Risk Management Strategy
2012 - 2015

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HRSSSTR002

NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET

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Clinical Governance Co-ordinating Group	
Strategy and Redesign Committee	

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Examples of reasons for presenting to the group	Examples of outcomes following meeting
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21 March 2012	Change of title for CAG to 'Risk Management Group' [RMG] agreed
28 March 2012	Appendix A (CGCG Terms of Reference) considered by CGCG and amendments proposed included in document
8 May 2012	More generic wording required in 'Level of Action' column in table on Page 12 to reflect the position that action on 'Amber' risks could be co-ordinated by a non-clinical committee/group Description of the Control of Infection Committee [CoIC] to be removed on the basis of consistency i.e. the functions of other committees operating at this level are not described. (The description of the role of the Health and Safety Committee to remain given the statutory nature of this group and its pivotal role in risk management.) It was noted that changes to the Terms of Reference of the Clinical Governance Co-ordinating Group [CGCG] have still to be formally approved by the Group
16 May 2012	Risk Management Action Plan 2012/13 approved by RMG and incorporated into document as Appendix E
22 August 2012	Revised ToR for CGCG approved and incorporated
August 2013	Update of Corporate Objectives for 2013-14 (Section 1) Update of Risk Management Objectives for 2013-14 (Section 5) Update re CHCPMT (Section 6) Update on the progress of arrangements for the integration of health and social care services (Section 6) Update on Scottish Patient Safety Programme (Section 6) Update of CGCG Terms of Reference (Appendix A) Risk Management Action Plan 2013/15 approved by RMG and incorporated into document as Appendix E Updated Terms of Reference for the Health and Safety Committee (Appendix H)

February 2014	Update of Risk Management Objectives for 2014-15 (Section 5)

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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 process has four stages:

- 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.

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. This includes both clinical and non-clinical risks.

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 following groups (**Appendix B**):

- Risk Management Group [RMG] – reporting to the Strategy and Redesign Committee [SRC]
- Clinical Governance Co-ordinating Group [CGCG] - reporting to the Clinical Governance Committee [CGC]
- Health and Safety Committee [HSC] – reporting to the Staff Governance Committee [SGC]

The Board's safety and risk management system is operated on a day-to-day basis by the Safety and Risk Support Team, part of the Directorate of Human Resources and Support Services. The team's reporting lines are illustrated in **Appendix C**.

The Risk Management Strategy is reviewed triennially by the RMG before being submitted to the SRC and Board for approval. Additionally, on behalf of the Board, the RMG monitors an annual Risk Management Action Plan, which includes Key Performance Indicators [KPIs]. The current plan is attached at **Appendix E**.

[1] HSE (2004), p. 16

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 encompasses both clinical and non-clinical risks to ensure a streamlined and systemic approach to risk.

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 promoting a just, fair and responsible culture, which fosters learning and improvements when mistakes happen.

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 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
- To ensure sufficient organisational capacity and resilience.

2. Values and Principles Underpinning Risk Management

The Board seeks to develop an open, just and non-punitive culture where all staff feel able to report adverse incidents, near misses and hazards in the knowledge that incidents/errors are not normally investigated through the disciplinary procedure. The Board's disciplinary procedure promotes an approach where action will only be taken when it is felt that staff deliberately attempt to disguise errors and/or dangerous practice or when an incident involves negligence or poor standards of care. The Board's approach to identifying the immediate, underlying and root causes of adverse events is designed to allow system

failures to be corrected rather than laying blame on one or more individuals, thereby giving staff the confidence to be open and honest when participating in an investigation.

This strategy is underpinned by the principles of openness and transparency, which, in practice, means acknowledging, apologising and explaining when things go wrong. Patients and staff appreciate an apology for distress caused, if appropriate, and expressions of sympathy and concern. Apologising does not necessarily mean acceptance of responsibility but rather it creates a basis for improving stakeholder confidence and trust.

3. 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 involves the following:

Identification of hazards	A hazard is anything with the inherent ability to cause harm to: • People • The organisation (finance and reputation) • The environment (pollution and inefficient use of resources)
Deciding who could be harmed and how	Identifying which personnel are involved in the activity or circumstances under consideration and what their roles are – giving special consideration to the following groups: • New and expectant mothers • Young people (under 18) • Night workers • Lone workers • Workers with disabilities Additionally, considering anyone else who could potentially be affected by the activity or circumstances e.g. • Patients • Visitors/Members of the Public • Contractors • Delivery Personnel • Volunteers

[2] AZ/NZS 4360: 2004; 1.3.13
[3] *ibid*. 1.3.20

Evaluation of risks	Determining the level and priority of risks using a quantitative method of risk assessment. This looks at the severity rating of the hazard and the probability of exposure using a Risk Matrix and assigns a value to the outcome (**Appendix D**) Following local policy on risk management to ensure that risks are appropriately managed and monitored (**Appendix F**)
Treatment of the risk	Recording findings, deciding on precautions and implementing them i.e. systematically working out how the risk can be eliminated, transferred, controlled or accepted
Communication about risks	Informing staff, clients and other stakeholders what measures are being taken to reduce risk
Incident reporting and investigation	Reporting adverse events and carrying out investigations provides a deeper understanding of the risks associated with work activities
Monitoring of risks	Determining the risk level will help to identify how the risk should be monitored and audited

In order to succeed, risk management must be embedded at all levels within the organisation. To this end, the following components are important:

- Clear and effective governance arrangements
- Sound leadership with accountability
- Explicit strategic objectives
- Appropriate resource allocation
- Integrated planning arrangements
- Effective stakeholder involvement
- Education and training strategies
- Learning from others within and outwith the organisation
- Promotion of a fair and open culture
- Recognising the value of innovation and creative thinking
- Appreciating the contribution that all staff make to the overall management of risk
- Integration of risk management at all levels
- A risk management system that incorporates risk identification, recording and action.

4. 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].

5. Risk Management Strategic Objectives

The Risk Management Objectives for 2014-15

- Comply with all relevant statutory requirements
- Meet requirements of Internal and External Audit with respect to the Statement on Internal Control
- Meet the requirements of the risk management components of the NHS HIS Clinical Governance and Risk Management standards
- Continue to monitor and refine the system of control by ensuring that all strategic groups and services have processes in place to identify and manage risks and that the Risk Management Group is kept informed of relevant actions and treatments
- Continue to monitor and refine the education and training programme which meets the needs of staff across the organisation with a particular emphasis on embedding the Datix electronic risk management system
- Ensure that risk registers are further developed at a departmental level, recorded and managed using the Datix Risk module and routinely reviewed across the organisation focusing on quality and ensuring identification and treatment of all relevant physical and psychosocial hazards

- Ensure that the centrally maintained Corporate Risk Register is kept up to date and the history of corporate risks recorded on Datix
- Monitor and review key risk management policies and procedures to ensure that risks are effectively managed (e.g. Incident Reporting, Investigation and Management Policy)
- Continue to develop more formal mechanisms for sharing and learning from incidents and near misses
- Review and evaluate the management of major service change ensuring that appropriate risks and control measures are incorporated into service change plans
- Contribute to the development of a Community Risk Register
- To further develop adverse event management and reporting arrangements taking into account national guidance
- To develop understanding of improved outcomes from the Board's Risk Management Strategy and work programme, and, therefore, our measurement of the effectiveness of the Risk Strategy
- Develop joint risk and incident/adverse event management procedures for teams working in the integrated community health and social care directorate.

The objectives set within this strategy are revised annually via the RMG to ensure that they remain valid and up-to-date. They also form the basis of the annual Risk Management Action Plan (**Appendix E**), which is drawn up by the Safety and Risk Support Team and monitored by the RMG on behalf of the Board.

6. Roles and Responsibilities

NHS Shetland

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 each meeting of the Strategy and Redesign Committee and the Board receives an annual report on corporate risks.

Standing Committees of the Board are expected to understand the corporate risks assigned to them within the overall risk management process overseen by the Strategy and Redesign Committee.

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, the Board and the Strategy and Redesign Committee 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 C**.

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, through the Strategy and Redesign Committee 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 Strategy and Redesign Committee and to the Board.

The role, remit and terms of reference of the Risk Management Group are set out in **Appendix G**.

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 Senior Management Team level. The DHR&SS leads the development, agreement and maintenance of the risk management reporting system including incident reporting, risk register review and performance against corporate objectives.

The Strategy and Redesign Committee [SRC]

The Strategy and Redesign Committee was established as a standing committee by the Board to oversee policy and strategy development, to have strategic oversight of the redesign of the Board's services and to provide oversight of the Board's Corporate Risk Register and risk management process.

The remit and terms of reference for the SRC can be found in **Appendix I**.

The Clinical Governance Committee [CGC]

The CGC is a standing committee of the Board with delegated responsibility for ensuring that quality assurance systems are in place. CGC is responsible for ensuring that monitoring arrangements are developed to ensure that quality improvement systems are working well across the organisation. CGC 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, CGC receives a quarterly Incident and Risk Management Report (including an Incident Reporting Summary) outlining the ongoing work and progress made in the incident and risk management aspect of clinical governance.

CGC works with the Board's Audit Committee where appropriate in relation to risk including preparation of the annual Statement on Internal Control.

The Audit Committee

The Audit Committee is a standing committee of the Board with delegated responsibility for ensuring that quality assurance systems are in place. The Committee also agrees the internal audit programme and as such plays a key role in the assurance process. It also

receives and passes comment on the annual Statement on Internal Control jointly with the Clinical Governance Committee.

The Clinical Governance Co-ordinating Group [CGCG]

The CGCG acts as the Board's integrated incident and risk monitoring group through conducting regular reviews of incident and risk data as it applies to clinical governance and clinical risk and oversight of relevant business.

The CGCG receives reports from an established network of groups and individuals dealing with risk management as part of their remit. The main groups/individuals providing reports are:

- Hospital Transfusion Committee
- Resuscitation Committee
- Control of Infection Committee
- Area Drug and Therapeutic Committee
- Radiation Safety Committee
- Medical Gas Committee

CGCG is the Board's main operational risk management group for all clinical risks. It is the lead group on identifying, monitoring and mitigating clinical risk within the Board and liaises with the Risk Management Group. CGCG also monitors incident reporting, investigation and management. It highlights any risk management issues that should be brought to the attention of the Risk Management Group and Board standing committees (Clinical Governance Committee, Audit Committee) through the RMG, and provides assurance through the Chief Executive to the Board, that these are being adequately managed. There is a key link, through cross membership, between the CGCG and the RMG.

