THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk and Resilience Annual Report

2021-2022

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Approved by: Director of Security, Estates and Resilience

Contents

1. Risk Management Department

1.1 Introduction

The Risk and Resilience Department, part of the Security Directorate, 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 to 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 presented to the Security and Resilience Group, Climate Change and Sustainability Group and Health, Safety and Welfare Committee with oversight from the Security, Risk, Resilience, Health and Safety Oversight Group. 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.

The Groups within the Directorate have changed within the last year and are supported now by the following Groups and Committees:

- **Health, Safety and Welfare Committee (HSW)** operates in partnership with staff, and plays a key role in monitoring and reviewing Health and Safety incidents and policy implementation.
- **Security and Resilience Group (SRG)** 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.
- **Climate Change and Sustainability Group (CCSG)** is a new group whose aim is to ensure that the principles of sustainability are embedded in NHS The State Hospital Board for Scotland's strategic programme. The Group will ensure an integrated approach to sustainable development, harmonising environmental, social and economic issues.
- **Security, Risk & Resilience, Health & Safety Group** oversees the progress of HSW Committee, SRG and CCSG. The purpose is to govern and direct work across all three sub-groups to align to the overall strategy for the hospital.
- The committee and groups report issues to the **Audit Committee** after each meeting and the minutes are circulated at that committee.
- **Hospital Management Team** and **Organisational Management Team** are 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.**
- **Patient Safety Group** for which a report is prepared separately on an annual basis for Clinical Governance Committee.

In addition to the above Groups and Committees. Risk and Resilience also have a presence at other Hospital Groups including Infection Control, Information Governance, Corporate Governance and Clinical Governance.

3. Key Work Activities (2021-2022)

3.1 Risk Management

3.1.1 Changes within Department

Head of Risk and Resilience

In December 2020 the Risk Management Team Leader left post. Recruitment began in March 2021 for a new full time post – Head of Risk and Resilience which was filled in May 2021. The post reports directly to the Director of Security, Estates and Resilience and works alongside the Head of Security and Head of Estates. The Department continues to be supported by the full time Risk Management Facilitator and Part-Time Risk Project Support Officer.

Committee and Groups Structure

Following consultation, it was agreed to split the Security, Risk and Resilience and Health & Safety Group into the following groups/committees:

- Health, Safety and Welfare Committee
- Security and Resilience Group
- Climate Change and Sustainability Group

Each group meets quarterly and reports into the Security, Risk and Resilience, Health and Safety Oversight group chaired by the Director of Security, Estates and Resilience.

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 all of the 10 actions with a final action now signed off.

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	Medium	30 April 2021	Closed, action has been implemented.

score/ comfort over the effectiveness of the controls.			

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.

The process for the Local Risk Register continued to be managed by the Risk Management Facilitator with each department within the hospital having an active register which is reviewed frequently. The register continues to develop in response to changes within the hospital environment. This is managed by members of the Hospital Management Team and Organisational Management Team.

CMT are updated on progress by the Director of Security, Estates and Resilience.

3.2 Resilience

The Head of Risk and Resilience has overall responsibility for the management of Resilience within TSH on behalf of the Director of Security, Estates and Resilience. The Director also chairs the Security, Risk and Resilience, Health and Safety oversight group and Security and Resilience Group. The Risk and Resilience Department also produces an annual report for the Boards' Audit Committee and regular Resilience Reports to the relevant groups.

3.2.1 Resilience Plans

TSH currently has the following plans in place to deal with the impact of the following situations:
Over the course of this year ALL plans are being reviewed and placed onto a new format with the addition on a new Business Impact Assessment and Critical Activity Recover

Level 2 Plan	Review Date	Status
Loss of Card Activated Access / Egress systems	June 2025	*Plan review was overdue but has been recently reviewed and updated to reflect new systems. Plan up to date and walk through test has been completed to ensure plan is accurate.*
Electrical Supply	May 2025	*Plan review was overdue. Full review of plan complete and plan updated to new format. Our resilience is tested on a regular basis with on-load and off-load generator tests, but there is a full function tests carried out yearly bringing on-site supply generators to reflect and test full load impacts.*
Procurement	January 2025	*Plan review was overdue. Full review of plan is now complete and plan updated to new format. As a result new SLA's and MOU's have been signed with partners and other boards to reflect changes*
eHealth	June 2020	*Plan review is overdue but is under review. This plan is sitting with Head of E-Health for review.*

