Royal National Orthopaedic Hospital NHS
NHS Trust

RISK MANAGEMENT ANNUAL REPORT

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1.0 Introduction

The report covers the period of the 1st April 2007 to the 31st March 2008.

Risk Management systems underpin the Trust's system of internal control and the assurance framework which enables the Trust to fulfil it's corporate governance responsibilities. The assurance framework simplifies Board reporting and prioritisation, which in turn allows more effective performance management. The assurance framework also facilitates reporting key information to the Board, providing that it is maintained as a dynamic document. This document therefore identifies priorities for the Board and the organisation is able to understand its capacity to deliver within defined limits and the Board has an accurate understanding of the risks that the Trust faces.

The aim of the Risk Management programme is to make the effective management of risk an integral part of everyday management practice. This can be achieved if there is a comprehensive and cohesive risk management system in place, underpinned by clear accountability arrangements throughout the management organisation structure. The Trust takes a holistic approach to risk management.

2.0 Activity This Year

2.1 Risk Management Organisational Structure

The Risk Management structure has been monitored and reviewed throughout the year to ensure that it is integrated, supportive and cohesive. The structure is detailed overleaf.

The role of the Audit Committee has been further developed to ensure that it nurtures a wider responsibility for scrutinising the risks and controls which affect all aspects of the Trust's business. Broaden the Committee's traditional remit to include an overview on clinical risks and build the programme of work around an embedded assurance framework that is fit for purpose.

The Risk Management Board is responsible for overseeing risk management and reports regularly to the Trust Board. Both the Chief Executive and a non-executive Director are members of this over-arching committee. The risk management organisational structure is robust and supports the implementation of risk management throughout the organisation.

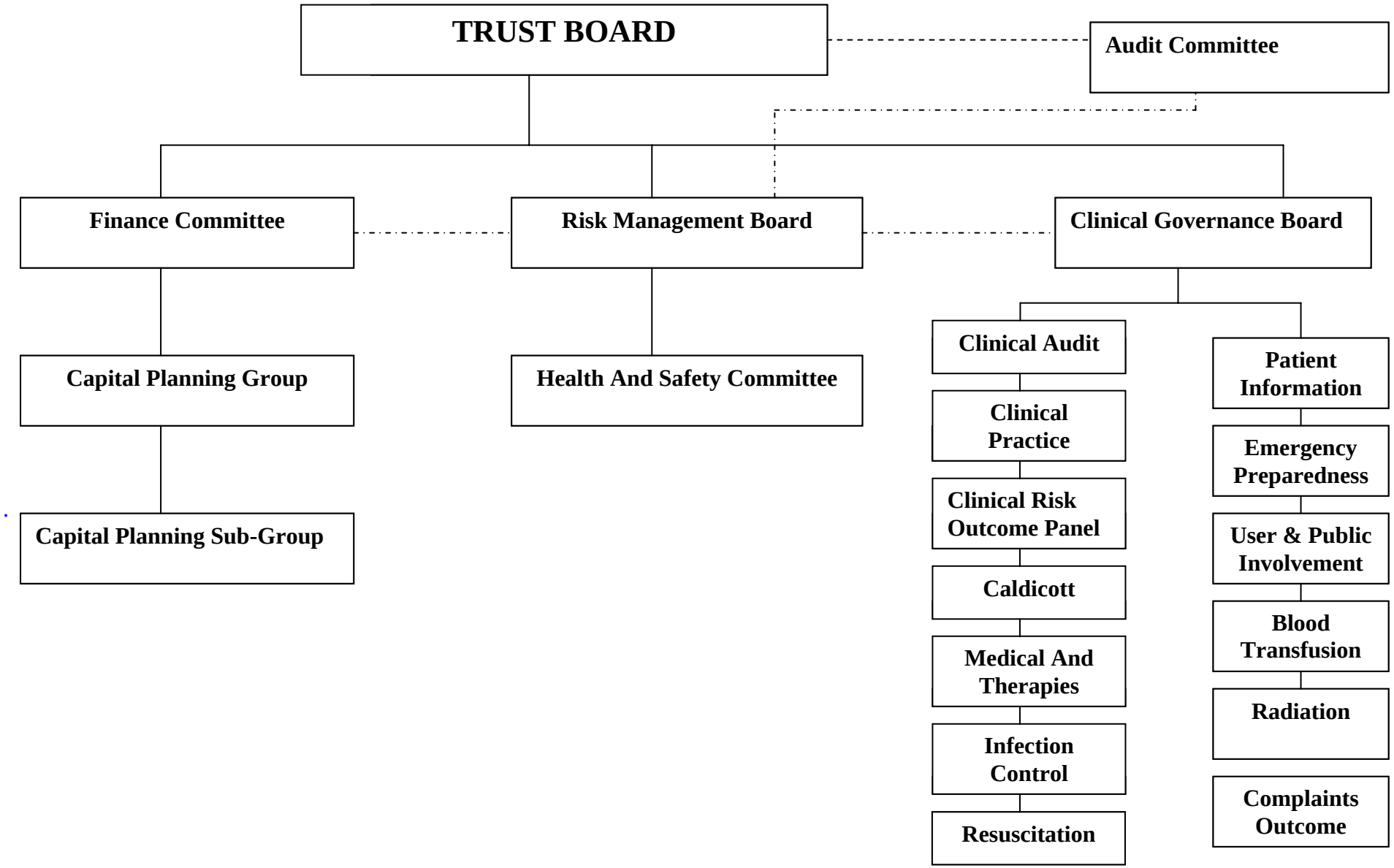
2.1.1 Key Targets: 2008 – 2009

- Continue to monitor and review the risk management organisational structure to ensure that the strands of governance such as financial, clinical, research and risk are brought together in a coherent way.

