Risk Management Strategy
2017 - 2020

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HRSSSTR002
NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET

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Author: Clinical Governance & Risk Lead
Executive Lead: Director of HR & Support Services

Proposed groups to present document to:
- Risk Management Group (RMG)
- Joint Governance Group (JGG)
- Strategy and Redesign Committee (SRC)
- Board
- Area Clinical Forum (ACF) and Area Partnership Forum (APF)
- Health & Safety Committee

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Examples of reasons for presenting to the group

Examples of outcomes following meeting

| Professional input required re: content (PI) | Significant changes to content required – refer to Executive Lead for guidance (SC) |
| Professional opinion on content (PO)       | To amend content & re-submit to group (AC&R) |
| General comments/suggestions (C/S)         | For minor revisions (e.g., format/layout) – no need to re-submit to group (MR) |
| For information only (FIO)                 | Recommend proceeding to next stage (PRO) |

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February 2018

Minor update to reporting arrangements due to the dissolution of the strategy and redesign committee

Risk management objectives and KPIs reviewed and updated
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Executive Summary

'Risk' is ever present in relation to people, the environment and systems of work. The management of risk plays a pivotal role in developing the effectiveness of the organisation and has a critical impact on the delivery of Shetland NHS Board’s (the Board’s) strategic objectives.

Risk Management is a process for managing exposure to risk that enables us to recognise the situations and events that may result in unfortunate or damaging consequences, their severity, and how they can be controlled.

This is a three-year strategy, building on previous work, to continue to develop and strengthen the Board’s risk management capability, in order that the risks to which the Board, its staff and service users are exposed can be actively and systematically managed.

The Board acknowledges that commitment from senior managers is necessary if this strategy is to achieve its objectives, and in so doing have endorsed an approach which aims to promote responsible risk-taking within “a fair and just system where people are held to account for their behaviour, without being unduly blamed”1.

The Board retains responsibility for the management of risk in its entirety. The Board delegates the development and detailed work associated with its implementation to the Risk Management Group (RMG) which reports to the Board and other groups as outlined in the organisational chart (Appendix A).

1. Introduction

Risk Management is an essential feature of a modern healthcare organisation. Although a risk free environment is impossible, much can be done to minimise risk by having comprehensive policies and procedures that cover and permeate all areas of Board activities.

The aim of this strategy is:

- To minimise risk and, in particular, the risk of harm to patients
- To create a culture of continuous improvement
- To enable a positive approach to risk management
- To develop and promote policies and procedures that support practitioners and managers in risk decisions
- To provide an educational framework that encourages the sharing of knowledge relating to both risk assessment and risk management

The Board is committed to ensuring that Risk Management forms an integral part of its philosophy, practices and business plans and that the responsibility for implementation is accepted at all levels within the organisation. This strategy covers all care provided by NHS Shetland, including NHS services provided on behalf of the Integration Joint Board or jointly with Shetland Islands Council (SIC) including:

- Acute care and managed community services
- Primary care (GP practices, dental practices, community pharmacies and optometrists)

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1 HSE (2004), p. 16
• Social care
• Employees and independent contractors,

and relates to
• Clinical and non-clinical risk (including information governance, PREVENT concerns, health and safety at work, adverse publicity and finance)

Occasionally, despite our best efforts, things can go wrong. It is important to remember, however, that risk management is not about apportioning blame, but about creating an environment that is open, just and informed, in which reporting and learning from error is the norm.

Organisations should be striving to embed a positive safety culture. Those that manage risk effectively and efficiently are more likely to achieve safe and effective care. The underpinning principle of this strategy is that a positive risk management culture is developed within the Board that empowers all staff to make sound judgements and decisions concerning the management of risk and risk taking.

The principles and strategy for action are consistent with and integral to the following corporate objectives:

- To continue to improve and protect the health of the people of Shetland
- To provide quality, effective and safe services, delivered in the most appropriate setting for the patient
- To redesign services where appropriate, in partnership, to ensure a modern sustainable local health service
- To provide best value for resources and deliver financial balance.

2. Risk Management Definitions

Risk is the chance of something happening that will have an impact on objectives. A risk is often specified in terms of an event or circumstance and the consequences that may flow from it. Risk is measured in terms of the combination of the consequences of an event and their likelihood. Risk may have a positive or negative impact\(^2\).

Risk Management is the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects\(^3\) and incorporates all the activities required to identify and control exposure to risk.

Risk management proactively reduces identified risks to an acceptable level by creating a culture founded upon assessment and prevention, rather than reaction and remedy. It plays a vital role supporting and informing decision-making in providing a safe and secure environment for patients, carers and staff. Furthermore, as an integral component of the Statement on Internal Control, it is a mandatory requirement that NHS Boards have systems in place to manage risk.

