THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk and Resilience Annual Report

2022-23

Prepared by: Risk Management Facilitator & Head of Risk and Resilience

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.
- Develop and maintain how we respond in times of crisis by maintaining a resilient hospital,that can adapt and operate outwith normal parameters.
- Develop and maintain relationships with our partner agencies, having a shared understanding and opportunity to learn.

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.

The Risk Management process has been embedded within all the TSH committees and groups, with members of the team present at the majority of the groups. Regular reports on risk activity are 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.

An example of some of the main groups Risk and Resilience report to are below:

- **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)** aims 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 Oversight 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.
- **Organisational Management Team** is the main operation group within the 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. This group feeds 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.

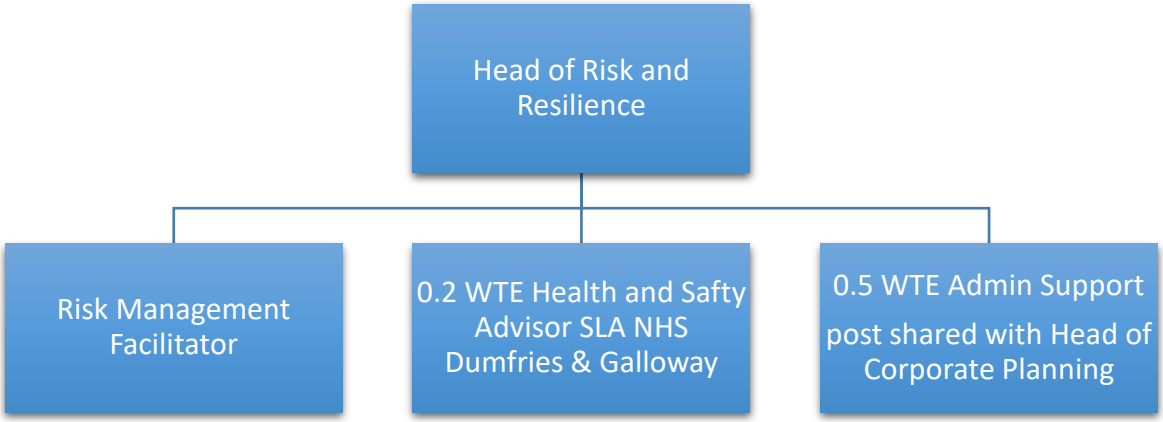
3. Key Work Activities (2022-2023)

3.1 Risk and Resilience

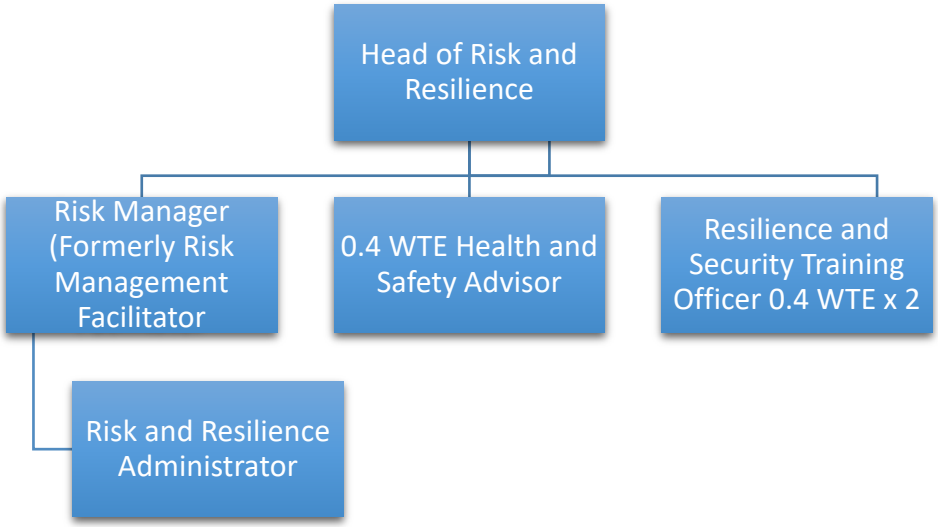
3.1.1 Changes within Department

In order to focus and develop the department it has been agreed to expand and review roles within the team to reflect the needs of the hospital.

