Agenda Item

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| **Meeting:** | Shetland NHS Board |
| **Date:** | 18 August 2020 |
| **Report Title:** | Risk Management Summary Report 2019/20 |
| **Reference Number:** | Board Paper 2020/21/29 |
| **Author / Job Title:** | Emma Garside, Clinical Governance and Risk Lead |

**Decisions / Action required:**

The Board is asked to note the risk management summary report 2019/20.

**High Level Summary:**

The summary report 2019/20 has been drafted for presentation to the Board as required in the risk management strategy. The report includes a section setting out the priorities going forward for 2020/21 and any risks to the delivery of the risk management framework.

**Corporate Priorities and Strategic Aims:**

The summary report is linked to the following NHS Shetland corporate objectives:

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

**Key Issues:**

This annual summary report was due to be presented at the Board meeting in April 2020 and the Audit Committee Chairs meeting in May 2020 which were cancelled due to the pandemic revised arrangements.

The report was presented at the Audit Committee meeting on 10th August 2020. Following audit committee, a conversation will be held at the next RMG on the KPIs for 2020/2021 led by the Executive Lead (Medical Director).

| **Implications :** *Identify any issues or aspects of the report that have implications under the following headings* | |
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| **Service Users, Patients and Communities:** | It is important that there are robust and reliable processes in place to effectively manage risk, and that lessons learned are shared widely and used to support improvements in care and service delivery. |
| **Human Resources and Organisational Development:** | The implementation of the strategy may require staff to be trained. |
| **Equality, Diversity and Human Rights:** | The impact of the Risk Management Strategy and supporting documents (including this policy) has been assessed as positive in relation to equality and diversity. |
| **Partnership Working** | N/A |
| **Legal:** | Health and Safety at Work etc Act 1974. |
| **Finance:** | The strategy includes clinical risks involving patients, families, staff and carers (including health and safety, accidents or incidents) and non-clinical risks (including information governance and finance). |
| **Assets and Property:** | The strategy includes clinical risks involving patients, families, staff and carers (including health and safety, accidents or incidents) and non-clinical risks (including information governance and finance). |
| **Environmental:** | The strategy includes clinical risks involving patients, families, staff and carers (including health and safety, accidents or incidents) and non-clinical risks (including information governance and finance). |
| **Risk Management:** | Providing this summary report demonstrates implementation of the risk management arrangements as detailed in the risk management strategy. |

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| **Policy and Delegated Authority:** | Risk Management Group | |
| **Previously considered by:** | RMG via email<br>Audit Committee | July 2020<br>10 August 2020 |

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| **“Exempt / private” item** | N/A |

*The main report is to be attached together with a list of the appendices and references to any background documents or material e.g. include web links.*

# Risk Management Summary Report 2019/20

## Introduction

The Board retains responsibility for the management of risk in its entirety. The Board delegates the development and detailed work associated with its implementation to the Risk Management Group (RMG) which reports to the Board.

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

The purpose of this report is to provide a summary of the risk management arrangements in place during 2019/20 and the work undertaken to strengthen the current arrangements. The report also outlines the risk management priorities for 2020/21 to further embed the risk management framework.

## Risk Management Strategy

The Board provides oversight of the Corporate Risk Register (CRR) and risk management process. The corporate risks were overseen by the Board with review of the CRR and actions report at the meetings in April 2019 and December 2020 (deferred from the October 2019 meeting due to leave). The corporate risks overview was maintained by the RMG through review of the CRR and actions report at each meeting (with the exception of March 2020 which was cancelled due to the pandemic). The Chief Executive requested a review of the corporate risks at the RMG meeting in March 2020 and this was cancelled due to the pandemic so will be undertaken during 2020/21. The relevant Committees also reviewed their corporate risks and actions on a 6 monthly basis with exception reporting where required, to the Board via the RMG or the Committee Chair.

During the year there was one corporate risk closed in June 2019 (1355 - Lack of training opportunities and staff trained in continuous service improvement techniques leads to slower progress on change than is required). There was also one new corporate risk (1372 - NHS Shetland is required to provide healthcare, including provision of forensic medical examinations in line with the HIS standards) which was reviewed by the RMG in September 2019, the CCPGC meeting in December 2019 and noted at the December 2019 Board.