- Review the work of the Risk Management Board on an annual basis, to ensure that the group continues to meet it's terms of reference and is receiving and reviewing information on risks of all types.

- At appropriate intervals monitor and review the work of the Audit Committee to ensure that it continues to take a holistic approach to the monitoring and review of risks and controls which affect the Trust's business.

Figure One: Organisational Structure For Managing Risk Within The Trust



2.2 National Health Service Litigation Authority (NHSLA) Acute Risk Management Standards

The NHSLA have undertaken a major review of the risk management standards to ensure that there is compliance with the principles of Concordat between bodies inspecting, regulating and auditing healthcare. The review involved a 6-phased approach which included:

Phase 1 Background information, literature searches, claims data, assessment data

Phase 2 Focus Groups

Phase 3 Consultation with other bodies

Phase 4 Development of Standards and assessment process

Phase 5 Pilots

Phase 6 Review and implementation

Following pilot assessments in 2006, to which the RNOHT took part, a number of changes have been introduced to each criterion to avoid duplicate of information requested from a variety of external assessments. This has been introduced following extensive discussions with all other bodies involved in Concordat.

The final version of the risk management standards for acute Trusts became available at the end of April 2007, allowing the RNOHT almost 7 months to self-assess and provide substantial evidence of policy and procedure guidance and good practice against those policies.

The Trust was required to supply information within 10 criterion for each of the following standards:

Standard 1 Governance

Standard 2 Competent & Capable Workforce

Standard 3 Safe Environment

Standard 4 Clinical Care

Standard 5 Learning from Experience

The responsibility lies with each Trust to demonstrate that they have robust processes in place to minimise risks against the 5 standards and associated criteria. Individual Trusts have to decide which Level they wish to be assessed against, and the RNOHT decided to attempt a difficult level 2. There are 3 main Levels with an additional Level 0 against which Trusts can be scored.

Level 0		Trusts have to be assessed annually until compliant
Level 1	Policy	Trusts would then be assessed every two years
Level 2	Practice	Trusts would be assessed every three years
Level 3	Performance	Trusts would be assessed every three years

For compliance at level 2 at our formal assessment in November 2007, the RNOHT were required to achieve a specific score.

For the initial assessment for all Trusts the minimum score required for each individual standard is 5/10 with an overall score of 40/50, irrelevant of which level is being assessed.

Together with extensive collaboration and a dedication to maintain the complexities of data facilitation, the RNOHT achieved a level 2 status, at the time one of only 77 acute Trusts nationwide to achieve this.

This accomplishment not only improved the Trust status, but enabled the RNOHT to save 20% on insurance premiums as it is considered to have safe working policies and practice.

2.2.1 Key Targets 2008 - 2009

- To liaise closely with the Trusts' NHSLA assessor

- To ensure that all relevant staff are aware and comply with updated guidance from the NHSLA

- To work towards achieving Level 2 status of the new standards and assessment criteria.

- The Trust will require another formal assessment before November 2010, however future assessments will require a minimum score of 7/10 for each standard and a total score of at least 45/50 irrelevant of which level is being assessed. An action plan has since been development and is under review to address the areas that the Trust could improve.

2.3 Controls Assurance

The NHS Controls Assurance regime ceased on the 1st August 2004. The twenty two standards have helped the NHS successfully embed good risk management practice into its everyday work. However, the main criteria underpinning the standards, central reporting requirements, verification procedures, and prescriptive guidance has meant that the NHS has considered them an unnecessary burden for some time. Rigorous checks and controls will remain in place but the process will now be managed locally, by using the existing Assurance Framework.

The important elements of the standards have been incorporated into the Standards For Better Health (refer to section 2.4.) This enables NHS organisations to bring

together good risk management practice and link it directly to continuous quality improvement and improve patient care. In light of this no self-assessment has been undertaken since 2006.

2.4 Annual Health Check (Standards For Better Health)

2.4.1 Background

The Healthcare Commission is an independent body responsible for reviewing the quality of healthcare and public health in England and Wales. In 2005/2006 it developed a new system of assessment for NHS organisations – the annual health check. It focused on whether healthcare organisations were getting the 'basics right', by measuring their performance in meeting the Government's targets and the basic core standards set out by the Department of Health. Trust Boards are responsible for the standards of healthcare in their organisations and have to provide a self-declaration of their performance in meeting the standards. In 2007/2008 the Healthcare Commission continues to focus on 'getting the basics right'.

2.4.2 Purpose

Every NHS Trust in England is responsible for ensuring that it is complying with the Department of Health's core standards. As part of the annual health check all Trusts are asked to asses their performance against the core standards and to publicly declare this information. If the Trust's Board is not satisfied that it is meeting them, it must take appropriate action.

This year the Trust's performance will be cross checked against a greater and more detailed range of data sets that have national coverage including information from other regulators as well as review agencies, in order to identify those Trusts to be most at risk of not meeting the Core Standards.