\(^2\) AZ/NZS 4360: 2004; 1.3.13
\(^3\) ibid. 1.3.20
3. Risk Management Strategic Objectives

To monitor the effectiveness of the Risk Management processes and policies the following strategic objectives have been set which are reviewed annually via the Risk Management Group (RMG) to ensure that they remain valid and up-to-date. They also form the basis of the annual Risk Management Work Plan, which is drawn up by the Clinical Governance and Risk Team and monitored by the RMG on behalf of the Board:-

- Embedding risk management at all levels of the organisation – creating a safety culture
  - Greater ownership of risks at a local level
  - Enhance the use of risk registers at Departmental and Directorate level
  - Dynamic risk registers are held within all departments covering key risks
  - Undertake review of Datix functionality with view to enhance reporting of risk, analysis of reporting trends and culture
  - Working towards more aligned risk management systems for health and social care

- Leading and supporting staff and promoting reporting
  - Implementation of the Duty of Candour (DoC) regulations
  - Utilise both formal and informal opportunities with staff for teaching
  - Monitor adverse event reporting patterns to identify areas/groups of staff who may not be reporting and investigate whether reporting patterns are reflective of risk activity

- Ensuring there is appropriate provision of training
  - Delivery of Department/Directorate specific training to enhance the use of Datix functionality
  - Delivery of investigation skills training and management bundles on adverse events and risk

The following Key Performance Indicator’s (KPIs) are also being put in place:

- Measures defined in the Learning from Adverse Events Through Reporting and Review are reported in the adverse event quarterly report
- The implementation of the DoC regulations is monitored via the quarterly adverse event report and submission of an annual report to Scottish Government
- Evidence of shared learning from adverse events through newsletters, departmental feedback, etc
- The risk management workplan is reviewed by the RMG at each meeting

4. Risk Appetite and Opportunity

The NHS Shetland’s risk appetite is described in the risk appetite statement below, defined via the scoring matrix (Appendix C) and is supported through the risk management procedures. The statement has been adapted from the SIC’s Risk Management Policy with their prior agreement.

**Risk Appetite Statement**

To deliver its objectives NHS Shetland supports well managed risk taking and recognises the need to be risk aware, not risk averse. Appetite for risk will vary across service areas.
However, if we are to be successful, avoiding all types of risks is not realistic and is not an effective use of limited resources.

While NHS Shetland does everything in its power to prevent harm to an individual, and wants to limit its exposure to health & safety, environmental, reputational, legal, financial and regulatory and compliance risks, it recognises that some level of risk is necessary in pursuit of better outcomes for the community and service users. NHS Shetland embraces the idea that opportunities can be positive risks in that their outcomes may be uncertain, but there could be the potential for, or likelihood of, worthwhile outcomes.

When considering whether or not a risk is being managed appropriately, the following should be considered:

- The potential benefits from accepting the risk as it is;
- The views of key stakeholders;
- The possible costs (including opportunity costs) of taking action to manage the risk;
- The risk rating (likelihood and severity of the risk) as scored using the risk assessment tool/scoring matrix;
- NHS Shetland’s capability to manage the risk effectively, e.g. does effective management of the risk sit outside core competencies or is NHS Shetland getting involved in activities it has little track record in delivering?

When considering any risk, account must be taken of:

- If accepting the risk or taking an action would breach any NHS Shetland policy or procedure;
- If the risk represents a breach of any relevant laws or regulations;
- At what level NHS Shetland’s scheme of delegated authority allows the risk to be managed.

Opportunity

NHS Shetland seeks to exploit opportunities within areas of its core competencies. Risks to successfully exploiting an opportunity should be identified and recorded in the same way as risks to other objectives, and appropriate control measures recorded and actioned as appropriate. This paragraph on opportunity has been adapted from the SIC’s Risk Management Policy with their prior agreement.

5. Roles and Responsibilities

NHS Shetland Board

The Board is ultimately responsible for managing risk. Board members have a corporate responsibility for the management of risk and each member must be aware of their obligations to promote this and protect the public from risk in the normal course of events within local NHS provision. The RMG receives a report detailing corporate risks and controls at every meeting. An updated Corporate Risk Register Summary Report is presented to the Board on a 6 monthly basis and the Board receives an annual report on risk management.
A 6 monthly summary of the corporate risks is provided to the relevant committees and reports by exception. Committees report any exceptions to the Board as and when required via the Committee update.

The Risk Management Group (RMG)
The RMG is a senior management group, chaired by the Director of Human Resources and Support Services. It has overall responsibility for the integration, co-ordination and standardisation of risk management throughout the Board. It provides assurance to the Board on the establishment and implementation of risk management processes and systems. It oversees the identification and monitoring of corporate risks, including maintenance of the Corporate Risk Register, and deals with significant and escalating risks, reporting formally to the relevant Committees and to the Board.

The Risk Management Strategy is reviewed triennially by the RMG before being submitted to the Board for approval. Additionally, on behalf of the Board, the RMG monitors the Risk Management Work Plan, which includes KPIs.

The role, remit and terms of reference of the RMG are set out in Appendix B.

The Clinical Care and Professional Governance Committee (CCPGC)
The CCPGC is a statutory Committee required to be established by the Board of Directors of a health body to provide assurance to the Board that appropriate clinical governance mechanisms are in place and effective throughout the organisation. It is recognised as a formal sub-committee of Shetland NHS Board i.e. the CCPGC will fulfil the assurance role with regard to the clinical governance arrangements of all the health services delivered or purchased by the Health Board as required by statute including health services directed by the Integration Joint Board (IJB) established to implement the requirements of the Public Sector (Joint Working) (Scotland) Act 2014.

The CCPGC is required to ensure that an appropriate approach is in place to deal with clinical risk management (including patient safety) across the system, working within the overall NHS Shetland Risk Management Strategy. In order to review performance in the management of clinical risk, CCPGC receives a quarterly Adverse Event Report.

The Audit Committee
The Audit Committee is a standing committee of the Board and its purpose is to provide assurance to the Board, based on evidence gained from review, on the adequacy, efficiency and effectiveness of NHS Shetland’s governance, risk management and internal control framework.

The Joint Governance Group (JGG)
The JGG has been established to oversee and support the implementation of clinical, care and professional governance throughout NHS Shetland and jointly managed services with the Local Authority. The JGG works closely with the RMG on risk management issues.

