Appendix 1

RISK MANAGEMENT ANNUAL REPORT 2017/2018

Patient Safety & Improvement
Managing Risk Protecting Patient Safety

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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 2017 and 31 March 2018
- 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 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 four occasions in 2017/2018. The committee seeks to monitor and gain assurance through:

- Reviewing the Board's Risk Management Strategy and advising the Board of the Committee's views as to its adequacy.
- Forming an opinion on the exposure to risk relevant to the Board's Risk Appetite, and the adequacy and effectiveness of the systems of internal control for individual areas/subjects.
- Reviewing, discussing and assessing organisational risk and seeking assurance that effective risk management systems are in place.

- Drawing attention to weaknesses in systems of risk management, governance and internal control, making suggestions as to how these weaknesses can be addressed.
- Considering the Corporate Risk Register and risk management arrangements for key organisational projects on a quarterly basis.
- Gaining assurance that financial risk and change in risk are being monitored.
- Monitoring financial risk management.

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 2017/2018.

The role and function of the Risk Executive Group is:

- To agree a Risk Management Strategy for NHS Dumfries and Galloway, integrating, overseeing and directing the Risk Management agenda
- To oversee and provide assurance to the Audit and Risk Committee of the effectiveness of Risk Management arrangements
- To provide direction and guidance to the Risk Management Steering Group
- To ensure that Risk Management is integral to all business decision making, planning, performance reporting and delivery processes
- To set a model for agreeing and monitoring risk appetite
- Responsible for the review and monitoring of the Corporate Risk Register and any escalated/uncontrolled risks from Directorates.

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 (2 meetings were cancelled due to adverse weather) and considered and progressed work around:

- IJB Risk Strategy development and implementation
- Policy and Procedure Updates
- Risk Training Plan; including promotion of LearnPro module and training needs analysis
- Internal Audit Report and Action Plan (DATIX)
- Adverse Event Terminology Review – 3 levels of review were agreed: Strategic i.e. Significant Adverse Event Review (SAER), Tactical (Directorate Review) and Operational (Local Review)
- Categorisation of incidents – agreement was reached to reduce adverse event categories from 9 to 3 in line with the National Adverse Event and Learning Framework
- Key Performance Indicators – Risks/ Adverse Events/ Health and Safety
- Risk Register Configuration including new build and Health and Social Care structure refinements
- Development Learnpro Module for adverse events
- Safety Action Notice (SAN) (SC) 17/01
- Duty of Candour Implementation

Work is ongoing to provide support on risk to the IJB and the IJB Audit & Risk Committee as part of the ongoing support to the Health & Social Care Partnership (H&SCP).

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.

Work Plan 2017/2018:

- Review tactical implementation of Board and IJB Risk Strategy
- Development of Risk Register module
- Refinement of KPI's
- Deliver Risk Training/Learning Plan

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, coding and advances in the technology itself.

During 2017/2018 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 IM&T and will be taken forward into 2018/19 work programme.

Work Plan 2017/2018:

- 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 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.

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. NHS Dumfries and Galloway has an established Corporate Risk Register around the core areas of Governance:

- Information Governance
- Staff Governance
- Financial Governance
- Clinical Governance.

The Corporate Risk Register 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. The 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 to manage changes and provide management reports.

The number of risks identified and assessed per Directorate as of 31 March 2018 is shown below. There has been a 25% decrease in the overall number of risks recorded and it is believed that this can be further reduced by 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. We are working with Mental Health to understand the increase in risks recorded.

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 2018.

Work continued this year to support development of the IJB Risk Register. The 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 2018/19 to ensure both health and social care staff can access Datix.