In 2007/2008 there has been increased reliance placed on the findings from the NHS Litigation Authority's Risk Management Standards and on information from Patient Environment Action Teams.

Where necessary declarations will be checked by targeted inspections. Selected inspections will take place on two sets of Trust:

- A group of Trusts for which cross checking indicates a high risk of an undeclared lapse in Core Standards – inspections will focus specifically on those standards where there are particular concerns that the Trust has not met the standard

- A randomly selected group – the focus of these inspections will vary annually but may include any standards where there is little data for the cross checking process to rely on

Final declarations including any required qualifications as a result of selective inspections, will be published by the Healthcare Commission on its website, along with the rating achieved by the Trust.

2.4.3 Healthcare Commission Inspection June 2007

Following the submission of the declaration in 2006/2007 10% of Trusts were identified for a visit selected on a risk basis through analysis of the information already held on the organisation. The RNOH was selected for a visit in June 2007 to review five of the core standards.

The Trust was found not adequate for two standards C13(b) and C16.

For C13 (b) the Trust failed to provide consent training for nursing staff or for staff who take clinical photographs or video recordings and there was the lack of a system to ensure the effective use of the medical staff consent competency assessment tools. The Trust also failed to provide evidence of a policy or procedure for staff to follow when obtaining consent about the sharing of personal information. There was no evidence to demonstrate that staff check patients' understanding about their choices to disclosure of their personal data and the Trust does not provide information to patients attending outpatients about what information is recorded in their records or when their health records are accessed.

Work has progressed for this standard but the Trust is declaring not met for this standard for 2007/8.

For C16 there was no evidence submitted confirming that patients, and where appropriate carers have opportunities to ask questions about anything they do not understand or would like further information about. Information should be provided to patients and where appropriate carers in a timely manner and at relevant points during their treatment and care. There are now posters and information leaflets available and therefore the Trust is declaring itself compliant with this standard.

2.4.4 Standards Not Met

C13 (b)
Element One
Valid consent, including those who have communication or language support needs is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) and investigations in accordance with the Reference Guide to Consent for Examination or Treatment (Department of Health 2001), Families and post mortems: a code of practice (Department of Health 2003) and Code of Practice to the Mental Capacity Act 2005 (Department of Constitutional Affairs 2007).

The actions required to ensure compliance include the provision on consent training for nursing staff and for staff who take clinical photographs or video recordings. To write a policy or procedure for staff to follow when obtaining consent about the sharing of personal information which includes staff checking patients' understanding about their choices to disclosure of their personal data. To provide information to patients attending outpatients about what information is recorded in their records and when their health records are accessed.

C20 (a)
Element One
The healthcare organisations effectively manages the health, safety and environment risks to patients, staff and visitors, including by meeting the relevant health and safety

at work and fire legislation, The management of Health, Safety and welfare Issues for NHS staff (NHS Employers 2005) and the Disability Discrimination Act .

(Adequate levels of assurance for this standard can be provided by level 2 and above of the NHSLA's Risk Management Standards for Acute Trusts, however due to the condition of the estate the Trust is continuing to declare this standard as non-compliant).

Element Two
The healthcare organisation provides a secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.
(Adequate levels of assurance for this standard can be provided by level 2 and above of the NHSLA's Risk Management Standards for Acute Trusts, however due to the condition of the estate the Trust is continuing to declare this standard as non-compliant).
C20 (b)
Element One
The healthcare organisation provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation

2.4.5 Fire Backlog Maintenance

The Trust has an estimated total backlog maintenance of £54m, with £3.2m being directly attributed to Fire Safety. The Trust invests approximately £1.1million per annum on capital developments based on its Capital Resource Limit and a proportion is spent on fire safety improvements. However the inherent design of the buildings and estate restrict the Trust from ever being fully fire compliant until the site redevelopment is completed. The Trust has developed a strategic overview, with Fire Engineering consultants, and agreed a programme of works with the London Fire and Emergency Planning Authority. This programme will enable the Trust to systematically reduce fire backlog year on year on a risk basis.

2.4.6 Security

The Trust has invested significant amounts in improving security management and has carried out the following actions:

- Installed Access Control for all main entrances to wards
- CCTV at the Main Gate
- Personal alarms for staff
- Improvement to external lighting
- Handling of Patient Valuables Policy approved by Trust Board
- Two senior members of staff trained as Local Security Management Specialists (LSMS)
- Installed ward safes to all wards

- Reviewed and updated patients valuables record book

The reason for not reporting fully met relates to the inherent design weaknesses as well as the fabric of the buildings and estate. A good example of this is the main hospital thoroughfare with approximately fourteen points of potential entry. These design issues cannot be fully addressed until site redevelopment.

The action plan to meet compliance with this standard is the redevelopment of the Trust, which is awaiting approval of its OBC

C21
Element One
The healthcare organisation has taken steps to provide care in well designed and well maintained environments in accordance with Building notes and Health Technical Memorandum, the Disability Discrimination Act 1995 and the Disability Discrimination Act 2005 and associated practice.

Element Two
Care is provided in clean environments in accordance with the National specification for cleanliness in the NHS (National Patient Safety Agency, 2007) and the relevant requirements of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, 2006).