The remit and terms of reference for the CGCG can be found in **Appendix A**. The document includes a chart denoting the reporting and accountability lines for clinical governance and strategic risk management across the organisation as well as a governance organisational chart.

The Community Health and Care Partnership Management Team [CHCPMT]

The CHCPMT also has responsibility for monitoring risks and incident trends, in this case, across community and primary care services. The CHCPMT has a proactive role directing resources and interventions towards areas where they are most required.

The CHCP Risk Register is a joint document between the NHS and Shetland Islands Council [SIC]. The register records appropriate sector-level risks and sits with the SIC's Director of Community Care. The CHCPMT regularly reviews the CHCP Risk Register and each meeting also receives a copy of the Board's Corporate Risk Register (with risks relevant to the CHCP highlighted).

The RMG, which is the high-level risk management group for the Board takes an overseeing role to ensure that there is harmonisation of the corporate/joint risk areas identified by the CHCPMT and the Board's Clinical Services Management Team.

The Public Bodies (Joint Working) (Scotland) Bill was introduced by the Scottish Government on 28 May 2013 and sets out a number of proposals to enable local authorities and health boards to integrate the planning and delivery of health and social care. The Bill includes provision for:

- The establishment of integration joint boards and monitoring committees as the partnership arrangements for the governance and oversight of health and social care services. The Bill will remove Community Health Partnerships from statute
- A requirement for NHS Board and local authority partners to enter into arrangements to delegate functions and appropriate resources to ensure the effective delivery of those functions
- The appointment of a chief officer, who will be jointly accountable, through the board, to the constituent Health Board and local authorities, and responsible for the management of the integrated budget and the delivery of services for the area of the integration plan.

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 incidents, including co-ordinating incident management and organisational learning. A more detailed description of the core functions of the CRAT can be found in the *Incident Reporting, Investigation and Management Policy*. The policy can be found at the following link:

http://shb-extranet/documents/pphandbook/documents/IncidentReportingAndInvestigation.pdf

The Health and Safety Committee

Health and Safety is a significant part of Risk Management. Managing Health and Safety is a legal requirement and involves preventing people from being harmed or becoming ill as a result of work activities. Given the statutory nature of the Health and Safety Committee and its pivotal role in the Board's Risk Management Strategy, a detailed description of the role of the committee is included below.

The Health and Safety Committee is made up of both management and staff side representatives. (**Appendix H**). The roles of the Trades Union safety representatives (as laid down in the Safety Representatives and Safety Committee Regulations [SR&SCR] 1977) are as follows:

- To investigate possible dangers at work, the causes of accidents, complaints by employees on health and safety and welfare issues and to take these matters up with the employer
- To carry out inspections of the workplace particularly following accidents, diseases or other events
- To represent employees in discussions with health and safety inspectors and to receive information from those inspectors

- To go to meetings of safety committees[4].

The role of the Health and Safety Committee is, therefore, to help the employer develop, promote, monitor and amend their health and safety management system. The committee's role is primarily to advise and review, identifying areas where health and safety advice is needed as well as non-conformances in working conditions or practices.

The committee also has a role in actively monitoring the delivery of the organisation's Health and Safety Action Plan. The current plan and latest update can be found via the following link: http://intranet/committees/healthandsafety/index.html

The governance chart (**Appendix B)** 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 Scottish Patient Safety Programme [SPSP]

The Board is part of the Scottish Patient Safety Programme initiative which, in partnership with Healthcare Improvement Scotland, is implementing a systematic approach to improving the safety and reliability of patient care.

The Adult Programme, which was the original workstream, comprises various areas, for example Critical Care, General Ward, Leadership, Paediatric, Medicines Management and Peri-operative care. In these work streams there are a number of process and outcome measures that are pivotal to the overall improvement of long-term quality and service improvement. The measures are used as tools to achieve an overall reduction in patient harm, adverse events and inpatient mortality.

Additional workstreams that have now been incorporated into the SPSP Programme include Primary Care, Maternity, Mental Health and DVT/Sepsis reduction. These new workstreams are delivered with the existing patient safety methodology and include their own process and outcome measures.

At local level, Patient Safety Leadership Walk Rounds continue, with every clinical department being visited annually to review patient safety issues and concerns.

7. 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 of:

1. Identification
2. Analysis and evaluation
3. Control
4. Review

[4] SR&SCR 1977

Full details of the risk management system and how the practicalities of risk management are approached in NHS Shetland are detailed in the local policies and procedures that underpin this strategy (**Appendix J**). The risk management approach is taken from the 2004 Australia/New Zealand Standards (currently licensed by HIS for use by Scottish Health Boards until June 2012) and is described in more detail in the following sections.[5]

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 incidents (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 and projects.

Risk Analysis and Evaluation

Once identified, an analysis of the risks is undertaken using the Risk Assessment Tool/Scoring Matrix (**Appendix D**). This involves making an estimate of the probability and frequency of the risk occurring, its impact and a consideration of action required. The overarching risk management process is detailed in the form of a flow chart and can be found in **Appendix F**. All assessed risks are recorded on either the corporate or a departmental risk register using the Datix electronic risk management system. Some risks are assessed as having applicability wider than an individual department and these are recorded (also via Datix) on a directorate risk register (e.g. Nursing, CHCP).

[5] Risk Management Standards Australia/New Zealand 4360:2004

Control, Action and Review Guidance

The assessed level (grade) of the risk determines what action is to be taken. This is detailed in the Risk Assessment Procedure and Risk Register Guidelines. In summary:

RISK RATING	PRIORITY	RESPONSE	LEVEL OF ACTION
Green Low	Low	None/ long term	No further action or records required
Yellow Medium	Low/Medium	Medium term	Departmental management action required to reduce risk as low as reasonably practicable
Amber High	Medium/High	Short term	Action required from clinical/non-clinical committees/groups (as deemed appropriate) to reduce risk as low as reasonably practicable
Red Very High	High	Immediate	Strategic (SMT/RMG) action/ Board level awareness required

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 Clinical Services/CHCP Management Team agenda item, that helps inform planning, management decisions and priorities. Management Teams are expected to regularly review and update their risk registers. A Departmental Risk Register Status Update Report is presented to each meeting of the RMG.

The Safety and Risk Support Team are responsible for maintaining a Corporate Risk Register, on behalf of the Senior 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 Senior 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. The RMG reviews the Corporate Risk Register at every meeting and a summary report is presented to each meeting of the Strategy and Redesign Committee and annually to the Board.

Risk Management Plan

All significant risks (high or very high) identified within the Departmental/Directorate 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 Senior Management Team to determine the most appropriate form of action and to allocate responsibility for implementation to (an)

appropriate individual(s). More detail around the process of managing significant risks and incidents is contained in the *Risk Assessment Procedure and Risk Register Guidance* and the *Incident Reporting, Investigation and Management Policy* (http://shb-extranet/documents/pphandbook/documents/RiskAssessmentProcedureAndRiskRegisterGuidance.pdf and http://shb-extranet/documents/pphandbook/documents/IncidentReportingAndInvestigation.pdf).

Risk Escalation

If high or very high risks have been identified that are deemed impossible or impractical to manage at a Departmental or Directorate/Clinical Services/CHCP Management Team level, then they are submitted to the Senior 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 Senior Management Team to be considered for inclusion in the Corporate Risk Register. Within Clinical Services/CHCP Management Teams, similar escalation arrangements are implemented to ensure that low and medium level risks are highlighted as departmental level risks where appropriate.

8. 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 incidents 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 Senior 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.

9. Working Arrangements with Partners

As the Board develops in accordance with national and local initiatives, such as the replacement of Community Health and Care Partnerships with Health and Social Care Partnerships, the risks emerging from joint working require joint solutions. The Board commits to minimise any risk by ensuring:

- All Departments manage risk in partnership with partner agencies and contractors, where appropriate

- An adequate risk management framework is incorporated as part of the governance arrangements for joint management and partnership agreements
- Common objectives are agreed with partner agencies, contractors and the voluntary sector
- The CHCP report risk management issues through the CHCP management team and to the CHCP Committee
- Development of the public's understanding of risk by working with stakeholders via Shetland's Public Partnership Forum

10. 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, management training programmes and specific risk management and incident 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.

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.

11. Strategy Dissemination and Communication

The Risk Management Strategy is accessible to:

- All Departments (including Community Health and Care Partnership services)
- All staff
- Patients and members of the public
- Area Partnership Forum
- User groups
- Scottish Ambulance Service
- Inter-organisational groups

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 Risk Management and Health and Safety pages of the intranet.

12. 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
- Monitoring reports from teams, departments and the CHCP, which includes the clinical governance and risk management reports presented to the CGCG, RMG and CGC, 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 SMT and RMG. Three monthly reviews of the corporate level risks on the risk register by the Strategy and Redesign Committee.
- Risk Management Action Plan update reports to every RMG meeting including of the risk management key performance indicators identified in **Appendix E**
- Regular review by the RMG of the Risk Management Strategy and related documents and monitoring of the Risk Management Action Plan
- Reports on the Corporate Risk Register to each meeting of the Strategy and Redesign Committee
- Corporate Risk Register report annually to the Board from the RMG
- Compliance against the NHS HIS Clinical Governance and Risk Management Standards.

Reporting mechanisms are summarised in **Appendix C**.

13. Appendices

Appendix A - Clinical Governance Coordinating Group Remit and Terms of Reference Updated in August 2013

1. Remit

The Clinical Governance Co-ordinating Group (CGCG) has been established to oversee and support the implementation of Clinical Governance throughout Shetland NHS Board area. The group reports to the Clinical Governance Committee, which, as a standing committee of the Board, has the official responsibility to oversee and monitor all clinical governance activity within the Board. CGCG works closely with the Risk Management Group (RMG) on risk management.

Appendix 1 is an organisational chart showing the main reporting and accountability lines for clinical governance and strategic risk management and **Appendix 2** shows the organisation's governance structure.

Whilst the group will co-ordinate clinical governance activity, Heads of Departments along with their staff are responsible for the implementation and delivery of the clinical governance agenda within their own area.

The Clinical Governance Support Team provides advice and assistance to all Board staff in relation to all aspects of clinical governance activity.