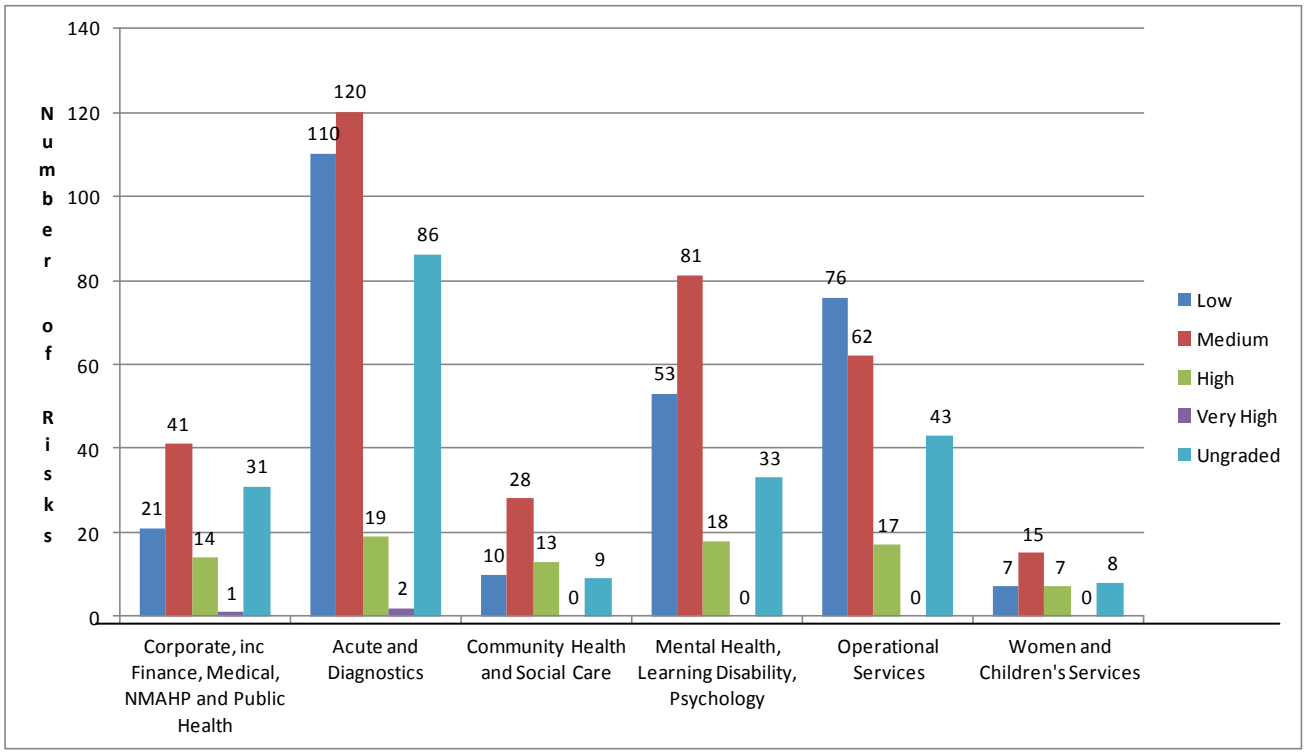
Area/Directorate	2016/2017	2017/2018	+/- %
NHS Dumfries and Galloway Corporate Risk Register	15	16	+6%
Corporate Directorate Risks			
Corporate, inc Finance, Medical, NMAHP and Public Health	123	108	-12%
Directorate Risks			
Acute and Diagnostics	285	175	-39%
Community Health and Social Care	182	60	-67%
Mental Health, Learning Disability, Psychology	52	83	+60%
Operational Services	211	198	-6%
Women and Children's Services	40	37	-7.5%

Risk Grading by Directorate 2017/18:

Directorate	Low	Medium	High	Very High
NHS Dumfries and Galloway Corporate Risk Register	0	5	10	1
Corporate Directorate Risks				
Corporate, inc Finance, Medical, NMAHP and Public Health	21	41	14	1
Directorate Risks				
Acute and Diagnostics	47	104	21	3
Community Health and Social Care	10	28	13	0
Mental Health, Learning Disability, Psychology	24	45	13	1
Operational Services	76	62	17	0
Women and Children's Services	7	15	7	0

Although some Directorates appear to have a high number of risks as stated above, the majority (89%) are graded medium or low, as seen below in Graph 1.

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

Work Plan:

- 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.
- 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. **5288** Adverse Events were reported this year.

Significant Adverse Events

Significant Adverse Events 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.

Significant Adverse Events (SAEs) are reviewed and monitored on a weekly basis by the Quality and Patient Safety Leadership Group (QPSLG). .

QPSLG 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 QPSLG 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

Significant Adverse Event's (SAE's) are classified as any adverse event with a category G, H, I or, since the 1st of April 2018, any Category 1 adverse events. All SAE's are taken to QPSLG who consider whether a SAER should be commissioned.

In total there were 5288 adverse events reported between 1st April 2017 and 31st March 2018. Of these 72 were categorised as SAE's with 23 commissioned by QPSLG as full SAER's.

