Appendix 1

RISK MANAGEMENT ANNUAL REPORT 2018/2019

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Contents

1. Introduction

NHS Dumfries and Galloway acknowledges that the sound and effective implementation of risk management is considered best business practice at a corporate and strategic level, as well as a means of improving operational activities and continually improving patient and staff safety.

The purpose of this report is to:

- summarise the key activities and achievements relating to risk management undertaken between 1 April 2018 and 31 March 2019
- highlight the progress in the ongoing development of our risk management arrangements
- outline the risk management objectives for the coming year

The report aims to provide assurance and evidence to the NHS Board, Chief Executive and Audit and Risk Committee that a programme of work is in place to identify, assess and manage risk within NHS Dumfries and Galloway.

The management of risk is achieved by ensuring an effective Governance Framework is in place and operating effectively. This Report sets out to confirm that there have been adequate and effective risk management arrangements in place throughout the year and highlights material areas of risk.

The process of risk management is an increasingly complex one, which addresses all areas that challenge the Board in terms of safe, effective, person centred service delivery and management. This means being financially viable, having good governance, skilled staff and centrally delivering safe, reliable and effective care to people who use our services.

Good risk management has the potential to impact on performance improvement, leading to:

- Improvement in service delivery
- More efficient and effective use of resources
- Improved safety of patients, staff and visitors
- Promotion of innovation within a risk management framework
- Reduction in management time spent ‘fire fighting’
- Assurance that information is accurate and that controls and systems are robust and defensible.

Application of the Risk Management Framework will ensure the Organisation’s management understands the risks to which it is exposed and deals with them in an informed, proactive manner.

Staff are empowered to use their professional judgement in deciding which risks are significant. The complete elimination of risk will not be a feasible goal for the Board – however, in certain circumstances calculated risk management will be required to achieve creative or innovative solutions that will help to improve the services to patients.

The Annual Risk Management report provides an assessment of the effectiveness of these risk management arrangements which were in place throughout the year.

2. Risk Management

The management of risk within NHS Dumfries and Galloway is everyone's responsibility and forms an essential and integral part of the governance arrangements. For both users and providers, it is vital that robust mechanisms are in place to identify, mitigate and escalate risks associated with the delivery and planning of our services.

Risk Management is the systematic identification, assessment and reduction of risks to patients, staff and the Organisation

We are continually working to strengthen our approach to Risk Management and this year we have refreshed our Risk Management Strategy to incorporate a Risk Appetite Statement which details the level of risk that the Board is willing to tolerate in pursuit of its objectives and strengthened our management of Significant Adverse Events.

2.1. Risk Management Responsibilities

The risk management function is integrated into the Patient Safety and Improvement team with executive Leadership and direction being provided by the Risk Executive Group, co chaired by Executive Director for Nursing, Midwifery and Allied Health Professionals (NMAHP) and the Director of Finance. The team provides quality improvement, patient safety and risk management advice, guidance and support to the Board, its managers and staff.

All Directors within NHS Dumfries and Galloway have a clear responsibility and role for the identification and management of risk. Directorate Management Teams and Corporate Functions retain operational responsibility for managing risk within their areas of responsibility.

Risk Facilitators have been identified within each Directorate. Their role is pivotal in providing Risk Management support to their Directorate and in liaising with the corporate risk function to ensure that the day to day management of risk is informed and can inform Board policy and shared learning.

Audit and Risk Committee

The Board has an established Audit and Risk Committee which supports the Board in their responsibilities for issues of risk control and governance. The Audit and Risk Committee meets quarterly and met on three occasions in 2018/2019. The committee seeks to monitor and gain assurance that:

- There is a comprehensive risk management system in place to identify, assess, manage and monitor risk at all levels of the organisation.
- There is appropriate ownership of risk in the organisation and that there is an effective culture of risk management.
- The Board has clearly defined its risk appetite (i.e. the amount of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and that the Executive's approach to risk management is consistent with that appetite.

Risk Executive Group

The Risk Executive Group was established in January 2015 to oversee arrangements for Risk Management and ensure NHS Dumfries and Galloway has appropriate governance arrangements in place to maintain operational co-ordination of risk management, in accordance with the Board's Risk Management Strategy. The Risk Executive Group meets quarterly, and met on four occasions in 2018/2019.

"The Risk Executive Group will ensure NHS Dumfries and Galloway has appropriate governance arrangements in place to maintain operational co-ordination for risk management, in accordance with the Board's Risk Management Strategy.

The Group contributes towards the establishment of a Risk Appetite for the Board, which will be reviewed on an annual basis.

Risk Steering Group

The Risk Steering Group takes a balanced approach to risk (including clinical, service, reputational, financial and environmental) and reports directly to the Risk Executive Group. It meets bi-monthly with membership drawn from across the Board areas. This forum enables risk to be shared and discussed from a tactical perspective and informs future risk management policy and procedure. The group provides assurance to the Risk Executive Group that appropriate governance arrangements are in place to maintain operational co-ordination for risk management in accordance with the Boards Risk management Strategy.

The purpose of the Group is to:

- Develop, review and seek assurance on Risk Management Strategy, Policy and Procedures
- Bring together those with responsibility for delivering Risk Management across the Board, including technical experts and Directorate Leads to ensure that a consistent approach is being applied across NHS Dumfries and Galloway
- ensure that the Risk Management Strategy is implemented effectively across NHS Dumfries and Galloway – this will include reviewing Key Performance Indicators (KPIs), Internal Audit Reports, external reports and performance reviews
- Develop and review annual Risk Management Work Plan – this will include a Training Plan and Annual Report
- Escalate areas of concern to Risk Executive Group
- Share areas of good practice/learning

The Risk Steering Group met on 3 occasions during the year and considered and progressed work around:

- Risk Management Strategy Implementation and review
- Operational Risk Management including review of Key Performance Indicators
- Internal Audit – outstanding actions
- Risk Training Plan
- Duty of Candour Implementation
- Patient Safety Alerts / Safety Action / Hazard Notices
- Information Governance & Security

Risk Facilitators

Risk facilitators provide support and co-ordination of risk management within Directorates. They work on behalf of managers to:

- Manage the development of clinical/non clinical risk across their Directorate, ensuring risk, patient and staff safety underpins the Directorate's approach to Risk Management
- Take responsibility for the effective management and co-ordination of all clinical/non clinical risks and adverse events across the Directorate
- Provide support and co-ordination during an adverse event/risk investigation and are the first point of contact in their Directorate
- Develop and maintain efficient and effective systems that ensure lessons are learned and shared as appropriate to continually improve services across NHS Dumfries and Galloway
- Co-ordinate Directorate Risk Management structures and process.

General Managers

General Managers retain operational responsibility for implementing the Boards Risk Management Strategy within their Directorate. The Chair of the Risk Steering Group meets with General Managers as a group and individually 2-3 times annually.

IJB/H&SCSMT

Work continues to provide support on risk to the Integrated Joint Board (IJB) and IJB Audit & Risk Committee as part of the ongoing support to the Health & Social Care Partnership (H&SCP). A Risk Workshop was held with the IJB and the Health and Social Care Senior Management Team (H&SCSMT) to agree and assess risks for their respective Risk Registers.

Work Plan 2019/2020:

- Systematic Review of Risk Management
- Work with General Managers and Directorate Leads to ensure they are represented at Risk Steering Group Meetings
- Agree Risk Development Plan with Risk Executive Group

2.2 Risk Management System

NHS Dumfries and Galloway, in line with many other Boards in Scotland, use DATIX Risk Management System to record and manage Risks and Adverse Events. The DATIX system has a wide range of configurable modules, which can be tailored to the needs of the end user. NHS Dumfries and Galloway currently use the following modules:

- Risk Register
- Adverse Events
- Complaints
- Actions Module.

The modules were configured to meet local needs and, as such, continually require to be updated to reflect changes in Organisational structure, legislation, national guidance, coding and advances in the technology itself.

During 2018/2019 we continued to upgrade DATIX system to keep pace with changes to organisational structure and to improve end user functionality. We planned to, overhaul the Risk Register Module to simplify the process and forms for end users however this did not happen due to a lack of capacity within Patient Safety & Improvement Team and Information Management and Technology (IM&T), this will be taken forward into 2019/2020 work programme.