To deliver this remit the CGCG will:

- Lead the implementation of the Clinical Governance Strategy by providing support and advice to all staff on implementation of the clinical governance agenda within their area of practice/responsibility.

- Oversee and ensure the delivery of the range of Clinical Governance activity (see section 8 for definition of clinical governance) by liaising with all professional groups and staff groups from hospital-based services and the community health partnership in Shetland.

- Ensure the implementation and monitoring of SIGN Guidelines, NHS Healthcare Improvement Scotland Standards and Best Practice Statements locally as appropriate to services provided by the Board through allocating responsibilities to appropriate individuals or groups.

- Contribute to the Board's Risk Management Strategy by acting as the Board's Integrated Risk and Incident Management monitoring group through conducting regular reviews of incident and risk data as it applies to clinical governance and clinical risk and oversight of relevant business (see organisational chart Appendix 1).

- Support the RMG in developing the Board's Risk Management Strategy.

- Liaise with/ensure close working relationship with the **Clinical Risk Advisory Team**, which is established to carry operational responsibility for managing clinical risk and poor performance, which includes instigating and overseeing the appropriate course of action for suspected/poor performance, and for significant or potentially significant clinical incidents, including co-ordinating incident management and organisational learning.

Note: The process of Risk and Incident Management is the subject of further development in the context of national guidance and may need further clarification of detail. Separate guidance on the procedure for managing a significant incident is contained within the Board's Incident Reporting, Investigation and Management Policy.

- Facilitate and support appropriate clinical audit programmes in place across the Board, which reflect local and national priorities.

- Provide advice and support to staff and promote best practice in relation to audit activity whilst monitoring, promoting and reporting on clinical audit, patient survey and service improvement work throughout the Board thus ensuring evaluation is taking place.

- Support the development and procurement of educational packages relevant to clinical governance, liaising with the Staff Development Department, so that Board staff are aware of, and can deliver, all the components of Clinical Governance.

- Develop appropriate culture, policy and practice on Clinical Governance within NHS Shetland.

- The CGCG will ensure that due process is followed for all relevant policies and that all relevant stakeholders have been consulted and that a programme of review is in place before advising the Clinical Governance Committee and the Board to approve the policies.

- Clinical guidelines and procedures will be developed and managed within the relevant area of service, as the responsibility of the relevant manager. CGCG may be asked to advise and participate in the process of approval if they affect a range of services or professional groups, or have some other wider organisational significance, or where they differ from national guidance due to local circumstances, in which case the advice and support of the Clinical Governance Support Team, and/or the Chair of CGCG should be sought.

- Keep abreast of national policy initiatives, ensuring implementation of those that require action locally. Maintain an overview of current local issues that may impact on effective Clinical Governance throughout the Board.

- Prepare a quarterly report on clinical governance activity for the Board's Clinical Governance Committee, and develop the Clinical Governance Strategy for the Board with an associated action plan, which will be reviewed annually, and which will be published on the Internet.

- Promote the Board's commitment to a Fair and Open Culture acting as an exemplary role model by, for example, holding open meetings from time to time on specific topics of general interest, publishing the agenda in advance on the Intranet, publishing the approved minutes on the Internet ensuring that local policy complies with the diversity standards and that all relevant policies have been evaluated using the EQIA tool. CGCG will invite relevant members of staff or others to meetings for specific items. Members of staff can attend by arrangement with the Chair.

2. Membership

Designation of member	Status for Quorum
Medical Director (Chair)	Clinical
Assistant Director of Clinical Services	Non-clinical
2 Nursing representatives - the Nurse Director (joint Chair) and a Senior Charge Nurse	Clinical
CHP 3 places including CHP Clinical Lead or his/her Deputy, Assistant Director of Nursing (Community) and 1 other representative	Clinical
Supervisor of Midwives	Clinical
Staff Governance Representative	Dependent on attendee
Consultant Representative	Clinical
Allied Health Professionals Representative	Clinical
Lead Clinical Pharmacist	Clinical
Dental Director or nominated Dental Representative	Clinical
Public Health Representative	Clinical
Healthcare Scientists Representative	Clinical
Mental Health Representative	Dependent on attendee
Safety and Risk Manager	Non-clinical
Clinical Governance Representative	Non-clinical
Datix Support Officer	Non-clinical

3. Chair of CGCG

The Medical Director and the Nurse Director will share the duties of the Chair.

The role of the chair is to act as lead on clinical governance within the organisation as well as to chair meetings.

4. Responsibilities of Members

The members of the CGCG should:

- Attend meetings.
- Give a range of opinions that reflects the breadth of services within the organisation (Members are not there to represent their professional group)
- Play a part in the co-ordination of Clinical Governance throughout the Board, by taking responsibility for the actions of the Group as described in its remit
- Act as an effective conduit between the Clinical Governance Coordinating Group and the rest of the organisation
- Send apologies and any comments in advance to the Secretary or Chair of the CGCG if unable to attend
- Members are asked to make every effort to attend meetings and to be actively involved in them

Quorum:
The group shall be quorate with 5 members of whom at least 3 should be clinical.

5. Terms of Reference – Meetings

The group will meet 6-8 weekly. The Clinical Governance Administrator will arrange the dates annually.

The Clinical Governance Administrator will provide secretarial support to the group including minute taking, and agenda setting in consultation with the Chair.

Meetings will be structured around standing agenda items so that all aspects of Governance can be covered. The agenda will be arranged as follows:

- Welcome and Apologies
- Minutes from last meeting

- Matters arising not covered by agenda
- Quality Improvement (including outstanding actions, audit and research review)
- Risk Management (including quarterly review of incident data, complaints and outcomes/learning)
- Patient Safety
- National standards & clinical practice guidance
- Healthcare Improvement Scotland peer review preparation, findings and feedback on progress of action plans from previous peer reviews
- General Clinical Governance items and development issues covering the range of Clinical Governance concerns

CGCG will co-ordinate the business of the Clinical Governance Committee, ensuring that the range of Clinical Governance matters are presented to and discussed at Committee over the course of the year.

6. Disseminating Information to Staff

The CGCG recognises the importance of ensuring staff are fully apprised of its activities and the subsequent development of clinical governance throughout the Board. All staff will therefore be able to:

- Attend meetings of CGCG as observers by arrangement with the Chair
- Raise issues relating to Clinical Governance (and represent them as appropriate) at the CGCG, through one of the members of the group or the Clinical Governance Administrator
- View approved minutes of the meetings on the Intranet

There may, on occasions, be matters discussed that require a greater degree of confidentiality and which would be excluded from disclosure within the terms of Data Protection or Caldicott guidance. These may be discussed in a private session and minuted separately.

7. Reporting Arrangements

i) CGCG

The Chair of the Clinical Governance Co-ordinating Group will report directly to the Board's Clinical Governance Committee, as well as reporting directly on Clinical Governance matters to the Chief Executive. Additional reporting arrangements will be via the Clinical Governance Co-ordinating Group members present at the Board's Clinical Governance Committee meetings and via the submission of a quarterly report on Clinical Governance activity. This report will be split into three parts: Clinical Effectiveness, Incident & Risk Management and Patient Involvement. The Assistant Director of Clinical Services will be responsible for writing the Clinical Effectiveness report, the Incident & Risk Management report will be compiled by the Health & Safety Manager and the report on Patient Involvement will be the responsibility of the Director of Nursing.

ii) Governance sub committees

The following committees report into the CGCG to ensure that there is appropriate communication of key actions around governance issues across the organisation (both vertically and horizontally):

- Area Drugs and Therapeutic Committee
- Cancer Lead Team
- Control of Infection Committee
- Dental Audit Group
- Falls Group
- Gases Committee
- Health & Safety Committee
- Hospital Transfusion Committee
- Medical Gases Committee
- Managed Clinical Network Groups (CHD, Stroke, Diabetes, Eye Care, Respiratory Care, Neurology)
- Radiation Safety Committee
- Resuscitation Committee
- Theatre Users Group

Additionally, working groups such as the Nutritional Care Steering Group and Quality & Safety Group report into the CGCG as appropriate.

8. Pillars of Clinical Governance

For the purposes of the work of the CGCG and the development of clinical governance within NHS Shetland, the following definition from NHS Healthcare Improvement Scotland is used to describe the elements of clinical governance:

> "The NHS Healthcare Improvement Scotland (NHS HIS) standards for clinical governance and risk management have been developed to support all NHS Boards to put in place the necessary systems and processes to ensure that safe, effective, patient-focused care and services are being delivered across Scotland."

The standards are the conclusion of a two year process of development and consultation by a multidisciplinary project group, whose members have been drawn from a range of backgrounds, reflecting the many dimensions of healthcare governance.

The scope of the standards covers all aspects of clinical governance and risk management from the perspective of patient outcomes, and incorporates the following elements:

Standard 1 - Safe and effective care and services

- Risk management
- Emergency and continuity planning
- Clinical effectiveness and quality improvement