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:

Categories A – D (from 3 April 2018 – Category 3 'Near Miss/No Harm') Close within 10 working days	
Category A	Circumstances or Events that have the capacity to cause error
Category B	An error that did not reach the patient or person
Category C	An error that reached the patient or person but did not cause harm
Category D	An error that reached the patient and required monitoring or intervention to confirm that it resulted in no harm to the patient or person

Categories E and F (from 3 April 2018 – Category 2 'Temporary Harm') Close within 20 working days	
Category E	Temporary harm to the patient or person and required intervention
Category F	Temporary harm to the patient or person and required initial or prolonged hospitalisation
Categories G to I (from 3 April 2018 – Category 1 'Significant Harm/Death') Close within 90 working days	
Category G	Permanent patient or person harm
Category H	Intervention required to sustain life
Category I	Patient or person death

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.

Number of incidents closed within each of the categories.

	Total Closed	**Closed within 10 working days**	**Closed within 20 working days**	**Closed within 90 working days**	**Closed outwith Timescales**	**Remain Open**
Cat A to D	3490	1507	669	1076	238	335
Cat E and F	1208	647	198	295	68	169
Cat G to I	50	5	7	22	16	28

- 43% of Category A to D Adverse Events were reviewed and closed within the agreed timescales
- 70% of Category E and F Adverse Events were reviewed and closed within the agreed timescales
- 68% of Category G to I Adverse Events were reviewed and closed within the agreed timescales

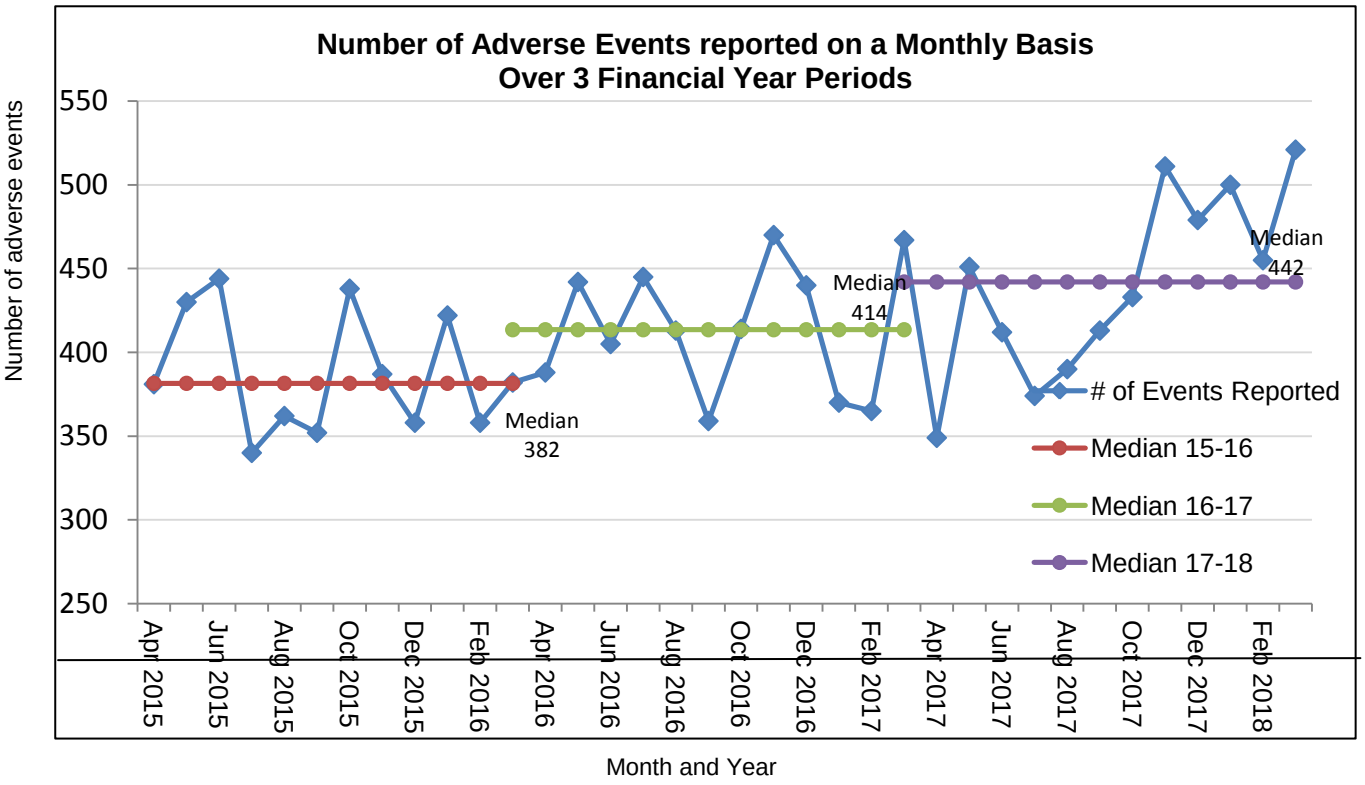
Work is ongoing with directorates to improve the time from open to closed. In relation to significant adverse events, the nature of these dictates that a more robust and thorough investigation be carried out, which can take longer than the prescribed timescale.
On occasions this can also be due to other factors, for example waiting on information from other agencies e.g. Toxicology results from Post Mortem examination.