		Over the last few years the way of working and new systems have been introduced to E-Health to assist with resilience, meaning that the whole new plan will require to be re-developed. This is under way. A full test is planned once review is complete
Fuel Shortage	September 2020	*Initial review completed, further review required. Working with Head of Estates*
Lockdown	September 2020	*Currently with Head of Security for review. Plans being drawn up to test imminently.*
Loss of Control Room	March 2025	*Plan review was overdue but has been recently reviewed and updated to reflect new systems. Plan up to date. A full test of the plan was carried out in December 2021 and actions were taken as a result of the test. All outstanding actions are now complete and plan has been updated to reflect accuracy.*
Pandemic Flu	January 2022	*Plan review is overdue but we are aware. Plan is with Infection Control for review. A fuller and concise review will take place in due course to ensure that all lessons learned over the last two years have being captured.*
Pharmacy	May 2022	*Plan review is overdue. Review has commenced. Plan with Head of Department for review. New Head of Department has just been appointed. Extension has been requested. Over the last 2 years resilience planning has played an important part in providing the service and have no concerns that this is not fit for purpose to continue in the interim.*
Water Supply	September 2022	*Under review will change to new format*
Heating Failure	September 2022	*Under review will change to new format*
Telecommunication Failure	September 2022	*Plan reviewed and ready to publish. Testing took place earlier in the year of the plan and actions arose from the testing. These remedial actions are now complete.*
Food Supplies	September 2022	*Under review will change to new format*
Loss of Accommodation	September 2022	*Under review will change to new format*
Adverse Weather	October 2022	*Under review will change to new format*
Loss of Staff	March 2023	*Under review will change to new format*
Extreme Loss of Staff	May 2023	*Under review will change to new format*
Laundry	July 2023	*Under review will change to new format*

During 2021/22, the Head of Risk and Resilience carried out a full review of the TSH Level 2 Resilience Plans, with the findings being as follows:

- Eight Level 2 Resilience Plans required to be reviewed. These reviews are now complete and four plans are fully developed and published with four being currently updated with relevant information for accuracy. This will be complete as soon as practicable, but current plans are still fit for purpose.

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 Security, Risk and Resilience Group.

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

Over the year April 21 – March 22, there have been 0 level 3 and 19 level 2 incidents.

	2017/18	2018/19	2019/20	2020/21	2021/22
Level 2	7	4	2	0	19
Level 3	0	0	0	4	0

Staffing Issues
17 of the Level 2 incidents were caused by staffing issues. Staff Resource incidents have been increasing over the last year due to impact from Covid-19. Of these incidents 17 were deemed to have significant impact on patient care resulting in ward closures and cancellation of activities/outings

Site Wide IT Failure
IT web based systems stopped working i.e. outlook, MS Teams, PMTS, all personal drives and departmental drives. Due to an issue with an internal switch the system locked itself to prevent corruption of data. The system was put back into a usable state although one system remained offline for longer than anticipated. When the issue with that system was found it was also restored. No data was lost during this time but there was a lack of availability.

Power Failure
Following an external power failure, several systems within the control room failed to restart once generator kicked in. Incident command team stood up to oversee all issues as they arose and the ongoing operational issues within the organisation. Two UPS's supplying the rear desk and a section of the front desk failed. Estates staff attended and replaced the units within a 30-minute period.

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 Group.

Police Scotland

The Head of Risk and Resilience he has been responsible for taking forward the relationship with Police Scotland. There is now an active and positive relationship with Police Scotland. Development has taken place in several areas of operation and this will continue.

From a local level we now have a direct team from Police Scotland responsible for all activity within the State Hospital in regards to general policing matters. This team is led by the local response Sergeant for the area. This in turn will bring a consistent approach to any crimes we may have to report, but will also allow us to learn and develop our procedures and practices and we receive input from the single team. As part of this development we have delivered awareness sessions to all local shift response teams. These teams will be first on scene for any ongoing incident and it is important that both them and us understand what to expect on arrival during any incident. The next stage in this project is to deliver information to all local response Inspectors who will be Police Incident Officer during a level 3 incident within the hospital.

Tactical plans have been developed with other strategic and tactical departments within Police Scotland. Additionally, TSH and PSOS are currently finalising a new Memorandum of Understanding to help develop our relationship and understanding of our interoperability with each other. This work will continue.