The JGG co-ordinates clinical governance activity, although actions are expected to be carried out and reported back to the JGG from professional groups and team meetings. It
contributes to the risk management requirements of the Health Board and Jointly Managed Services (the Health Board and the Council) by acting as the risk and adverse event management monitoring group. It conducts regular reviews of adverse event and risk data as it applies to clinical and care governance and clinical risk and oversight of relevant business.

The Health and Safety Committee

The role of the Health and Safety Committee is to support the Board in developing, promoting, monitoring and amending the organisation’s health and safety management systems. The Committee’s role is primarily to advice and review, identify areas where health and safety advice is needed as well as non-conformances in working conditions or practices. This is achieved through review of the audit of the departmental H&S Control Books and discussion with managers, supervisors and staff.

The Health and Safety Committee is chaired by the Director of Human Resources and Support Services. The Vice-chair is elected by the safety representatives and is, therefore, a nominated, accredited trade union representative. The Committee reports to the Staff Governance Committee (SGC) submitting committee minutes and, on behalf of the Health and Safety Committee, the Health and Safety Manager contributes written quarterly updates on progress made in managing identified Health and Safety issues as well as preparing an Annual Report.


The organisational chart (Appendix A) shows a number of other committees and groups that play a key role in contributing to effective risk management across the Board. Further information about these can be found on the intranet.

The Chief Executive

The Chief Executive, as Accountable Officer, has, on behalf of the Board, responsibility for maintaining a sound system of internal control. This requires the organisation to have in place the necessary controls to manage its risk exposure. The Chief Executive and the Board require evidence that the Risk Management Strategy is being actively implemented, that systems/procedures are being regularly reviewed and that, where required, developments and improvements are being made. The reporting process that enables this to happen is illustrated in Appendix A.

The Director of Human Resources and Support Services (DHR&SS)

The Director of Human Resources and Support Services (who chairs RMG) has the lead responsibility for risk management at Executive Management Team level. The DHR&SS leads the development, agreement and maintenance of the risk management reporting system including adverse event reporting, risk register review and performance against corporate objectives. The Board’s safety and risk management system is operated on a day-to-day basis by the Clinical Governance and Risk Team, part of the Directorate of Human Resources and Support Services.
The Community Health and Social Care Directorate

NHS Shetland and Shetland Islands Council (SIC) have identified a core set of risks that relate to health and social care services for delegated integration functions. The Community Health and Social Care Risk Register ensures active management of risks, mitigation of negative impacts and promotion of positive risk taking. All Directorate risks, which provides a high level overview of service areas risks, have been reviewed by the Operational Management Group. The Director of Community Health and Social Care is a member of the RMG. A report summarising these high level risks that could impact upon the Services of the delegated functions under Community Health and Social Care is presented to the IJB on a quarterly basis.

In addition, the IJB have identified a core set of risks that relate to their responsibility for directing the integrated functions. They receive a quarterly report summarising the high level risks that affect the IJB which ensures that appropriate controls are considered and put in place.

The Clinical Risk Advisory Team (CRAT)

The CRAT is a tactical team which is established to carry operational responsibility for managing clinical risk and poor performance (moderate/high risk rating), which includes instigating and overseeing the appropriate course of action for suspected poor performance and for significant or potentially significant clinical adverse events, including co-ordinating adverse event management and organisational learning. A more detailed description of the core functions of the CRAT can be found in the Procedure for Managing Significant Adverse Events and the Role of the Clinical Risk Advisory Team (CRAT) (http://intranet/corporate/risk/documents/CRATProcedureMarch2017.pdf).

Responsibility of Employees

The management of risk is the responsibility of all managers and staff throughout the organisation and they have a responsibility to be risk aware at all times. Every effort should be made to maintain a safe environment and safe systems of work thereby reducing the potential to cause harm to patients, staff and others and negatively affect the reputation and assets of the organisation. The Board aims to achieve this within a progressive, honest and open environment, where risks, adverse events and near misses are identified quickly and acted upon in a positive and constructive way. Staff are provided with education, training and support to enable them to meet this responsibility.

All employees have a personal responsibility to:

- Comply with policies and procedures
- Be aware of risks at all times and take reasonable action to identify and eliminate (where possible) or control them
- Notify line managers of risks they have identified which cannot be adequately managed
- Participate in risk management education and training.
All managers across the Board have a responsibility to encourage staff to identify risks and ensure that they are familiar with the latest risk management guidance and controls. Risk registers capture formally the assessment and management of each risk identified.

These duties are enshrined in the Health and Safety at Work Act 1974 (and subordinate legislation) and outlined in Core Dimension 3 of the NHS Knowledge and Skills Framework (KSF).

6. Risk Management Approach

There is a need to ensure a common approach for the management of risk across NHS Shetland that supports the assurance and business requirements of the Board.

Risk management is a systematic process:
- Identification of hazard or risk
- Analysis and prioritisation of the risk
- Management of risk by elimination, substitution, reduction or transfer
- Audit and review of chosen risk management options.

Full details of the risk management system and how the practicalities of risk management are approached in NHS Shetland are detailed in the local procedures and guidance that underpin this strategy available on the intranet and internet. The risk management approach is taken from the 2004 Australia/New Zealand Standards and is summarised in the following sections.4

Risk Identification

The aim of risk identification is to develop a comprehensive list of sources of risks and events that might have an impact on the achievement of objectives and the continuity of service delivery.

