Quality and risk management are complementary and together, are key components of healthcare governance. Effective risk management underpins healthcare quality management activity.”
Risk Management is about being aware of the potential of things that can adversely affect your service (risks) and putting in place actions (controls) to make sure that the likelihood of them occurring is reduced in so far as is reasonably practicable. Health services are inherently risky: their core activities involve a response to unpredictable events where the potential for harm is high. Healthcare providers’ sensitivity to operations, together with anticipation and preparedness enables them to reliably manage risks in the interests of both service users and staff (Vincent et al., 2013). The HSE launched an updated Integrated Risk Management Policy in March 2017c, outlining the policy of the HSE to manage risk on an integrated basis. All services manage risk by proactively identifying risks that threaten the achievement of objectives, e.g. the delivery of high quality safe care, compliance with legal and regulatory requirements and to putting in place actions to reduce these to an acceptable level. Risks can be identified as either strategic or operational.

Assurance processes are sometimes considered to be at odds with quality improvement. In practice processes such as risk management, compliance reporting, scrutiny and inspection are integral to improvement and provide learning and pointers to opportunities for improvement.

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When people say, ‘quality and safety’, what I hear is ‘fruit and bananas’. Quality improvement is the big tent. It’s the enterprise of constant improvement to everything we care about. The quality of my car is dimensional. It has safety, durability and fuel economy and so does healthcare. I think reuniting our endeavours is crucial to our future. We don’t have the resources to waste on tribalism. We have to think systematically. (Berwick, 2017)

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**Board Assurance**

Boards of healthcare providers oversee proactive risk management by ensuring the following is in place:

- **Quality and Safety Plan:** A comprehensive quality and safety plan is in place which includes risk management.
- **Board Committee:** A board quality and safety committee is in place with terms of reference (that includes risk) which meets regularly and provides assurance to the board.
- **Risk Register:** The board reviews and monitors the services risk register, ensuring appropriate action is taken to mitigate risks.
- **Standards / reviews:** The board has a mechanism in place to monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. HIQA, HSE Audit, Health and Safety Authority and ensure there is a plan in place to address compliance.
- **Audit Plan:** The board informs and monitors the annual audit plan.
- **Report Analysis:** The Board critically analyses reports received from the Executive Management Team in respect of risk management, serious reportable events and incident management.
- **Strategy:** The board has assessed its strategic objectives and identified the following:
  - Risks to delivering strategic objectives and controls in place to support delivery
  - Sources of assurance and deficits in control
  - Obtaining assurance on action plans for mitigating risks to board strategy
Risk and Incident Management

Effective governance for quality and safety structures ensure that there are clear lines of accountability for risk and incident management and that all staff are aware of their responsibilities and accountability. The management of incidents is an executive responsibility, the board has a key role in providing support and oversight. The board seeks assurance that the structures and processes for incident management are working effectively; thereby caring for the needs of those harmed, obtaining understanding of what went wrong and ensuring that lessons learned are implemented and shared (see Table 6). The HSE Incident Management Framework (2017) provides comprehensive guidance and resources.

Table 6: Principles for Incident Management

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Centred</td>
<td>The needs of persons affected (service users and staff) are considered of primary importance and required supports are put in place from the outset and throughout any review process required.</td>
</tr>
<tr>
<td>Fair and Just</td>
<td>That all staff are treated in a manner which is respectful and supports them to recognise, report and learn from incidents. Where issues of individual accountability are identified that the service responds to these in a manner which is proportionate and safety focused.</td>
</tr>
<tr>
<td>Openness and Transparency</td>
<td>That all persons affected by an incident are aware of the incident and the steps to be taken to learn from it.</td>
</tr>
<tr>
<td>Responsive</td>
<td>That the actions taken following the identification of an incident are taken in a timely and proportionate manner.</td>
</tr>
<tr>
<td>Improvement Focused</td>
<td>That incidents occurring are viewed by the service as an opportunity to improve.</td>
</tr>
<tr>
<td>Learning</td>
<td>That the incident management system is focused on learning both locally and within the wider service.</td>
</tr>
</tbody>
</table>

Source: adapted from HSE (2017d)

Boards have a key role in creating a climate of “psychological safety” which is founded on respectful interactions by everyone and disrespectful behaviour is rapidly and consistently addressed. People feel confident that others will respond positively when they ask a question, seek feedback, admit a mistake, or propose an idea (Institute for Healthcare Improvement, 2017). Board actions, consistent with a just culture focus on staff knowing that they will not be punished for human errors in unsafe systems.

Another element of risk management relates to reputational risk. It is vital for healthcare boards to maintain the trust of the communities they serve. Concerns arising from a serious incident or poor professional standards can result in a breakdown in public confidence and can be demoralising for staff. Very often, it is how the incident is handled by the organisation and its leaders, including the board that maintains the public’s trust. In order to manage and maintain public confidence at a time of crisis it is important for boards to have a communication plan in place for when the need arises (Totten et al., 2011).
Board Considerations - Risk Management and Assurance

- Does our board take time to discuss and anticipate the healthcare provider’s risks to service delivery?
- Has our board identified ways of seeking assurance on the quality and safety of services provided?
- Has our board considered the risks to delivering the healthcare providers plan for improving quality?
- Does our board have a communication plan in place for responding to a serious incident with public attention?
- Does our board have a clearly defined role in supporting the executive in responding effectively to a serious incident?