In October of last year working alongside Police Scotland TSSH staff helped to deliver training to new negotiators. This relationship has now developed further and we are working alongside Police Scotland to develop and deliver training for our own Critical Incident Communicators with delivery of the first course due in November of this year. This will be a great development for the State Hospital.

Incident Command training

Over the last year development work has been ongoing to improve our Incident Command structure and operation. A full review of our incident command structure has taken place with recommendations put forward to improve the way in which we prepare and respond to incidents. Work is now ongoing to deliver the recommendations. Training has also been reviewed and new training has been developed to improve our delivery and input.

Two Silver Command courses were ran last year seeing three new Silver Commanders being appointed to the on call cohort. All three were tested under realistic conditions following training and development. Work is ongoing to develop on-line training to ensure commanders have a reference point for learning. A further Silver Command course is scheduled for July 2022. This will culminate in a live exercise with involvement from our partner agencies but using remote access arrangements.

Three ‘Golden Hour’ sessions were delivered during 2021/22 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

Testing took place on two ‘level 2’ plans over the year.

Loss of Control Room. A full test was carried out during working hours successfully. Small points of action arose, these actions have now been completed and the plan has been updated accordingly.

Loss or Telecommunications. The opportunity to test arose from a need to upgrade our incoming telephone lines. BT requested the opportunity to complete the work. To allow BT to carry out their work, telephone system controller AX2 was taken off line. This resulted in all internal phone lines connected to AX2 being inoperable, with all phone lines on controller AX1 still working. Following the incident small points of action arose. These actions have now been completed and the plan has been updated accordingly.

The Extreme Loss of Staff plan was fully reviewed 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 plans were restricted due to the Covid-19 restrictions at the time.

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 has now restarted.

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.

Risk and Resilience are working in line with these standards and an annual report is returned to Scottish Government for assurance. At this time the standards are being reviewed, but we continue to work toward the current standards.

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/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 and lack of trained Control Book Holders impacted on the ability to schedule Control Book audit programme during 2021/22.

3.3.2 Recommendation from 2021/22 Audit

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.

Action: Training details in section 3.3.3.

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

Action: Audit paused until training schedule is underway

3.3.3 2022/23 Training Plan

As a result of the imposed restrictions Control Book training was unable to be facilitated in 2021/22. A decision was made at Health and Safety Group to pause the Audit Programme until training resumes. Over the last year there has been a number of changes in existing posts which has resulted in the need for further training.

A training plan has been created for 2022/23 to target new and deferred control books as well as any staff who require further training to improve audit score. Staff in new posts who have been allocated as Control Book Holder have also been targeted for training.

Training delivery has been reviewed and has been combined into 1 full day training rather than 2 separate half days. Decision for this was due to difficulties in scheduling Day 2 training which suffered from a lower uptake due to staffing resource issues.

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 a slight increase of 1 in reported RIDDOR incidents in comparison to 2020/21.

	Q1	Q2	Q3	Q4	2019/20	2020/21	2021/22
'Specified' Injuries*	0	0	0	1	**1**	**2**	**1**
Over 7 day lost time Injury	3	0	1	0	**9**	**2**	**4**
Total	3	0	1	1	**10**	**4**	**5**

3.4 Fire

Two fire alarms occurred during the year to which both received a response from Scottish Fire & Rescue Service. On one occasion, this was due smoke from the use of a toaster setting off the alarm. The other was an instance 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.

