THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk and Resilience Annual Report

2020-2021

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Approved by: Head of Risk and Resilience and presented to Audit Committee in September 2021

Contents

1. Risk Management Department

1.1 Introduction

The Risk and Resilience Department (Formerly Risk Management) is now part of the Security, Facilities and Estates Directorate (Previously under the Finance and Performance Directorate) and is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour and the administration of Datix.

1.2 Aims and Objectives

- Development, implementation and review of Risk and Resilience policies and procedures;
- Proactive identification of risks potentially impacting on The State Hospital (TSH), with the subsequent management of these risks through recognised risk management tools and techniques;
- Implementation of Incident Review processes to ensure significant adverse events are adequately investigated with the development of Action Plans to enhance organisational learning; and
- Supporting a "Quality" culture by developing staff competencies and improving risk management practices within TSH.

2. Governance

2.1 Committees/Groups

The Audit Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures.

Risk management has been embedded within a variety of TSH committees, with regular reports on risk activity been presented to the Security, Risk & Resilience, Health and Safety Groups. Relevant incidents, the corporate risk register and policy management are also reported to the Audit, Clinical Governance and Staff Governance Committees on a quarterly basis.

Supporting committees include:

- ***Health, Safety and Welfare Committee** operates in partnership with staff, and plays a key role in monitoring and reviewing Health and Safety incidents and policy implementation.
- The committee reports issues to the **Staff Governance** Committee after each meeting and the minutes are circulated at the **Audit Committee**.
- **Hospital Management Team** and **Organisational Management Team** are new group structures within The State Hospital. Risk and Resilience have a presence at both these meetings to provide updates on current risk and resilience work as well as receive and monitor actions. Both of these groups feed into the **Corporate Management Team.**
- ***Resilience Committee** monitors and reviews progress on emergency and resilience plans, ensuring that core plans are in place, tested and reviewed, with the minutes being reported to the CMT.
- **Patient Safety Group** for which a report is prepared separately on an annual basis for Clinical Governance Committee.

*At time of reporting, these groups were in the process of being absorbed by the larger Security, Risk & Resilience and Health & Safety Committee.

3. Key Work Activities (2020-2021)

3.1 Risk Management

3.1.1 Changes within Department

During 2020/21 various changes were made within the department following a review by senior management:

Change of Name and Directorate

Following an internal review of Directors portfolios, the Risk Management Department was moved from the Finance and Performance Directorate to the Security, Estates and Facilities Directorate. The department was renamed the Risk and Resilience Team to reflect new roles and the focus of the department.

Change in Management Structure

In December 2020 the Risk Management Team Leader left post. Recruitment began in March 2021 for a new post – Head of Risk and Resilience with an aim to have the position filled by the end of May 2021. The post reports directly to the Director of Security, Estates and Facilities and work alongside the Head of Security and Head of Estates. As a result, the Risk Management Facilitator worked in a promoted post since December 2020 – Interim Risk Management Team Leader.

Complaints and Claims

The State Hospital complaints and claims function has been managed by the Board Secretary under Corporate Services since December 2020. The Complaints and Claims Officer also moved from Risk Management to continue their role, due to the removal of this role and service within the department the team member was not replaced. The Risk and Resilience Team continues to provide Datix administrative support to the Complaints as part of their function as Datix Administrators.

Merger of Committees

The Health and Safety Committee, Resilience Committee and Risk Management Group underwent a process of merging into one larger oversight group, and this was an ongoing workstream at the close of the financial year (meaning actions taken over by the Hospital Management Team/Organisational Management Team or relevant sub Group).

3.1.2 Corporate Risk Register (Appendix A)

A corporate risk is a potential or actual event that:

- interferes with the achievement of a corporate objective/target; or
- would have an extreme impact if effective controls were not in place; or
- is operational in nature but cannot be mitigated to acceptable level of risk

The corporate risk register has been in existence since 2005 with incremental changes being made as risk exposure changes. In February and March 2012, board members and hospital managers participated in two, half-day workshops to review and update the Corporate Risk Register to ensure that it continued to reflect the risk profile of the organisation following the move to the new hospital. A report was published in April 2012, and presented to the Audit Committee. The Corporate Risk Register was evaluated by internal audit and a report published in January 2016. This was reviewed by the Audit Committee. The frequency of risk review and detail contained within the Corporate Risk Register has been reviewed and updated.