The identification of risk is an ongoing and proactive process and is the responsibility of staff at all levels within the organisation. Risks may be identified in a number of ways. For example through health and safety inspection visits, team based discussions, workshops, risk profiling, SWOT analysis, audits, analysis of adverse events (including near misses) and public feedback, including complaints. Risks can also be identified through information received from a number of external sources (e.g. Health and Safety Executive, Confidential Enquiry Reports, Medicines and Healthcare products Regulatory Agency (MHRA), Health Facilities Scotland, National Patient Safety Agency and via NHS Healthcare Improvement Scotland and the Scottish Government Health Department) and via Audit Reports and Audit Scotland results.

At a strategic level the focus is on identifying the key risks to the successful achievement of the corporate objectives and delivery of local delivery plan. At an operational level the focus is on looking in detail at the risks affecting operational services including work based tasks and projects.

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4 Risk Management Standards Australia/New Zealand 4360:2004
Risk Analysis and Evaluation

Once identified, an analysis of the risks is undertaken using the Risk Assessment Tool/Scoring Matrix (Appendix C) which also defines the action to be taken. This involves making an estimate of the probability and frequency of the risk occurring, its impact and a consideration of action required. Task based risks are recorded via the Health & Safety Control book ad all other risks are recorded on either the corporate or a departmental risk register using the Datix electronic risk management system.

Risk Register

Each Department is responsible for maintaining its own Risk Register via the Datix electronic risk management system. The Clinical Manager/Head of Department is responsible for ensuring that risk assessments are recorded on the register. This is used by their Management Team to inform priorities for the local implementation and monitoring of agreed controls. Each risk is allocated a risk owner(s) who is responsible for taking appropriate action to minimise its impact. Review of departmental risk registers is a standing Acute and Specialist/Community Health and Social Care Operational Management Group agenda item, that helps inform planning, management decisions and priorities. Management Teams are expected to regularly review and update their risk registers.

The Clinical Governance and Risk Team are responsible for maintaining a Corporate Risk Register, on behalf of the Executive Management Team, which records and reports on action being taken to manage the strategic risks facing the Board. The risks included on the Corporate Risk Register are informed by the escalation procedures noted below, as well as the collective input of the Executive Management Team, the Board and its Standing Committees. Public input into the development of risk registers is achieved through engagement via Shetland’s Public Partnership Forum.

Risk Management Plan

All significant risks (high or very high) identified within the Departmental registers and the Corporate Risk Register require a supporting action plan to be put in place, which ensures that the risk is managed to an acceptable level. It is the responsibility of the Management Teams and Executive Management Team to determine the most appropriate form of action and to allocate responsibility for implementation to (an) appropriate individual(s).

Risk Escalation

If high or very high risks have been identified that are deemed impossible or impractical to manage at a Departmental level, then they are submitted to the Executive Management Team to be considered for inclusion in the Corporate Risk Register. In the absence of such escalation, the responsibility for the management of risks remains with the Management Teams. In addition, any risk that could adversely affect achievement of the Board’s objectives or present a large loss to the organisation must also be submitted to the RMG and Executive Management Team to be considered for inclusion in the Corporate Risk Register. Within Clinical Services/Community Health and Social Care Management Teams, similar escalation arrangements are implemented to ensure that low and medium level risks are highlighted as departmental level risks where appropriate.
7. Emergency Service Continuity Planning

The Board has in place a Major Emergency Procedure, supported by a number of specific Emergency Plans which cover responses to particular threats. These are published on the Board’s web-site and staff are familiarised with them through a regular testing and training plan which includes annual exercising and regular review and updating. These plans include national and local policies and procedures to manage major adverse events and disasters impacting on Board services. In addition the Board has in place a Strategy for Resilience and Business Continuity, and service continuity plans for clinical and non-clinical services.

The Director of Public Health has Executive Lead responsibility for Emergency Planning and Resilience, reporting annually to the Board, and the Executive Management Team has overall responsibility for the management of risks associated with these plans, monitored regularly via the Board’s Risk Management Group.

The NHS plans and procedures are linked to Shetland’s multi-agency response and planning through the local Emergency Planning Forum, and key risks are shared and published via the Shetland Community Risk Register.

8. Training

Effective risk management depends on all staff having a clear understanding of the subject and the contribution they can make to risk control. Appropriate and targeted Risk Management training ensures that staff are sufficiently aware and competent to identify hazards and to assess and manage risk within their working environment. A programme of learning opportunities has been established in conjunction with the Staff Development Department. This includes updates provided as part of the Board’s compulsory training, and specific risk management and adverse event reporting training events to provide a more detailed insight into risk management issues for Heads of Department and individual teams. Datix training is also provided. A management training programme that will include risk management training is also in development.

Managers are responsible for ensuring that their staff are able to access and attend training appropriate to their needs including compulsory training. Individual members of staff also have a responsibility, through their Personal Development Plans (PDPs), to identify and participate in risk management training. New staff receive information on risk management as part of the organisation’s corporate induction arrangements.

9. Strategy Dissemination and Communication

The strategy is made available via the intranet and internet to ensure ease of access.

Through the usual information cascade process, managers are responsible for communicating this strategy to all staff, in a manner appropriate to their area. Notification to all staff of changes to the strategy is through inclusion in Team Brief and/or via an intranet Message of the Day.