The Table below provides figures on the number of Adverse Events reported within the Directorates for 2016/17 and 2017/18.
The year on year figure shows a >5% increase for all but one directorate, however, we have seen reporting rates grow year on year as can be seen in graph below. This can be interpreted positively in that our staff are more comfortable and confident to report incidents whilst also providing an indication of systems under pressure. The only Directorate showing a decrease in the number of reported adverse events over the past year has been Operational Services. This may be due to changes in the Directorate Structure which saw catering and support services move to Acute and Diagnostics Directorate.

Directorate	2016/2017	2017/2018	+/- %
Acute and Diagnostics	2323	2449	+5%
Corporate (inc Finance, Medical, NMAHP and Public Health	133	144	+8%
Community Health and Social Care	1004	1117	+10%
Mental Health, Learning Disability, Psychology	1113	1191	+7%
Operational Services	83	54	-34%
Women and Children's Services	322	333	+3%

Graph 2 below provides the detailed 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 and is an indication that staff recognise and feel supported to report when things go wrong.

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



The Top 5 reported type of Adverse Event/Accident occurring is set out below for each of the last 3 years. The Top 5 reported categories have remained fairly constant although variation does exist between Directorates.

2015/2016	2016/2017	2017/2018
1) Slips, Trips and Falls (1573)	1) Slips, Trips and Falls (1541)	1) Slips, Trips and Falls (1480)
2) Violence and Aggression (538)	2) Treatment Problem (697)	2) Treatment Problem (759)
3) Treatment Problem (502)	3) Violence and Aggression (496)	3) Violence and Aggression (556)
4) Medication Incident (429)	4) Medication Incident (363)	4) Medication Incident (469)
5) Other Incidents (196)	5) Communication (188)	5) Communication (209)

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

Work Plan 2017/2018:

- We will work with Health and Social Care Directorate to ensue all health and 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:
    - Prepare for roll out of Duty of Candour legislation by April 2018
    - Produce local learning summaries for all SAER
    - Share learning summaries nationally.

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 2017 to March 2018 a total of 59 Walkrounds took place across the organisation. Walkrounds take place each week in different areas of the organisation and are part of a continuing cycle of improvement.

Themes raised include:

Theme	Discussion Points
Staffing	• Staffing levels, sickness and vacancies. • GP crisis • Lack of induction for locum doctors. • Challenges of recruiting to the area, central belt being preferred. • Issues with how long the recruitment process takes. • Issues when staff are re-deployed or new into a clinical area. Lack of experience causes issues.
IT Systems	• Localities experiencing issues with mobile phone connections – causes delay in text messages being received and calls are cut off.

Communication	• Communication between clinical staff. • "communication from the top could be better" • Duplication in paperwork due to localities and acute not using the same forms.
Visibility of the Leadership Team	• The departments welcome more frequent but less timely walkrounds to their departments.
Move to the New Hospital	• Concerns around providing care to patients, now in new build, due to single beds. • Staff in Mountainhall feel they may be isolated once new build migration has taken place. • Design of new build enhances privacy and dignity for patients.
Patient Safety	• Highest normal birth rate in Scotland for last 7 years. • Peri-natal mortality is increasing (both locally and nationally). • Patient transport being cancelled prior to appointments and therefore patients are unable to attend their scheduled appointments. • Falls – numerous sensors tested but not always robust for patients with different needs/ abilities.