The hospital's risk register process was subject to internal audit in February 2019 with the final report presented in March 2019. 10 recommendations were made, 5 graded as low, 5 graded as medium. RSM have closed off 9 out of the 10 actions with a final action awaiting confirmation of closure.

Action	Priority	Estimated Completion	Current Status
The current version of the Risk Register does not currently record any assurances that have been received. This is important to support the assessment of the current risk score/ comfort over the effectiveness of the controls.	Medium	30 April 2021	Assurances have been added to the Risk Assessment form and have been updated on all current risk register risk assessments. Evidence has been sent to RSM and is awaiting sign off

3.1.3 Department/Local Risk Registers

Department/Local Risk Registers contain risks that are particular to a specific department, are within the capability of the local manager to manage and are monitored and reviewed by the Head of Department. All departments are expected to develop a Local Risk Register, together with relevant risk assessments and action plans (if indicated).

The Head of Department will inform the relevant Executive Director of their departmental/local risks and indicate those risks to be reviewed (by exception) for inclusion to the Corporate Risk Register. This will include all current very high and high graded risks. The Head of Department is also responsible for developing, reviewing, and updating the local Risk Register.

Updates to LRR

The Risk Management Facilitator spent time training and working alongside Heads of Departments to update and create a new Local Risk Register. Following this work each department now has an active Local Risk Register, this is stored on the Microsoft Teams Channel to allow easy and regular updating of the risk assessments. The LRR is reported to various committees throughout the hospital and there is a clear route of escalation to the Corporate Risk Register should there be any increase in level of risk via the hospital management teams. This process will continue throughout the year with the Risk Management Facilitator meeting with heads of department regularly to ensure assessments are up to date and fit for purpose as well as assist with any training requirements.

3.2 Resilience

The Security Director is responsible for the management of Resilience within TSH and will also chair the Security, Risk and Resilience Health and Safety Group when it is up and running, The Security Director previously chaired the Resilience Committee. The Risk Management Department also produces an annual report for the Boards' Audit Committee.

3.2.1 Resilience Plans

TSH currently has the following plans in place to deal with the impact of the following situations:

Level 2 Incident Resilience Plans	Review Date	Incident Command Plans
Adverse Weather Conditions	October 2022	Part One Resilience and Emergency Planning Framework
Covid-19 Extreme Loss of Staff Plan	April 2023	
E-Health Resilience Plan	June 2020	

Electrical Supply Failure	March 2020	Part Two Incident Command Manual - Section A: Guide for Incident Commanders - Section B: Checklists and Actions
Heating Systems Failure	September 2022	
JANUS Failure	October 2017	
Lack of Food Supplies	September 2022	
Laundry Provision Interruption	January 2020	
Lockdown of Site Plan	September 2020	Part Three Level 2 Incident Resilience Plans
Loss of Control Room	October 2020	
Loss of Patient Accommodation	September 2022	Part Four Level 3 Incident Emergency Plans - Siege - Escape - Fire - Intruder - Abscond
Loss of Staff	March 2023	
Pandemic Influenza Contingency Plan	January 2022	
Procurement Department	April 2020	
Shortage of Fuel Plan	September 2020	
Shortage of Pharmaceutical Supplies	May 2022	
Telecommunications Failure	September 2022	
Water Supply Failure	September 2022	

During 2020/21, the Risk Management Facilitator carried out a review of the TSH Level 2 Resilience Plans, with the findings being as follows:

- Covid-19 Extreme Loss of Staff Plan was produced in light of the Covid-19 situation at the end 2019/20, review of this will take place once pandemic declared over alongside Pan Flu and Loss of Staff Plan to ensure learning is captured.
- 8 Level 2 Resilience Plans currently require to be reviewed.

Work on the plans was delayed due to ongoing staffing struggles across the hospital due to Covid-19 and specifically staffing issues within the Risk and Resilience Department. Once recruitment is completed for the Head of Risk and Resilience a programme will be developed for 2021/22 to progress plan reviews and a testing schedule agreed.

3.2.2 Resilience Related Incidents

In line with the approved Resilience Framework all resilience related incidents are reported via Datix, with Level 2 and 3 incidents being reported directly to the Resilience Committee.