Work Plan 2019/2020:

- Overhaul Risk Register Module; simplify levels to reflect operational, tactical and strategic risks
- Ensure social work staff have access to DATIX

2.3 Risk Register

Risk Registers are an essential component of the organisation's internal control system. They are used as a systematic and structured method of recording all risks (clinical, financial and organisational) that threaten the objectives of the organisation. This process forms an integral part of day-to-day practices and culture, utilising a single co-ordinated approach to the identification, assessment and management of all types of risk.
Risk Registers are designed:

- to achieve greater visibility of exposures and threats that may prevent NHS Dumfries and Galloway from achieving its objectives
- to implement a rigorous basis for decision making and planning
- to create a record of the identification and control of key organisational risks
- to achieve a more effective allocation and use of resources by prioritising risk
- to respond more effectively when potential risks occur
- to assess and monitor if management controls or resources are adequate to manage risks
- to achieve pro-active, rather than reactive, management and therefore reduce the likelihood that risks will occur

- to further develop the integrated approach to risk management, whether the risk relates to clinical, non clinical, financial or organisational risk
- to ensure all significant risk management concerns are properly considered and communicated to the Board.

Each Director, Corporate Team and Directorate is responsible for maintaining their own Risk Register. The Risk Register is used by management teams to inform priorities, planning and decision making. Management teams are expected to regularly review and update their risk registers in line with the Risk Register Procedure.

Each risk is allocated a risk owner(s) who will be responsible for taking appropriate action to control or minimise its impact.

NHS Dumfries and Galloway Management Team is responsible for maintaining a Corporate Risk Register which records and reports on action being taken to manage the strategic risks facing NHS Dumfries & Galloway.

The Corporate Risk Register (**See appendix 1**) has been monitored and reviewed throughout the year and overseen by Management Team, Board and Audit and Risk Committee. Each of the standing committees review their section of the Corporate Risk Register

The Directorate Risk Registers are reviewed and monitored by Directorate management teams and reflect core business. The Review Process is fully owned by the Directorate management team. Risk Registers are managed in Directorates by Risk Facilitators (Key Contacts) on behalf of General Managers. They are maintained on the DATIX system with nominated persons, usually the Risk Facilitator to manage changes and provide management reports.

> Maintaining adequate levels of staffing has been cited as High Risk across the organisation and is incorporated in the Corporate Risk Register. A range of controls and improvements have and are being applied to minimise the impact on patients, staff and our communities.

The number of risks identified and assessed per Directorate as of 31 March 2019 is shown below. There has been a 27% decrease in the overall number of risks recorded between 2017/2018 and 2018/2019. This is a further reduction from previous years with a cumulative reduction of 32% over the two financial years. It is believed that this can be attributed to the amalgamation of risks and the closing of risks which are now obsolete.

The Acute & Diagnostics Directorate has the highest number of risks and the most risks graded as High, this is partly due to scale and partly due to the nature of its business.

Work continued this year to support development of the IJB Risk Register and the H&SCP risk register.

The Community Health and Social Care Directorate in particular have reviewed their risks to ensure they reflect the integrated nature of health and social care. Work will continue into 2019/2020 to ensure both health and social care staff can access Datix.

Mental Health have integrated Risk Management into their Performance Management and Governance processes to ensure that risks are reviewed, agreed and controlled at the most appropriate level.

Table 1: Percentage Change in Directorate Risk Registers

Area/Directorate	17/18	18/19	+/- %
NHS Dumfries and Galloway Corporate Risk Register	16	17	+6
Corporate Directorate Risks:			
Corporate, inc Finance, Medical, NMAHP and Public Health	108	96	-11
Directorate Risks:			
Acute and Diagnostics	228	105	-54
Community Health and Social Care	60	41	-32
Mental Health, Learning Disability and Psychology	185	85	-54
Operational Services	198	135	-32
Women and Children's Services	37	24	-35

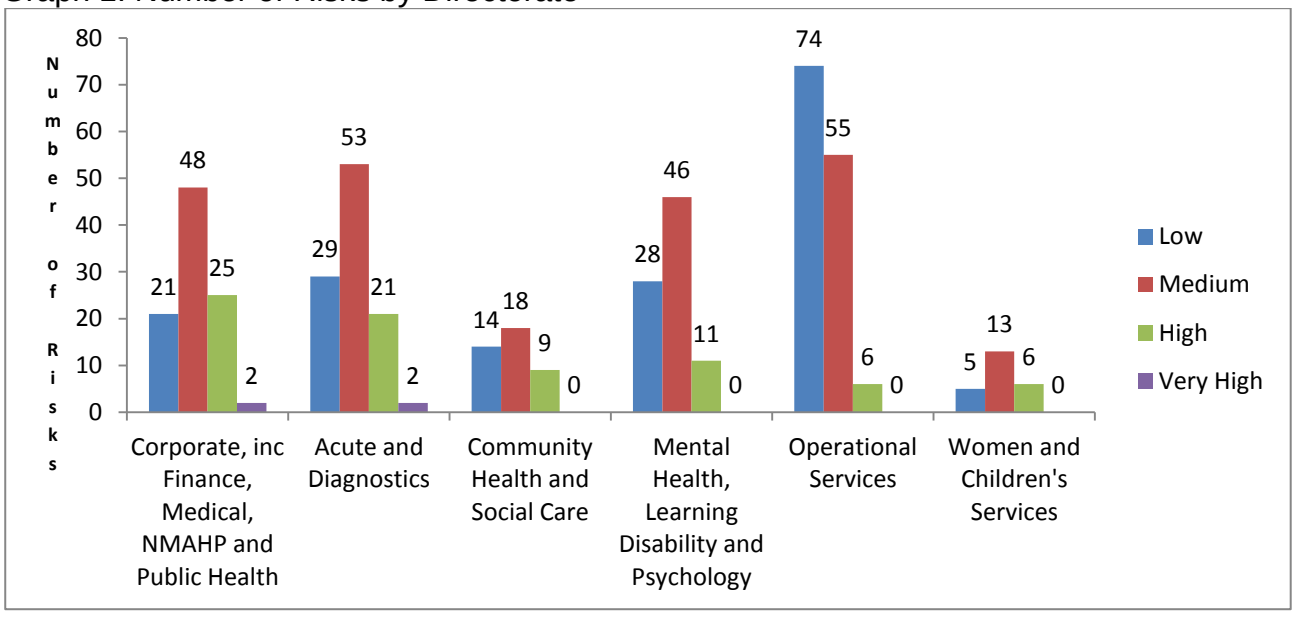
Table 2: Risk Grading by Directorate 2018/2019

Area/Directorate	Low	Medium	High	Very High
NHS Dumfries and Galloway Corporate Risk Register	0	7	9	1
Corporate Directorate Risks				
Corporate, inc Finance, Medical, NMAHP and Public Health	21	48	25	2
Directorate Risks				
Acute and Diagnostics	29	53	21	2
Community Health and Social Care	14	18	9	0
Mental Health, Learning Disability and Psychology	28	46	11	0
Operational Services	74	55	6	0
Women and Children's Services	5	13	6	0

[Caution should be taken when reviewing the data. DATIX is a live system and figures may change over the course of a day. The figures are correct at the point at which they were drawn for this report on 2 April 2019.]

Although some Directorates appear to have a high number of risks as stated above, the majority (83%) are graded medium or low indicating that these are well controlled.