Current Model as of 2022/23



Planned Model for 2023/24



This model was developed to better incorporate the need for resilience support, security training, Health and Safety and a focused approach to analysis of Risk with development of the Risk and Resilience portfolio.

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

Appendix A contains the current Corporate Risk Register containing 28 risks spread across the 6 Directorates. Risks are reviewed regularly throughout the year with updates shared with CMT and The Board. 4 of the risks were graded High with the rest following in the Medium and Low gradings.

A project is underway to update the Corporate Risk Register and ensure it aligns with the strategic aims of the hospital. This will be presented to the Board in 2023/24.

3.1.3 Department/Local Risk Registers

Department/Local Risk Registers contain risks that are particular to a specific department and are within the capability of the local manager to manage and are monitored and reviewed by the Head of Service. 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 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

Level 2 Plans are primarily Loss of Service Plans and are handled by our internal operations. No external assistance from partner agencies are required therefore, command structure is minimal for control and return of operations. Normally return to normal operations is swift and is controlled within normal service functions and operations.

Currently, all level 2 plans are in date with the exception of eHealth. These plans are in active development and will be finalised shortly.

Level 3 Plans

Our current level 3 plans remain fit for purpose and all agencies are content with current arrangements. Our level 3 plans are those of a multiagency joint working model. These plans involve input from our partner agencies, Police Scotland, Scottish Fire and Rescue, Scottish Ambulance Service, South Lanarkshire Council and the West of Scotland Regional Resilience Partnership. Work continues to develop and refresh Level 3 plans in a the format that are easily understood.

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 22 – March 23, there have been 0 level 3 and 8 level 2 incidents plus 3106 relating to staffing.

	2018/19	2019/20	2020/21	2021/22	2022/23
Level 2	4	2	0	19	8 (+ 3106 staffing resource)
Level 3	0	0	4	0	0

Level 2 incidents covered a rage of areas from Security Systems to eHealth and Heating Systems. All incidents were resolved internally with only minimal disruption, no incidents required escalation to Level 3.

No Level 3 incidents were reported in 2022/23, the hospital will continue to monitor and report all disruptions to day to day operations.

3.2.3 Training and Exercising

Risk Management Training

A review of the current Control Book arrangements has taken place due to changes in departmental management structures, locations and roles. 29 staff were identified as a Control Book or Deputy Control Book requiring initial training. 4 training sessions were scheduled and 23 of the identified staff attended.

Datix Training was provided to 21 staff in management roles. The training aims to teach staff how to use the Datix system, quality check all Datix entries, investigate Datix entries thoroughly and how to interrogate the system for data. Training for Datix runs continuously and is provided by the Risk Management Facilitator.

Resilience Training

In July 2022 a total of 28 staff were trained in Level 3 PPE. This has been tested and the policy was approved for use in Feb 2023. To date it has not been deployed.

In partnership with Police Scotland a bespoke Critical Incident Communicator (previously known as Negotiators) course was developed based on the full training that Police Scotland deliver to operational officers, while also incorporating the needs of the hospital. This training opportunity was offered to staff to across the site who were invited to apply. At total of 14 staff were successful in passing the course are now fully trained in this new role.

Silver Command Training was delivered training to three new senior leaders to ensure they are capable and comfortable managing events of an operational nature. This consisted of two days training for each senior leader to develop knowledge then finally and a mock exercise to consolidate the learning.

Gold Command Training was also provided in 2022/23. We introduced our staff to decision making models, incident command structure, resilience plans and escalation process to enable them to deal with a developing incident on-site. This is a one day course that develops knowledge and then culminates in a mock exercise to consolidate learning. In the last twelve months a total of 10 staff were trained in this role. 8 new and 2 refresher.