Further information has been developed for staff and can be found on the Clinical Governance and Risk Management page of the intranet.
10. Monitoring and Review

In the context of this strategy the Board uses a variety of internal and external mechanisms to monitor, audit and review its risk management arrangements. These include:

- External assessment reports from bodies such as NHS HIS, Audit Scotland and the Health and Safety Executive
- Internal and external audit reports
- Reports of Health and Safety inspection visits
- Clinical governance and risk management reports presented to the JGG, RMG and CCPGC, annual reports and corporate level monitoring of risk action plans
- Regular review of the level of risks on the departmental risk register by the relevant group, and corporate level risks by the EMT and RMG. Review of the corporate level risks on the risk register by the Board and relevant Committees
- Monitoring of the Risk Management Work Plan via update reports to every RMG meeting including of the risk management KPIs
- Annual risk management report to the Board from the RMG
- Compliance against the NHS HIS Clinical Governance and Risk Management Standards

11. Appendices listed below
Appendix A – Organisational chart

NHS Shetland organisational chart denoting the reporting and accountability lines for clinical governance and strategic risk management updated in December 2017

**Solid lines** denote the committee’s accountability and assurance structure

**Dashed lines** denote functional links between committees/forums with shared accountability and assurance roles

- **Clinical, Care & Professional Governance Committee**
- **Audit Committee**
- **Staff Governance Committee**
- **Risk Management Group**
- **eHealth & Information Strategy Group**
- **Information Sub Group**
- **Area Drug & Therapeutics Committee**
- **Hospital Transfusion Committee**
- **Resuscitation Committee**
- **Cancer Lead Team**
- **Radiation Safety Committee**
- **Departmental Governance Groups e.g. Medical, Surgical, Dental**
- **Control of Infection Committee**
- **Infection Control Team**

- **Patient Focus Public Involvement Group**
- **Joint Governance Group (JGG)**
- **Our Voice Participation Standards**
- **Person Centred Care Collaborative (PCHCC)**
- **Moving & Handling Committee**
- **Fire Safety**
- **Health & Safety Committee**
- **Diversity Taskforce**
- **Area Partnership Forum**
- **NHS Shetland Strategic Nurse Group**
- **Medical Education Group**
- **Safeguarding and Public Protection Group (Health)**
- **Strategic Nurse Group**
- **Antimicrobial Mgmt Team**
- **Non Medical Prescribing Group**
- **Medical Education Group**
- **Cancer Lead Team**
- **Radiation Safety Committee**
- **Control of Infection Committee**
- **Infection Control Team**
Appendix B - Shetland NHS Board Risk Management Group Role, Remit and Terms of Reference

Role and Remit

The role and remit of the Risk Management Group (RMG) is as follows:

- To produce, review and update the Board’s Risk Management Strategy
- To produce and oversee an annual work plan to progress risk management in line with the Risk Management Strategy, which takes account of guidance issued by Audit Scotland, NHS Healthcare Improvement Scotland and other relevant bodies
- To ensure risk management is embedded at all levels throughout the Board
- To lead the development and implementation of communication and reporting systems for risk management throughout the organisation, including with the Board’s Standing Committees and the Joint Governance Group (JGG)
- To oversee the preparation and maintenance of a Corporate Risk Register which identifies all main categories of risks faced by the organisation and assesses the likelihood and impact of such risks adversely affecting the achievement of the Board’s objectives, and take appropriate action to deal with significant and escalating risks
- To identify and assign executive responsibility for any aspect of risk which is not being managed
- To prepare an annual report to the Board on risk management and to provide information on relevant corporate risks to Board Committees every 6 months and by exception
- To work closely with the JGG and the Clinical Governance and Risk Team to ensure the Risk Management Strategy and annual work plan are implemented
- Through the JGG and the Clinical Governance and Risk Team, to support and sponsor awareness raising, education and training, and development of risk management processes
- To work in parallel with the Health and Safety Committee to ensure a whole systems approach to risk which may include health and safety risks
- To seek assurance that the Procedure for Managing Significant Adverse Events and the Role of the Clinical Risk Advisory Team (CRAT) is being implemented
- To provide an assurance role for risk management in order for the standing Committees to pass assurance onto the Board

Membership of RMG

- Executive Management Team
- In attendance: Members of the Clinical Governance and Risk Team

Chair of RMG

Director of Human Resources and Support Services.

Frequency of Meetings

The RMG will meet a minimum of four times a year.
Quorum

There will be a minimum of 3 members in attendance.

Reporting

A 6 monthly summary of the corporate risks to the relevant committees will be provided and reports by exception. The Board will receive a copy of the corporate risk register on a 6 monthly basis and an annual risk management report. Committees will report any exceptions to the Board as and when required via the Committee update.
Appendix C - Risk Assessment Tool and Matrix

This risk assessment tool is taken from the Australian/New Zealand Standards, which is the recommended framework for risk management by Healthcare Improvement Scotland.

An assessment of the risks attached to a particular practice or activity may be undertaken using the Risk Assessment Matrix by mapping the likelihood (the probability or frequency of a consequence occurring) against the consequence (the outcome or impact component) to determine the risk grading/score. This can be used as the basis of identifying acceptable and unacceptable risk.

<table>
<thead>
<tr>
<th>RISK RATING</th>
<th>PRIORITY</th>
<th>RESPONSE</th>
<th>LEVEL OF ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green Low</td>
<td>Low</td>
<td>None/ long term</td>
<td>No further action or records required</td>
</tr>
<tr>
<td>Yellow Medium</td>
<td>Low/Medium</td>
<td>Medium term</td>
<td>Departmental management action required to reduce risk as low as reasonably practicable</td>
</tr>
<tr>
<td>Amber High</td>
<td>Medium/High</td>
<td>Short term</td>
<td>Action required from clinical/non-clinical committees/groups (as deemed appropriate) to reduce risk as low as reasonably practicable</td>
</tr>
<tr>
<td>Red Very High</td>
<td>High</td>
<td>Immediate</td>
<td>Strategic (EMT/RMG) action/ Board level awareness required</td>
</tr>
</tbody>
</table>
In terms of grading risks, the following grades have been assigned within the matrix.