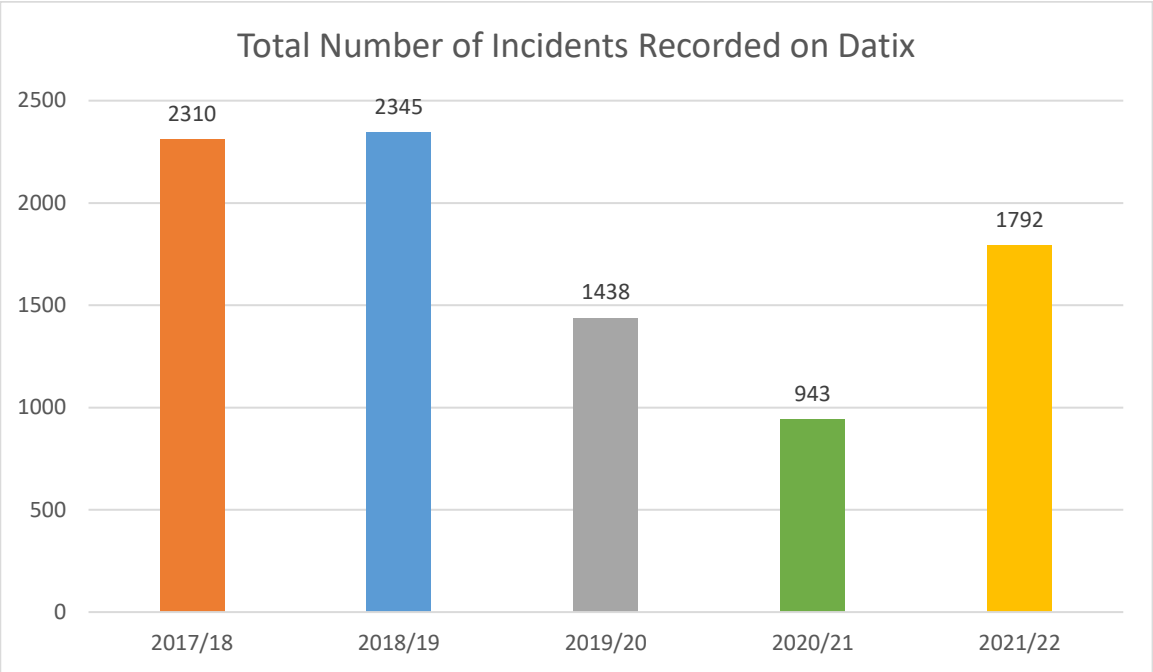
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

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

1792 incident reports were finally approved during 2021/22; a significant increase in the number of incidents finally approved in 2020/21 (943). 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	2017/18	2018/19	2019/20	2020/21	2021/22
Health & Safety	1219	1095	712	413	**461**
Security	326	396	138	93	**139**
Direct Patient Care	270	214	146	142	**146**
Other	231	426	219	115	**846**
Equipment/Facilities/Property	175	117	106	78	**75**
Communication/Information Governance	66	51	32	48	**65**
Infection Control	23	46	82	55	**60**
Totals	**2310**	**2345**	**1435**	943	**1792**
*Average Patient Population	109	107	106	114	115

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

In comparison with the figures for 2021/22, there has been an increase in the number of incidents reported from 2020/21 in all categories with the exception of Equipment, Facilities and Property.

The number of incidents recorded in 2021/22 has almost doubled on the previous year. This has been fuelled by the rise in incidents with the 'Other' category which contains the Staffing Resource Incident Category. 838 Incidents were recorded under this category as TSH continues to monitor current staffing resource issues.

Another substantial increase is within the Security Directorate. This is as a result of prohibited items at Security being recorded on Datix in an effort to reduce the number of items being found during the staff search.

Incidents continue to be monitored by the Risk and Resilience Team and fed into the relevant groups

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 2017/18, which have increased substantially. Incidents were as a result of an increase in Communication/Information Governance Incidents specifically relating to confidential information being sent to the wrong recipent and Staffing Resource Issues where a ward was closed for period of time. Due to the incidents happening more frequently likelihood was increased and incidents were graded as High or Very High. Both issues are being monitored.

Year	No. of “High” or “Very High”Graded Risk Incidents
2017/18	3
2018/19	4
2019/20	1
2020/21	0
2021/22	628

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.