The Incident levels are defined within the Resilience Framework as follows:

> **Level 1**: Incidents which cause minor service disruption with one area/department affected which can be contained and managed within the local resources
>
> **Level 2**: Incidents which cause significant service disruption, interruption to hospital routine, special deployment of resources and affect multiple areas/departments.
>
> **Level 3**: A major/emergency situation which seriously disrupts the service and causes immediate threat to life or safety. These incidents will require the involvement of the Emergency Services

Since 2015, the number of Level 2 and 3 resilience related incidents reported to the Resilience Committee are as follows:

	2016/17	2017/18	2018/19	2019/20	2020/21
Level 2	6	7	4	2	0
Level 3	2	0	0	0	3

Three Level 3 incidents were reported to the Resilience Committee, which was still in place during 20/2021, the details of which are as follows:

May
Incident involving patient requiring external assistance to ensure safe resolution. Incident Command structure was established to deal with incident. Incident was subject to further investigation with a Category 1 Review being commissioned thereafter.

July
Incident involving patient requiring external assistance to ensure safe resolution. Incident command structure was established. Incident was subject to further investigation with a Category 1 Review being commissioned thereafter.

October
Incident involving patient requiring external assistance to ensure safe resolution. Incident command structure was established. Incident was subject to further investigation with Category 2 Review being commissioned thereafter.

3.2.3 Training and Exercising

The Resilience Committee previously planned and reviewed exercises in relation to resilience. This will be a focus of the new Head of Risk and Resilience and will be monitored by the Security, Risk and Resilience and Health and Safety Group.

Police Scotland

No Police Scotland test exercises took place in 2020/21. It has been difficult to facilitate these types of exercises due to Covid-19 restrictions and pressure on the services. Planning for this will take place in 2021/22.

Following a Cat 1 recommendation the Security and Risk and Resilience Team have been working with Police Scotland to support the position of a Police Liaison Officer for the hospital. Work is ongoing to complete this.

Incident Command – 'Golden Hour' training

One 'Golden Hour' session was delivered during 2020/21 to refresh existing staff and provide training to new staff fulfilling the role of senior clinical cover/security manager. Other planned sessions were unable to begin due to Covid-19 Restrictions. Future sessions are planned alongside some additional training provided by the Security Department.

Incident command was stood up multiple times throughout the year allowing staff to put into practice previous learning. Debriefs and Category 1 and 2 Reviews provided the hospital with a chance to hear feedback and use incidents as a learning opportunity.

Level 2 Exercises

Extreme Loss of Staff plan was developed due to the ongoing Covid-19 pandemic situation. This is used in conjunction with the Loss of Staff plan and Standard Operating Procedures should staffing levels drop to even more severe levels.

Planned exercises and testing for Level 2 exercises were unable to be completed due to the Covid-19 restrictions at the time. The Head of Risk and Resilience will progress this once in post.

Level 3 Plans

Work was unable to progress on the continued development of Level 3 plans due to pressures on the emergency services during the Covid-19 pandemic. Work on this will restart as restrictions begin to relax and the NHS returns to normal service.

During 2020/21 the hospital experience multiple Level 3 situations which required external support. Each incident was subject to a Cat 1/2 Review which provided a chance to review the policies and procedures in place to manage these types of incidents.

3.2.4 NHS Standards for Organisational Resilience

In May 2018, the Scottish Government updated its "NHS Scotland: Standards for Organisational Resilience document (2016), to reflect changes within the health and social care context, new policy imperatives and newly identified "Best Practice". This document specified minimum standards and related measure/performance indicator criteria for resilience within NHS Boards across Scotland.

TSH's Lead for resilience (Security Director) has responsibility for ensuring these Standards are achieved and are monitored by TSH Security, Risk and Resilience and Health and Safety Group.

The Security, Risk and Resilience and Health and Safety Work plan for 2020/21 is currently being reviewed as plans for the group continue to progress.

3.3 Health & Safety

3.3.1 Control Book Audits
Health & Safety electronic Control Books (eCB's) provide the infrastructure to manage Health & Safety arrangements across TSH.