One of the risk management priorities for 2019/20 was to embed risk appetite within existing risk management systems. The Good Governance Institute (GGI) 'risk appetite for NHS organisations – a matrix to support better risk sensitivity in decision taking' was adopted for use within the Board with a slight amendment (scale at the bottom of the table was removed). Each executive used the matrix to identify the risk appetite and the rationale for their corporate risks which were presented at the RMG meeting in March 2019. Following discussion at the meeting the risk appetite scores and rationales were added to the CRR template on Datix. The matrix and risk appetite scores were then discussed at a Board development session in May 2019 with an output for the RMG to review a number of corporate risks based on risk rating and appetite level. This commenced in

June 2019 and the corporate risks reviewed were identified by the risk rating and risk appetite level prioritising the high risks with low risk appetite. The risk appetite level and rationale was added to the Corporate Risk Register (CRR) report for the RMG in September 2019 and the Board and Committees from October 2019.

An internal audit on risk management was undertaken in December 2019. From the draft report the conclusion in the executive summary confirmed that 'NHS Shetland has made several improvements to its risk management arrangements during 2018/19 and 2019/20 and we have gained assurance that NHS Shetland is taking steps to ensure a risk management framework is embedded throughout the organisation. This includes the introduction of risk appetites within the corporate risk register and further development of departmental risk registers, which are now recorded on DATIX. We have, however, identified that a number of documents outlining the framework have not been updated in line with practical developments achieved and there is further scope for improvement regarding Audit Committee reporting'.

The audit identified a number of areas for improvement which internal audit suggests, if addressed, would further strengthen our control framework. These included reviewing and updating the Risk Management Strategy to reflect the latest national and international standards and contemporary good practice, providing clear links to the Board's strategic objectives within the annual risk management workplan, identifying ownership of actions/measures within the annual risk management workplan, risk management reporting and risk register updates to be included in the Audit Committee agenda as a standing item and reviewing the Risk Management Procedures and Risk Register Guidance.

In order to address these improvements we will review our underpinning Risk Management Strategy to ensure it aligns with contemporary national and internationally recognised standards including the Scottish Public Finance Manual. As part of the Risk Management Strategy update we will review the linkages between the risk management plan and ensure that the risk management workplan is contiguous with corporate strategy and objectives. We will also ensure that the development of a clinical strategy aligns with strategic risk management. The next review of the strategy is April 2020 and the document will remain under review while this work is carried out. The risk management objectives and priorities have been updated to reflect these areas for improvement and will be monitored by the RMG via the risk management workplan.

**Risk Management Objectives**

In line with the risk management strategy, the risk management objectives and Key Performance Indicators (KPIs) were reviewed with the interim Medical Director. The key objectives of the risk management strategy are to:-

- Embed risk management at all levels of the organisation – creating a safety culture
- Lead and support staff and promote reporting
- Provide the tools and training to support risk management
- Ensure lessons are learned and changes in practice are implemented

The risk management objectives and progress against the KPIs from 2019/20 are included in Appendix A identifying if they have been completed/business as usual or have been carried forward into 2020/21. The updated and new risk management objectives for 2020/21 have also been included in the appendix and will form the basis of the risk management workplan for 2020/21. Following presentation of this report to the Audit Committee, a conversation will be held at the next RMG meeting on the KPIs for 2020/21 led by the Executive Lead.

An update on progress against the risk management objectives was included in the risk management workplan 2019/20 which was presented at each RMG meeting.

Awareness sessions for staff on adverse events and risk management were delivered during 2019/20 and will continue throughout 2020/21. The programme of management bundles were also delivered during 2019/20 and a progamme of dates will be identified for 2020/21. Evaluations from each of the sessions held were reviewed with updates made accordingly to the sessions.

A gap was identified in one of the corporate risks relating to locums and the absence of an induction on clinical governance and risk management. A process was agreed and has been implemented. For locums here for 4 weeks or more an induction session is held. If a locum is here for less than 4 weeks or due to their working hours can not attend an induction session a presentation was drafted and sent out. The presentation was also put onto learnpro to enable us to monitor uptake.

The HIS adverse events management – NHS board self evaluation report was published in September 2019. The link to the report was circulated to members of the CCPGC and JGG. One of the priorities for HIS from the baseline exercise was to implement a new national notification system. Following national stakeholder events guidance was published in December 2019 and national reporting commenced in January 2020. A paper was presented to EMT in January 2020 highlighting the implications of the new system and the actions being taken locally. As the work around the national notification system will be evolving this has been identified as a risk management priority for 2020/21.

