling risk assessments, patient assessments, internal audit program and external financial audits.

All staff are encouraged to routinely assess activities to identify actual and potential risks.

3.2 Risk Analysis

Risk analysis is the process used to determine the likelihood and consequence of a risk occurring.

Using the risk analysis matrix adapted for EGHS context, each risk will be individually assessed to determine the risk rating and priority for action.

The Improving Performance Committee will review risk reports and monitor ratings monthly as indicated from both strategic and operational risk registers.

3.3 Risk Evaluation

The purpose of risk evaluation is to determine which risks need treatment and the priority for treatment implementation.

3.4 Risk Treatment

Risk treatment involves selecting one or more options for modifying risk and implementing those options leading to risk control once implemented.

Risk control/mitigating factors are documented on the risk register and rated for effectiveness

Risk treatment plan/resource requirements are documented and monitored, and reassessed by the Improving Performance Committee periodically.

3.5 Risk Register Review

Managers and risk owners have responsibility for reviewing risks and the status of their controls at a minimum of annually.

3.6 Risk Reporting

Risks will be reported to the Board of Management annually, to the Board Clinical Governance and Audit & Risk committee quarterly and other relevant committees such as the Finance and OH&S committees six monthly.

Reports will detail strength of controls, effectiveness of controls, performance indicators, trends and emerging risks.

3.7 Risk Communication

The risk framework, policy and procedure will be communicated to the Board and executive via the annual review process and educational opportunities by the attendance of the Director of Development and Improvement at organisational committees.

3.8 Risk Appetite

The risk appetite statement is defined as the amount and type of risk an organisation is willing to accept in pursuit of its long term goals or business objectives. This statement is provided and endorsed by the Board.

3.9 Risk Tolerance

Risk tolerance is the organisations readiness to bear the risk after treatment in order to achieve objectives. Risk tolerances are based on the maximum level of acceptable risk and it may be expressed in various ways depending on the nature of the risk.

3.10 Risk Attestation

Risk attestation is the declaration by the organisation that adequate risk management processes are in place. Attestation is provided in the organisation's annual report.

4. REFERENCES

Risk Management Principles and Guidelines AS/NZS ISO 31000:2018-02

Victorian Government Risk Management Framework; June 2016

National Safety and Quality Health Service Standards – Standard One

5. RELATED DOCUMENTS

Risk Management Strategy-Framework

Risk Management Procedure

Risk Management and Continuous Improvement Plan