Standard 2 - The health, wellbeing and care experience

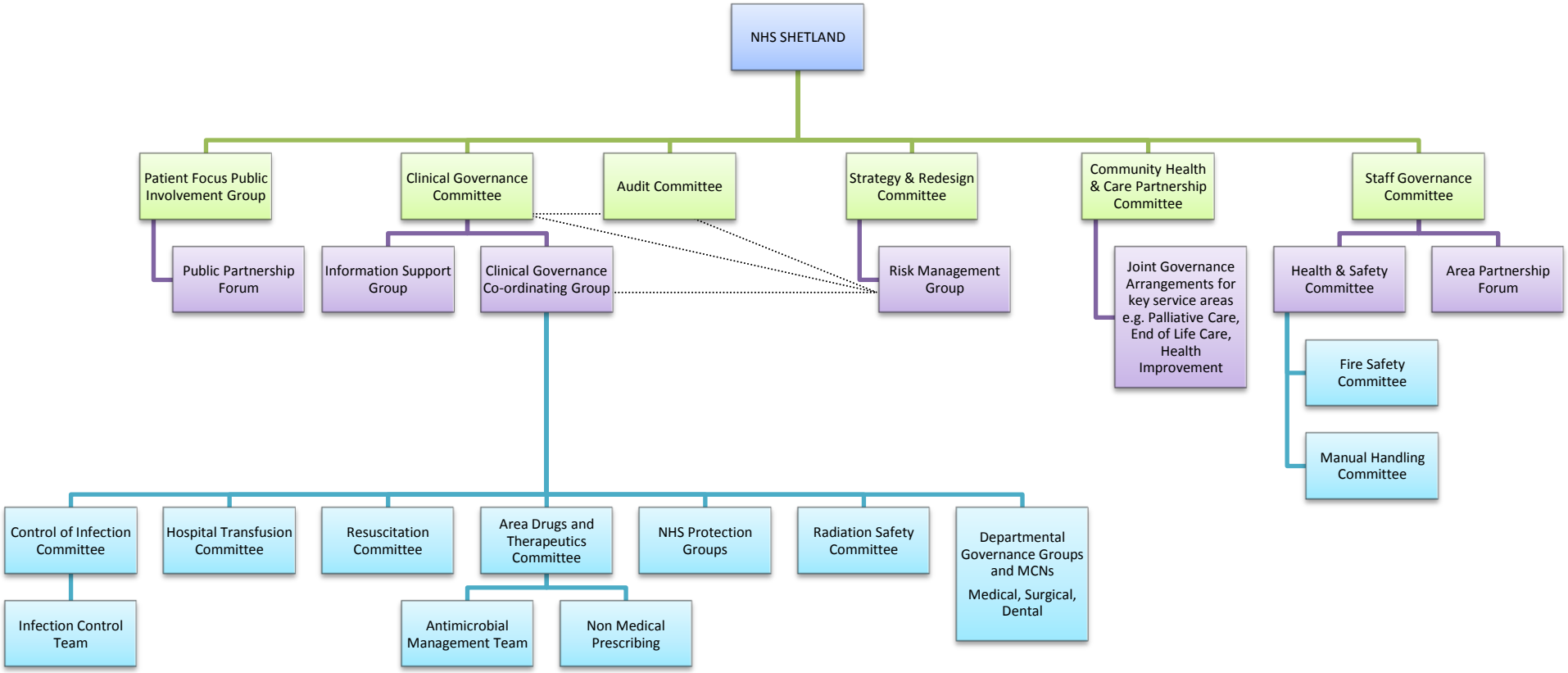
- Access, referral, treatment and discharge
- Equality and diversity
- Communication

Standard 3 - Assurance and accountability

- Clinical governance and quality assurance
- Fitness to practice
- External communication
- Performance management
- Information governance

Appendix 1 – CGCG Terms of Reference
Appendix B – Risk Management Strategy

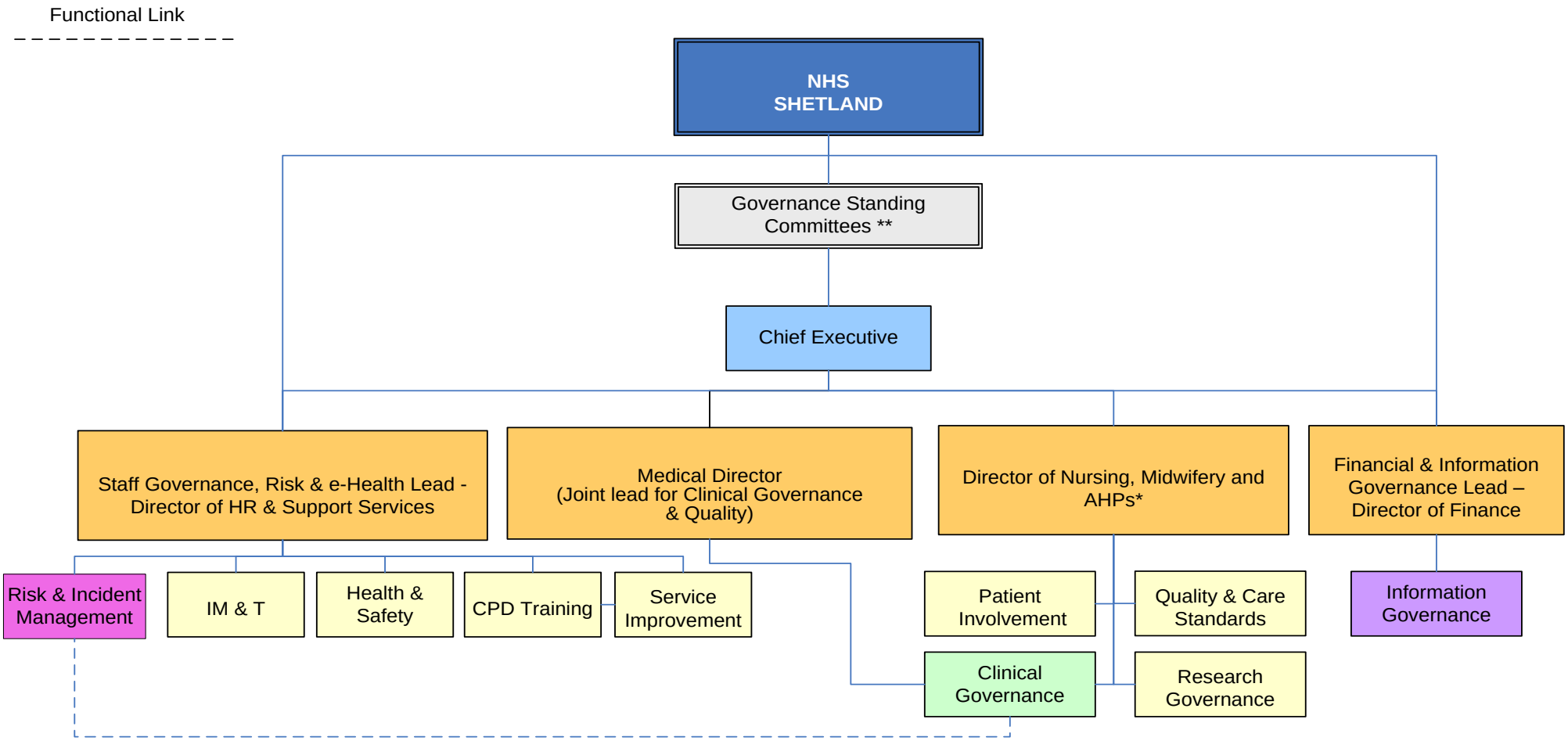
Organisational chart denoting the reporting and accountability lines for clinical governance and strategic risk management updated in August 2013



Dotted Lines: Functional links with shared accountability and assurance roles

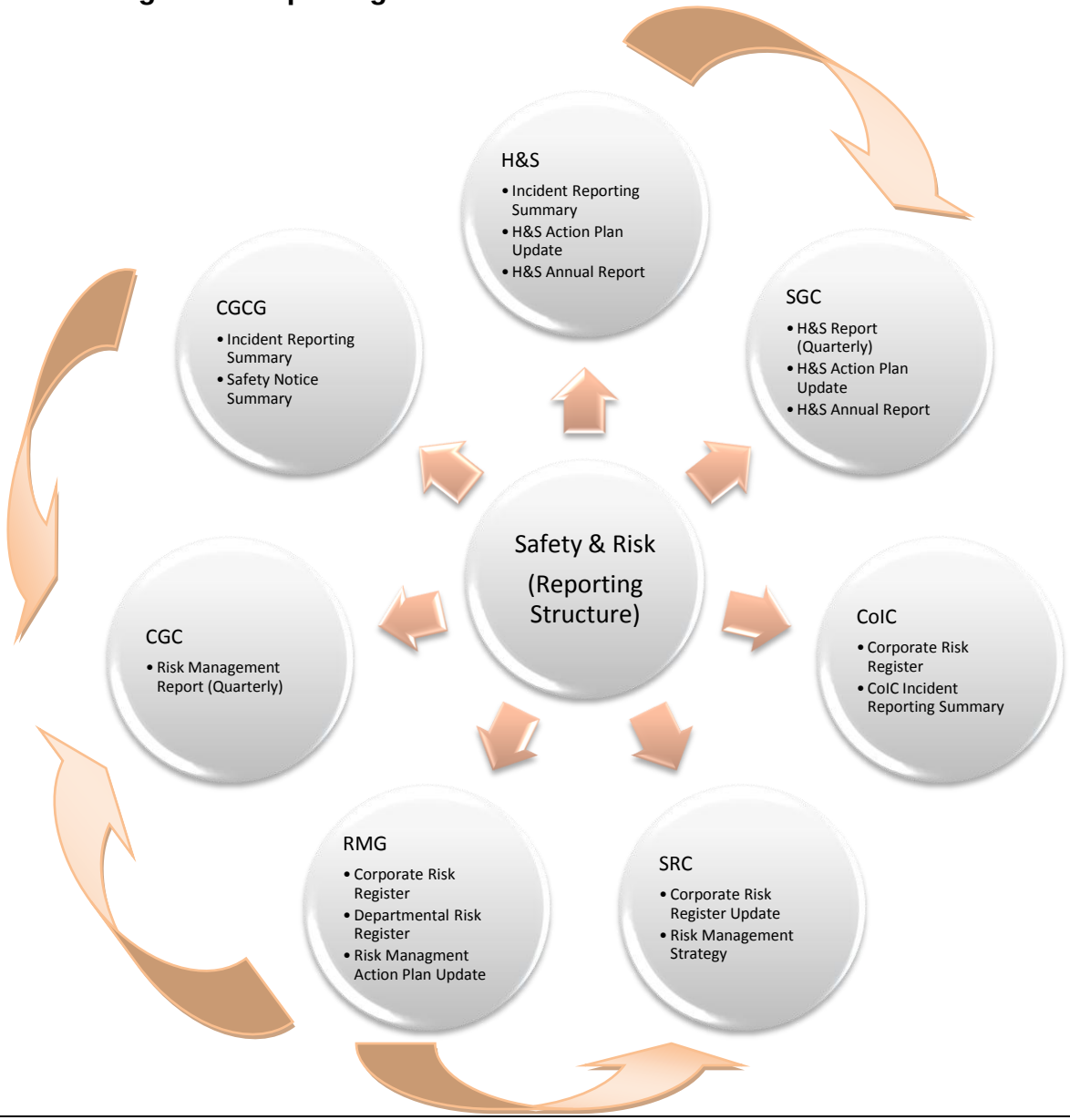
APPENDIX 2
(Revised 2013)

NHS SHETLAND
GOVERNANCE ORGANISATIONAL CHART



* Strategic lead for clinical governance
** Standing committees are responsible for assuring the Board that appropriate governance arrangements are in place

Appendix C - Organisational Risk Management Reporting Mechanisms



Appendix D - Risk Assessment Tool

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

An assessment of the risks attached to a particular practice or activity may be undertaken using the Risk Assessment Matrix (see Figure 1 below) by mapping the likelihood (the probability or frequency of a consequence occurring) (Figure 2) against the consequence (the outcome or impact component Figure 3) to determine the risk grading/score. This can be used as the basis of identifying acceptable and unacceptable risk

Figure 1: Risk Assessment Matrix

	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Extreme
Almost certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Remote	L	L	L	M	M

In terms of grading risks, the following grades have been assigned within the matrix.