A review of the Learning from Adverse Events through Reporting and Review Policy has been undertaken in line with the review date. There were minor changes made to the policy. The procedure was also reviewed and updated in January 2020 further to the update to the national framework on the new national notification system.

There has also been work undertaken during the pandemic including supporting the risk assessment process for homeworking, developing a process and risks assessments for volunteers and redeployed staff and the development of contingency and recovery plans.

**The Risk Management Group (RMG)**

The RMG is an executive management group, chaired by the Director of HR and Support Services until September 2019 when it changed to the interim Medical Director. It has overall responsibility for the integration, co-ordination and standardisation of risk management throughout the Board. It

provided assurance to the Board on the establishment and implementation of risk management processes and systems. It oversaw the identification and monitoring of corporate risks, including maintenance of the CRR, and dealt with significant and escalating risks, reporting formally to the Board.

To meet the requirements as set out in the strategy and strengthen the existing risk management arrangements, the RMG during 2019/20:

- Reviewed and updated their Terms of Reference (TOR)
- Monitored the CRATs held
- Reviewed and approved the new risk management workplan for 2019/20
- Reviewed the risk management work plan progress report and KPI update at each meeting as defined in the strategy
- Reviewed the CRR and actions report at each meeting
- Reviewed new corporate risks before submission to the relevant committee
- Reviewed the corporate risks in order of highest rank table at each meeting (Appendix B)
- Reviewed the departmental very high and high risks in accordance with the internal audit requirement
- Reviewed the departmental risk register status update at each meeting
- Reviewed the draft Risk Management Annual Report 2019/20
- Included Brexit as a standing agenda item and received updates at the meetings
- Agreed the format of the risk appetite matrix for use in NHS Shetland
- Reviewed the risk appetite levels and rationales for each corporate risk, for presentation to the Board

**Risk Management Priorities 2019/20**

A number of the risk management priorities identified for 2019/20 have been completed and some are still in progress:

- Review of the departmental risks – The review was managed as a quality improvement project using the organisational software package (Life QI). Further to discussions at the RMG meeting in September 2019 and agreement to prioritise the review of departmental risks with responsible leads, the clinical governance and risk team met with the health and safety consultant to review all the departmental risks. This was to identify where there was duplication with health and safety control book risks and departmental risks. It also involved the identification of those departmental risks that potentially could be closed as they were no longer relevant, were low level or enduring risks, covered by the control book or by the business continuity plans. Using the findings from the review the clinical governance and risk team met with responsible leads to review their departmental risks held on Datix. The departmental risk report to RMG detailed the progress. This work will ensure the relevant risks are in the control book and only the departmental risks that can not be managed through the control book are on Datix. The next stage is to review and update the risk assessment form on Datix and this will be an action for 2020/21
- Implementation of the Health & Safety Control books – the priority was for all areas to complete section 3 and for the health and safety consultant to sign off section 3 through

audit and this was at 32% when the pandemic started. The agreement by the Health and Safety Committee in May 2020 is to restart the checks during the recovery phase with the aim to complete by the end of quarter 2 2020/21

- Implementation of the Duty of Candour procedure – the annual report for 2018/19 was produced and presented to CCPGC and the Board in June 2019. Data and updates on the DoC were included in the adverse events quarterly report which reflects the requirements of the annual report including numbers completing the e-learning module. An annual report for 2019/20 has been drafted and the data and updates will continue to be included in the adverse event quarterly report
- Implementation of the actions identified in the Health Improvement Scotland (HIS) adverse events baseline exercise – this is monitored through the adverse event quarterly report and actions are nearing completion
- Development and implementation of a departmental risk register report for JGG and CCPGC – this was put on hold while the review of the departmental risks was being undertaken. This will be included in the review and update of the risk management strategy and associated documents. A paper is being presented to the Board in August 2020 showing where assurances are currently happening while the CCPGC is on hold and part of a review
- Embedding risk appetite within existing risk management systems - work has been undertaken on risk appetite for the corporate risks as outlined above. This will also be incorporated within the risk management strategy review and update
- Development of the risk management procedure – the processes for departmental risks and the health and safety control books have been mapped. These process maps will be used in the review and update of the risk management strategy and associated documents