TSH currently operate circa 41 eCB's hosted on TSH's intranet which are usually audited within a 2-year cycle to ensure compliance with organisational and local policies and procedures including but not exclusive to recording, progressing and escalation of 'Health & Safety' issues and identification of new or emerging hazards and associated risks.
Covid restrictions impacted ability to schedule Control Book audit programme during 2020/21.

3.3.2 2020/21 Audit Summary
23 control books were initially identified for audit during the 2020/21 Control Book audit programme, in line with the two year audit plan.
A revised audit programme identified 17 control books for audit from Quarter 3, 2020/21 with modified control book audit format to comply with Covid restrictions. This format heavily relied on electronic Control Book content and availability of Control Book Holders for remote 1:1.

Quarter 1 and 2 audit activity was suspended in response to Covid restrictions.
Ongoing restrictions on classroom training delivery and availability of staff to attend training / facilitate audit process has impacted progress of 2020/21 audit programme.

Control Book arrangements and responsibilities within Hub shared office accommodation were clarified as Security Managers. Hub shared accommodation control books were deferred to allow Security manager to attend Control Book training prior to audit.

Resultant eCB audit scores were released by email to Control Book Holders with detailed feedback on audit findings and recommendations to improve quality of evidence within the eCB.

One Control book failed to achieve an acceptable score on both aspects of audit, Control Book Holder requested refresher training prior to re-audit.

Department/	CB Audit	RA Audit
6 'new' or previously deferred Control Books		
Clinical Administration including Hub reception	0%	0%
Family Centre	81%	95%
Allied Health Professionals	87%	80%
Forensic Network	No progress in identifying Control Book Holder / Control Book Arrangements	
Psychology	No progress in identifying Control Book Holder / Control Book Arrangements	
Psychiatry	No progress in identifying Control Book Holder / Control Book Arrangements	
6 Control Books with 18/19 eCB and RA audit score 61 - 80%		
Lewis 3	Desktop audit complete- 1:1 deferred	
Mull 2	82%	87%
Estates	90%	98%
HR	Request to defer Control Book audit due to Control Book Holder long term absence	
Skye Centre Heath Centre	93%	84%
Physical Security	Agreement to defer	

Five further Control Books were identified for audit and Control Book Holders contacted to schedule appointments, however audit activity was suspended in line with new and emerging priorities in response to further Covid restrictions.

Department	
2x Control Books with 18/19 eCB audit and risk assessments scores >81%	
Learning and Development	Audit programme suspended
Communications	Audit programme suspended
2x Control Books with 19/20 audit scores 61-80%	
Management Centre	Audit programme suspended
Gardens	Audit programme suspended
1 x Control Books with 19/20 eCB audit score 61-80% and risk assessments score >81%	
Main Kitchen & Staff Dining Room	Audit programme suspended

Key Findings

- Improved implementation of previous audit feedback recommendations/advice
- Improved compliance with requirement to inspect Workplace/ Healthcare waste/ Fire safety arrangements on a quarterly basis
- Positive action on identifying Control Book Holders for areas of shared responsibility
- Ongoing limitations to local orientation evidence for Students and Junior Doctors
- Ongoing development of additional eCB section should facilitate evidencing safe working procedures for TSH staff working on non TSH premises
- Identifying and training DSE assessors to improve compliance with requirements of DSE Regulations suspended due to Covid restrictions

- Ongoing restrictions on classroom training delivery and availability of staff to attend training / facilitate audit process impacted progress of 2020/21 audit programme.

Recommendations
There are a number of new Control Book Holders with outstanding training needs.
With ongoing restrictions in classroom training delivery and staff availability to attend training, review the audit programme to determine if focus of audit activity should move from outstanding books to established control books to allow progression of subsequent audit programmes.

Audit format should also be reviewed to ensure it continues to meet the organisations 'needs'.

3.3.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR requires employers to report incidents that 'arise out of or in connection with work resulting in: the death of any person; specified injury to any person or hospital treatment to non-employees; employee injuries resulting in over 7-day absence from work; dangerous occurrences and specified occupational diseases'. There has been decrease of 6 in reported RIDDOR incidents in comparison to 2019/20.