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

Figure 2: Likelihood of Recurrence Ratings

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

Figure 3: Consequence ratings

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Objectives / Project	Barely noticeable reduction in scope / quality / schedule	Minor reduction in scope / quality / schedule	Reduction in scope or quality, project objectives or schedule	Significant project over-run	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient / visitor / staff.	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required	Agency reportable, e.g. Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Patient Experience	Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care	Unsatisfactory patient experience / clinical outcome **directly related to care provision – readily resolvable**	Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery <1wk	Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery - >1wk	Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects
Complaints / Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim
Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care	Some disruption in service with unacceptable impact on patient care Temporary loss of ability to provide service	Sustained loss of service, which has serious impact on delivery of patient care resulting in major contingency, plans being invoked.	Permanent loss of core service or facility Disruption to facility leading to significant "knock on" effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day) Short term low staffing level (>1 day), where there is no disruption to patient care	Ongoing low staffing level reduces service quality **Minor error** due to ineffective training / implementation of training	Late delivery of key objective / service due to lack of staff. **Moderate error** due to ineffective training / implementation of training Ongoing problems with staffing levels	Uncertain delivery of key objective / service due to lack of staff. **Major error** due to ineffective training / implementation of training	Non-delivery of key objective / service due to lack of staff. Loss of key staff. **Critical** error due to ineffective training / implementation of training
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss (£<1k)	Minor organisational / personal financial loss (£1-10k)	Significant organisational / personal financial loss (£10-100k)	Major organisational / personal financial loss (£100k-1m)	Severe organisational / personal financial loss (£>1m)

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating Critical report.	Prosecution. Zero rating Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage Little effect on staff morale	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services affected	National / International media / adverse publicity, more than 3 days. MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry

Appendix E - Risk Management Action Plan 2013/15

1. Strategy, policies, procedures, guidelines and related documentation

NHS Shetland Risk Management Objectives:

- **Comply with all relevant statutory requirements**
- **Monitor and review key risk management policies and procedures to ensure that risks are effectively managed**
- **Further develop adverse event management and reporting arrangements taking into account national guidance**
- **Develop understanding of improved outcomes from the Board's Risk Management Strategy and work programme, and, therefore, our measurement of the effectiveness of the risk strategy**

Topic Area	Actions	Milestones/Timescales/Indicative Completion Date	Lead	Outcomes

a) **Risk Management Strategy** - the current Risk Management Strategy was reviewed in 2012-13 and noted by Shetland NHS Board in June 2012. The strategy is next due for review in June 2015. In the interim a number of updates to the document are required annually along with a general refresh of the document to ensure that information contained is accurate and up-to-	• Update of the Board's Corporate Objectives for 2013-14 (Section 1)
	• Update of the Risk Management Objectives for 2013-14 (Section 5) – agreed by RMG on 31 January 2013
	• Update of Governance Organisational Chart (Appendix 2)
	• Addition of Risk Management Action Plan 2013-15 (Appendix E)
		• Draft Risk Management Action Plan 2013-15 to be presented to RMG for sign-off on 10 July 2013
		• Other updates and general refresh of the document during June/July 2013
		• Updated strategy presented to RMG on 8 August 2013
		• Updated strategy presented to Strategy and Redesign Committee on 10 September 2013
			SRM	• The strategy reflects and incorporates current thinking and best practice - in terms of principles, advice and guidance - for continued development of the Board's risk management framework
				• Clear lines of accountability are defined and reflective of NHS Shetland's governance structure
				• The framework remains fit for purpose in terms of:
				  ○ Decision making and planning for risk management
				  ○ Development and implementation of processes to manage risk
				  ○ Development and implementation of processes for identifying external

date				and internal factors that could give rise to risk • Information contained in the strategy is accurate and up-to-date • Board, committee and staff members involved in addressing and managing risk are informed and guided in their work • Agreement as to the right targets and meaningful measures to drive forward improvements in risk management performance across the Board thereby contributing to the achievement of high level organisational KPIs • Attainment of organisational resilience
b) **Incident Reporting, Investigation and Management Policy** - the current Incident Reporting, Investigation and Management Policy was reviewed in 2012-13, approved by the Clinical Governance Committee in	(i) Agree what types of incident trigger a 'significant adverse event' – taking into account the current guidance from the national review/recommendations	• Circulate example lists to the RMG, CSMT & Consultants group by 5 September 2013 • RMG to gather feedback and agree final list of triggers by mid-November 2013	DHRSS	• Update of Incident Reporting, Investigation and Management Policy • All staff have supporting up-to-date information and guidance to enable them to make full and correct use of the Datix Incidents module • There is an active and planned approach to engaging with patients, family and carers affected by a significant adverse event • Post-event feedback to
	(ii) Agree how we then classify 'significant adverse events' in terms of the cut off point for low and high level adverse events	• Circulate examples of the different approaches to RMG, CSMT & Consultants group by 5 September 2013 • RMG to gather feedback and agree the final model for use locally by mid-November 2013	DHRSS	

November 2012 and ratified by the Strategy and Redesign Committee in January 2013. The revised policy was introduced on the understanding that: a) Implementation issues would be worked through over the six months to the end of June 2013 b) The document would be subject to early review in the light of the HIS Management of Adverse Events Review report c) Any subsequent changes to the policy would be informed by national guidance	(iii) The guidance in the policy regarding the convening of either a Clinical Risk Advisory Team [CRAT] and/or a Significant Incident Team [SIT] needs to be clarified and implemented	• Discuss the current process with RMG, CSMT & Consultants group by 5 September 2013 • Agree any revisions required through the gathering of feedback and approve at RMG by mid-November 2013	DNMHAP	individual patients, families and/or carers happens in all cases • NHS Shetland operates a standardised and formal process for managing adverse events and staff consistently apply policy guidance
	(iv) Agree a process for informing and involving patients and families in investigation arrangements Agree a mechanism to engage and feedback to individual patients/families concerned to ensure consistency	• Review the IHI paper, *Respectful Management of Serious Clinical Adverse Events* and set out principles for review by RMG, CSMT & Consultants group. Gather comments and approve via RMG by mid-November 2013 • Update Datix system to enable recording of engagement with individual patients, families and/or carers in line with system upgrade	MD SRM	
c) **Risk Management Action Plan 2013-15**	• Monitoring of Action Plan delivery	• Risk Management Action Plan 2013-15 due to be approved by RMG on 10 July 2013 • Following approval, plan to be incorporated into the updated Risk Management Strategy 2012-2015 (see item (a) above for timescale). Subsequent update of relevant intranet pages with updated strategy	SRM	• Evidence is provided for the SMT and CGC that the Risk Management Strategy is being actively implemented, systems/procedures are being regularly reviewed and, where required, developments and improvements are being

		document and staff alerted via a Message of the Day by end of September 2013 • Risk Management Action Plan update report provided for each RMG meeting • Overall progress against Risk Management Action Plan reported quarterly to CGC • Risk Management Annual Report compiled for 2013/14 and circulated by end June 2014		made

2. Management of Adverse Incidents

<u>NHS Shetland Risk Management Objectives</u>:

- **Further develop adverse event management and reporting arrangements taking into account national guidance**

In addition to the actions identified in Sections 1 and 3 of the Action Plan, the following additional actions have been identified:

Topic Area	Actions	Milestones/Timescales/Indicative Completion Date	Lead	Outcomes
a) **Information management**	(i) Ensure Reporting, Investigation and Management Policy contains information for staff on document control and storage on Datix including: • Dates • Version number • Author(s)	As noted in Section 1 above, a review of the Reporting, Investigation and Management Policy will take place during the year and incorporate the recommendations contained the HIS Management of Adverse Events Review report. The review to be completed by 31 March 2014. • Introduction of reporting templates (see below)	SRM	Document control and related information systems are integrated and robust and provide a clear audit trail of adverse event management
	(ii) Design standard documentation for: • Table top investigation exercise • Local team debrief	• Review current documentation and examples available from other HBs and discuss with RMG, CSMT & Consultants group by 5 September 2013	DNMAHP	

	• Full RCA • Enhanced external RCA	• Agree the document set via RMG by mid-November 2013		
b) **Joint reporting, Investigation and management of incidents involving NHS Shetland and NHS Grampian, and NHS Shetland and the Scottish Ambulance Service [SAS]**	(i) Agree a mechanism to record, investigate and share learning from incidents involving both NHS Shetland and NHS Grampian, making use of the Datix systems	• Discuss options with key staff from NHS Grampian Quality, Governance and Risk Unit on 10 June 2013 • Develop an initial process by end August 2013 • Continue to refine and develop process during remainder of 2013-14 reporting progress to RMG	ADCS & SRM	Adverse incident information is fully reported and discussed and there is are clear processes for joint management of adverse incidents across boards and partner agencies
	(ii) Develop the process of joint incident investigation and management with the SAS	• Continue to refine and develop process during remainder of 2013-14 reporting progress to RMG	ADCS	
c) **Reporting, investigation and management of significant adverse events across health and social care systems**	(i) Find ways of addressing the challenges of joined-up working across agencies	• Agree the process for significant adverse event management in the acute setting and use this as a basis for discussion with community and social care partners through the CHCP committee structure • Review initial outline in December 2013	DHRSS	
d) **Assurance that the process of reporting, investigation and learning from incidents is working effectively**	(i) Define process measures through RMG e.g. expected report completion timescales, number of actions completed and quality of report content Once the national consultation is complete, implement nationally agreed outcome measures plus any locally derived measures	• Agree a set of process and outcome measures including: ○ The implementation of policy deadlines and monitoring of timelines for staff recording and investigating incidents ○ A monitoring system to provide assurance that action plans are completed and actions being implemented ○ Evidence of capturing and sharing of lessons learned via discussions at meetings and consistent feedback to staff • Review initial outline in September	DHRSS	Investigation of adverse events is being used by NHS Shetland to reduce the risk of these events occurring again and drive service improvement Management of significant adverse events is completed in a timely manner and thematic learning is appropriately disseminated and acted upon throughout the organisation