**Risk Management Priorities 2020/21**

The following priorities have been agreed to strengthen the risk management arrangements:-

- Review and update of the risk management strategy and associated documents
- Review of the corporate risks
- Delivery of risk management training
- Implementation of the national notification system for Category 1 Significant Adverse Event Reviews
- Updates to Datix for risk reporting, whistleblowing and sharing of lessons learnt

The main risk to delivery of these priorities is the impact of the pandemic and reduced capacity across the organisation. The RMG will be reviewing the progress against these priorities via the risk management workplan updates at each meeting and therefore will highlight any additional risks to delivery.

## Appendix A - Risk Management Strategic Objectives

To monitor the effectiveness of the Risk Management processes and policies the strategic objectives are set and reviewed annually via the Risk Management Group (RMG) to ensure that they remain valid and up-to-date. They formed the basis of the annual Risk Management Work Plan 2019/20, which was drawn up by the Clinical Governance and Risk Team and monitored by the RMG on behalf of the Board. Progress against the objectives are as follows:-

| **Risk Management Objectives 2019/20** | **Status** |
|---|---|
| **Embedding risk management at all levels of the organisation – creating a safety culture** | |
| • Enhance the use of risk registers at Departmental and Directorate level | • Business as usual |
| • Evidence that dynamic risk registers are held within all departments covering key risks | • Business as usual |
| • Greater ownership of risks at a local level | • Business as usual |
| • Undertake review of Datix functionality with view to enhance reporting of risk, whistleblowing, analysis of reporting trends and culture | • Continue during 2020/21 |
| • Working towards more aligned risk management systems for health and social care | • Continue during 2020/21 |
| **Leading and supporting staff and promoting reporting** | |
| • Utilise both formal and informal opportunities with staff for teaching | • Business as usual |
| • Monitor adverse event reporting patterns to identify areas/groups staff who may not be reporting & investigate whether reporting patterns are reflective of risk activity | • Business as usual |
| • Implementation of the Duty of Candour (DoC) regulations | • Business as usual |
| **Ensuring there is appropriate provision of training** | |
| • Delivery of investigation skills training and management bundles on adverse events and risk | • Business as usual |
| • Delivery of Department/Directorate specific training to enhance the use of Datix functionality | • Business as usual |

The following table gives progress against the Key Performance Indicator's (KPIs) put in place during 2019/20:

| KPI | Evidence of Achievement | Performance |
|---|---|---|
| Measures defined in Learning from Adverse Events Through Reporting & Review policy are reported in adverse event quarterly report | Measures supporting implementation of the national framework and local organisational adverse event policies – 7/7<br>Measures supporting learning and improvement – 2 achieved,1 awaiting confirmation from HIS if this will be a national priority identified in the baseline assessment and 2 still being implemented (climate survey, effectiveness actions) – 2/5 | 100%<br>40% |
| Implementation of the DoC regulations is monitored via the quarterly adverse event report and submission of an annual report to SG | DoC update included in each ¼ report – 4/4<br>Annual report 18/19 produced & sent to SG – 1 | 100% |
| Risk management workplan reviewed by RMG at each meeting | Workplan reviewed at each RMG meeting with minutes to evidence – 4/4 | 100% |
| Evidence of shared learning from adverse events through newsletters, departmental feedback, etc | H&S lessons learnt shared at each H&S Committee & in team brief, learning summary shared with eISG0, JGG & in team brief on data breach, managers have dashboard reports on lessons learnt recorded in Datix, one of measures in policy & data reported in each adverse event quarterly report, sharing of learning promoted in management bundles on risk & adverse events, & investigation skills & 1-1s | 100% |

**Risk Management Objectives 2020/21**

1. **Embed risk management at all levels of the organisation – creating a safety culture**
    - **a.** Review and update of the risk management strategy and associated documents
    - **b.** Review of the corporate risks
    - **c.** Work towards more aligned risk management systems for health and social care
2. **Lead and support staff and promote reporting**
    - **a.** Ensure compliance with the national notification system for Category 1 Significant Adverse Event Reviews
3. **Provide the tools and training to support risk management**
    - **a.** Deliver training on risk management
    - **b.** Undertake review of Datix functionality with view to enhance reporting of risk, whistleblowing, analysis of reporting trends and culture
    - **c.** Review and update risk assessment forms on Datix through involvement of staff in their design
4. **Ensure lessons are learned and changes in practice are implemented**
    - **a.** Analyse and review any themes relating to adverse events and risks to highlight trends and areas requiring further investigation/action
    - **b.** Update the functionality of Datix to enable more effective sharing of lessons learnt from Datix within and across departments/organisation