3.2.4 Partner Agency Working

It is important to maintain and develop our relationships with our partner agencies, who at times we may rely upon to assist us during times of crisis. Our partner agencies include the following:

- Police Scotland
- Scottish Fire and Rescue
- Scottish Ambulance Service
- South Lanarkshire Council
- West of Scotland Resilience Partnership

Below highlights the work that has been undertaken in the last 12 months to develop relationships with TSH partner agencies:

Police Scotland

Over the past twelve months relationships have strengthened with Police Scotland with the following milestones achieved:

- Police Scotland has created a dedicated response team for the hospital. Since introduction this has borught forward a consistent approach in all policing matters. This is led by the local community Sergeant and a team of 3 community officers, who now have an active relationship with the hospital and work closely with the Security Team. Security staff are already seeing benefits from this relationship.
- An overview presentation of the State Hospital was provided to all response policing teams covering this area. The response teams are the first on scene for any incidents and the presentation provided details of how the hospital operates and has received positive feedback.
- Developed an updated "*memorandum of understanding"* with Police Scotland. This provides details to reach agreement on primacy and levels of autonomy during incidents. This is awaiting legal sign off.
- STORM plan. Following a recent incident where firearms were deployed TSH have engaged with Police Scotland Tactical Firearms Unit to help them gain a better understanding for their Incident Commanders and decision makers. The firearms unit has developed a full intelligence

plan. This will allow Force Overview Inspectors make an informed decision before taking a decision to deploy firearms is reached. This is critical in regards to response and expectations.

- 3D modelling options are being explored with a view to creating a virtual hospital environment for incident purposes. This allows an operation overview in real time for anyone faced with an incident in the hospital. This type of work also is of great benefit to the hospital, as it would also allow us to create a virtual tour of the premises for talks, presentation and visitors. This is still in development.
- Continued work with Police Scotland negotiation team
- Operational familiarisation visits to the hospital with key departments.

Scottish Fire and Rescue

Over the last twelve months the following milestones were achieved:

- Restarted operational familiarisation visits to the hospital with key departments. This is an important aspect for the fire service to understand the risks on site
- Development of Operational Intelligence to allow incident commanders to understand and plan tactical interventions for an incident within the hospital
- Development of exercises, utilising the SFRS training and development team to engage and develop training scenarios that will test both our operational plans but also test the response of the fire service, with a hope to deliver a full exercise in the 1st quarter of next year.
- Maintain and develop relationships and shared opportunities

Scottish Ambulance Service

Re-engaging with the Scottish Ambulance Service is the next stage in our resilience development for the department. This process has already started with intial meetings taking place but needs more development. The development will be similar to that of the other partner agencies, whereby we will learn from each other and develop a shared understanding of expectations.

South Lanarkshire Council

As part of the local LRP we work closely with South Lanarkshire Council. We have facilitated familiarisation visits for new to role staff to help them understand hospital activity and allow opportunity to develop shared learning of what we can both offer if required. This work will continue.

3.2.5 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 (Director of Security, Risk Resilience and Estates) has responsibility for ensuring these Standards are achieved and are monitored by TSH Security, Risk and Resilience and Health and Safety Group.

Scottish Government(SG) are currently reviewing the resilience standards looking to develop and adapt new ones to work too. This remains an ongoing objective for SG. Risk and Resilience are working in line with these current standards where applicable.

3.3 Health & Safety

3.3.1 Control Book Audits

Currently, Health & Safety electronic Control Books (eCB's) provide the infrastructure to manage Health & Safety arrangements across TSH. This was a service provided by NHS Lanarkshire for which the service level agreement has now ended. The State Hospital will remain using Control Books until a new H&S Advisor is appointed and the arrangements will be reviewed.

TSH currently operate around 30 eCB's hosted on TSH's intranet which are audited within a 2-year cycle to ensure compliance with organisational and local policies/procedures.

Control Book Audits restarted in 2022/23 focusing on the areas with the lowest scores. The control books identified as priority were successfully audited with all 'Green' scores with the exception of one which was given an amber score, a work plan was developed to improve the score at the next audit.

The remaining Control Books will be audited in 2023/24 and continue to be reported and monitored by the Health and Safety Committee.

3.3.2 2022/23 Training Plan

A training plan was 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.

29 staff were identified as a Control Book or Deputy Control Book Holder who required to attend their initial training. 4 training sessions were scheduled which 23 of the identified staff attended.