Graph 1: Number of Risks by Directorate



The level of confirmed Risk Grading dictates the maximum timescale by which that particular risk is required to be reviewed. The agreed timescales for reviewing risks are:

- Low – annually
- Medium – 6 monthly
- High – quarterly
- Very High – monthly

Table 3: The Number of Risks that are Overdue for Review

Directorate	Low		Medium		High		Very High	
	Total	Overdue	Total	Overdue	Total	Overdue	Total	Overdue
NHS Dumfries and Galloway Corporate Risk Register	0	0	6	1	10	4	1	0
Corporate Directorate Risks:								
Corporate, inc Finance, Medical, NMAHP and Public Health	19	17	44	24	23	13	1	1
Directorate Risks:								
Acute and Diagnostics	24	2	37	33	19	17	2	2
Community Health and Social Care	7	0	26	2	12	8	1	0
Mental Health, Learning Disability and Psychology	28	5	45	7	8	1	0	0
Operational Services	70	65	50	45	5	5	0	0
Women and Children's	5	0	11	3	6	0	0	0

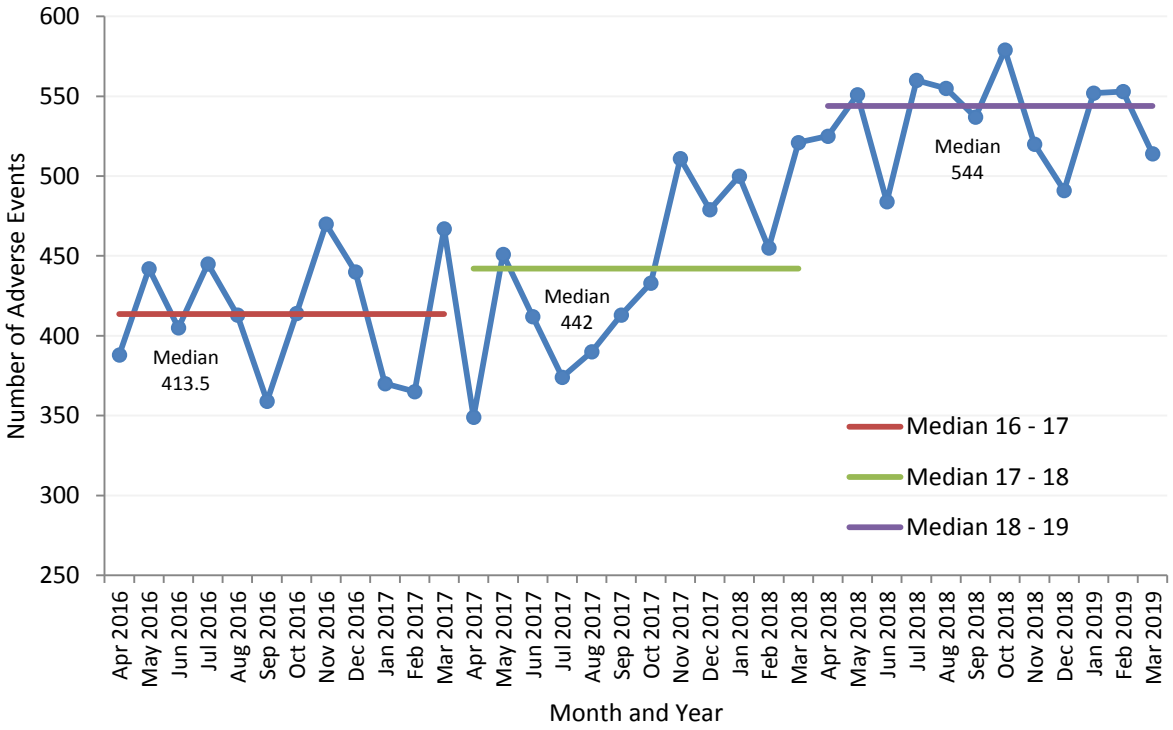
Work Plan 2019/2020:

- During 2019/2020, work will continue to systematically review Risk Registers to ensure all risks are updated within the specified timeframes or closed if they are no longer valid.
- A fundamental review and simplification of Risk Register Structure will be undertaken.
- We will work with Directorates to simplify their risk register, reducing number of levels to 3; strategic, tactical and operational.

2.4 Adverse Events

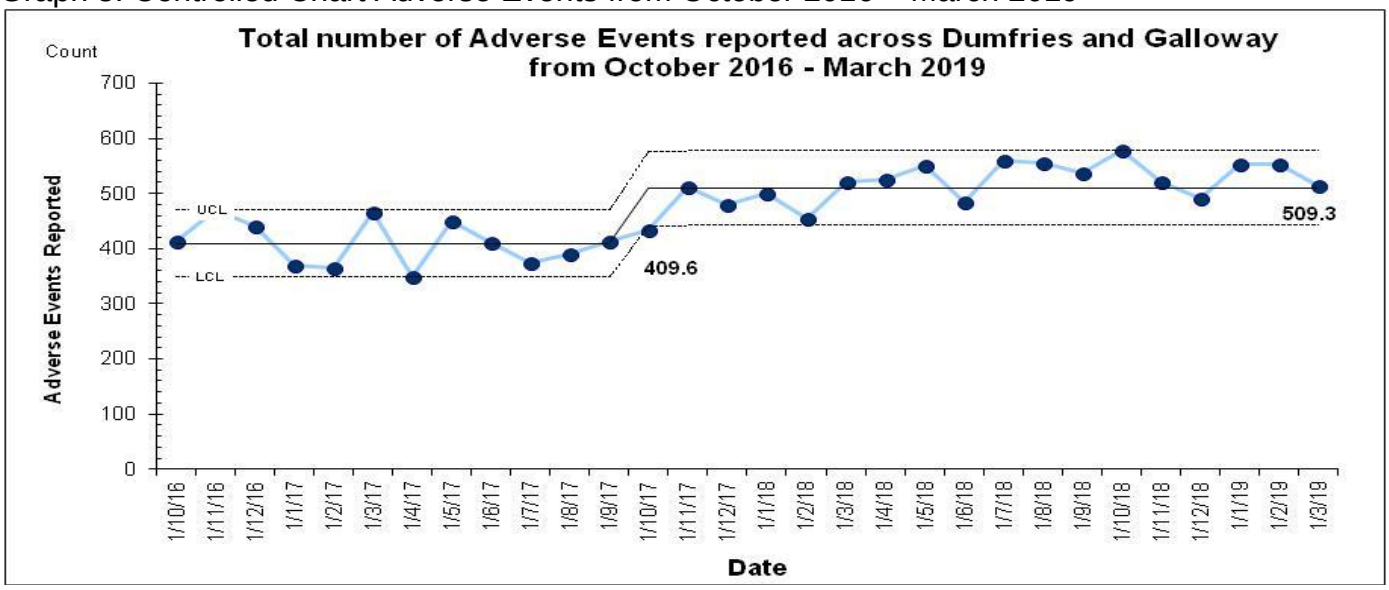
Adverse Events are reported on DATIX System. All members of staff have the ability to submit an adverse event report on the system, which is immediately flagged via email notification to their Manager and their local Risk Facilitator. The Risk Facilitator reviews the report and allocates the adverse event to the appropriate individual or team for investigation. **6423** Adverse Events were reported this year, this represents a 21% increase in reported adverse events from the previous year.

Graph 2: Number of Adverse Events reported monthly over 3 financial year periods



Graph 2 above provides the number of adverse events submitted on a month by month basis for each of the last three financial years. The year on year increase should be viewed positively as an indication that staff recognise and feel supported to report when things go wrong however directorates are struggling to investigate and close incidents in the timeframes prescribed as indicated below.

Graph 3: Controlled Chart Adverse Events from October 2016 – March 2019



The above control chart, displays data from October 2016 to March 2019; apart from the 25% rise in adverse events reported from the end of 2017, we are within our control limits which suggest a positive reporting culture.

Adverse Event Key Performance Indicators

NHS Dumfries and Galloway adhere to Healthcare Improvement Scotland (HIS) guidance for the time taken from reporting an adverse event to closure following investigation. The closure times for adverse events are as follows:

Category 3 'Near Miss/No Harm' - Close within 10 working days
Category 2 'Temporary Harm' - Close within 20 working days
Category 1 'Significant Harm/Death' - Close within 90 working days

Timescales are set from the point the adverse event is reported to its closure following investigation. The Table below provides a breakdown of the number closed within each of the categories and time to closure.

- 40.5% of Category 3 Adverse Events were reviewed and closed within the agreed timescales
- 60% of Category 2 Adverse Events were reviewed and closed within the agreed timescales
- 56.5% of Category 1 Adverse Events were reviewed and closed within the agreed timescales

Table 4: The Number of Incidents closed within each of the categories.