		2013		

3. Risk Registers

<u>NHS Shetland Risk Management Objectives</u>:

- **Continue to monitor and refine the system of control by ensuring that all strategic groups and services have processes in place to identify and manage risks and that the Risk Management Group is kept informed of relevant actions and treatments**
- **Ensure that risk registers are further developed at a departmental level, recorded and managed using the Datix Risk module and routinely reviewed across the organisation focusing on quality and ensuring identification and treatment of all relevant physical and psychosocial hazards**
- **Ensure that the centrally maintained Corporate Risk Register is kept up to date and the history of corporate risks recorded on Datix**
- **Contribute to the development of a Community Risk Register**

Topic Area	Actions	Milestones/Timescales/Indicative Completion Date	Lead	Outcomes
a) Corporate Risk Register [CRR]	i) Maintain the CRR	• Throughout the year, the Safety and Risk Support Team ensure that the CRR is kept up to date and that the history of corporate risks is recorded on Datix • Suggestions from key stakeholders for improvements to the layout of the CRR are Incorporated on an ongoing basis	SRM	• The CRR continues to be fit for purpose and accurately reflects the risk profile of the organisation i.e. the nature and level of the threats faced, the likelihood of adverse effects occurring, the level of disruption and costs associated with each type of risk and the effectiveness of controls in place to manage those risks
	ii) Maintain and develop the process in place to identify, record and review corporate risks and the actions to mitigate them	• The RMG reviews the CRR at every meeting to ensure appropriate handling of risks leading to either escalation/status quo/reduction of risk ratings or removal from risk register (every four weeks) • All risks rated as high/very high and deemed impossible or impractical to manage at a Departmental or	SRM	• Risks are accurately recorded and reviewed on a regular basis • Regular review of the CRR enables the organisation to map and understand its risk profile • The outcome of risk profiling ensures that:

		Directorate/Clinical Services/CHCP Management Team level are submitted to RMG to be considered for inclusion in the Corporate Risk Register (every four weeks) • Any risk that could adversely affect achievement of the Board's objectives or present a large loss to the organisation is submitted to the RMG via the appropriate Director to be considered for inclusion in the Corporate Risk Register (every four weeks) • The Board and the Strategy and Redesign Committee [SRC] are involved in identifying and reviewing corporate risks: o At each meeting of the SRC o Annually at the Board o Annually as part of a Board Information Session		o The right risks have been identified and prioritised for action o Minor risks have not been given too much priority o Appropriate mitigating factors/control measures are in place and residual risk is decreasing/as low as possible
b) Departmental Risk Registers [DRRs]	i) DRRs are regularly reviewed by senior management as a standing agenda item at RMG including understanding the quality of the registers in place	• Departmental Risk Register Status Update report provided for each RMG meeting (every four weeks) • Directors follow up with HoDs any areas where DRRs are not in place or risks have not been reviewed/updated • During 2013/14, a mechanism is agreed to monitor the quality of DRR contents (action carried forward from 2012/13 plan) • During 2013/14, a mechanism is developed to aggregate risk narratives that come out of DRRs to ensure that (where appropriate) a discussion takes place around more than just departmental mitigating	DSO Directors RMG RMG	• Assurance that Risks are identified across all NHS Shetland Departments to ensure that appropriate controls are in place throughout the organisation • Supporting actions are reviewed in accordance with assigned review dates stated in the registers • Risk registers are checked for quality – i.e. adequacy, accuracy and sense of narrative and completeness • Processes are reinforced and learning is embedded within departments

		factors to ascertain whether or not the risk should be reclassified as Directorate or Corporate (action carried forward from 2012-13 plan) • HoDs are supported in the development and maintenance of their DRRs throughout the year by the Safety and Risk Support Team via individual and group training and telephone/email help	SRST	
c) **Directorate Risk Registers [DirRRs]** Creation of DirRRs is an action carried forward from the 2012-13 Action Plan for completion	i) Establish Directorate Risk Registers to categorise and manage risks that have wider implication than at departmental level but are not at corporate level	• By the end of August 2013, identify Directorate level risks via: o A review of Department Risk Registers by Directors (facilitated by the DSO) o Review of the risks identified by HoDs on Datix as 'corporate' but which are not deemed appropriate for inclusion on the CRR by RMG o Review of risks identified by HoDs on Datix as 'directorate' • September 2013 - Once such risks are identified the RMG to allocate them to appropriate Directorates with the Director designated as the 'manager' of the risk • September 2013 - The Director will then allocate the risk to an appropriate HoD as the 'handler' for ongoing monitoring and review • A Directorate Risk Register Update Report is provided for each meeting of the RMG beginning in October 2013	DSO	• There are processes in place to effectively manage risks identified as cross-organisational but which are not strategic or corporate
d) **Strategic Risk Sharing Partnership**	i) A Partnership between the local public sector agencies has been established to focus on	• Strategic Risk Sharing Partnership established in August 2010 with the purpose of sharing knowledge and	SIC	• There is a more sophisticated and cohesive approach to successfully

• No progress was made by the Partnership in 2013-14 and this action has been carried forward	the collective risks that may threaten achievement of joint strategic aims	critically appraising the risks relating to Shetland's strategic aims and forming a comprehensive graded assessment with control measures/actions to minimise risk to an acceptable level • Lead organisation is the SIC who convene quarterly Partnership meetings • Risks will be electronically managed through the SIC's risk management system, JCAD, and remote access will be afforded to the core members of the Partnership (timescale to be agreed) • Training in the use of JCAD will be provided by the SIC (timescale to be agreed) • The Safety and Risk Manager to participate in the Partnership on behalf of NHS Shetland and report back to the RMG	SRM	managing the strategic risks facing Shetland across key public sector bodies

4. Risk Management Training and Development

<u>NHS Shetland Risk Management Objectives</u>:

- **Continue to monitor and refine the education and training programme which meets the needs of staff across the organisation with a particular emphasis on embedding the Datix electronic risk management system**
- **Continue to develop more formal mechanisms for sharing and learning from incidents and near misses**
- **Review and evaluate the management of major service change ensuring that appropriate risks and control measures are incorporated into service change plans**

Topic Area	Actions	Milestones/Timescales/Indicative Completion Date	Lead	Outcomes
a) Risk management training and development	i) Continue to develop and build on current training opportunities provided for staff including: • Input into Corporate	• Review and refresh Corporate Induction and Compulsory Refresher training sessions at regular intervals throughout the year in the light of	SRM	• Trained and aware staff contribute to a positive organisational culture, which helps to reduce the

	Induction Training • Input into Compulsory Refresher Training	feedback from participants, changes to local processes and procedures, and learning points from topical events both internal and external • Monthly Corporate Induction and Compulsory Refresher sessions scheduled throughout 2013-14 (ongoing) • Continue to monitor the impact and usefulness of compulsory training sessions via feedback sheets, aiming to maintain 90% satisfaction – i.e. evaluations rated at 4 out of 6 or above – over the course of the year		risks faced by patients, visitors, colleagues and themselves and prevent the occurrence of adverse incidents • Support and awareness-raising for all staff on good risk identification and assessment and incident reporting and management • Up-to-date, tailored and effective presentations actively engage staff so they fully take in risk management messages
	ii) Develop and deliver formal training on Datix, risk management and investigations	• Datix Update and Refresher Training delivered to Senior Managers and HoDs (including new starts) on an ad hoc basis throughout the year (ongoing) • Risk Assessment training session developed for tailored delivery to individual departments by May 2013 • Investigation training which supports staff to: ○ Manage the immediate response ○ Agree the level of discussion that is appropriate/necessary with the patient/family ○ Agree what needs to be recorded on Datix with clinical/management team – including classification of high/low level rating ○ Communicate/agree how the investigation will be undertaken across the wider	SRM SRM Training design and materials - DHRSS Training materials and content DNMAHP Training delivery - ADCS and SRM	• Prevent adverse events occurring. If they do, to establish the causes, take appropriate steps to prevent a recurrence and learn from the experience, ensuring that learning is applied to future situations • Staff involved in managing significant adverse incidents have a clear understanding of investigation methods and apply them to adverse event reviews and action planning • Drive service improvement by creating opportunities to learn and change things for the benefit of patients, staff, members of the public and others who use NHS Shetland's services and

		team ○ Analyse the investigation findings – including classification of high/low level of rating ○ Reporting findings ○ Sharing lessons ○ Agreeing specific actions • Report on progress re all risk management training: ○ To each meeting of the RMG via the Risk Management Action Plan Update Report ○ To the CGC via the Risk Management Quarterly Report	SRM	facilities
	iii) Risk management of major service change	• Throughout the year, each project will have a risk matrix completed in partnership and engagement with the service providers and service users	HoDs, Project Managers and RMG	• HoDs and others involved in the planning and delivery of projects have the necessary skills to assess risks associated with delivery of significant service change
	iv) Maintain and develop procedures for the reporting of adverse incidents, the dissemination of safety advice and the control of risks relating to health, social care, estates and facilities equipment	• Assess, filter and cascade all relevant Safety Notices received by the organisation as per the Safety Notice Procedure • Report problems with medical products and devices to National Procurement and the Incident Reporting and Investigation Centre [IRIC] • SRM to liaise with Supplies Department and National Procurement to highlight and resolve issues with medical consumables raised by staff feeding back to CGCG • SRM to fulfil role of Equipment Co-	SRM	• Efficient and effective internal cascade systems are in place to ensure that Safety Notices are received, assessed and acted upon • Improved patient safety

		ordinator for the Board including participation in national meetings held three times per year		
5. Datix				
<u>NHS Shetland Risk Management Objectives</u>: • **Continue to monitor and refine the education and training programme which meets the needs of staff across the organisation with a particular emphasis on embedding the Datix electronic risk management system**				
Topic Area	Actions	Milestones/Timescales/Indicative Completion Date	Lead	Outcomes
a) Datix electronic risk management system – NHS Shetland is currently running version 10.1 (2009) and we have been advised by the Datix Helpdesk that support for this version will be withdrawn soon	i) Upgrade Datix risk management software	• April 2013: Test system (12.1/2012) installed. This is a copy of the live system to ensure usability • June 2013: SRM and DSO visit to NHS Grampian Quality Informatics Department to liaise re upgrade • July/August 2013: Training for SRST on new features of updated system provided by Datix • Autumn/Winter 2013/14: Ensure functionality of Datix security systems; form redesign; addition of new features in consultation with RMG/HoDs • Spring/Summer 2014: Roll-out of and training on new functionality	SRM/DSO	• The ability to record involvement of patients/families/carers in the incident review process • Incorporation of improved mechanisms to prevent over-grading of incidents • Improved audit trail on Datix system • Improvement in a key component of NHS Shetland's risk management arrangements thereby contributing to the delivery of organisational objectives and enhanced patient outcomes
	ii) Clear the backlog of incidents recorded on the Datix system categorised as 'In holding area awaiting review' that have not been opened and/or investigated	• Agree process for tackling backlog with RMG by end August 2013 and put into practice with a view to reducing this to <30 by end March 2014		• Outstanding incidents recorded on Datix are addressed
	iii) Continue to monitor use and usability of Datix system	• Improve use of Datix across NHS Shetland, in particular by Consultants and GP Practices	SRM	• Effective embedding of the Datix Incidents module • Assessment of actual