Future training will be provided on a 1-1 basis and delivered by Risk Management Facilitator and the Health and Safety Advisor. This session will include detailing the requirements for the control book, how to complete risk and assessments and how to manage the control book in general.

Training service will be updated in 2023/24 with the appointment of permanent Health and Safety Advisor.

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 an increase of 3 in reported RIDDOR incidents in comparison to 2021/22.

	Q1	Q2	Q3	Q4	2020/21	2021/22	2022/23
'Specified' Injuries*	1	0	0	0	**2**	**1**	**1**
Over 7 day lost time Injury	0	1	2	4	**2**	**4**	**7**
Total	1	1	2	4	**4**	**5**	**8**

RIDDORs reported came from a variety of incidents including Slips, Trips and Falls, Moving and Handling and PMVA. All reported incidents were investigated by the relevant manager or person responsible. Relevant action was taken if required and staff supported by their managers and Occupational Health. All RIDDORs were reported to the Health and Safety Executive timeously in line with legislative requirements, TSH has not been notified of any further action to be taken as a result of our reported incidents.

Incidents will continue to be monitored through Datix and the Risk and Resilience Team will support the RIDDOR notification process where required.

3.4 Fire

Four fire alarms occurred during the year to which all received a response from Scottish Fire & Rescue Service. No actual fires were present in TSH.

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.

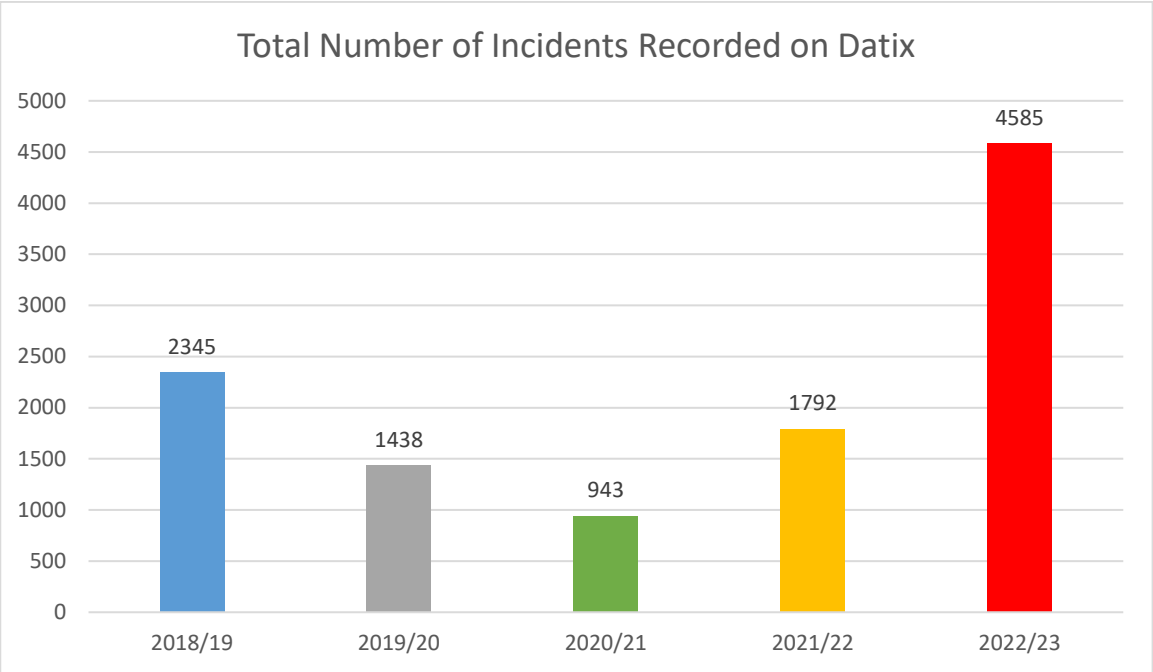
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

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

4585 incident reports were finally approved during 2022/23; a significant increase in the number of incidents finally approved in 2021/22 (1792). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years. The significant increase is due to the improved compliance reporting of Staff Resource Incidents on the Datix System, although many other categories did also show an increase. (See below)