Category	Total Closed	Closed within 10 working days	Closed between 11 and 20 working days	Closed between 21 and 90 working days	Closed > 90 working days	Closed out with agreed Timescales
3	3427	1388	557	1183	299	2039 (59.5%)
2	2495	1114	391	735	255	990 (40%)
1	85	10	7	31	37	37 (43.5%)

Work is ongoing with directorates to improve the time from open to closed. In relation to significant adverse events, the nature of these dictates that a more robust and thorough investigation be carried out, which can take longer than the prescribed timescale.

On occasions this can also be due to other factors, for example waiting on information from other agencies e.g. Toxicology results from Post Mortem examination.

Table 5: Number of Adverse Events reported by Directorate

Directorate	2017/2018	2018/2019	+/- %
Acute and Diagnostics	2449	3064	+25%
Corporate (inc Finance, Medical, NMAHP and Public Health	144	101	-30%
Community Health and Social Care	1117	1075	-4%
Mental Health, Learning Disability and Psychology	1191	1717	+44%
Operational Services	54	46	-15%
Women and Children's Services	333	418	+25.5%

The year on year figure shows an 18% increase in number of reported incidents. These increases are felt most keenly in Acute & Diagnostics, Mental Health, Learning Disability and Psychology and Womens and Children's directorates.

The Top 5 Adverse Events reported is set out below for each of the last 3 years. The Top 5 reported categories have remained constant although variation does exist between Directorates.

Table 6: The Top 5 Adverse Events

2016/2017	2017/2018	2018/2019
1) Slips, Trips and Falls (1541)	1) Slips, Trips and Falls (1480)	1) Slips, Trips and Falls (1581)
2) Treatment Problem (697)	2) Treatment Problem (759)	2) Treatment Problem (887)
3) Violence and Aggression (496)	3) Violence and Aggression (556)	3) Violence and Aggression (774)
4) Medication Incident (363)	4) Medication Incident (469)	4) Medication Incident (555)
5) Communication (188)	5) Communication (209)	5) Communication (234)

Adverse Event data informs both local and national quality improvement initiatives and is aligned to local and national improvement programmes, e.g. Scottish Patient Safety Programme (SPSP), Pressure Ulcer Collaborative, Medicines Safety Group.

Significant Adverse Events

Significant Adverse Events (SAEs) are defined as an event with the capacity to cause death or significant harm. Not all events reported as a Significant Adverse Event are preventable or avoidable.

SAEs are reviewed and monitored on a weekly basis by the Patient Safety Group (PSG).

PSG consider the need for a full Significant Adverse Event Review (SAER) and, where relevant, commission a SAER with clear Terms of Reference to guide the investigator. They receive the SAER report and continue to oversee the significant adverse event review process ensuring that actions are taken and lessons are learned and shared.

The remit of PSG is to:

- Oversee SAER process – ensuring actions have been taken and lessons learned are shared
- Commission SAER's - including setting Terms of Reference for investigator, identifying investigators, agreeing when report due
- Oversee Significant Complaints process - ensuring actions taken and lessons are learned and shared
- Oversee the process of Safety Action and Risk Notices
- Provide reports to Management Team and commission reports for Healthcare Governance Committee

PSG review all category 1 Significant Adverse Events and commission a level of review. 125 Category 1 Significant Adverse Events were reported and reviewed by Patient Safety Group (PSG) -;

- 30 were commissioned at Level 1 strategic review

- 59 were commissioned as Level 2 , tactical review
- 23 were not commissioned by PSG but were taken forward as a level 3 operational review by the directorate (all Cardiac Arrests)
- 10 were rejected as not being an adverse event
- 2 were duplicate reports
- 1 was processed as a complaint

A Strategic review (Level1) is commissioned when it is thought at its conclusion it is likely to identify learning which can be shared across the organisation and with other boards, will result in a change of organisational policy or a significant change in procedure or working practice. A strategic review should always be carried out in the case of a "never event" (e.g. wrong site surgery).

A Tactical review (Level 2) is applicable to an adverse event which the review of is, at its conclusion, likely to identify learning which will result in a change to departmental practice, policy or procedure or is applicable to multiple teams.

An Operational review (Level 3) is the basic level of review for which improvement actions can be completed with immediate effect.

At the end of the investigation PSG assign an outcome code to each completed level 1 and 2 commissioned reviews.

Outcome code 1 - Appropriate care: well planned and delivered unavoidable outcome / event.

Outcome code 2 - Issues identified but they did not contribute to the event: lessons can be learnt although it did not affect the final outcome/ event.

Outcome Code 3 - Issues identified which may have caused or contributed to the event: different plan and/or delivery of care may have resulted in a different outcome (uncertainty regarding impact on patient outcome/ event).

Outcome Code 4 - Issues identified that directly related to the cause of the event: different plan and/or delivery of care would on the balance of probability have been expected to result in a more favourable outcome i.e. systemic factors considered to have an adverse and causal influence on patient outcome / event.

From the number of Significant adverse events reviewed and commissioned by PSG
- 14 were closed with an outcome code 1 assigned.
- 18 were closed with and outcome code 2 assigned
- 12 were closed with an outcome code 3 assigned
- 9 were closed with an outcome code 4 assigned

Duty of Candour

Duty of Candour Legislation came into effect on 1 April 2018.

The number of adverse events commissioned and closed in year that are subject to Duty of Candour Legislation:

- Ten category 1 adverse events
- Six category 2
- Five category 3

Of the ten Category 1 significant adverse events reviewed and commissioned by PSG the following outcome codes were assigned -;

- 0 were closed with an outcome code 1 assigned.
- 2 were closed with and outcome code 2 assigned
- 2 were closed with an outcome code 3 assigned
- 1 was closed with an outcome code 4 assigned
- Five were closed before the time of PSG assigning Outcome codes

21 Duty of Candour incidents were reported in 2018/19. The table below indicates the type of incident. These include Category 1, 2 and 3 incidents. More than half of these incidents resulted in increased treatment and length of stay.

Table 7: Duty of Candour Incidents by Type

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2018 and 31 March 2019)**
A person died	1
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	12
The structure of a person's body changed	0
A person's life expectancy shortened	2
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	1
A person needed health treatment in order to prevent them dying	3
A person needing health treatment in order to prevent other injuries as listed above	0
Number not categorised	2
Total	21

Work Plan 2019/2020:

- We will work with Community Health and Social Care Directorate to ensure all social care staff are able to report on DATIX.
- Work with Directorates to ensure that incidents are reviewed within prescribed timescales
- For significant adverse events we will:
    - Consider Duty of Candour legislation
    - Continue to produce local learning summaries for all SAER

2.5 Leadership Walkrounds

The Patient Safety Leadership Walkround process is designed to give frontline staff and senior leaders in the organisation an opportunity to discuss safety and improvement and the things which can help in delivering safe, effective, person centred care. The walkround conversation is intended to engage staff in order that:

- They can discuss what they do well and are proud of.
- They can raise safety or quality concerns.
- The participants can agree actions and timescales to address any concerns.

From April 2018 to March 2019 a total of 71 Walkrounds took place across the organisation on a weekly basis and are part of a continuing cycle of improvement.

Table 8: Themes raised at Leadership Walkrounds

Theme	Discussion Points
Staffing	• Staffing levels, sickness and vacancies. • Challenges of recruiting to the area • Time to induct new staff • Inexperienced staff • Inability to take breaks due to work pressure • No designated break areas within clinical environment • Training/ability to release staff
Community Hospitals	• Issues around storage for equipment • Patients and their families have reported that visiting is harder due to remote locations – Public Transport is limited
Visibility of the Leadership Team	• The departments welcome more frequent but less lengthy walkrounds to their departments.
Move to the New Hospital	• Concerns around the safety of providing care to patients in single rooms. (audibility of buzzers, patient falls) • Parking issues for staff
Patient Safety	• Patient transport being cancelled prior to appointments and therefore patients are unable to attend their scheduled appointments.

Actions identified during discussions are agreed and taken forward by the senior managers or nominated staff members. Themes identified are discussed by Management Team and incorporated into risk and business planning processes. Samples of the actions are detailed below.