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

Theme	Actions
Staffing	• Conversations with Vacancy Control Group (VCG) regarding new starts/ redeployment skills
IT Systems	• Conversations with IT regarding mobile phones.
Communication	• Action plan for improved communication to be put into place.
Visibility of the Leadership Team	• From April 2017 there will be 2 Leadership Walkrounds a week when possible to give staff more opportunities to meet with the Leadership Team.
Move to the New Hospital	• Shuttle service will be put in place to accommodate journeys between sites.
Patient Safety	• Conversations regarding frequent missing medication charts.

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 of the recommendations have now been closed.

Progress is being made in relation to the re-design of the Risk Register module, however, due to the plans for the move to the new hospital and Risk Co-ordinator vacancy the development work was postponed until 2018.

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, six of these have now been closed.

Appendix 1 *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.

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. The table below gives highlights from each Directorate.

Directorate	In Year Highlights	Plans for 2018/19
Mental Health	• MH Healthcare Quality Committee • Establishment of a quarterly SAER Leadership Group • Development of an action plan template (which includes bespoke QI Projects) for the mitigation and management of risks and incidents. • Establishment of a reciprocal arrangement with NHS Borders, to support objective scrutiny and shared learning from SAERs. • Routine monitoring of KPIs associated with risks and incidents, monitored through the MH HCQC • Clinical Risk Management Training to 95% of staff .	• Information from the SPSP climate tool will be aligned with findings from iMatters survey and Leadership Walkrounds, to improve experiences for patients and staff. • Commitment to improving safety and reducing harm will be further realised through our on-going development of a culture of continuous quality improvement. • Priorities for QI work will be considered through the refreshed risk management and governance structures, to ensure they attend to areas of highest risk. • Projects underway which aim to mitigate risk include: Understanding Staff Absence, Prevention of Harm from Falls and Improved Access to Detox Beds.
Acute & Diagnostics	• Handover of new Acute Hospital • Move to new hospital went very well • Busiest winter in 10 years • Significant staffing challenges • Increase Nursing staff templates for wards and review of skill mix to take account of new environment and ways of working • Increase in incidents and complaints correlating with pressure on staff and the system • Vulnerability of Galloway Community Hospital • Split site working for some specialties	• Review and refresh risk management approach • Overhaul Risk Register • Strengthen Risk Triage with slot at monthly leadership meeting • Increase integration with localities • Work with corporate recruitment and communications team to increase profile and presence on social media

Directorate	In Year Highlights	Plans for 2018/19
Women Children's & Sexual Health	• Handover of new Women & Children's Unit within DGRI • Integrated the multi-disciplinary Clinical Incident Review Groups to have joint neonatal, obstetric and paediatric group • Datix reporting has increased for neonatal and acute paediatrics due to awareness raising. • Perinatal review process now involves parent's views and they receive feedback and apology. • Improved sharing of learning across Directorate Nurse Manager and Team leader for service now update risks aligned with 1:1 meetings to ensure review dates are met.	• Adverse incident and Risk Training for key staff • Implement national peri natal review tool • Review structure and composition of Directorate Risk Register to ensure risk dependencies are explored and mitigated
Health & Social Care	• Integration of Health and Social Care Risk Management Systems at tactical and operational level • Relaunch of Directorate 'Connecting Quality Group' • Supporting third and independent sector organisations • STARS team full Datix users • Emergent risks around sustainability of Out of Hours Service, Workforce, Estate and Information sharing	• Enable all Social Work teams full access to Datix incident and risk register modules • Primary Care Transformation Programme • Review of Estate • Improve information sharing arrangements • Increase utilisation of Technology enabled care • Support third and independent sector organisations to become equal partners
Operations	• Handover of new Acute Hospital • Agreement of Risk Transference Arrangements with Highway Health • Weekly Triage established with SERCO to ensure 'snagging' addressed in timely manner • Monthly management Team meetings incorporate all aspects of Risk Management • Introduction of Equipment Librarian & Repair service	• Improve KPI around incident review and closure • Ensure Incidents are correctly assigned • Provide peer support for RM via Directorate Management Team • Establish role of Estates Compliance Officer to ensure compliant with legislation and policy • Comprehensive Review of Risk Portfolio

2.8 Internal and External Hazard and Safety Notices and Alerts

NHS Dumfries and Galloway received 83 Safety/Hazard Notices during this financial period from bodies such as HIS.

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

QPSLG 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. 95 % 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. 42% of declarations were returned within 20 working days of receipt.

The table below details last year's activity.