	Q1	Q2	Q3	Q4	2020/21	2019/20	2018/19
'Specified' Injuries*	0	1	1	0	**2**	**1**	**1**
Over 7 day lost time Injury	1	0	1	0	**2**	**9**	**27**
Total	1	1	2	0	**4**	**10**	**28**

3.4 Fire

Three fire alarms occurred during the year to which two received a response from Scottish Fire & Rescue Service. On one occasion, this was due to contractor work of drilling holes in the ceiling resulting in the alarm being sounded. The other two were instances where the fire alarm was activated with no obvious signs of smoke or flames.

3.5 Incident Reporting

Datix is the hospital's electronic incident reporting system, and is accessible to all staff via the intranet and a link from each computer desktop in the hospital.

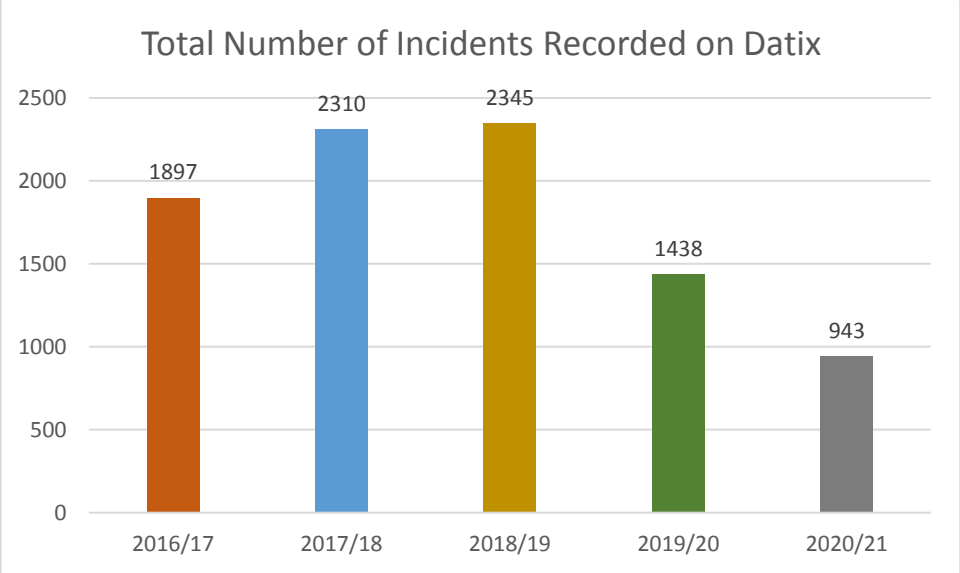
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

Datix classifies 7 overarching 'Type' of incident:

- Health and Safety
- Security
- Direct Patient Care
- Other
- Equipment, Facilities & Property
- Communication/Information Governance
- Infection Control

3.5.1 Datix Incidents

943 incident reports were finally approved during 2020/21; a significant decrease in the number of incidents finally approved in 2019/20 (1435). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years.



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2016/17	2017/18	2018/19	2019/20	2020/21
Health & Safety	974	1219	1095	712	**413**
Security	324	326	396	138	**93**
Direct Patient Care	269	270	214	146	**142**
Other	58	231	426	219	**115**
Equipment/Facilities/Property	166	175	117	106	**78**
Communication/Information Governance	70	66	51	32	**48**
Infection Control	36	23	46	82	**55**
Totals	**1897**	**2310**	**2345**	**1435**	**943**
*Average Patient Population	114	109	107	106	114

* based on bed compliment at end of each quarter/4

In comparison with the figures for 2019/20, there has been a reduction in the number of incidents reported during 2020/21 related to: Health & Safety (42%); Security (33%); Direct Patient Care (3%); Other (47%); Equipment/Facilities/Property (26%) and Infection Control (33%). However, there has been an increase in the number of incidents related to Communication / Information Governance (50%).

The number of incidents recorded in 2020/21 is lowest recorded since inception of Datix (excluding first year) with incidents decreasing in most categories, notably a reduction of 300 in the Health and Safety category, a 43% decrease. This decrease may have been impacted by the change in clinical care due to the Covid-19 pandemic as well as the reduction in staff onsite however an even larger decrease was noted in the previous year prior to Covid-19. Monitoring of this situation will continue throughout 2021/22.