		• Complete projects with NHS Shetland Anaesthetists and Laboratory Service to more effectively record incidents on Datix system • Monitoring incident reporting by following up one incident per week (chosen randomly) to get feedback from users on the Datix system and its operation (ongoing)	DSO SRSA	practice against formally documented processes • Improved recording, reporting and analysis of all adverse events leading to better learning and continuous improvement in care and services • Staff are encouraged to make reports and reassured that they are investigated promptly and effectively

6. Audit

<u>NHS Shetland Risk Management Objectives</u>:

- **Comply with all relevant statutory requirements**
- **Meet requirements of Internal and External Audit with respect to the Statement on Internal Control**

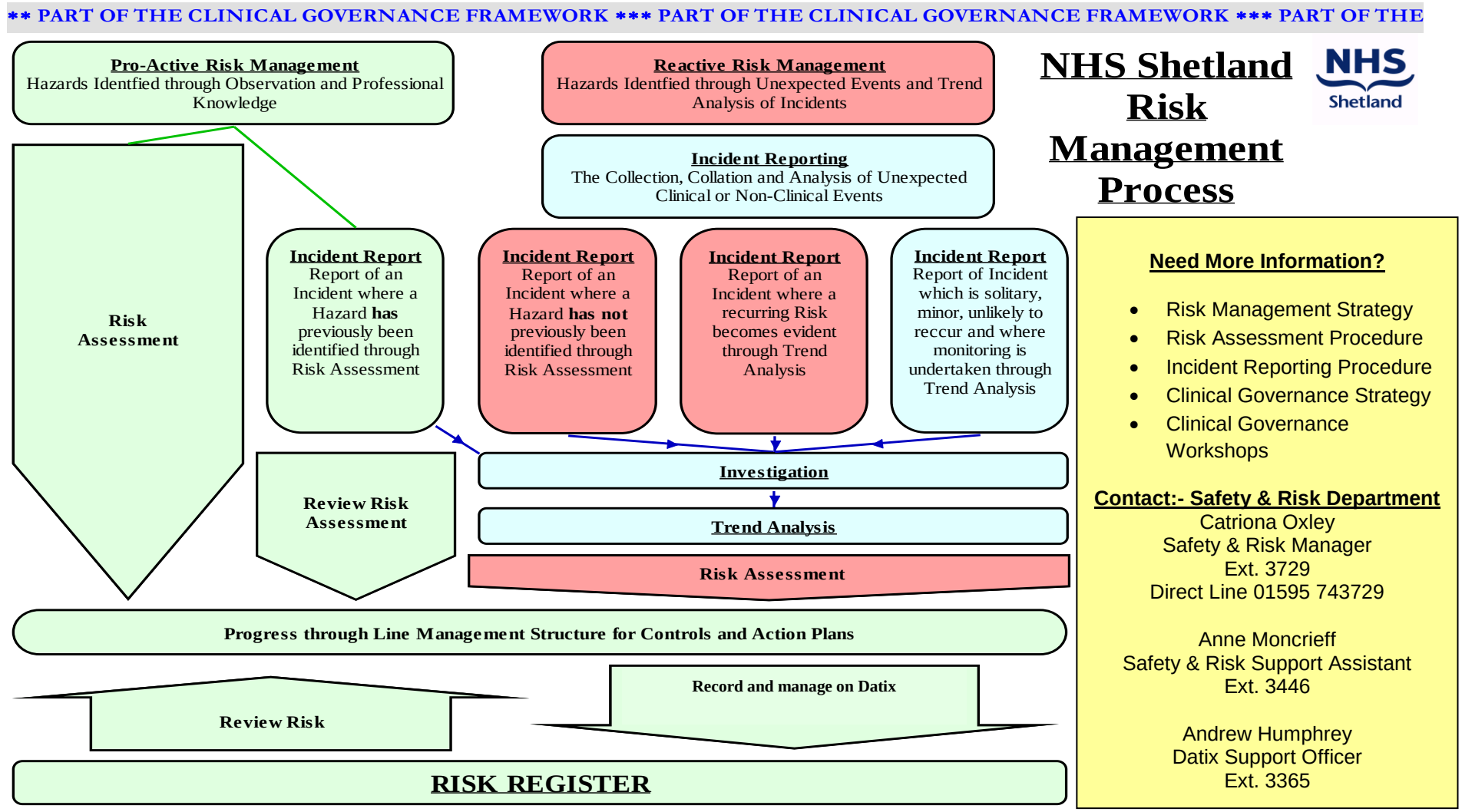
N.B. Risk Management is not an area identified in the Board's internal Audit Plan for 2013/14

Topic Area	Actions	Milestones/Timescales/Indicative Completion Date	Lead	Outcomes
a) Systematic review and assessment of elements of the risk management process and risk management performance	i) Continue to work with NHS Healthcare Improvement Scotland to develop clinical governance and risk management performance	Build on the positive outcome of the Clinical Governance Risk Management review in April 2010 as NHS Healthcare Improvement Scotland's scrutiny role develops (ongoing) Once the national HIS Management of Adverse Events consultation is complete, review current incident reporting, investigation and management processes in the light of published findings and recommendations	DNMAP DHRSS	• Areas of good practice and efficiency are identified and can then be shared and, if appropriate, adopted more widely • Areas of poor practice and deficiencies are identified and are then addressed and managed

7. Key Performance Indicators [KPIs]	
What are the main goals of the Risk Management Action Plan 2013-15?	**How will we know if we've achieved them?**
• Update of current Risk Management Strategy • Review of Incident Reporting, Investigation and Management Policy • Development and implementation of clear process for involvement of patients, families and carers affected by a significant adverse incident • Risk Management Annual Report 2013/14 • Improvement in document control in relation to incident investigation • Development of joint incident reporting and investigation mechanisms • Directorate Risk Registers in place • Engagement of Consultants in use of Datix risk management system • Delivery of formal training on Datix, risk management and incident investigation • Upgrade of Datix risk management software • Clearing the backlog of incidents on Datix 'In holding area awaiting review'	• Updated Risk Management Strategy presented to and signed off by Strategy and Redesign Committee by end September 2013 • Revision of Incident Reporting, Investigation and Management Policy complete by end March 2014 and final draft ready for committee approval process • Evidence of involvement of patients, families and carers in significant adverse incident investigations and ability to capture this on Datix system • Risk Management Annual Report 2013/14 completed and circulated by end June 2014 • All documents relating to incident investigations are complete and include author, date and version number • Process in place and operational for joint reporting and investigation of incidents and detailed in Incident Reporting, Investigation and Management Policy • Directorate Risk Registers fully operational on Datix system by end December 2013 • Consultant use of Datix to report, investigate and manage adverse incidents as evidenced by system reports • Feedback on training sessions presented to RMG and CGC as part of regular reporting mechanisms • Datix software upgrade completed and embedded by end August 2014 • Backlog of incidents on Datix 'In holding area awaiting review' reduced to <30 by end March 2014
Key: **ADCS** – Assistant Director of Clinical Services **CGC** – Clinical Governance Committee **CGCG** – Clinical Governance Co-ordinating Group **CRR** – Corporate Risk Register **DirRR** – Directorate Risk Register **DHRSS** – Director of Human Resources and Support Services	**HSC** – Health and Safety Committee **KPI** – Key Performance Indicator **MD** – Medical Director **PPF** – Public Partnership Forum **RMG** – Risk Management Group **SIC** – Shetland Islands Council **SMT** – Senior Management Team

DNMAHP – Director of Nursing, Midwifery and AHPs **DRR** – Departmental Risk Register **DSO** – Datix Support Officer **HIS** – Healthcare Improvement Scotland **HoD** – Head of Department	**SN** – Safety Notice **SRC** – Strategy and Redesign Committee **SRM** – Safety and Risk Manager **SRSA** – Safety and Risk Support Assistant **SRST** – Safety and Risk Support Team
• New objectives agreed by RMG in January 2013 • Content of the *Significant Adverse Event System Development – Action Plan* drawn up by DNMAHP on 13 February 2013 with subsequent amendments agreed at the meeting of the RMG held on 27 March 2013 • Recommendations contained in the HIS Management of adverse events Review Report | NHS Shetland, June 2013	

Appendix F - Risk Management Process



Appendix G - 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, ensuring the work plan is summarised in the Corporate Action Plan
- 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 Clinical Governance Co-ordinating Group
- 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 corporate risks and to provide information on relevant corporate risks to Board Committees
- To work closely with the Clinical Governance Co-ordinating Group and the Safety and Risk Management Team to ensure the Risk Management Strategy and annual work plan are implemented
- Through the Clinical Governance Co-ordinating Group and the Safety and Risk Management Team, to support and sponsor awareness raising, education and training, and development of risk management processes
- To oversee the annual preparation of the Board's Statement on Internal Control.

Membership of RMG

- Senior Management Team
- In attendance: Members of the Clinical Services and Safety and Risk Management Teams.

Chair of RMG

Director of Human Resources and Support Services.

Frequency of Meetings

The RMG will meet every eight weeks.

Appendix H - Shetland NHS Board Health and Safety Committee

TERMS OF REFERENCE

Introduction

Shetland NHS Board (the Board) recognises the requirement to convene a Health and Safety Committee as laid down by statute under the *Safety Representatives and Safety Committees Regulations* 1977. The Board fully supports the work of the committee and its members in discharging its remit.