- Low (L)
- Medium (M)
- High (H)
- Very High (VH)

### Risk Assessment Matrix

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Certain</td>
<td>M</td>
<td>H</td>
<td>H</td>
<td>VH</td>
<td>VH</td>
</tr>
<tr>
<td>(daily/weekly/monthly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely (quarterly)</td>
<td>M</td>
<td>M</td>
<td>H</td>
<td>H</td>
<td>VH</td>
</tr>
<tr>
<td>Possible (annually)</td>
<td>L</td>
<td>M</td>
<td>M</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Unlikely (2-5 years)</td>
<td>L</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Rare (5-10 years)</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>M</td>
<td>M</td>
</tr>
</tbody>
</table>

### Likelihood of Recurrence Ratings

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Rare</th>
<th>Unlikely</th>
<th>Possible</th>
<th>Likely</th>
<th>Almost Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td>Can’t believe this event would happen – will only happen in exceptional circumstances (5-10 years)</td>
<td>Not expected to happen, but definite potential exists – unlikely to occur (2-5 years)</td>
<td>May occur occasionally, has happened before on occasions – reasonable chance of occurring (annually)</td>
<td>Strong possibility that this could occur – likely to occur (quarterly)</td>
<td>This is expected to occur frequently / in most circumstances – more likely to occur than not (daily / weekly / monthly)</td>
</tr>
</tbody>
</table>
### Risk Consequence Ratings

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives / Project</strong></td>
<td>Barely noticeable reduction in scope / quality / schedule</td>
<td>Minor reduction in scope / quality / schedule</td>
<td>Reduction in scope or quality, project objectives or schedule</td>
<td>Significant project over-run</td>
<td>Inability to meet project objectives, reputation of the organisation seriously damaged.</td>
</tr>
<tr>
<td><strong>Injury (physical and psychologic) to patient / visitor / staff.</strong></td>
<td>Adverse event leading to minor injury not requiring first aid</td>
<td>Minor injury or illness, first aid treatment required</td>
<td>Agency reportable, e.g. Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling.</td>
<td>Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.</td>
<td>Incident leading to death or major permanent incapacity.</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care</td>
<td>Unsatisfactory patient experience / clinical outcome directly related to care provision – readily resolvable</td>
<td>Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery &lt;1wk</td>
<td>Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery &gt;1wk</td>
<td>Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects</td>
</tr>
<tr>
<td><strong>Complaints / Claims</strong></td>
<td>Locally resolved verbal complaint peripheral to clinical care</td>
<td>Justified written complaint peripheral to clinical care</td>
<td>Below excess claim. Justified complaint involving lack of appropriate care</td>
<td>Claim above excess level. Multiple justified complaints</td>
<td>Multiple claims or single major claim</td>
</tr>
<tr>
<td><strong>Service / Business Interruption</strong></td>
<td>Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service</td>
<td>Short term disruption to service with minor impact on patient care</td>
<td>Some disruption in service with unacceptable impact on patient care</td>
<td>Sustained loss of service, which has serious impact on delivery of patient care resulting in major contingency, plans being invoked.</td>
<td>Permanent loss of core service or facility Disruption to facility leading to significant “knock on” effect</td>
</tr>
<tr>
<td><strong>Staffing and Competence</strong></td>
<td>Short term low staffing level temporarily reduces service quality (less than 1 day)</td>
<td>Ongoing low staffing level reduces service quality</td>
<td>Late delivery of key objective / service due to lack of staff. Moderate error due to ineffective training / implementation of training Ongoing problems with staffing levels</td>
<td>Uncertain delivery of key objective / service due to lack of staff. Major error due to ineffective training / implementation of training</td>
<td>Non-delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to ineffective training / implementation of training</td>
</tr>
<tr>
<td><strong>Financial (including damage / loss / fraud)</strong></td>
<td>Negligible organisational / personal financial loss (£&lt;1k)</td>
<td>Minor organisational / personal financial loss (£1-10k)</td>
<td>Significant organisational / personal financial loss (£10-100k)</td>
<td>Major organisational / personal financial loss (£100k-1m)</td>
<td>Severe organisational / personal financial loss (£&gt;1m)</td>
</tr>
<tr>
<td><strong>Inspection / Audit</strong></td>
<td>Small number of recommendations which focus on minor quality improvement issues</td>
<td>Recommendations made which can be addressed by low level of management action.</td>
<td>Challenging recommendations that can be addressed with appropriate action plan.</td>
<td>Enforcement action. Low rating Critical report.</td>
<td>Prosecution. Zero rating Severely critical report.</td>
</tr>
<tr>
<td><strong>Adverse Publicity / Reputation</strong></td>
<td>Rumours, no media coverage</td>
<td>Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.</td>
<td>Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation</td>
<td>National media / adverse publicity, less than 3 days. MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry</td>
<td>National / International media / adverse publicity, more than 3 days.</td>
</tr>
</tbody>
</table>
Appendix D - Further Reading, References and Glossary of Terms

Further Reading
The above represents the Risk Management Strategy for the Board. It does not provide detailed information on the management of a specific area of risk or risk topic. The latter can be obtained from a number of sources including the Health and Safety Executive and Barbour Environment, Health & Safety (online access via ATHENS (for members of staff)).