3.5.3 Risk Assessment

The process of Risk Assessment within TSH involves the consideration of two key factors, i.e. likelihood (e.g. rare, unlikely, possible, etc.) of a given event occurring and the impact (or consequence) that the event may have on the organisation (e.g. financial, reputational, operationally, regulatory, etc.).

Likelihood	Potential Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very high	Very high
Likely	Medium	Medium	High	High	Very high
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The following table provides details of the number of "high" graded risk incidents reported since 2016/17, which are consistently low.

Year	No. of "High" Graded Risk Incidents
2016/17	4
2017/18	3
2018/19	4
2019/20	1
2020/21	0

3.6 Enhanced Adverse Event Reviews

All incidents/near misses assessed as being a Very High (red) risk, will result in a Level 1 Review. Other incidents may be subject to a Level 1 review at the request of CMT/Clinical Team.

Level 1 is the most rigorous type of incident review, using root cause analysis to ensure appropriate organisational learning. At least one appropriately trained reviewer, supported by a member of the risk management department, will undertake Level 1 investigations.

Level 2 Reviews are utilised for less serious incidents, whereby, an in-depth investigation is required to identify any learning points and to minimise the risk of the incident recurring. The Review is carried out by an appropriately trained member of the Risk Management Team, with the aim to establish the facts of an incident quickly with a target to report back to the CMT within 45 days of the terms of reference being agreed.

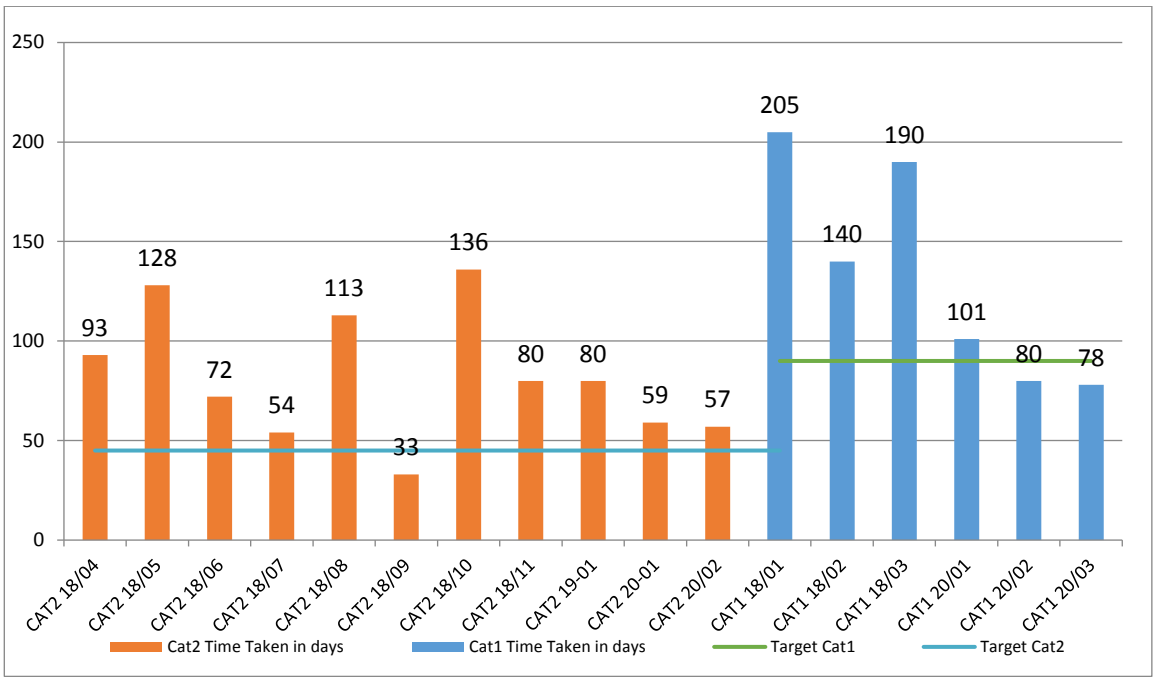
Three Category 1 Reviews were commissioned during 2020/21

- Cat 1 20/01 – Incident Command
- Cat 1 20/02 – Incident Command
- Cat 1 20/03 – Patient Death

Two Category 2 Reviews were commissioned during 2020/21 -

- Cat 2 20/01 – Self Harm
- Cat 2 20/02 – PS Incident

The graph below shows the length of time taken to complete the various Enhanced Adverse Event Reviews from approval of the terms of reference to the report being agreed by CMT.