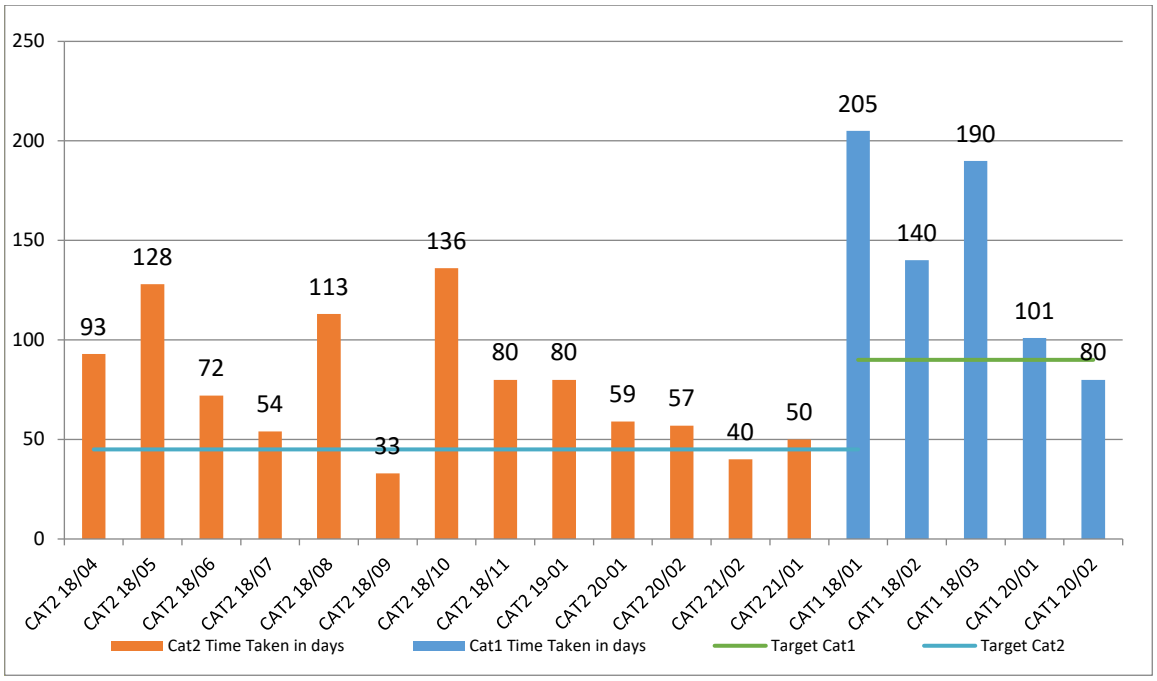
Level 2 Reviews are utilised for less serious incidents, whereby, an in-depth investigation is required to identify any learning points and to minimise the risk of the incident recurring. The Review is carried out by an appropriately trained member of the Risk Management Team, with the aim to establish 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.

No Category 1 Reviews were commissioned during 2021/22

Three Category 2 Reviews were commissioned during 2021/22:

- Cat 2 21/01 – Patient Acquitted Unexpectedly
- Cat 2 21/02 – SRK Use
- Cat 2 21/03 - Fracture

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.



***At time of writing Cat 2 21/03 is awaiting approval**

3.7 Training

3.7.1 Health & Safety Awareness Training

During 2021/22, a total of 556 staff completed the new Health & Safety Essentials online training module.

At 31 March 2022, overall compliance for Health & Safety Awareness training was 96.1% (an increase of 3.9% from 2020/21).

3.7.2 Manual Handling Training

During 2021/22, a total of 183 staff completed the Manual Handling Essentials online training module and 13 new staff completed the Level 2 Practical Training in Safer Manual/Patient Handling.

At 31 March 2022, manual handling training had been completed by 97.3% of staff (a decrease of 1.8% from 2020/21).

Of this total, 96.1% *of* staff had completed the Manual Handling Essentials online training programme, with 91.7% of this group fully compliant with the bi-annual refresher requirements. In addition, 86.3% of staff had completed Level 2 Practical Training in Safer Manual/Patient Handling (an increase of 2% from the previous year).

3.7.3 Fire Safety Training

During 2021/22, a total of 506 staff completed the Fire Safety Awareness online training module.

At 31 March 2022, a total of 98.4% of staff had completed fire safety awareness training (a decrease of 1.1% from 2020/21).

A total of 80.5% of the above group were fully compliant with annual refresher training requirements (a decrease of 5.8% from 2020/21). The reduction in compliance with annual refresher requirements was due primarily to high levels of COVID-related staff absence during Quarter 4, plus the associated impact on staff availability and capacity to complete refresher training within the required timeframe.

3.7.4 Level 1 PMVA Training

During 2021/22, a total of 170 staff attended PMVA Level 1 'Personal Safety & Breakaway' training.

Level 1 'Personal Safety & Breakaway' training is mandatory for non-clinical staff, with refresher training provided every 2 years. At 31 March 2021, 98.9% of staff in the target group had completed Level 1 'Personal Safety & Breakaway' induction training. A total of 76.8% of staff within the target group were fully compliant with Level 1 PMVA refresher training requirements (an increase of 2.4% from 2020/21).