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2018/19	2019/20	2020/21	2021/22	2022/23
Staffing Resource	X**	X**	X**	X**	**3192**
Health & Safety	1095	712	413	461	**660**
Security	396	138	93	139	**277**
Direct Patient Care	214	146	142	146	**206**
Equipment/Facilities/Property	117	106	78	75	**105**
Infection Control	46	82	55	60	**77**
Communication/Information Governance	51	32	48	65	**51**
Other	426	219	115	846	**11**
Totals	2345	1435	943	1792	**4585**
*Average Patient Population	107	106	114	115	110

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

** Staffing resource is recorded separately as of 2022/23, previously it was recorded under 'Other'.

In comparison with the figures for 2021/22, there has been an increase in the number of incidents reported in all categories with the exception of Communication Governance. 'Other' Category no longer reflects staffing resource incidents as they are reflected separately.

The number of incidents recorded in 2022/23 has more than doubled on the previous year going from 1792 to 4585. This has been fuelled by the rise in incidents under 'Staffing Resource'. Reporting in this category was encouraged through the year as management explored using the data to help identify areas of concern and distribute staff across the hospital. Although this category took up the majority of the incidents, most other categories did also see a substantial increase in the number of incidents recorded.

Incidents continue to be monitored by the Risk and Resilience Team and analysis 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 2018/19, which have increased substantially. These High / Very High graded 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. To again highlight the significant increase is due to the improved compliance reporting of Staff Resource Incidents on the Datix System, although many other categories did also show an increase.

Year	No. of "High" or "Very High"Graded Risk Incidents
2018/19	4
2019/20	1
2020/21	0
2021/22	628
2022/23	684

3.5.4 Duty of Candour

The organisational duty of candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. They are required to apologise and to meaningfully involve them in a review of what happened.

Duty of Candour Incidents	2020/21	2021/22	2022/23
Considered	**63**	**103**	**115**
Confirmed	**0**	**1**	**0**

There were no Duty of Candour incidents reported in 2022/23.

1 incident that was indentified was still under invesitigation at the time of the report being published in 2021/22, the following learning was taken from the review:

- Review and update the Duty of Candour Policy in line with Scottish Government Guidance
- Ensure PMVA Level 2 policy is being adhered to at all times with a focus to be on completion of documentation and ensuring refresher training process is being adhered to.
- Update PMVA policy to reflect the need for a risk assessment to completed as soon as refresher training is out of date rather than after 3 months.

Further information is available in the Duty of Candour Annual Report 2022/23

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 2022/23

One Category 2 Review was commissioned during 2022/23:

- Cat 2 22/01 Misuse of Telephone Number

Cat 2 22/01 was completed within timescales and recommendations are currently underway and being monitored by the Organisational Management Team.

3.7 Training

Training Module	Number of Staff Completed	Percentage of Staff Completed	Increase/Decrease on 2021/22
Health and Safety Awareness	141	98.1%	+2%
Manual Handling	416	99.5%	+2.2%
Fire Safety	627	99.3%	+0.3%
Level 1 PMVA	108	99.2%	+22.4%
Level 2 PMVA*	212	73.8%	+1.2%
WRAP	70	72.2%	3.9%

* Compliance levels for PMVA Level 2 Refresher training were impacted by high levels of staff absence during 2022/23, 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 April 2023, with a target to achieve a minimum of 90% compliance by the end of September 2023.

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 2022/23 the Risk Management Team received four FOI requests totalling nine questions. The team provided data for all of them where it was held by our department with the exception of one which was refused to protect both the identity of staff and the integrity of the investigation process.

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:

- Development of the Corporate Risk Register with risk owners, the risk register continues to see positive movement over the last year as a result of further control measures being implemented. High risks are now monitored monthly with a focus on reducing risks. Further development is continuing into 2023/24.
- Updated Local Risk Register work completed and now fully in use across TSH.
- Department delivered an array of training programmes across the hospital including Incident Command, Datix Training, Control Book Training and supported the negotiator training programme – all of which upskilled staff and increased our level of resilience.
- Audit from RSM completed in March 23 which focused on our incident management processes. We received positive comments from the auditors and received a ‘reasonable’ recommendation score which was the second highest score available. Work is underway to close the few actions recommended from the audit.