Well designed? (Not Met)

61% of the RNOH buildings are over 60 years old. The accepted method of assessing if buildings and facilities are well designed is by assessing their functional suitability. This describes how effectively a site, building or part of a building supports the delivery of a specific service. The criteria used in such assessments include space relationships, amenity, location, environmental conditions and overall effectiveness. The following table assesses the site:

Table One: Functional Suitability

Functional Suitability	
Condition A (Very satisfactory)	3%
Condition B (Satisfactory)	30%
Condition C (Major change needed)	30%
Condition D (Unacceptable in present condition)	18%
Condition DX (Nothing but a total rebuild or relocation will suffice)	19%

This clearly shows that 67% of the site is not suitable for modern healthcare and is therefore not well designed. The main wards and three of the Trusts operating theatres are rated as category DX. Two good examples of poor design are:

- The main link corridor for the wards is on a steep gradient, making patient moves very difficult. Tugs have to tow patients from the Theatres after operations.

- Patients are exposed to the elements when being transferred to the Rehabilitation ward from the main ward complex as there is no covered walkway.

Well Maintained? (Not Met)

The future of the RNOH was in the past uncertain and this led to minimal investment in maintenance and capital expenditure. The majority of buildings have performed their useful working life and replacement would be more cost effective than refurbishment. This is reflected in the high level of backlog maintenance now accrued, currently estimated at £54m.

The action plan to meet compliance with this standard is the redevelopment of the Trust, which is at OBC stage in the Capital Investment Process.

2.4.7 Process For Evidence Gathering

The process for planning the self assessment has followed the same format as in previous years. A senior clinician was identified to lead on the collection of the evidence bringing together information from governance, clinical quality, information, research, finance and other organisations. Staff both clinical and non-clinical were involved in reviewing each of the Core Standards and identifying evidence to support the Trust's assessment. In the cases where the standards had not been fully met, action plans have been developed. The Trust obtained NHSLA level 2 in November 2007 and this has been reflected in assessing the Core Standards.

As a result of this a detailed spreadsheet analysis was developed with all the core standards recorded, the suggested prompts, whether each prompt was met, partially met or not met and the lead person for each of the suggested prompts. Electronic evidence files and paper files were created and the paper files were available for staff to review.

The self assessment has been considered further at the following committees:

- Executive Directors Meetings

- Trust Board

- Patient Forum Meetings

- Clinical Governance Board

2.4.8 Conclusion

The Trust has undertaken a comprehensive review of its performance against the 24 Core Standards for the period April 2007 – March 2008. The evidence collected has been and is being discussed widely with internal and external stakeholders and our proposed self assessment is attached. Overall the self assessment confirms that the

Trust continues to provide a high quality and safe clinical service. The Trust will be declaring not met for standards C13, C20, and C21.

2.4.9 Key Targets: 2008 – 2009

- Ensure that the core standards continue to be met. This is not optional as they do not set out new expectations but are based on a number of standards and requirements that already exist.

- Continue to develop and implement action plans to progress compliance with the developmental standards.

2.5 Integrated Risk Management Database

Safeguard encourages good risk management practice, meeting the needs of the assurance framework and clinical governance. With comprehensive analytical tools, Safeguard highlights trends and risks that may lead to large financial claims being brought against the organisation.

Safeguard is central to the integration of the risk management strategy throughout the organisation. The Trust purchased the following components (incidents, risk, training, PALS, litigation, complaints) during November 2004 to assist with the implementation of the risk management strategy throughout the organisation and to ensure that a holistic approach to risk is achievable.

The following has being achieved this year; -

- On a monthly basis the executive team receive a copy of their directorate current and accepted risk register as well as a report detailing the target dates which are to be achieved during the coming month. The Chief Executive receives a copy of all risk registers.

- Training has continued for members of the executive team on the risk module.

- Departmental risk registers are being developed.

- A risk register workshop has been held for the Operational Manager to facilitate the review of their risk register.

- Work has continued on the implementation of e-reporting throughout the Trust.

- A new version of Safeguard has been installed.

- Incident summary reports are forwarded automatically to each ward and department on a weekly basis.

2.5.1 Key Targets: 2008 – 2009

- Continue to facilitate the development of local risk registers.

- Develop a template for the assurance framework report which demonstrates the links to the risk register. Also link the report to the Standards For Better Health.

- Add the Standards For Better Health data into the database.

- Pilot e-reporting and cascade out throughout the Trust.

- Develop a risk register relating to root cause analysis reports.

- Each director to review and consolidate their risk registers.

2.6 Assurance Framework

To ensure that the Board is confident that the systems, policies and people that are in place are operating in a manner that is effective in driving the delivery of objectives by focusing on minimising risk an assurance framework has been developed. This framework provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting our principal objectives. The framework has been developed by Board members in conjunction with the Risk Manager and is monitored and reviewed through the Risk Management Board (at all meetings) by the Audit Committee (at all meetings) and the Board itself (quarterly).

2.6.1 Key Targets: 2008 - 2009

- Continue to monitor and review the assurance framework so that it is maintained as a dynamic document.

- Continue to ensure that the assurance framework is fully embedded.

- Continue to implement the associated action plans.

- Develop a new assurance framework report template using the Safeguard Risk Management database which displays links with the corporate risk register as well as the standards for better health.

2.7 Risk Register

It is recognised that for the assurance framework to be truly effective it must be underpinned by a comprehensive risk register that is linked to the achievement of the principal objectives.