Delivery of PMVA Level 1 refresher training continued to be impacted by the COVID pandemic during 2021/22 – with a deferment in place for a significant part of the year for Level 1 refresher training for staff in non-patient contact roles. A compliance improvement plan was introduced in January 2022, with a target to achieve a minimum of 90% compliance for PMVA Level 1 refresher training by the end of June 2022.

3.7.5 Level 2 PMVA Training

During 2021/22, a total of 246 staff attended PMVA Level 2 Refresher training.

Level 2 'Prevention & Management of Violence & Aggression' training is mandatory for all clinical staff employed under TSH terms & conditions, with refresher training provided annually. At 31 March 2021, 100% of staff within the target group had completed Level 2 'Prevention & Management of Violence & Aggression' induction training. Of the staff within the target group, a total of 72.5% were fully compliant with PMVA Level 2 training requirements (a decrease of 16.3% from 2020/21).

Compliance levels for PMVA Level 2 Refresher training significantly reduced from September 2021 to January 2022. This was due primarily to high levels of COVID-related staff absence, plus the associated impact on staff availability and capacity to release staff to attend refresher training within the required timeframe. A compliance improvement plan was put in place in January 2022, with a target to achieve a minimum of 90% compliance by the end of June 2022.

3.7.6 Workshop on Raising Awareness of Prevent (WRAP) Training

A limited number of WRAP training courses were delivered during 2021/22 due to ongoing restrictions on non-essential face-to-face training in response to COVID-19. During 2021/22, there were 4 courses delivered and a total of 38 staff attended the WRAP training.

At 31 March 2022, WRAP training had been completed by 68.3% (an increase of 1.7% from 2020/21).

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 2021/22 the Risk Management Team received two FOI requests and provided data for both.

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, the risk register has seen some positive movement over the last year as a result of further control measures being implemented.
- Updated Local Risk Register work completed and continued development in place
- Completion and sign off of all of outstanding RSM recommendations
- Continued development within the Risk and Resilience Team including Datix Training, Having Difficult Conversations and Investigation Training. The team has also started to work towards their NEBOSH qualification.
- Appointment of Head of Risk and Resilience to the Risk and Resilience Team.

4.2 Identified issues and potential solutions

The main focus for the Risk and Resilience Team in 2022/23 will be to ensure that the training plan for the Control Book Holders is actioned to allow for the Control Book Audit Programme will resume. The team will also continue to ensure each Resilience Plan is up to date and fit for purpose to ensure TSH is prepared for every eventuality.

4.3 Future areas of work and potential service developments

TSH has been in talks with an external agency, RSM to assist with developing the organisations Risk Appetite. This work is planned to completed throughout 2022/23 with members of the board and the Security Directorate.

Work is ongoing to continue to develop Datix, Local Risk Register and Corporate Risk Register which will continue to help improve the way that risk is managed within TSH. This is being actioned by the Risk Management Facilitator and monitored by relevant groups.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in June 2023.

Appendix A: Corporate Risk Register

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/06/22	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	Chief Executive	01/09/22	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	Risk Management Team Leader	01/09/22	Risk and Resilience 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	Board Secretary	01/09/22	CMT	Y/Y	N/A	6 monthly	-
Corporate CE 14	ALL	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	Chief Executive	01/07/22	CMT	Y/Y		Fortnightly	Likelihood ↓
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/07/22	Clinical Governance Committee	Y/Y	Y/Y	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	01/08/22	CMT	Y/Y	N/A	Quarterly	-

Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	01/08/22	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	01/08/22	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 Rare	Extreme x Rare	Security Director	Security Director	01/08/22	CMT/Risk and Resilience Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/08/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	01/08/22	Infection Control Committee	Y/Y	N/A	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	01/08/22	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	Director of Nursing & AHP	01/07/22	CMT	Y/Y	Y/Y	Quarterly	-
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	Director of Nursing & AHP	01/07/22	CMT	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/07/22	PMVA Group and CMT	Y/Y	N/A	Monthly	Likelihood ↑
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	30/05/22	Audit Committee, RF&P Group & 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 & Performance Director	Head of eHealth	30/05/22	Information Governance Group & CMT	Y/Y	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 Rare	Finance and Performance Director	Head of eHealth	30/05/22	CMT/Risk and 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	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/07/22	Information Governance Group & CMT	Y/Y	Y/Y	6 Monthly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Unlikely	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/05/22	H&S Committee	Y/Y	N/A	Monthly	Likelihood ↑