Table 9: Actions taken from Walkrounds

Theme	Actions
Staffing	• Incorporated within Corporate, Tactical and Operational risk registers for action
Community Hospitals	• Community transport options are being explored to enable relatives to travel when patients are placed in outlying hospitals due to bed availability.
Visibility of the Leadership Team	• Julie White has recently invited staff to breakfast sessions • Local leadership teams arrange regular walkrounds
Move to the New Hospital	• Parking stewards have been put in place to ensure staff only park in designated areas. Additional parking within patient and visitor areas has been allocated for staff • Technological solution to audibility of buzzers tested and is now in place • Exploring/testing falls prevention strategies
Patient Safety	• Issues explored with Scottish Ambulance Service at regular liaison meetings

2.6 Risk Management Audit

During 2013 NHS Dumfries and Galloway's Risk Management process was reviewed by internal audit. From this audit a limited assurance report was issued with 12 recommendations identified. All but one of the recommendations have now been closed.

A further audit was undertaken in 2016, where a moderate level of assurance was issued, which demonstrated the significant improvements that have been made to our risk management systems.

The purpose of the second audit was to provide assurance on the adequacy and effectiveness of the Board's Risk Management Strategy and to demonstrate the Board's commitment as a driver in the process, 15 recommendations for action were made, nine of these have now been closed.

An audit of Adverse Incident processes was undertaken during the year which identified 7 recommendations for action. These actions have been completed and are awaiting final approval at Governance groups to enable closure.

Appendix 2 provides a table of the status of actions taken to address the recommendations.

2.7 Directorate Updates

All Directorates including those which come under corporate services have reviewed and updated or strengthened their approaches to Risk Management in year. This is subject to review as part of the Annual Performance Reviews. Directorates have undertaken a Self Assessment of their approach to managing risk.

Each of the Directorates now produces an 'Improving Quality Reducing Harm' paper which is presented to HCGC on an annual cycle.

These papers highlight the Directorates approach to risk, safety and improvement and demonstrate an increasing level of sophistication or maturity in connecting and learning from areas of identified risk.

2.8 Internal and External Hazard and Safety Notices and Alerts

NHS Dumfries and Galloway received 120 Safety/Hazard Notices (an increase of 38% on last year) during this financial period.

An update on Circulars and Safety Action Notices is presented to Healthcare Governance Committee (HCGC) on a bi-annual basis to give assurance that notices are reviewed and acted on as appropriate.

PSG receive and review responses to any high risk notices where there is a risk of severe death or harm.

Our local Protocol ensures that notices and alerts received into the organisation are reviewed, risk assessed, implemented and monitored. Notices are reviewed for applicability by Specialist/Technical Advisors and then sent out to appropriate areas for review and action. 93% of notices were sent out within the specified timescale of 3 days.

Directorates are required to complete a signed declaration and respond within 20 working days of receipt of the Notice. 80% of declarations were returned within 20 working days of receipt. Of the numbers that were over 20 working days the median number they were overdue by was 20 days. The least number of days overdue was 3 and the highest number of days overdue was 297 (this was dealt with appropriately and was an information alert that requires review by the whole organisation hence the length of time taken to complete review).

Table 10: This year's activity

Type	Total Received 2018-2019
Product Recall Notice	13
Medical Device Alert	43
Field Safety Notice	9
Customer Alert Notice	25
Estates Facilities Alert	9
Safety Action Notice	1
Information Message	19
SHTG* Advice Note	1

*Scottish Health Technologies Group

A number of directorates were failing to adhere to the timescales set within the Protocol and were supported to understand and improve performance which has resulted in a higher proportion of declarations being returned within timescale (42% to 80%). The protocol document now includes a clear escalation process.

Work Plan 2019/2020:

- Work with Directorates and Localities to further improve compliance with response timescales

3. Risk Appetite

NHS Dumfries and Galloway have agreed a Risk Appetite Statement which is included within the Risk Management Strategy, agreed by Audit & Risk Committee in June 2017. A copy of the approved Risk Appetite has been incorporated into the Risk Management Strategy. The corporate risk register now includes a statement on risk appetite in relation to each risk identified and Board and Committee templates now include a section on Risk Appetite which is being completed.
Further work is required to ensure that all Directorates and Corporate Services formally consider Risk Appetite when completing Risk Assessments

Work Plan 2019/2020:

- Embed Risk Appetite in Directorate and Project Risk Registers
- Board and IJB Workshop

4. Corporate Risks

During 2018/19 a number of changes were made to corporate risks to ensure they captured the challenges being faced by the Board, including financial constraints, changes to service delivery, the introduction or revision of legislation and the integration of Health and Social Care.

As part of the development of the register, the following 1 new risk was added to the register during the year:

In accordance with the Risk Management Strategy, quarterly meetings have been held with the Directors to undertake individual reviews of each of the corporate risks and to re-assess the risk grading, taking into account any further control measure that have been identified and implemented, as well as legislative changes and developments within service delivery.

The risks within the register continue to be wide ranging, covering a variety of areas including medical staffing, health inequalities and financial risks. The worksheet attached at ***Appendix 1*** details the Corporate Risks on the register and the level of risk associated with each. We currently have 1 risk graded as Very High, 10 risks graded as High and the remaining 6 risks as Medium.

Update on the progress that has been made around the Corporate Risk Register has been presented to the Risk Executive Group and Audit and Risk Committee as part of the Quarterly Risk Management Update paper, throughout the year.

Project risk registers are held for each key developments being progressed including Service Change Programmes and Mountainhall Treatment Centre Project.

These are presented routinely to Audit and Risk Committee for scrutiny; however, they are not recorded on DATIX.

Work Plan 2019/2020:

- Project Risk Registers to be recorded on Datix

5. Communication of Risk Management Information

All risk information and guidance is hosted within the Datix Risk Management Portal on Beacon.

The Datix portal enables access to the Risk Management Strategy, Risk Management Guidance, SAER Management, 'How to Section' and directly links to other associated internal and external web sites e.g:

- Health and Safety Executive
- Occupational Health and Safety (SALUS)
- SPSP
- DATIX

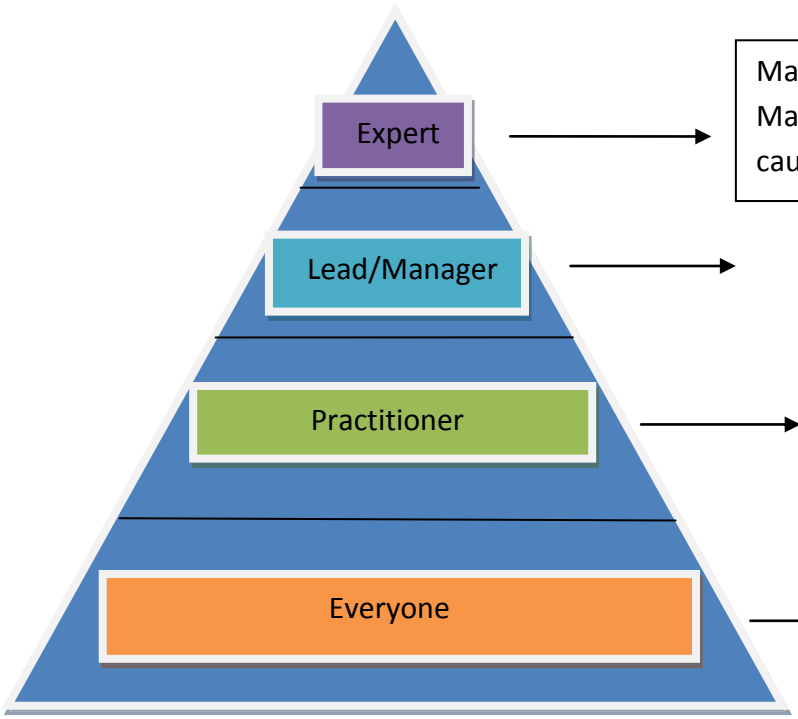
5.1 Reports

The Patient Safety and Improvement team provide a variety of papers and reports to Boards, directorates and management teams to stimulate reflection, learning and for governance purposes. During 2018/2019 reports were received by:

- NHS Board
- Healthcare Governance Committee
- Management Team
- Audit and Risk Committee
- Patient Safety Group - weekly
- Monthly directorate management teams
- On line live reports can be produced in DATIX and via Qlickview
- In house Safety notices and alerts for areas of emergent or significant risk

5.2 Training, Education and Development

Training has continued throughout the year with a mix of formal and informal workshops. The diagram below indicates the capability expected at each level and the training opportunities available. The numbers represent those trained this year.