Type	Total Received 2017-2018
Product Recall Notice	4
Medical Device Alert	42
Field Safety Notice	9
Customer Alert Notice	3
Patient Safety Alert	10
Estates Facilities Alert	4
Safety Action Notice	3
Information Message	8

A number of directorates were failing to adhere to the timescales set within the Protocol and were supported to understand and improve performance. We have also worked with the Lead Nurse for Primary and Community Care to improve the Locality Hazard and Safety Action Notice procedure. The protocol document is being reviewed and we have redesigned the current recording database.

Work Plan 2018/2019:

- Review and update HAZ/SAN protocol
- Work with Directorates and Localities to improve compliance with response timescales

3. Risk Appetite

Organisations are increasingly being asked by stakeholders, analysts and the public to express clearly the extent of their willingness to take risk in order to meet their strategic objectives. Risk Appetite goes to the heart of how an organisation does business, how it wishes to be perceived by stakeholders and can be described as the amount of risk the organisation is prepared to accept.

NHS D&G 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 newly approved Risk Management Strategy, the Risk Appetite is attached at ***Appendix 2*****.**

Work Plan 2017/2018:

- Risk Appetite will be incorporated into the Risk Training Plan.
- A communication plan will be developed to raise awareness of Risk Appetite.
- Board Paper templates to be amended to include consideration of Risk Appetite

4. Corporate Risks

In 2016, a complete review of the Corporate Risks was undertaken, reducing the number of risks from 30 to 14. The themes of all 30 old risks filtered through the new risks, to ensure a more focussed and manageable register.

During 2017/18 a number of changes were made to the risks to ensure they captured the challenges being faced by the Board, through 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 two new risks were added to the register during the year:

- Information Sharing within and across Children's Services
- Organisational culture and development (staff experience)

The first new risk focuses on the potential confusion that exists around information sharing across agencies due to changes regarding named person legislation implementation which has been put on hold by the Scottish Government.

The second new risk focuses on the 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, which could have an adverse impact on staff and/or patient safety, health, wellbeing, relationships and reputation of the Board, which could result in the Integration Joint Board failing to deliver anticipated cultural change resulting in fragmentation and disjointed services impacting adversely on patient / user and staff experience.

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 3*** 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 5 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.

Risk registers are held for each key developments being progressed including the New Hospital project, Service Change Programme 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 2018/2019:

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.

5. Risk Assurance Framework

From discussions that were held at Audit and Risk Committee in both March and June 2016, it was highlighted that as part of good governance and the management of risk assurance, the Board should be able to demonstrate the assurance routes for all areas of Board business.

An Assurance Framework is used to provide a structure and process that enables the Board to focus on the risks to achieving its annual objectives and be assured that adequate controls are operating to reduce these risks to an acceptable level.

The Audit and Risk Committee receive a copy of the Assurance Framework as part of the quarterly Risk Management Update Reports throughout the year to ensure that there is an appropriate spread of assurance across the Board that will demonstrate that risk management is embedded within the organisation, enabling them to provide assurance on to NHS Board, as part of the Audit and Risk Committee's Annual Report, in support of the Governance Statement process.

The Corporate Business Manager will continue to meet with each of the Directors on a quarterly basis, when reviewing the Corporate Risk Register, to look at the assurances that were expected during the three months that have passed and to confirm the level of assurance they took from the information or process.

At present the Framework only focuses on the 16 Corporate Risks for the Board, however, a new Assurance Map is also being developed with will provide an overview of the assurance Board wide, identifying any gaps or challenges from the wider remit.

Work Plan 2017/2018:

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.

6. 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

6.1 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 2017/2018 reports were received by:

- NHS Board
- Healthcare Governance Committee
- Management Team
- Audit and Risk Committee
- Quality and Patient Safety Leadership Group - weekly
- Monthly directorate management teams
- On line live reports are available on DATIX and via Qlikview
- In house Safety notices and alerts for areas of emergent or significant risk

6.2 Training, Education and Development

During 2017/2018 there was no overarching Risk Training Plan, due to a gap in recruiting to Risk Coordinator post of 8 months. Where training needs were identified these were met with bespoke training modules delivered by the Patient Safety & Improvement Team. Local Risk Facilitators provide operational support and training within their Directorate.

Human Factors training which aims to increase understanding of factors involved in human error and how we might develop better resolutions to minimise risk and improve how adverse events are handled is delivered by the Education Centre. Three courses and a total of 35 staff attended this year.