3.7 Training

3.7.1 Health & Safety Awareness Training

At 31 March 2021, overall compliance for Health & Safety Awareness training was 92.2% (a decrease of 2.8% from 2019/20).

There were no Health & Safety Awareness training courses delivered during 2020/21 due to the suspension of face-to-face training in response to COVID-19. To support the continued delivery of this training, a new elearning programme was introduced at the end of January 2021. A total of 24 staff completed the new Health & Safety Essentials online learning programme during February/March 2021.

3.7.2 Manual Handling Training

At 31 March 2021, manual handling training had been completed by 99.1% of staff, (a decrease of 0.7% from 2019/2020)

Of this total, 98.5% *of* staff had completed the Manual Handling Essentials online training programme, with 90.8% of this group fully compliant with the bi-annual refresher requirements. In addition, 84.3% of staff had completed Level 2 Practical Training in Safer Manual/Patient Handling (a decrease of 5.8% from the previous year).

During 2020/21 a total of 434 staff completed the Manual Handling Essentials online training programme. Delivery of Level 2 Safer Manual/Patient Handling courses was limited during 2020/21 due to suspension of face-to-face training in response to COVID-19, and a total of only 8 staff completed Level 2 practical manual handling training during this period.

3.7.3 Fire Safety Training

At 31 March 2021, a total of 99.5% of staff had completed fire safety awareness training (no change from 2019/20).

A total of 576 staff completed the fire safety awareness training module during 2020/21. As of 31 March 2021, 86.3% of staff were fully compliant with annual refresher training requirements (an increase of 5.7% from 2019/20), 13.7% were overdue annual refresher training and 0.5% had still to complete the online module.

3.7.4 Level 1 PMVA Training

Level 1 'Personal Safety & Breakaway' training is mandatory for non-clinical staff, with refresher training provided every 2 years. At 31 March 2021, 100% of staff in the target group had completed Level 1 'Personal Safety & Breakaway' induction training. A total of 74.4% of staff within the target group were fully compliant with Level 1 PMVA refresher requirements (a decrease of 20.2% from 2019/20) and 25.6% were overdue refresher training.

During 2020/21 delivery of PMVA Level 1 'Personal Safety & Breakaway' training was significantly impacted by the suspension of face-to-face training as a result of COVID-19.
A total of 13 courses were delivered during 2020/21 with a total of 95 attendees – including 61 staff plus 34 'external' delegates (e.g. students and volunteers).

3.7.5 Level 2 PMVA Training

Level 2 'Prevention & Management of Violence & Aggression' training is mandatory for all clinical staff employed under TSH terms & conditions, with refresher training provided every 2 years. At 31 March 2021, 99.7% of staff within the target group had completed Level 2 'Prevention & Management of Violence & Aggression' induction training. A total of 88.8% of staff within the target group were fully compliant with PMVA Level 2 training requirements (a decrease of 7.4% from 2019/20) and 11.1% were overdue refresher training.

During 2020/21 delivery of PMVA Level 2 refresher training was significantly impacted by the suspension of face-to-face training as a result of COVID-19. A total of 18 refresher courses were delivered with 115 attendees. In addition, a further 21 new staff attended PMVA Level 2 induction training.

3.7.6 Workshop on Raising Awareness of Prevent (WRAP) Training

At 31 March 2021, WRAP training had been completed by 66.3% (a decrease of 1.9% from 2019/20).

There were limited WRAP training courses delivered during 2020/21 due to suspension of face-to-face training in response to COVID-19 and a total of 20 staff attended WRAP training.

3.8 Freedom of Information (FOI) Responses

The State Hospital changed the mechanism of recording FOI requests as from 1 April 2019. Instead of reporting the number of applications received we are now reporting the number of questions asked.

During 2020/21 the Risk Management Team received 0 FOI requests.