Remit

The Health and Safety Committee has the following remit:

- The committee will promote good practice in the field of health and safety at work through the co-operation of all staff and contractors employed in the various functions of the Board.

- The committee will study incident, accident and notifiable occupational disease statistics and trends so that reports can be made to management on unsafe and unhealthy conditions and practices.

- The committee, where appropriate, will convene working groups to examine and advise on issues identified by examination of incident and accident data.

- The committee will consider reports and factual information provided by inspectors of the enforcing authority appointed under the *Health and Safety at Work etc. Act* 1974.

- The committee will commission and monitor a triennial programme of Health and Safety visits to all clinical and non-clinical areas throughout the Board's premises on mainland Shetland and outlying islands.

- The committee will work in co-operation with the Clinical Governance Coordinating Group (CGCG) to ensure that Health and Safety data and issues appropriately inform the Board's clinical governance agenda. This will be achieved by the provision of Health & Safety Committee minutes and appropriate reports.

- The committee will commission and monitor appropriate Health and Safety audits ensuring that appropriately trained staff carry these out.

- The committee will consult (where appropriate) and comment on relevant draft policies prior to passing these on for formal approval and ratification by the Board.

- The committee will ensure that its members are provided with adequate training to discharge their duties. The committee will provide advice and guidance to the Board's managers and Senior Management Team on appropriate provision of Health and Safety Training in the work place for all staff.

- The committee will lead the promotion of good Health and Safety practice and communicate such information to all Board employees.

Membership

Members will be drawn from elected representatives of staff side organisations and management.

- **Management representation** will be aimed at providing adequate authority, knowledge and expertise to provide appropriate information to the committee and should be representative of the Board. Membership will be reviewed annually by the committee to ensure appropriate managers attend and that membership reflects contemporary management structures within the Board.

- **Staff Side representatives** will be elected representatives of recognised trades unions and professional organisations active within Shetland NHS Board. Such members should be accredited / recognised Health and Safety representatives of their respective union. There will also be two independent staff members. In addition a representative from the Board's Occupational Health Department will be an ex-officio member in an advisory role.

- **Chair** The Board's Director of Human Resources and Support Services is designated as chair in keeping with executive responsibility for Health and Safety issues throughout the Board. The staff side will elect a vice-chair who will serve for a minimum one-year period.

Management Representatives	**Staff Side Representatives**
Director of Human Resources & Support Services	UNITE
Safety & Risk Manager	UNISON (x4)
Assistant Director of Nursing (Hospitals)	RCN (x2)
Assistant Director of Nursing (Community)	RCM
Datix & Systems Support Officer	BMA
Service Manager Primary Care	CSP
Hotel Services Manager	Independent staff member (x2)
Head of Estates	
Training Officer/Manual Handling Adviser	
Health Improvement Manager	

Note: Names of Union Representatives will be held by the Safety & Risk Support Assistant.

Meetings

The committee will meet every 8 weeks and may be called at other times in exceptional circumstances. The dates of meetings will be published in each calendar year and members will be advised of same. Meetings will not be cancelled or postponed except in very exceptional circumstances and will not be postponed or cancelled without the agreement of the vice chair.

Quorum

The quorum will not be less than three members of management and three staff side representatives.

Attendance

In order for the committee to function effectively all members are expected to attend meetings. Management representatives will be expected to attend all meetings unless prevented by exceptional circumstances.

Those members who do not attend three consecutive meetings or whose attendance is generally poor will be asked to explain why in writing to the chair.

The committee may co-opt for any meetings individuals who are able to advise on specific issues appropriate to the committee's business.

Administrative support

Administrative support will be provided by the Safety & Risk Support Assistant. In his/her absence, the PA for the Director of Human Resources and Support Services will provide administrative services.

Any member may place items on the agenda and such items should reach the administrative team 10 days prior to scheduled meetings. Papers for meetings will be distributed no later than one week prior to the meeting. The Safety & Risk Support Assistant will be responsible for taking the minutes for each meeting.

Review of Terms of Reference

Terms of reference will be reviewed annually by the full committee.

Original Document Approved by Board	25 September 2000
Review 1:	May 2004
Review 2:	June 2005
Review 3:	November 2006
Review 4:	January 2008
Review 5:	August 2009
Review 6:	May 2011
Review 7:	October 2011
Review 8:	August 2013
Comments:	For next review August 2014

Appendix I - Strategy and Redesign Committee

TERMS OF REFERENCE November 2011

Purpose of the Committee

The Strategy and Redesign Committee is established by the Board to oversee policy and strategy development, to have strategic oversight of the redesign of the Board's services, and to provide oversight of the Board's Corporate Risk Register and risk management process.

Membership

The Committee will comprise:

- The Board Chair (who will also act as Chair of the Strategy and Redesign Committee)
- 6 x Non-executive Directors
- Chair of the Area Partnership Forum
- Chair of the Area Clinical Forum
- Chief Executive
- Director of Public Health and Planning
- Medical Director
- Director of Nursing, Midwifery, Allied Health Professionals
- Director of Finance
- Director of Human Resources and Support Services
- Director of Clinical Services

The lead officer for the Strategy and Redesign Committee shall be the Chief Executive.

Attendees may be invited to the Strategy and Redesign Committee as required.

Meetings of the Committee

Frequency

The Committee shall meet five times per year, with meetings normally held in the months between the bi-monthly Board meetings.

The Chairman of the Committee may at any time convene additional meetings of the Committee to consider business, which may require urgent consideration.

Agenda and Papers

The Chairman will set the agenda in conjunction with the Chief Executive.

The agenda and supporting papers will be sent out at least five working days in advance of the meetings.

All papers will clearly state the agenda reference, the author, the purpose of the paper and the action the Committee is asked to consider.

Quorum
No business shall be transacted at a meeting of the Strategy and Redesign Committee unless at least one third of the whole number of Members is present, of whom at least two Members are Non Executive Members of the Board. For the purposes of determining whether a meeting is quorate, Members attending by either video or tele-conference link will be determined to be in attendance.

Minutes
Formal minutes shall be taken of the proceedings of the Strategy and Redesign Committee. Draft Minutes shall be distributed for consideration and review to the Chairman of the Meeting prior to the Chairman giving a verbal update to the ensuing Board Meeting. The verbal update ensures any questions Members of the Board may have can be addressed promptly and/or other matters highlighted.

The draft Minutes shall then be presented at the next Meeting of the Committee for approval.

Formally approved Minutes shall be included in Board Meeting papers for noting following approval by the Strategy and Redesign Committee.

Authority
The Committee is authorised by the Board, within its Terms of Reference, to investigate any activity in the operations of NHS Shetland. It is authorised to seek and obtain any information it requires from any employee and all employees of NHS Shetland are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external legal or other independent professional advice and to secure the assistance of people from outside NHS Shetland or the wider NHS, with relevant expertise, if it is considered necessary.

Duties of the Strategy and Redesign Committee

Remit

- Oversee the development of the Board's annual redesign programmes;
- Oversee agreed (significant) redesign projects;
- Ensure appropriate engagement of clinicians, staff and stakeholders in the development of strategy and delivery of service redesign;
- Oversee the development and monitoring of the Board's Corporate Risk Register and overall risk management process;
- Ensure detailed and appropriate scrutiny of the development of all strategies, including the Local Delivery Plan and Financial Plan, and make recommendations on them to the Board;
- Ensure that strategies are compliant with the duties of the Board in respect of meeting legislative and good practice requirements;
- Ensure an integrated approach to workforce, finance and service planning;
- Encourage a continuous improvement in service quality; and

- Ensure the organisation develops the skills and culture for continuous improvement.

6. Reporting to the Board

The Committee has a duty to review its own performance and effectiveness, including performance against key performance indicators and to review its terms of reference on an annual basis.

Appendix J - 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, 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:

- Incident Reporting, Investigation and Management 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 (2003) 11, A Framework for Reform Devolved Decision-Making Moving Towards Single System Working.
- HDL (2004) 37, Community Health Partnerships (CHPs) and Integrated Mental Health Services
- Management of Risk: Guidance for Practitioners (2002). Published for the Office of Government Commerce (2002) under licence from Controller of HMSO, London
- 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
- Scottish Executive (2004). The NHS knowledge and Skills Framework (NHS KSF) and the Development Review Process. Edinburgh: Scottish Executive

References

Health and Safety Executive [HSE] (2004). *Investigating accidents and incidents*. HSG245

Risk Management Standards Australia/New Zealand 4360:2004

Abbreviations

CGCG	Clinical Governance Co-ordinating Group
RMG	Risk Management Group
SMT	Senior Management Team
CGST	Clinical Governance Support Team
CGC	Clinical Governance Committee
CSMT	Clinical Services Management Team
CHCPMT	Community Health and Care Partnership Management Team
DHR&SS	Director of HR and Support Services
HoD	Head of Department

Glossary of Terms

This glossary has been drawn from a variety of sources, notably AS/NZS4360: 2004. Risk Management Standard, National Patient Safety Agency, NHS Grampian Risk Management Strategy and NHS Fife Risk Management Strategy.

***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 organisations 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.

14. 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 2012-15 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	What positive and negative impacts do you think there may be? The Risk Management Strategy 2012-15 should have a positive impact. The key piece of legislation underpinning the strategy is the *Health and Safety at Work etc Act 1974*, 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. Additionally, the strategy recognises the requirement to give special consideration to specific groups including night workers, lone workers and workers with disabilities. 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.
	Which groups will be affected by these impacts? As noted above, the Risk Management Strategy 2012-15 has universal application across Shetland NHS Board and, as a consequence, affects all groups, including the minority groups listed above.
What impact will the proposal have on lifestyles? For example, will the changes affect: • Diet and nutrition • Exercise and physical activity • Substance use: tobacco, alcohol and drugs? • Risk taking behaviour?	The strategy outlines an approach which aims to promote responsible risk-taking (in a work context) within “a fair and just system where people are held to account for their behaviour, without being unduly blamed”.

• 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.

	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.
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?	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	
Positive Impacts (Note the groups affected) The Risk Management Strategy 2012-15 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.	**Negative Impacts (Note the groups affected)** None
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 2012-15 complies with current equalities legislation and good practice. Due to its positive impact on all equality groups a full EDIA process is not required.	