A LearnPro module is available for online adverse event management training. More than 200 members of staff have accessed the module. The module has been updates and will be further promoted during 2018/19.

Greater Glasgow and Clyde supported us to train nearly 80 people in Significant Adverse Event Review. These people will be further supported during 2018/19 with facilitated workshops and coaching.

Risk Workshops were facilitated for IJB, Health & Social Care Senior Management Team and NHS Board to support the development and review of their Risk Registers.

A Training Needs Analysis was undertaken to help us understand development needs and this has informed the training/learning plan for 2018/19.

The focus of training and development during 2018/2019 will be on the proactive identification and management of risk. Themes from recurrent risks will continue to be an integral component of our safety and improvement programmes.

The ultimate aim is to provide staff with the necessary knowledge and understanding to achieve:

- A workforce with the competence and capacity to manage risk and handle risk judgements with confidence;
- An organisational focus on identifying malfunctioning systems rather than people
- Organisational learning from adverse events
- Ensure risks are identified, assessed and managed in accordance with policy and procedure
- Lessons are learned and improvements reliably applied to prevent further harm/risk exposure

Work Plan 2018/2019:

- A Prioritised Risk Training/Learning Plan will be agreed to support implementation of IJB Risk Strategy
- DATIX Training will continue to be delivered throughout 2018/2019 by the Adverse Event Coordinator and Risk Project Officer with a focus on social work staff.
- NHS Dumfries and Galloway will continue to work with NHS Glasgow and Greater Clyde to share training resources

7. 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
- HIS Adverse Event Education Framework - Short Life Working Group
- Adverse Events Network
- Scottish Patient Safety Programme

7.1 Learning from Other Boards

The above national meetings and work groups enable NHS Dumfries & Galloway to continuously review and refine our approach to Risk Management in line with other Boards across Scotland and to work with HIS to define national policy and share best practice.

As a result we have taken forward developments around Adverse Event form design, Risk and Adverse Events Training and implementation of "Duty of Candour" legislation.

We have worked with HIS to test a national template for collating learning from Significant Adverse Events which will enable lessons to be shared across Scotland via a secure database and are now rolling this out for all SAER's.

7.2 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
- Primary Care which includes Care Homes and Dentistry
- Mental Health
- Maternal/Neonates/Paediatrics (MCQIC)
- Early Years

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
- Catheter Associated Urinary Tract Infection (CAUTI)
- Management of stress and distress
- Safety Culture

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

Falls

As a Board we have seen an increase in the number of falls and falls with harm.

We have developed and tested a falls bundle which is now a core component of assessment documentation on admission for all inpatients in DGRI.

Mental Health have worked to improve identification and management of older adults at risk of falls in Midpark and have seen a significant reduction in their falls rate.

We are currently exploring the use of assisted technology, interventions and engagement to prevent social isolation.

Falls links with the frailty collaborative which we are working on with support from HIS.

Next steps include development of a real time falls investigation process, which will further support teams to minimise risk of falling and possible harm for those at highest risk.

Medicines

Four local dental practices took part in a pilot improvement collaborative to reduce harm in dentistry. High risk criteria were identified, and processes in each practice were improved to ensure medical histories were at the heart of conversations between dental patients and staff, so that appropriate treatment plans are made. Results were fed back to the national team to feed into a potential national rollout of the initiative.

Deteriorating Patients

Increasing recognition and response to patient deterioration continues to be a priority across the system, with teams in Acute Care, Paediatrics and Mental Health all working to implement early warning or risk assessment processes to highlight patients at risk.

The National Early Warning Score has been implemented within Acute, contributing to a 52% reduction in hospital cardiac arrests.

Pressure Ulcers

We have seen a significant increase in Pressure Ulcers both in and outwith hospital.

In response to this and the severity of impact this has on individuals a focussed collaborative programme of work, will be under taken for 12 months commencing on 30th April 2018. Teams from community and inpatients will participate and support the changes required to reduce harm.

During 2017/17 a local collaborative of 5 care homes worked to reduce pressure ulcer prevalence in older adults. The project focused on staff engagement, awareness and training, recognising that a culture of safety is essential to proactively manage risk of harm. 3 of the 5 care homes have virtually eradicated acquired pressure ulcers with more than 300 days since the last pressure ulcer.

Communication

As a key factor in most adverse events, we know this is an area that requires continued focus.