Masters level or equivalent - QI, Risk Management (NEBOSH etc), Root cause analysis

SAER investigation training and Root cause analysis, IOSH, Duty of Candour learn pro

Adverse Event Investigation Training and Duty of Candour learn pro module, Risk Assessment – **65**

Learn pro module introduction to incident reporting – **143 members of staff**

Work Plan 2019/2020:

- Consider procurement of Datix Dashboard to enable management teams quick and easy access to a suite of customised live reports
- Training Plan 2019/20 to be agreed with the Risk Executive Group and Risk Steering Group

6. Involvement in National Programmes

NHS Dumfries and Galloway have members of staff who represent the Board at the following meetings:

- Risk Manager's Network
- Datix Scottish User's Group
- Adverse Events Network
- Scottish Patient Safety Programme

6.1 Improving Safety, Reducing Harm

Clinical Risks and patient harm identified through Adverse Events reporting are incorporated in our Patient Safety and improvement Programmes.

We currently have programmes in:

- Acute Adult Care
- Heath and Social Care
- Mental Health
- Maternal/Neonates/Paediatrics (MCQIC)

Each of the programmes has distinct aims, interventions and a management framework to assess impact. These are reported through Management Boards, HCGC, NHS Board and externally to HIS.

Areas of high risk being addressed include:-

- Medication Management
- Management of patient deterioration
- Falls
- Communication
- Healthcare Associated Infection (HAI)
- Pressure Ulcers
- Management of stress and distress
- Safety Culture

A brief synopsis of some of this work is described below.

Acute Adult care

Within acute services senior managers having reviewed their adverse event data have identified three key priorities for improvement:

- Falls
- Pressure Ulcers
- Deteriorating Patients

Improvement teams have a better understanding of their data and are actively testing a range of interventions to reduce avoidable harm.

Patients at risk of falling are discussed at the morning huddle, with on average 39 people identified every day**.** A range of interventions to reduce risk have and are being tested. Risk of falls is multifactorial and closely related to frailty**.** The number of falls is not reducing although there is evidence to suggest that falls with harm have decreased.

A falls prevention master class was held on 25th February 2019 for Health and Social Care Staff across the region. This was well attended by Health, Care Home and Care at Home staff. There is now opportunity to work more collaboratively with our colleagues across all sectors sharing learning and improving patient pathways when being discharged from hospital into community settings.

Women & Children's
The Directorate have continued to prioritise work to reduce still birth and infant mortality as part of SPSP Maternity and Children's Quality Improvement Collaborative (MCQIC) and have recently commenced work on implementing 'Best Start', a redesign of Maternity & Neonatal Services.

The maternity team have worked to improve CTG monitoring (heart monitoring of baby during labour) and introduction of the 'snuggle bundle' to keep babies warm which prevents complications leading to transfer to the neonatal unit. Both these interventions are known to reduce risk of mortality and morbidity during the perinatal period.

Mental Health
Incidents of aggression and violence are high risk in Mental Health. Work is ongoing to reduce the risk and the stress and distress to patients, visitors and staff. SPSP focus in Mental Health in Dumfries and Galloway includes:

- Risk assessment and safety planning (e.g. more effective daily safety huddles, safety briefs implemented in all wards)
- Falls in older adults ward
- Communications at transitions (e.g. more effective and efficient handovers using electronic systems)
- Safer medicines management (e.g. improved compliance with prescribing standards for 'as required' medication)
- Restraint and seclusion (e.g. weekly risk triage meetings has increased understanding of attitudes to restraints and better management - this includes work to reduce incidents of violence and aggression)
- Leadership and culture (e.g. implementation of the Nominated Hospital Lead Role)

Medicines
A Medicines Safety Group has recently been reformed to address areas of known risk, initially within Acute & Diagnostics.

Communication
Communication issues account for a significant number of adverse events and complaints. Works to improve inter and intra team communication is ongoing within and across directorates with an increased understanding around the patient journey and flow.

Hospital and team huddles are now common place across the organisation but there is still a requirement to improve the coordination of care in complex cases where people may have multiple health issues and be seen by a number of health and social care staff.

Anticipatory Care Planning (ACP) provides an opportunity to put the patient and their needs and wishes at the centre of care planning. The ACP document can be shared with their GP and hospital and care practitioners to convey the care and treatment that patients want, reducing miscommunication and in some cases over treatment.

Work Plan 2019/2020:

- Seek support from Risk Management (RM) Network to review Dumfries and Galloway risk systems
- Continue to support SPSP and local priorities for improvement
- Set improvement aims with Directorates for areas of high risk
- Support the development of Capacity & Capability in relation to RM and Improvement

7. Assurance Statement

The Audit and Risk Committee advises the Board and Accountable Officer on their responsibilities for issues of risk, control and governance and associated assurance and seeks to ensure that:

- There is a comprehensive risk management system in place to identify, assess, manage and monitor risk at all levels within the organisation.
- There is appropriate ownership of risk in the organisation and that there is an effective culture of risk management.
- There is a clearly defined risk appetite statement in place, which is regularly reviewed and utilised organisation wide to assess risk tolerance.

Based on the core requirements of the framework already in place the following are the areas of significance for both strengthening of the Risk Management Framework and the areas identified for improvement in this review period : –

Strengthening of the Risk Management Framework:

- A comprehensive review of the Board's approved Risk Management Strategy and Risk Management systems and processes are undertaken to ensure continuous development of Risk Management.
- Annual reviews of the Board's approved Risk Appetite Statement are undertaken to ensure the appropriate tolerance levels for risk is managed and embedded within Risks Management organisation wide.
- Formally approve review of Adverse Event Framework
- Continue weekly meeting of Patient Safety Group to consider Significant Adverse Events, commission investigations, seek assurance with regard to action and promote learning.
- Continue to use adverse event data to inform local and national Quality Improvement initiatives overseen by Management Team and aligned to programmes of improvement, e.g. Scottish Patient Safety Programme
- Continuous review of Risk Profile through the management of the Corporate and Directorate Risk Registers to reflect current and emerging risk through Management Team.
- Support Directorates to embed Risk into all management processes.

The Risk Facilitators within all directorates with the additional support of Patient Safety and Improvement team ensure that operational risks are consistently monitored and managed. This is further enhanced by the bi-monthly Risk Steering Group meetings which feed directly into the Risk Executive Group, ensuring a clear line of communication and awareness of Risk at all levels of the organisation.

In addition to the above directorates operate a weekly/monthly 'Risk Triage' meeting to ensure risk is being managed at an operational level. This ensures repeat trends are dealt with at an early stage and the appropriate managers are being provided with the necessary assistance. These meetings have the added benefit of ensuring risk is discussed and embedded in to daily business.