A risk register has been developed and is currently compiled of risks that have been highlighted through the Standards For Better Healthcare, controls assurance, CNST, internal and external audit reports, the estates risk profile as well as incident report forms, root cause analysis reports and minutes from Clinical Governance Board, Infection Control Committee, Finance Committee and Audit Committee. Summary reports detailing the work of each of these committees are presented to the Risk Management Board for discussion and review.

Key members of staff (Risk Manager, Clinical Risk Manager and Health And Safety Advisor) to attend template report training.

Directorate risk registers are automatically sent to each director on a monthly basis for review. The Chief Executive receives a copy of each of the directorate risk registers. These risk registers are supported by a report to each director which summaries those actions with a target date of completion within the next month. Each director has started work on consolidating their risk registers to ensure that there is no duplication of data.

An accepted risk register has been developed which details risks that can be removed from the corporate risk register. These risks are reviewed and approved by the Risk Management Board and Trust Board. Directorate accepted risk registers are also sent automatically to each director on a monthly basis.

The risk register is presented to the Board annually and is supported by an update and summary of progress against actions on a six monthly basis.

At each Risk Management Board directorate (current and accepted) risk registers are reviewed. From March 2008 the Risk Management Board will take two directorate risk registers each meeting which the group will review in-depth.

Departmental risk registers can be created through the use of Safeguard and a report template has been created, however these are not yet automatically sent to each department.

The Risk Management Strategy has been updated to reflect changes in systems of work relating to the development, monitoring and review of the Trusts risk registers

2.7.1 Key Targets: 2008 – 2009

- Develop and implement a programme to ensure that local risk registers are compiled, monitored and reviewed by all wards and departments.

- Schedule departmental risk registers (current and accepted) so that they are received by each ward / department on a regular basis.

- Produce a report template which details the links between the assurance framework, the risk register and the standards for better health.

- Each director to progress the work in consolidating and monitoring their risk registers

2.7.2 Summary Report From Each Director Regarding The Progress Made Against Their Directorate Risk Register

2.7.2.1 Directorate of Nursing - Key Achievements

The key achievements for this year are:

- Blood transfusion policies approved in line with NPSA Safer Practice notices

- Appointment of a full time Tissue Viability Nurse

- Appointment of children's nurses on the paediatric unit

2.7.2.1.2 Key Targets: 2008 – 2009

- Root cause analysis's to be completed within 60 days.
- Improve attendance at infection control training
- Medical staff to have infection control updates at Medical Staffing Committee
- Continue teaching re medicines policy

2.7.3.1 Finance Directorate - Key Achievements

The key achievements for this year are detailed below:

- 2006/07 Audited Annual Accounts were delivered on time to the Department of Health despite very challenging timescales.
- Payments by Results (PbR) – agreement was reached with DH to exclude material loss making HRGs from the national tariff and allow local negotiation to mitigate financial losses.
- Business Plan, Revenue and Capital budgets ere all agreed by the Trust Board ready for the new financial year although not all savings initiatives were in place for 1st April and it is now recognised that an over ambitious target was set.
- Contracts with PCTs were signed by June – earlier than ever before.
- Patient Level Costing system purchased September 2007 to support development of financial reporting into regular service line reporting formats – this continues to be rolled out as we move to the new financial year.
- Private Patient Billing system purchased November 2007 to support improved accuracy and timeliness of billing
- The risk register has been simplified and consolidated to eliminate duplications and is now used by the senior finance team as a tool to monitor risks and implementation of audit recommendation.

2.7.3.2 Current Highest Risk Areas

- Timeliness of annual accounts (whilst recognising much progress has been made last year)
- PbR funding risks
- Statutory breakeven duty
- CIPs delivery

- Asset management – including fixed asset register reconciliations & procedures
- Stock Control system implementation
- Signing contracts with PCTs
- Documenting objective setting (linking to Trust objectives)
- Use of Resources rating action plan (Auditors Local Evaluation (ALE)
- Patient Level Costing

2.7.3.3 Key Targets: 2008 – 2009

- Deliver 2007/08 annual audited accounts to national timetable
- Continue work with DoH and Specialist Commissioners to mitigate PbR funding risks
- Agree revised break even recovery period with SHA as part of FT application for April 2009
- Close CIP monitoring to Finance & Performance Committee and Trust Board
- Asset management policies and procedures to be put in place for the new financial year
- New stock control system to be in place by the end of the financial year
- PCT contracts to be signed consistent with delivering 18 week access targets and financial plan
- Document Trust objective setting process for Trust Board approval
- Improve ALE rating from 1 to 2 overall with evidence of moving from 2 to 3 in some areas
- Roll out patient level costing system and develop data quality.

2.7.4.1 HR & Corporate Affairs - Key achievements

- Met trust yearly target for headcount and payroll expenditure reduction
- Implementation of the ESR (electronic staff record) in October 2007
- Successful completion of public consultation to become a foundation trust including the recruitment of over 2,600 foundation trust members
- Appraisal uptake up to 70% (as reported in staff survey)

- Implementation of ban on use of temporary agency staff (exceptions in theatres/ Allied Health Professionals)

- Development and agreement of trust Gender and Disability Equalities Schemes

- Introduction of annual mandatory training update programme

2.7.4.2 Key Targets: 2008 – 2009

- Recruiting sufficient staff to ensure capacity in place to meet 18 week target e.g. in theatres

- Continue to reduce staff costs in line with trust CIP (cost improvement programme)

- High levels of perceived bullying & harassment in trust – achieve reduction.