We are currently taking a whole system approach to understand and review both written and verbal communication to enable effective handover of patient care at all points of transition within acute care. From assessment, admission and transfers through to discharge. Engaging with teams to give assurance of good practice and identify areas for improvement which it is hoped will reduce duplication between paper and electronic systems.

Hospital and ward based huddles continue to be refined in Women, Children's and Sexual Health, in DGRI and in Midpark to improve communication.

Work Plan 2018/2019:

- A Patient Safety and Improvement Workplan that incorporates areas of known risk is developed and updated annually.
- NHS Dumfries & Galloway will continue to participate in SPSP
- The Patient Safety & Improvement Team will work with Directorates to prioritise areas for improvement
- Continue to develop Quality Improvement Capability through delivery of Scottish Improvement Skills (SIS)
- Provide coaching support to individuals and teams working on areas of risk/improvement

8. 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:

- Annual reviews of the Board's approved Risk Management Strategy are undertaken to ensure continuous development of Risk Management Systems.
- 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.
- Review and re-launch of the Risk Management Guidance on Beacon – Adverse Event Recording; SAER; Root Cause Analysis
- Regular (usually weekly) meeting of the Quality & Patient Safety Leadership Group to consider Significant Adverse Events, commission investigations, seek assurance with regard to action and promote learning.
- Use of 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.

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 RSG 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.

9. Priorities

Summary of Progress against Priorities 2017 – 2018

Work activity identified for 2017/2018	Activity Progress
Increase Compliance against Risk Key Performance Indicators	Continuing to support Directorates to improve compliance through refinement of local review and improvement process'
Validation of CHI numbers in Datix through SCI store	Complete
Risk Register Development and Upgrade	Preparation has progressing to upgrade the risk register module but was delayed due to lack of IM&T and Patient Safety & Improvement capacity.
Risk Management and Adverse Events Training Plan	Prioritised training on SAERs with bespoke training and facilitated workshops offered to Management Teams
Develop a more robust "learning system" to ensure that lessons learned are clearly articulated, reviewed and shared.	QPSLG lead this activity and now publish a quarterly newsletter and Learning summaries for all SAER's.
Adverse Event System Development	Complete. Reduced Adverse Event categories from 9 to 3 in line with National Guidance.
Rollout Datix Adverse Event System to Social Care Staff	STARS team now use Datix, further roll out planned.
Duty of Candour Legislation Implementation	Implementation Plan developed and being progressed.

Summary of Priorities for 2018 - 2019

Risk Management Strategy Implementation	• Review tactical implementation of Board and IJB Risk Strategy
	• Development of Risk Register module
	• Refinement of KPI's
	• Deliver Risk Training/Learning Plan
	• 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.
	• We will work with Health and Social Care Directorate to ensue all health and social care staff are able to report on DATIX.
	• For significant adverse events we will:
	  • Prepare for roll out of Duty of Candour legislation by April 2018
	  • Produce local learning summaries for all SAER
	  • Share learning summaries nationally
	• Review and update HAZ/SAN protocol
	• Work with Directorates and Localities to improve compliance with response timescales

Risk Appetite	• Risk Appetite will be incorporated into the Risk Training Plan. • A communication plan will be developed to raise awareness of Risk Appetite. • Board Paper templates to be amended to include consideration of Risk Appetite
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.
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.
Risk Management Learning System	• A Prioritised Risk Training/Learning Plan will be agreed to support implementation of Board and IJB Risk Strategy • DATIX Training will continue to be delivered throughout 2018/2019 by the Adverse Event Coordinator and Risk Project Officer with a focus on social work staff. • NHS Dumfries and Galloway will continue to work with NHS Glasgow and Greater Clyde to share training resources • QPSLG will produce quarterly newsletters • A communication plan will be developed to ensure learning is shared
Improving Safety Reducing Harm	• A Patient Safety and Improvement Workplan that incorporates areas of known risk is developed and updated annually. • NHS Dumfries & Galloway will continue to participate in SPSP • The Patient Safety & Improvement Team will work with Directorates to prioritise areas for improvement • Continue to develop Quality Improvement Capability through delivery of Scottish Improvement Skills (SIS) • Provide coaching support to individuals and teams working on areas of risk/improvement

10. 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 cultural of learning and the development of IT based Risk Management systems will ensure continued maturity of Risk Management within NHS Dumfries and Galloway.

2017/18 was a challenging year with many major projects including the integration of health and social care, build and opening of a new hospital, a very busy winter period and continued financial constraints and difficulty in recruiting to key staff groups.

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.