8. Priorities

Summary of Progress against Priorities 2018 – 2019

Work activity identified for 2018/2019		Progress Update
Risk Management Strategy Implementation	Review tactical implementation of Board and IJB Risk Strategy	Ongoing
	Development of Risk Register module	Limited progress due to IT access requirements
	Refinement of KPI's	Ongoing
	Deliver Risk Training/Learning Plan	Training plan developed and delivery adapted to suit local needs
	During 2018/2019, work will continue to systematically review Risk Registers to ensure all risks are updated within the specified timeframes or closed if they are no longer valid.	RR reviews ongoing
	We will work with Health and Social Care Directorate to ensure all health and social care staff are able to report on DATIX	Limited progress due to IT access requirements
	For significant adverse events we will: ➢ Prepare for roll out of Duty of Candour legislation by April 2019 ➢ Produce local learning summaries for all SAER ➢ Share learning summaries nationally	Duty of Candour Implementation plan developed and delivered in year Learning summaries produced for all SAER where learning was identified
	Review and update HAZ/SAN protocol	Complete
	Work with Directorates and Localities to improve compliance with response timescales	Significant improvement in response timescale. 80% responses within timeframe.
Risk Appetite	Risk Appetite will be incorporated into the Risk Training Plan.	Incorporated within training
	A communication plan will be developed to raise awareness of Risk Appetite.	Ongoing
	Board Paper templates to be amended to include consideration of Risk Appetite	Complete

Corporate Risks	The Corporate Business Manager will continue to meet with each of the Directors on a quarterly basis to update the live risks and develop new and existing controls with the aim of reducing the risk grading to the target position in the long term, which would be 13 medium rated risks and 3 high risks on the Corporate Risk Register.	Complete & ongoing Regular meetings with Directors established to review risks.
Risk Assurance Framework	Further development of the Framework and the new Assurance Map will be discussed with Audit and Risk Committee and Risk Executive Group to ensure they are fit for purpose and give the appropriate levels of assurance to both Committee and Board members.	A new assurance map is being developed and will be discussed with Audit and Risk Committee and Risk Executive Group to ensure that they give appropriate levels of assurance to both Committee and Board Members around our three lines of defence in relation to risk
Risk Management Learning System	A Prioritised Risk Training/Learning Plan will be agreed to support implementation of Board and IJB Risk Strategy	Investigation training took place throughout the financial year with 3 full sessions for significant adverse event, 3 sessions for adverse events and numerous people accessing our learn pro module on how and what to report.
	DATIX Training will continue to be delivered throughout 2019/2019 by the Adverse Event Coordinator and Risk Project Officer with a focus on social work staff.	The adverse event coordinator provided regular and varied development sessions to key risk contacts in each directorate.
	NHS Dumfries and Galloway will continue to work with NHS Glasgow and Greater Clyde (NHS GGC)to share training resources	NHS GG&C have continued to share their resources and provide support to the Adverse Event Coordinator
	PSG will produce quarterly newsletters	To date there have been 4 newsletters distributed throughout the organisation in relation to our top themes emerging from category 2 and 3 adverse events
	A communication plan will be developed to ensure learning is shared	PSG communication plan was developed and agreed
Improving Safety Reducing Harm	A Patient Safety and Improvement Workplan that incorporates areas of known risk is developed and updated annually	Annual work plan in place

	NHS Dumfries & Galloway will continue to participate in SPSP	Participated in Acute, Mental Health and MCQIC SPS programmes as well as supporting local improvement priorities identified from adverse events, risks, patient feedback and Scottish Government Directives.
	The Patient Safety & Improvement Team will work with Directorates to prioritise areas for improvement	As above
	Continue to develop Quality Improvement Capability through delivery of Scottish Improvement Skills (SIS)	2 SIS cohorts delivered in year
	Provide coaching support to individuals and teams working on areas of risk/improvement	Scottish Coaching and Leading Improvement Programme Delivered to 30 local participants Coaching core to Improvement Advisor role

Summary of Priorities for 2019 – 2020

Work activity identified for 2019/2020	
IJB Audit & Risk Committee and Health and Social Care Partnership	Systematic review of Risk Management
	Work with General Managers and Directorate Leads to ensure they are represented at Risk Steering Group Meetings
	Agree Risk Development Plan with Risk Executive Group
Risk Management System	Overhaul Risk Register Module; simplify levels to reflect operational, tactical and strategic risks
	Ensure social work staff have access to DATIX
Risk Appetite	Embed Risk Appetite in Directorate and Project Risk Registers
	Board and IJB Workshop
Corporate Risks	Project Risk Registers to be recorded on DATIX
Adverse Events & Duty of Candour	We will work with Community Health and Social Care Directorate to ensure all social care staff are able to report on DATIX.
	Work with Directorates to ensure that incidents are reviewed within prescribed timescales
	For significant adverse events we will: • Consider Duty of Candour legislation • Continue to produce local learning summaries for all SAER

Internal & External Hazard and Safety Notices and Alerts	Work with Directorates and Localities to further improve compliance with response timescales
Training, Education and Development	Consider procurement of Datix Dashboard to enable management teams quick and easy access to a suite of customised live reports
	Training Plan 2019/20 to be agreed with REG and RSG
Improving Safety and Reducing Harm	Seek support from Risk Management Network to review D&G Risk Systems
	Continue to support SPSP and local priorities for improvement
	Set improvement aims with Directorates for areas of high risk
	Support the development of Capacity & Capability in relation to Risk Management and Improvement

9. Conclusion

NHS Dumfries and Galloway aims to deliver excellent care that is person-centred, safe, effective, efficient and reliable and to reduce health inequalities across Dumfries and Galloway. To ensure this is achieved we have embraced a proactive approach to Risk Management and aim to promote a positive culture of learning and sharing the learning in order that we improve our systems and processes. The information detailed in this report provides assurance that Risk Management is being embedded into the organisation and that processes are in place to ensure the appropriate people are managing risks and promoting a culture of learning within the organisation.

It is recognised that continual development of staff, maintaining links with other Boards, promoting a culture of learning and the development of IT based Risk Management systems will ensure continued maturity of Risk Management within NHS Dumfries and Galloway.

2018/19 was a challenging year with significant staff shortages across directorates, a very busy winter period and continued financial constraints.

We have continued to work with IJB and locality and Directorate teams to ensure a consistent approach to Risk Management is adopted and that Governance Mechanisms ensure safe and planned transitions of risk between partner agencies.

Positive risk taking is as important in such times as the need to develop creative and innovative solutions to meet service pressures, societal changes and the move to regionalisation of some services.

The priorities identified for next year we believe will strengthen our approach to Risk Management.

APPENDIX 1

Corporate Risk Register

ID	Ref	Description	Risk level (Current)	Risk level (Target)	Risk Appetite Level	Date of last review
2392	New Corp Risk 1	Failure to recruit and retain essential and sustainable workforce poses a significant risk to service sustainability. This could results in a lack of availability of suitably qualified and competent medical (including GPs), other clinical and other staff/carers/volunteers, resulting in inability to deliver services for partners as set out in the IJB Strategic Plan.	Very High	High	Medium	Mar-19
2393	New Corp Risk 2	Failure of the Board to meet financial target	High	High	Low	Apr-19
2394	New Corp Risk 3	Infrastructure is inadequate to meet both physical and technological service user needs in future.	Medium	Medium	High	Mar-19
2395	New Corp Risk 4	Failure to address inequalities resulting in poorer health outcomes for certain groups or parts of the population.	High	High	Medium	Nov-18
2396	New Corp Risk 5	A person dies or comes to significant harm as a result of failure to protect vulnerable individuals / support families.	High	Medium	Low	May-18
2397	New Corp Risk 6	Unable to redesign quickly enough to meet the demands of the service. Services will need to be redesigned to address demographic / workforce / financial realities into 2020s.	High	Medium	Low	Apr-19
2398	New Corp Risk 7	Failure to realise optimal health and wellbeing of staff impacts adversely on service delivery and financial sustainability.	High	Medium	Medium	Mar-19
2399	New Corp Risk 8	Failure to assure and improve quality of care and services.	Medium	Medium	Low	May-18
2400	New Corp Risk 9	Loss of focus on operational delivery due to other significant change programmes, such as the Integration of Health and Social Care and the Primary Care Transformation Programme.	Medium	Medium	High	Mar-19
2401	New Corp Risk 10	Failure to take action on prevention and early intervention which impacts on future health and wellbeing of our population in medium to long term.	High	Medium	Low	Nov-18