## Appendix B - Corporate Risk Register in order of Highest Rank Annual 2019/20

As a result of the request by the Chief Executive to review the corporate risks at the March meeting 2020 the corporate risks were not reviewed prior to the meeting. With the RMG meeting being cancelled due to the pandemic the table below includes up to the last review which was in December 2019.

| Lead | Theme | Risk Description | Jan 19 | Mar 19 | Jun 19 | Sept 19 | Dec 19 | Trend | Target | Movement in last year |
|---|---|---|---|---|---|---|---|---|---|---|
| MD | Resources - workforce | Inability to secure a sustainable future medical workforce due to inability to attract/engage/ retain substantive/non locum staff to working and living in Shetland because of local and national demographics/ local work patterns (i.e. levels of on call and generalism vs specialist services) and the potential impact of Brexit (506) | 16 | 16 | 16 | 16 | 16 | ↔ | 9 | 0 |
| MD | Resources - workforce | Provision of a sustainable medical workforce (in particular managing the impact of changes to junior doctors and the ability to recruit and retain senior medical staff) (509) | 16 | 16 | 16 | 16 | 16 | ↔ | 6 | 0 |
| CE | Compliance | Board performance against key (HEAT) targets and interim trajectories deteriorates, resulting in less effective services to the local population (27) | 16 | 16 | 16 | 16 | 16 | ↔ | 6 | 0 |
| DCHSC | Resources - Workforce | Inability to provide consistent, high quality, sustainable Out of Hours care in Primary care, Mental Health, Community Nursing, and Pharmacy leading to inability to respond to need in the community (17) | 16 | 16 | 16 | 16 | 16 | ↔ | 2 | 0 |
| CE | Quality | Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit (1307) | 15 | 15 | 15 | 15 | 15 | ↔ | 4 | 0 |
| DoF | Resources - Finance | Failure to maintain financial control and deliver efficiency targets, resulting in a failure to deliver financial targets over the next 3 financial years (500) | 20 | 12 | 12 | 12 | 12 | ↓ | 8 | -8 |
| MD | Quality | Inconsistencies with respect to the reporting, and subsequent resulting actions, within the adverse event reporting framework across health and care systems which is impacting on organisation learning. (1303) | 12 | 12 | 12 | 12 | 12 | ↔ | 4 | 0 |
| CE | Quality | A lower focus on Quality and learning, because of non-optimal Governance results in the potential for reduced quality and increased clinical and safety risk to patients (502) | 12 | 12 | 12 | 12 | 12 | ↔ | 8 | 0 |
| DNAS | Reputation | Negative publicity, loss of confidence in the organisation from breaches of key ACCESS targets and the potential of poorer patient outcomes as a result in delays in assessment of treatment (19) | 12 | 12 | 12 | 12 | 12 | ↔ | 6 | 0 |
| CE | Transformation | Inadequate quality and capacity in services because of a failure to implement the necessary Service redesign to meet the changing needs of the population (503) | 12 | 12 | 12 | 12 | 12 | ↔ | 6 | 0 |
| DCHSC | Quality | Inability to deliver safe and effective Mental Health Services where capacity is insufficient to meet demand (629) | 12 | 12 | 12 | 12 | 12 | ↔ | 6 | 0 |