- Continue to improve appraisal rates

- Introduce Bradford Scoring Index for recording sickness absence and reduce levels across trust

- Ensure membership rates for FT (foundation trust) are maintained and improved.

- Ensure governance arrangements are in place for FT status including election of Council of Governors

- Ensure plan is developed, agreed and in place for EWTD (European working time directive) 48 hour target in 2009

- Develop robust workforce strategy and plan for hospital redevelopment plans

- Launch fundraising campaign for new hospital

2.7.5.1 Directorate of IM&T - Key Achievements

The key achievements for the year are as follows:

- Completed a large number of ICT infrastructure projects to upgrade the entire Trust ICT network and infrastructure. This has delivered a modern, stable and robust ICT network with 99% up time mitigating significant number of risks in the risk register.

- Significantly improved IM&T customer service levels

- Completed the implementation of highly successful PACS projects on time and on budget, delivering all the tangible and non-tangible benefits specified in the business case. In terms of risk management the number of missing x-rays, a significant issue in the PAS is now zero, resulting in a reduction in cancelled operations, re-imaging and therefore improvement in patient care.

- Submitted external returns on time despite severe staffing problems.

- Consistently met the new and very challenging coding targets ensuring that risk of loss of income to the Trust was minimised. Improved clinical data quality and provided valuable input to assist in tariff to significantly improve Trust income.

- Improved IM&T governance by updating policies and procedures and developing new ones. This has mitigated some of the risks in the risk register particularly with reference to data security and information governance.

- Consolidated the corporate risk register and developed a simplified IM&T risk register to provide the IM&T Board better visibility of the risks

- Improved Trust's information governance processes, procedures and awareness. This has resulted in improving the Trust's information governance scores, from 39% in 06/07 to 63% in 07/08. The information governance score is one of the inputs to the Trust's overall performance rating.

- Delivered a budget surplus over the 5% cost improvement target.

- Providing support for the 18 weeks project – including major upgrade of the Patient Administration System, input for the data cleaning process and training and process support.

2.7.5.2 Ongoing High Risk Areas

- Ability to submit external returns on time due to staff shortages.

- Provision of high quality and timely information for operations, planning and strategic management due to lack of modern data warehousing system and lack of skills within the information management team.

- Ability to recruit and retain key staff.

- Information security and information governance – although significant progress has been made this year, successfully changing the culture takes time and can be difficult.

2.7.5.3 Key targets: 2008 – 2009

- Implement a modern data warehousing system to provide high quality information for all management and operations

- Continue to improve customer service levels

- Deliver a robust and resilient ICT infrastructure

- Improve information security and information governance. This includes a detailed information mapping exercise.

- Submit all external returns in a timely manner

- Continue to maximise Trust income by maintaining a high quality clinical coding function.

- Roll out wireless infrastructure in all clinical areas

- Complete the implementation of the Electronic Ordering System, implement bed management system, develop the orthotics systems including process improvement, roll out voice recognition for clinical notes

- Increase the use of the intranet

- Develop a comprehensive and integrated IM&T strategy

2.7.6.1 Directorate of Estates and Facilities - Key Achievements

- Implementation of the LFEPA approved fire safety plan of 2007 – 2008.

- Adherence to the HSE action plan.

- An emergency preparedness tabletop exercise has been attended by all Estates staff.

- Emergency preparedness policies and procedures have been reviewed.

2.7.6.2 On-going High Risk Areas

- £54 million backlog maintenance

- Electrical infrastructure

- Legionella precaution works

- Fire safety statutory compliance

2.7.6.3 Key Targets: 2008 – 2009

- To implement the proposed Capital Plan with consideration of the re-development of the site.

2.7.7.1 Directorate of Operations and Service Improvement - Key Achievements

- Workshop for general managers and service managers to develop better understanding of directorate risks and risk management planning.

- Waiting times for all imaging procedures are now managed using sound methodology and monitored via weekly local waiting list meetings.

- Analysis of demand for imaging procedures has been enabled by the new RIS and capacity is now monitored on a monthly basis.

- Waiting times for all imaging procedures are now within 6 weeks (March 2008 target).
- Sound governance arrangements for the 18 week RTT targets established: 18 Week programme manager; steering group with executive and non-executive

Membership reporting to Trust Board; project plan and designated workstreams

- Processes and resources established to minimise unknown clock starts and improve information submitted monthly on 18 week performance to NHS London.

- Framework and policies established as the first step to implementing information governance, which has now passed back to IM&T.

2.7.7.2 Current high risk areas

- 18 week RTT targets and other access targets

- Activity target

- Tracking demand and capacity planning.

2.7.7.3 Key targets for 2008-09

- Review and consolidate risk register with operational management team and establish regular review process throughout the year at monthly team meetings in order to monitor and manage risk.

- Revise access, booking and choice policy in line with demands of 18 week RTT.

- Improve data quality to minimise need for data cleansing of 18 week pathways.

- Implement 18 week patient tracking list (PTL).

- Develop and implement policy reporting plain film.

- Systems and training to eliminate breaches of 28 day readmission guarantee for cancelled operations.