ID	Ref	Description	Risk level (Current)	Risk level (Target)	Risk Appetite Level	Date of last review
2402	New Corp Risk 11	Emergency Planning – failure to plan for major incidents and disasters. This could lead to harm to patients & staff (as well as reputational damage) through the failure of effective business continuity processes.	Medium	Medium	Low	Apr-19
2403	New Corp Risk 12	Failure to maintain information security standards leading to loss of reputation and severe financial penalty.	High	Medium	Low	Apr-19
2404	New Corp Risk 13	Board breaches compliance with standards on Corporate Governance including risk of best value not being obtained.	Medium	Medium	Low	Apr-19
2405	New Corp Risk 14	Strategic commissioning fails to identify and adequately plan for the health and care needs of the people of Dumfries and Galloway	Medium	Medium	Medium	Mar-19
2406	New Corp Risk 15	Potential confusion exists around information sharing due to changes in legislation regarding information sharing across professional groups within Children's Services. This can allow practitioners and children potentially to be at risk due action or omission.	High	Medium	Low	May-18
2407	New Corp Risk 16	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up and raise concerns and ideas for improvement, resulting in adverse impact on staff and/or patient safety, health, wellbeing and/or relationships and reputation of the Board. This could result in a risk that the IJB fails to deliver anticipated cultural change resulting in fragmentation and disjointed services which have an adverse impact on patient / user and staff experience.	High	Medium	Medium	Mar-19
2408	New Corp Risk 17	Exit from EU creates disruption to required availability of staff, goods and services necessary for the provision of safe care.	High	Medium	Low	Apr-19

APPENDIX 2

Status of outstanding Internal Risk Audit Actions

Audit	Action Plan Subject	Issue	Recommendation	Management Response	Expected Completion Date
2013 RM-01-13 Risk Management	Management of Risk Registers	Where the structure of Datix does not reflect the Board directorates this impacts the ability of the system to generate valuable reports and the current structure does not facilitate searching by corporate directorates.	The pending Datix risk module upgrade must give due attention to the Board directorate There is a current an inability to effectively search the Datix risk module by directorate for corporate directorates given the structure around the Health Services sub-directorates.	Risk Register update is pending and will be scheduled for completion 2019. Corporate Directorate sub structure to be added to Datix	Dec 2019 July 2019
2017 IJB-01-17 IJB Governance Arrangements	Risk & Performance Management Action Plan - Risk Management Monitoring	There is a risk that risk management monitoring arrangements are not actioned as described by the Risk Management Strategy. This arises following a discrepancy in what has been set out and that discussed at H&SCSMT for exception reporting.	It must be ensured that the risk management monitoring arrangements stipulated by the Risk Management Strategy are implemented as described or the necessary amendments made to reflect how assurances are intended to be delivered in practice.	Paper to be presented to IJB Audit and Risk Committee in September providing information on corporate risk register and ongoing plans to develop risk.	July 2019
2017 RM-01-17 Risk Management	Risk Management Strategy, Policies & Procedures Action Plan	There is a risk to the achievement of risk management goals where the Risk Management Strategy does not define what will be measured and reported to demonstrate the achievement of such goals.	The Risk Management Strategy should be inclusive of KPIs setting out how compliance with the strategy will be measured, i.e. the review of risks within defined timescales and the closure of adverse events. Including KPIs in the Risk Management Strategy will also add value to the annual reporting process.	Existing KPI's will be routinely reviewed by Risk Steering Group with proposals taken to Risk Executive Group on how they can be developed throughout the year to improve on the performance reporting aspects of risk and adverse incidents.	June 2019

Audit	Action Plan Subject	Issue	Recommendation	Management Response	Expected Completion Date
2017 RM-01-17 Risk Management	Risk Management Training and Awareness Action Plan	Where there is no framework for risk management training there is a risk that staff knowledge of risk management and local arrangements is varied and inconsistent. Ultimately this could impact risk maturity where the Risk Management Strategy is not being fulfilled.	There is a need to progress the training plan through the Risk Steering Group and Risk Executive Group as required to ensure that the necessary training is available to all staff.	Training plan to be agreed by Risk Steering Group for approval by Risk Executive Group	May 2019
2017 RM-01-17 Risk Management	Risk Management in Practice Action Plan	There is a risk to the embedding of organisational risk management arrangements where risk registers are not routinely reviewed in accordance with the stipulations of local policy.	A review of overdue risks is required to bring all risk registers up-to-date for active management.	Risk Facilitators to undertake this work within their directorate. Corporate Business Manager to undertake for corporate directorates.	September 2019
2017 RM-01-17 Risk Management	Risk Management in Practice Action Plan	Where all directorates are not represented by the RSG and the group is lacking a clear workplan to advance risk management practice there is a risk to the embedding of risk management arrangements and achievement of the organisational goals set out by the Risk Management Strategy.	The membership of the RSG should be reviewed to ensure that there is sufficient representation of all directorates to promote a consistency in risk management arrangements. Further this should be supported by a workplan for the group and to prioritise action which should be reflected by the agenda and pertinent standing items.	Review complete and agreed by RSG Group, suggested amendments to the membership taken to Risk Executive Group for approval. Annual Workplan to be agreed by RSG and REG.	September 2019
2019 A-11-19 Adverse Event Reporting	Roles and Responsibilities Action Plan	There is a risk that instructions to staff are not explicit and embedded.	The appendices within the NHS D&G Framework and Procedure for the Management of Significant Adverse Events should be clearly referenced within the body of the report and presented in order to reflect and facilitate adherence to the local process.	Organise appendices to flow better in line with the management steps to adverse events	Work complete awaiting Governance sign off.

Audit	Action Plan Subject	Issue	Recommendation	Management Response	Expected Completion Date
2019 A-11-19 Adverse Event Reporting	Roles and Responsibilities Action Plan	There is a risk of non-compliance with the NHS D&G Document Development and Approval Policy where policies are not subject to the necessary scrutiny and approval.	The approval route of the Adverse Event Policy Statement should be verified as no evidence of approval could be found through the NHS Audit and Risk Committee. As required this should be rectified and the necessary approval for this policy obtained.	Resend the policy through the correct route for approval. Policy's document control table updated to reflect the status of approval.	
2019 A-11-19 Adverse Event Reporting	Adverse Event Reporting Action Plan	There is a risk that the local framework for significant adverse events is creating confusion in differentiating between a Category 2 adverse event and Level 2 review leading to ineffective communication and deviation from the desired process.	The NHS D&G Framework and Procedure for the Management of Significant Adverse Events should be reviewed to enhance the clarity of direction to staff in relation to the Level 2 review process for adverse events and when this would be initiated. The procedure should also include the Level 2 review template as an appendix as information to staff implementing the process.	Framework updated to provide clearer explanation.	Complete awaiting Governance approval
2019 A-11-19 Adverse Event Reporting	Adverse Event Reporting Action Plan	There is a risk that Datix is not being utilised to its potential as a document repository.	The NHS D&G Framework and Procedure for the Management of Significant Adverse Events should capture the minimum expectations of documents to be uploaded to Datix as part of the adverse event handling process; this could be captured within the content of the procedure or incorporated into existing checklists.	Update the Framework to capture the minimum expectations and update checklist.	Complete awaiting Governance approval

Audit	Action Plan Subject	Issue	Recommendation	Management Response	Expected Completion Date
2019 A-11-19 Adverse Event Reporting	Adverse Event Reporting Action Plan	There is a risk that adverse events within the corporate directorates are not being managed effectively due to lack of awareness and engagement.	The monthly General Manager KPI Report should be circulated to the corporate directorates either directly or through the Key Risk Contact in order for adverse event data relating to these areas to be reviewed and utilised proactively.	Laura Geddes to be key risk contact for corporate team. She will receive and action monthly corporate report.	Complete
2019 A-11-19 Adverse Event Reporting	Adverse Event Reporting Action Plan	There is a risk that existing reporting arrangements lack operational value to drive performance improvement.	The operational value of performance reports must be considered as a means of driving directorate level improvement in adverse event handling and ensuring that the information being communicated is actionable.	Review content and impact of report with recipients with view to improving the quality and usefulness of the report	Complete
2019 A-11-19 Adverse Event Reporting	Adverse Event Reporting Action Plan	There is a risk that departmental processes within the PS&IT are not being followed where expectations are not clearly communicated and monitored.	Departmental expectations for the notification of Level 1 reviews as instructed by PSG should be clearly set out to staff and overseen where possible to enhance consistency and a standardised approach, i.e. notifications issued through the Datix email system inclusive of terms of reference and attaching the framework.	A Standard Operating Procedure checklist for Communication around Level 1 reviews will be reviewed and used routinely.	Complete