A list of Statutory Instruments (Regulations) underpinning safety and risk management can be found at: [http://www.hse.gov.uk/legislation/statinstruments.htm](http://www.hse.gov.uk/legislation/statinstruments.htm), which also gives links to the legislation via the Office of Public Sector Information (OPSI) website.

The Risk Management Strategy is an overarching, three-year strategy setting out the direction of travel for the organisation. A suite of policies, procedures, guidelines and arrangements have been developed to support the strategy and, therefore, it should be read in conjunction with the following key documents:

- Learning from Adverse Events Through Reporting and Review Policy
- Risk Assessment Procedure and Risk Register Guidance
- Health and Safety Policy
- Safety Notice Procedure

All can be found on the Health and Safety and Risk Management pages of the intranet.

Bibliography
Successive versions of this strategy have been informed by the following publications:

- Risk Management Standards Australia/New Zealand 4360:2004
- Combined Code of Practice on Good Corporate Governance (Turnbull, 1999)
- HDL (2002) 11, Corporate Governance Statement of Internal Control
- HDL (2004) 37, Community Health Partnerships (CHPs) and Integrated Mental Health Services
- MEL (2000) 29, Clinical Governance
- MEL (1999) 75, Guidance on Clinical Governance
- MEL (1999) 14, Corporate Governance in the NHS
- Risk Management in the NHS 1994 Department of Health
References
Health and Safety Executive (HSE) (2004). Investigating accidents and incidents. HSG245

Risk Management Standards Australia/New Zealand 4360:2004

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>JGG</td>
<td>Joint Governance Group</td>
</tr>
<tr>
<td>RMG</td>
<td>Risk Management Group</td>
</tr>
<tr>
<td>EMT</td>
<td>Executive Management Team</td>
</tr>
<tr>
<td>CGRT</td>
<td>Clinical Governance and Risk Team</td>
</tr>
<tr>
<td>CCPGC</td>
<td>Clinical Care and Professional Governance Committee</td>
</tr>
<tr>
<td>CHSCMT</td>
<td>Community Health and Social Care Management Team</td>
</tr>
<tr>
<td>DHR&amp;SS</td>
<td>Director of HR and Support Services</td>
</tr>
<tr>
<td>HoD</td>
<td>Head of Department</td>
</tr>
</tbody>
</table>

Glossary of Terms


Adverse Event. Any incident/near miss, event or circumstance arising during NHS service provision that could have or did lead to unexpected harm, loss or damage.

Assurance. Stakeholder confidence in our service gained from evidence showing that risk is well managed.

Blame. Undesirable practice of attributing responsibility for an adverse event to an individual. Blame is undesirable because adverse events are usually due to system failures.

Consequence. The outcome of an event, being loss, injury, disadvantage or gain in respect of the physical, emotional, financial, social or credibility status of the individual or organisation

Contingency. Emergency plans/alternative arrangements that intervene should the risk become apparent.

Healthcare Governance. The system by which a healthcare organisation is directed and internally controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all three areas of clinical, corporate and staff governance.

Internal Control. Corporate governance arrangements designed to manage the risk of failure to meet NHS Shetland’s objectives.

Likelihood. Probability of an event occurring, wherever possible based upon the frequency of previous occurrences.
**Near Miss.** An incident where there was the potential for harm, loss or damage, and which did not actually result in an adverse outcome, but where there is the possibility of recurrence if preventative action is not taken.

**Partnership.** Way of working where staff at all levels and their representatives are involved in developing and putting into practice the decisions and policies, which affect their working lives.

**Risk.** The chance of something happening that will impact on the organisation’s ability to achieve its objectives.

**Risk Assessment.** An overall process to identify risk and evaluate whether acceptable or not taking into account new/best practice.

**Risk Control Measure.** An action undertaken to minimise risk to an acceptable level either by reducing the likelihood of an adverse event or the severity of its consequences or both.

**Risk Escalation.** The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impossible or impractical to manage locally.

**Risk Grade.** The classification of a risk expressed as a combination of its likelihood and severity of consequence.

**Risk Management.** Incorporates all the activities required to identify and control the exposure to risk, which may have an impact on the achievement of an organisation’s objectives.

**Risk Register.** A database of risks always changing to reflect the dynamic nature of the risk and our management of them. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made.

**Root Cause Analysis.** Structured techniques to establish the true systematic causes of an event as opposed to its apparent causes.

**Significant Risk.** One in which patients, staff or facilities may be subject to legal, media or other interest and where, if not managed effectively, the risk could result in loss of life or significant loss of the organisation’s assets or reputation. A ‘significant’ risk could be defined as one with a risk grading of ‘moderate’ (orange) or ‘high’ (red) determined using the Risk Grading Matrix.

**Statement on Internal Control.** A statement by the accountable officer within the published Annual Accounts, required by HDL (2002) 11, on the effectiveness of systems of internal control, for which risk management is a key component.

**System Failure.** The most likely cause of an adverse event. Typically due to a flaw or flaws in the design or operation of a system of work rather than an individual’s actions or inaction.