- Datix Incident Reporting System received many updates throughout 2022/23 including updated categories to capture better data, introduction of the staff hot and cold debrief process to Datix and updating the way staffing resource incidents are coded. Work will continue on the system throughout 2023/24 to ensure we are capturing high quality data that is useful in the management of incidents.
- Continued development within the Risk and Resilience Team including the Risk Management Facilitator achieving their NEBOSH Health and Safety qualification. They also completed other training programmes including Managing difficult conversations with HIS and NEBOSH Wellbeing in the Workplace. They continue to work closely with departments within the hospital and work with all disciplines to ensure that they have a strong relationship with risk management and learning from incidents. The role of Risk Management Facilitator has also changed over the last couple of years and is going through the Agenda for Change process. This will provide extra resilience for the department and open new avenues of work streams.
- Head of Risk and Resilience was able to build strong relationships with many external partners, embed themselves in the organisation, organisation and provide training courses covering different aspects of resilience as well as build on their skills through various courses and training programmes.
- Control Books were identified as an issue in the previous annual report. In 2022/23 over 20 staff were trained and 4 control books audited. This will make a positive impact on the future of the control book programme as audits continue into 2023/24.

4.2 Identified issues and potential solutions

The main focus for the Risk and Resilience Team in 2023/24 will be to review our Health and Safety Management System. The first step will be to recruit a permanent part-time Health and Safety Advisor with a focus on reviewing our current arrangements and how to move them forward.

There is also a vacancies within the department for the Risk Support Officer Role and Security and Resilience Trainer. Once in post this will free up time for the Risk Management Facilitator to focus on areas that require further development.

4.3 Future areas of work and potential service developments

RSM have worked with Directors and Board Members to help deliver an updated risk appetite document. Work will continue with this in 2023/24 as the Risk and Resilience Team reviews our Corporate Risk arrangements. The aim for this year is to produce a Corporate Risk Register that aligns with the strategic aims of the hospital.

A lot of progress was made on the Datix system in 2022/23 however this will continue in 2023/24 as the teams looks to optimise the Datix system and the way information is recorded, produced and analysed.

Risk and Resilience Team will continue to raise profile across hospital and continue to help the organise mitigate risk, increase resilience and learn from incidents.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in June 2024.

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/05/23	Clinical Governance Committee	Monthly	-
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	01/05/23	Clinical Governance Committee	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	Director of Nursing & AHP	01/05/23	Clinical Governance Committee	Monthly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Possible	Moderate x Unlikely	HR Director	HR Director	16/05/23	HR and Wellbeing Group	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	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	18/07/23	Corporate Governance Group	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	18/07/23	Clinical Governance Committee	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	18/07/23	Security, Risk and Resilience Oversight Group	Quarterly	-
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	Major x Almost Certain	Moderate x Possible	Minor x Possible	Chief Executive	Chief Executive	18/07/23	Corporate Governance Group	Quarterly	-

		a safe and secure environment for patients and staff.									
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/07/23	Covid Inquiry SLWG	Monthly	↓
Corporate MD 32	Medical	Ascension of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	20/04/23	Clinical Governance Committee	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	20/04/23	Clinical Governance Committee	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	20/04/23	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	18/07/23	Security, Risk and Resilience Oversight Group	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	18/07/23	Security, Risk and Resilience Oversight Group	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	18/07/23	Security, Risk and Resilience Oversight Group	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	18/07/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	09/06/23	Security, Risk and Resilience Oversight Group	Monthly	↓
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	18/07/23	Security, Risk and Resilience Oversight Group	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	Director of Nursing & AHP	18/04/23	Clinical Governance Committee	Quarterly	-
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	06/07/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Possible	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	06/07/23	Finance, eHealth and Performance Group	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	06/07/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	06/07/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	17/04/23	HR and Wellbeing Group	Quarterly	-

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
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	01/06/23	Corporate Governance Group	6 monthly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	01/05/23	Security, Risk and Resilience Oversight Group	6 monthly	-
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	06/10/23	Finance, eHealth and Performance Group	6 Monthly	-

Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Development Manager	01/05/23	Clinical Governance Group	6 Monthly	-