2.8 Incident Reporting

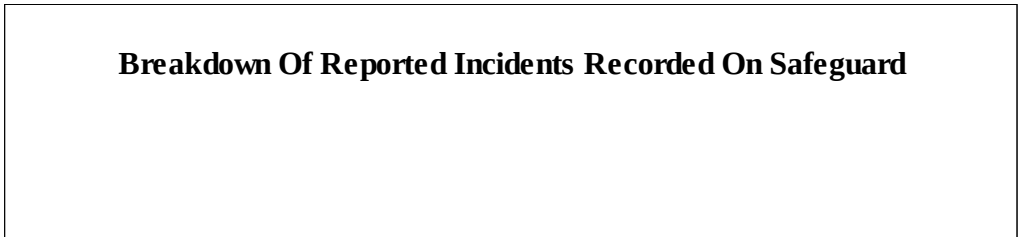
In all 4245 incidents have been entered onto the Safeguard risk management database between 1st April 2007 and 31st March 2008 compared to 3979 last year. This is an increase of 266 incidents. The breakdown of incident by risk rating is detailed below:

Table Two: Risk Rating of Incidents Added To Safeguard

Risk Rating	Number of incidents entered onto the Safeguard risk management database
High	2
Medium	230
Low	2858
Very low	1155
TOTAL	**4245**

Figure Two summarises how the reported incidents have been categorised.

Figure Two: Breakdown of Incidents Reported on Safeguard



It should also be noted that there is currently a backlog of clinical incidents to add to the database. In all there are 293 clinical incidents as well as 107 progress reports. Taking these outstanding incidents into account, the total number of reported incidents is 4538.

The Trust considers the increase of reported incidents by 559 throughout the year as positive. The increase reflects that the safety culture is becoming embedded throughout the organisation and in turn the reporting culture is improving.

As detailed in the table above there have been two reported incidents which have been categorised as high risk. These incidents refer to an incident in front of the main entrance to the hospital site where a pedestrian was knocked down by a taxi.

Last year 14 incidents were reported to the HSE in accordance with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) During 1st April 2007 and 31st March 2008 a total of 7 incidents have been reported to the HSE. These incidents have been investigated and appropriate action plans agreed, in line with the Trusts incident reporting policy.

Table Three: Summary Of Incidents Reported to HSE In Accordance With RIDDOR

Date of report	Patient / staff / other	Description
2007		
25.06.07	Staff	+ 3 day injury – due to old injury
28.06.07	Staff	+ 3 injury - manual handling injury
10.07.07	Staff	+ 3 day injury – sprain to knee
23.09.07	Staff	+ 3 day injury – slip, trip, fall
16.11.07	Staff	+ 3 day injury – manual handling
18.12.07	Staff	+ 3 day injury – manual handling
2008		
10.01.08	Staff	+ 3 day injury – manual handling

The Safeguard integrated risk management system has been used since April 2005 and has been successful in the development of meaningful reports and trend analysis. It is envisaged that this system will improve the feedback regarding actions taken as a result of incidents and will also facilitate ownership of incident investigation within individual wards / departments.

Automatic incident summary reports were been e-mailed to each ward / department on a weekly basis. Unfortunately a problem occurred in the system when a new version of Safeguard was recently introduced. However, work is been undertaken to ensure that these reports are re-scheduled as soon as possible.

The Incident Reporting Policy has been reviewed this year and two further policies have been written and approved by the Board – namely, the Serous Untoward Incident Policy and the Root Cause Analysis Policy.

2.8.1 Root Cause Analysis

Root cause analysis is a specific technique of investigation adapted by the National Patient Safety Agency that studies the what, when and how of an incident instead of

focussing on the people involved. This process allows the Trust to look at the development of systems and processes and helps to digress from the blaming of individuals.

The RNOHT are required to undertake root cause analysis investigations on all hospital acquired MRSA Bacteraemia and Clostridium Difficile incidents, all high risk and some medium risk incidents.

11 incidents have been investigated this year using root cause analysis. These have included 9 cases of Clostridium Difficile, an incident involving a crash call, and a grade 4 pressure ulcer. All but 4 of these investigations have been completed and their reports agreed at Clinical Governance Board.

All reports contain action plans enabling the Trust to continuously improve practice and learn from every issues addressed.

2.8.2 Key Targets: 2008 – 2009

- To ensure that all wards and departments receive a summary report of all their reported incidents on a weekly basis. These reports should be reviewed as part of team meetings and appropriate feedback provided to the Clinical / Risk Manager in order that Safeguard can be updated.

- To ensure that the backlog of clinical incidents is cleared and all incidents are added to Safeguard risk management database in a timely fashion.

- To review and re-launch CROP – Clinical Risk Outcome Panel.

- To launch e-reporting throughout the organisation.

2.9 National Patient Safety Agency (NPSA)

The Trust has enjoyed close links with the NPSA again this year and although many IT issues have been present, the Trust has managed to report a vast number of clinical incidents to their National Reporting and Learning System (NRLS). The NRLS is now well developed and the NPSA are sending 6 monthly reports to all Chief Executives and Director's of Nursing / Governance.
The RNOHT have been compared with a cluster group of other Acute Specialist Trusts and have continually reported high numbers of clinical incidents, indicating a good reporting and safety awareness culture.

The NPSA also provide the Trust with national Alerts and recommendations to generate a standard, improve practice and provide a safer environment. These alerts are disseminated to all concerned through the Safety Alert Broadcast System (SABS).