| Lead | Theme | Risk Description | Jan 19 | Mar 19 | Jun 19 | Sept 19 | Dec 19 | Trend | Target | Movement in last year |
|---|---|---|---|---|---|---|---|---|---|---|
| MD | Quality | Within the scope of treating paediatric patient, there is risk of an adverse event or adverse clinical outcome due the generalist nature of the workforce sometimes being responsible for very sick children or children who are deteriorating in clinical status. This risk also affects potential recruitment of consultant physicians as they are not keen to have paediatric care within their scope of practice especially when some of it could be in the emergency scenario (1045) | 12 | 12 | 12 | 12 | 12 | ↔ | 4 | 0 |
| DNAS | Quality | Inability to provide consistent, high quality and sustainable obstetric and neonatal care in Shetland (1356) | N/A | 10 | 10 | 10 | 10 | ↔ | 4 | 0 |
| CE | Transformation | The Organisational culture of continuous learning, development and service improvement does not support the necessary pace of service change required (1354) | N/A | 12 | 12 | 9 | 9 | ↓ | 9 | -3 |
| DCHSC | Quality | Inability to deliver sustainable, cost effective and affordable dental services through lack of capacity resulting in poor access to treatment and preventative services (508) | 9 | 9 | 9 | 9 | 9 | ↔ | 2 | 0 |
| DNAS | Reputation | That systems for monitoring access and waiting time targets will fail, leading to reputational damage and loss of confidence in local services (574) | 9 | 9 | 9 | 9 | 9 | ↔ | 4 | 0 |
| DCHSC | Infrastructure | Lack of access to services for those living in more remote areas of Shetland because of service configuration leading to worse outcomes for individuals (36) | 9 | 9 | 9 | 9 | 9 | ↔ | 2 | 0 |
| CE | Compliance | Non-compliance with statutory duties, contract obligations and policy requirements as a result of a failure of design or implementation of systems and processes resulting in damage to staff, patients or facilities and reputational damage / cost (501) | 9 | 9 | 9 | 9 | 9 | ↔ | 6 | 0 |
| CE | Compliance | NHS Shetland is required to provide healthcare, including provision of forensic medical examinations in line with the HIS standards.<br>However, it is difficult to attract medical staff into the FME role and train/sustain their skills in a remote and rural setting. Our current position is that 45% of our medical rota has FME cover, but the Doctors who have undertaken the training have very little practice exposure and therefore patients requiring forensic medical examination are still continuing to need to be transferred to a larger centre on mainland Scotland for examination.<br>As described in our HIS self assessment, we have plans in place to meet (or are already meeting) the required standards regarding Healthcare and Forensic Medical Services for People who have experienced Rape, Sexual Assault or Child Sexual Abuse: Children, Young People and Adults. (1372) | N/A | N/A | N/A | N/A | N/A | - | 8 | - |

| Lead | Theme | Risk Description | Jan 19 | Mar 19 | Jun 19 | Sept 19 | Dec 19 | Trend | Target | Movement in last year |
|---|---|---|---|---|---|---|---|---|---|---|
| DPH | Compliance | There is a risk of preventable death, serious injury / harm, disruption of core services and reputational damage as a result of a Major Incident / Service Disruption which cannot be dealt with by routine or existing services within the Board (9) | 8 | 8 | 8 | 8 | 8 | ↔ | 8 | 0 |
| MD | Reputation | There is a risk that patients will experience delays in transfer from the outer islands of Shetland for emergency or urgent care, resulting potentially in poorer clinical outcome. There also a risk that this reduction in flexibility and capacity with respect to interisland transfer will cause remote and rural staff to feel unsupported in their location. This is likely to have a negative impact on recruitment and retention (1044) | 8 | 8 | 8 | 8 | 8 | ↔ | 4 | 0 |
| MD | Quality | The application of clinical risk management is inconsistent across primary and secondary care which would result in increased levels of harm within NHS Shetland Board (1304) | 8 | 8 | 8 | 8 | 8 | ↔ | 4 | 0 |
| MD | Quality | Sub-optimal clinical outcomes as a result of failure of clinical governance, performance, continuous learning from adverse events and improvement through the implementation of corrective action (1297) | 6 | 6 | 6 | 6 | 6 | ↔ | 6 | 0 |
| CE | Quality | A lack of focus on the health needs of the Shetland community as a result of public sector reform leads to poorer health outcomes (504) | 6 | 6 | 6 | 6 | 6 | ↔ | 3 | 0 |
| CE | Compliance | Failure to meet environmental targets. Increased impact on the environment and increased cost because NHS Shetland does not adequately prioritise and resource environmental issues (961) | 4 | 4 | 4 | 4 | 4 | ↔ | 4 | 0 |
| CE | Compliance | Inability to sustain delivery of key services because of the failure of Business Continuity Plans and BCP development and testing resulting in failure to meet patient needs or delays in restoring services following major incidents or threats (285) | 4 | 4 | 4 | 4 | 4 | ↔ | 3 | 0 |