**Tolerable Risk.** A risk that is allowed to exist so that certain benefits can be gained, whilst there is an acceptable level of confidence that the risk is under control.
12. Rapid Impact Checklist  
NHS Shetland

An Equality and Diversity Impact Assessment Tool:

| Which groups of the population do you think will be affected by this proposal? |
| Other groups: |
| - Minority ethnic people (incl. Gypsy/travellers, refugees & asylum seekers) |
| - Women and men |
| - People with mental health problems |
| - People in religious/faith groups |
| - Older people, children and young people |
| - People of low income |
| - Homeless people |
| - Disabled people |
| - People involved in criminal justice system |
| - Staff |
| - Lesbian, gay, bisexual and transgender people |

The Risk Management Strategy 2017-20 has universal application across Shetland NHS Board and, as a consequence, affects all groups, including the minority groups listed above.
N.B The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed

<table>
<thead>
<tr>
<th>What positive and negative impacts do you think there may be?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Risk Management Strategy 2017-20 should have a positive impact. The key piece of legislation underpinning the strategy is the <em>Health and Safety at Work etc Act 1974</em>, which sets out the duty of employers to safeguard the health, safety and welfare of their employees and anyone else who might be affected by their activities. The Act, therefore, imposes a clear duty of care on employers towards persons other than employees e.g. patients, visitors, members of the public, contractors, delivery personnel and volunteers.</td>
</tr>
<tr>
<td>Additionally, the strategy recognises the requirement to give special consideration to specific groups including night workers, lone workers and workers with disabilities.</td>
</tr>
<tr>
<td>The strategy also makes clear that the promotion of a fair and open culture is regarded as an essential component of an effective risk management system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which groups will be affected by these impacts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>As noted above, the Risk Management Strategy 2017-20 has universal application across Shetland NHS Board and, as a consequence, affects all groups, including the minority groups listed above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What impact will the proposal have on lifestyles?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For example, will the changes affect:</td>
</tr>
<tr>
<td>- Diet and nutrition</td>
</tr>
<tr>
<td>- Exercise and physical activity</td>
</tr>
<tr>
<td>- Substance use: tobacco, alcohol and drugs?</td>
</tr>
<tr>
<td>- Risk taking behaviour?</td>
</tr>
<tr>
<td>The strategy outlines an approach which aims to promote responsible risk-taking (in a work context) within &quot;a fair and just system where people are held to account for their behaviour, without being unduly blamed&quot;.</td>
</tr>
</tbody>
</table>
- Education and learning or skills?

**Will the proposal have any impact on the social environment?**

Things that might be affected include:

- Social status
- Employment (paid or unpaid)
- Social/Family support
- Stress
- Income

A key risk management objective described in the strategy is to ensure that risk registers are further developed at a departmental level - recorded and managed using the Datix ‘Risks’ module - and routinely reviewed across the organisation focusing on quality and ensuring identification and treatment of all relevant physical and psychosocial hazards. The latter should have a positive impact on employees’ mental health, including stress.

**Will the proposal have any impact on the following?**

- Discrimination?
- Equality of opportunity?
- Relations between groups?

The strategy should have a positive impact, and, operationally, the strategy is likely to be of particular benefit to the disability equality group. The rationale for this is that there is a fundamental requirement under the *Health and Safety at Work etc Act 1974* to provide “so far as is reasonably practicable as regards any place of work...means of access to and egress from it that are safe” (*HSWA 1974*, Section 2(2)(d)). In addition, the *Disability Discrimination Act 2005* requires premises to be suitable for all disabled persons working there or likely to visit. The stated Risk Management Objective to comply with all relevant statutory requirements supports the general and specific duties on disability equality to eliminate discrimination as a result of a person’s disability.

For those under 18 years old, there is potential for a very positive impact. The rationale for this is the statutory requirement (as laid down in the *Management of Health and Safety at Work Regulations 1999*) to ensure that young people are protected at work from any risks to their health or safety which are a consequence of their lack of experience, or absence of awareness of existing or potential risks or the fact that they have not yet fully matured.
**Will the proposal have an impact on the physical environment?**
For example, will there be impacts on:
- Living conditions?
- Working conditions?
- Pollution or climate change?
- Accidental injuries or public safety?
- Transmission of infectious disease?

For New and Expectant Mothers, Lone Workers and Night Workers there would be a positive impact as the Risk Management Strategy recognises the requirement to give special consideration to these people.

The whole thrust of the Risk Management strategy (and the associated Health and Safety Policy) is to continually and positively improve the physical environment of our buildings thereby providing high quality working conditions for staff, contributing to public safety and control of infection and reducing accidental injuries.

**Will the proposal affect access to and experience of services?**
For example,
- Health care
- Transport
- Social services
- Housing services
- Education

Shetland NHS Board exists to provide safe, high quality, sustainable healthcare and health improvement services to the people of Shetland. The Board recognises that it cannot provide these services unless it ensures, as far as possible, freedom from risk to the health, safety and welfare of staff, and others affected by the work undertaken and/or the nature of the business. Improvement and protection of health is a primary objective of the Board and it is prioritised equally alongside other business and operating objectives.
### Rapid Impact Checklist: Summary Sheet

<table>
<thead>
<tr>
<th>Positive Impacts (Note the groups affected)</th>
<th>Negative Impacts (Note the groups affected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Risk Management Strategy 2017-20 has universal application across Shetland NHS Board and, as a consequence, will positively affect all groups employed by and/or using our facilities and services, including the minority groups listed above.</td>
<td>None</td>
</tr>
</tbody>
</table>

### Additional Information and Evidence Required

### Recommendations

**From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?**

The Risk Management Strategy 2017-20 complies with current equalities legislation and good practice. Due to its positive impact on all equality groups a full EDIA process is not required.