4. Summary

4.1 Areas of Good Practice

In addition to the positive outcomes highlighted throughout the report, there are a number of additional areas of good practice in relation to risk management across the hospital including:

- Effective monitoring of risk information by groups and committees
- Regular monitoring of patient-specific risks by clinical teams
- Strong evidence on learning from incidents, with local action being taken to minimise recurrences

Areas of good practice within the risk management department include:

- Continued development of the Corporate Risk Register with risk owners
- Updated Local Risk Register work completed and continued development in place
- Completion of implementation of RSM recommendations
- Support to Covid-19 Support Team throughout pandemic.

- Risk Management Facilitator has completed Root Cause Analysis Training to ensure at least one member of the team is fully trained as per policy.
- Risk Management Facilitator has been able to take on role of Interim Risk Management Team Leader whilst recruitment takes place.
- Improved delivery of Cat 1 and 2 reports, ensuring they are completed on time.

4.2 Identified issues and potential solutions

The Risk and Resilience are currently working at half capacity due to the departure of Risk Management Team Leader. Recruitment for Head of Risk and Resilience post has started, once in place a work plan will be developed to ensure the team is achieving its aims.

The Risk and Resilience Department is now part of the Security Directorate. Over the coming months the team will become acquainted with this new management structure through the development of a new reporting structure.

4.3 Future areas of work and potential service developments

Resilience will be a focus of the Head of Risk and Resilience as work on plans was delayed due to Covid-19 and lack of staff in the team. The Head will also help develop the team and make plans for the future by working alongside the Security Director and the other heads of department to ensure the department is fully resourced and able to achieve its aims.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in September 2022.

Appendix A: Corporate Risk Register

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Linked Corporate Objective	Governance Committee	RA ?	AP	Monitoring Frequency
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Better Care	Board	Y/Y	N/A	Quarterly
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Better Care	Clinical Governance	Y/Y	N/A	Quarterly
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Better Care	Risk, Finance & Performance Group	Y/Y	N/A	Quarterly
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Better Care	CMT	Y/Y	N/A	6 monthly
Corporate CE 14	Strategic	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Major x Possible	Minor x Possible	Chief Executive	Better Care	CMT	Y/Y	N/A	Fortnightly
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Better Health	Clinical Governance Committee	Y/Y	Y/Y	Monthly
Corporate MD 32	Reputation	Absconsion of patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Better Care	CMT	Y/Y	N/A	Quarterly

		with no doctor on site (5pm - 6pm)									
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate MD 35	Medical	Non-compliance with Falsified Medicines Directive	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Medical Director	Better Health	Medicines Committee	Y/Y	N/A	Quarterly
Corporate SD 50	Service/ Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate SD 51	Service/ Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	Better Care	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 52	Service/ Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate SD 53	Service/ Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	Better Care	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 54	Service/ Business Disruption	Climate change impact on The State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Better Care	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate SD 55	Service/ Business Disruption	Negative impact of EU exit on the safe delivery of patient care within The State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate ND 70	Service/ Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Better Care	CMT	Y/Y	Y/Y	Monthly
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Better Care	CMT	Y/Y	Y/Y	Monthly

Corporate ND 72	Service/ Business Disruption	Failure to evolve the clinical model, implement and evidence the application of best practice in patient care	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate ND 73	Service/ Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Better Care	PMVA group & CMT	Y/Y	N/A	Quarterly
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Better Value	Audit Committee & CMT	Y/Y	N/A	Quarterly
Corporate FD 91	Service/ Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance and Performance Director	Better Value	Information Governance Group & CMT	Y/Y	N/A	Quarterly
Corporate FD 93	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance and Performance Director	Better Care	CEBM, CMT	Y/Y	N/A	Quarterly
Corporate FD 95	Service/ Business Disruption	Lack of IT on-call arrangements	Moderate x Possible	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Better Care	CMT/Resilience Committee	N/A	N/A	Quarterly
Corporate FD 96	Service/ Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Better Care	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Major x Possible	Major x Unlikely	Finance and Performance Director	Better Value	Information Governance Group & CMT	Y/Y	Y/Y	Monthly
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Possible	Minor x Rare	Interim HR Director	Better Workforce	CMT	Y/Y	N/A	Quarterly
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Likely	Moderate x Unlikely	Interim HR Director	Better Care	SMT	Y/Y	Y/N	Monthly

Corporate HRD112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Major x Unlikely	Major x Rare	Interim HR Director	Better Care	H&S Committee	Y/Y	N/A	Quarterly