During 2007-8 these have included:

- **'**Actions that can make anticoagulant therapy safer'

- 'Promoting safer measurement and administration of liquid medicines via oral and other enteral routes'

- ‘Promoting safer use of injectable medicines’

- ‘Safer practice with epidural injections and infusions’

- ‘Reducing the risk of hyponatraemia when administering intravenous infusions to children’

2.9.1 Key Targets: 2008 - 2009

- To continue to report to the NRLS

- To undertake clinical audit as required

- To implement all NPSA recommendations and guidance

2.10 Claims And Complaints

The Customer Care Manager is responsible for the co-ordination of clinical, personal injury and public liability claims and the Risk Manager is responsible for property claims.

The organisation has a Legal Services & Procedures Policy that has been Board approved. The document incorporates clinical negligence, personal injury, public liability claims and property claims.

The Trust has received a slightly higher rate of claims of negligence this year (2006/7 we received 14 and 2007/8 we have received 16). The majority of claims raised either settle very swiftly or are discontinued when no negligence has been found.

Themes in medical negligence claims this year concern clinical outcomes and the complications that may have resulted. This is due to the complex cases we undertake.

Several litigations have resulted from complaints after complaints responses have been made which has meant we have been aware of the issues before the litigation results so are able to make robust responses and settle quickly when necessary.

Employers Liability Personal Injury claims have reduced dramatically this year as we received only 1 which was a manual handling claim.

Public Liability claims were nil this year.

The Risk Management Board receives regular updates and overviews on claims activity. All new medical negligence claims are taken to the Clinical Risk Outcome Panel.

The Customer Care Manager is also responsible for patient complaints handling co-ordination throughout the Trust. The Trust has an established Complaints Procedure Policy, which was re-viewed and approved by the Clinical Governance Board in September 2006. The policy mirrors the NHS Complaints Procedure Directions. The Trust emphasises local ownership of complaints and offers staff comprehensive support and advice on complaints handling through Induction and through its

Complaints Procedure Policy, which includes guidance for staff on how to document accurately statements and accounts of events relating to a complaint. All Complaints and Claims are risk classified through the Trust's Risk Classification Matrix.

2.10.1 Key Targets: 2008 – 2009

- The number of complainants remaining dissatisfied at the Local Resolution stage is still a concern. The Trust will continue to ensure the Local Resolution stage is more proactive and helpful to complainants. Complainant will have an opportunity to discuss outstanding grievances with the Customer Care Manager either before or after the Chief Executive's written response, depending on the complexity of the case, allowing for further opportunities to resolve the complaint through meetings with the key personnel and the complainant. This will give the Trust the opportunity to identify alternative and more successful ways to address concerns.

- With the increased role of the Matrons and Clinical Leaders local ownership of complaints will be made and it is envisaged that responses to formal complaints will become more robust.

- To ensure that lessons are learnt from the themes in complaints and actions taken to improve service provision through the Complaints Outcome Panel, Clinical Governance Board and local initiatives with the Matrons and General Managers.

2.11 Security

Security of people and property within the Trust is the concern of us all and as such all possible measures must be taken to deliver a properly secure environment for all who work, or receive treatment within the Royal National Orthopaedic Hospital NHS Trust.

Ensuring security within such a large and diverse service as the NHS is a challenge which requires the support and assistance of all those who work within the organisation. To manage this challenge effectively a clearly defined structure and vision for engaging with security issues is required.

The following actions have been implemented throughout the last year; -

- Personal alarms are available to all staff and are distributed during corporate induction.

- A Fire and Security Roadshow was held on the 23rd April and supported by the Metropolitan Police Safer Neighbourhood Team as well as a representative from the Counter Fraud And Security Management Service.

  The intention was to raise awareness amongst staff of security and fire issues, in an informative and fun manner. Plenty of information - posters, keyrings, leaflets - were available for staff to take back to their departments Staff who attended were invited to test their knowledge of security and fire in order to

win a bottle of champagne. The winner was Jana Markham (Occupational Health Nurse)

- Conflict resolution training sessions continue to be scheduled to run throughout the year.

- The programme of Crime Reduction Site Surveys has continued. Surveys are undertaken by Lynne Wilson and Michelle Nolan. The following areas have been reviewed and a formal report provided to the relevant managers:

    - Site Night Survey (October 2007)

    - Site Night Survey (June 2007)

    - Site Night Survey and Communication Exercise (August 2007)

    - Bolsover Street

    - Orthotics, Bio-Medical Engineering, Stanmore Implants Worldwide (August 2007)

    - Rehabilitation Ward Pathology and Pain Clinic (January 2008)

    - Alarm Installation Review (January 2008)

    - Summary Crime Prevention Action Plan

- The Trust participated in the Security Awareness Month (SAM) in conjunction with the CFSMS during November 2007.

- The new Non-Executive Director (Tony Watson) has agreed to lead and promote security management.

- Security logs are reviewed weekly by one of the LSMS'S.

- Monthly meetings are held in conjunction with a the Security Officers, Medirest Manager and the LSMS's.

- Local lone working risk assessments have been developed and introduced within the Community Liaison Department.

- The Security Management Action Plan (September 2007) has been reviewed and approved by the Board. This document details the actions that will be implemented to efficiently manage and engage and support staff in security management.

- Links have continued with the Local Community Police Team. The team participate in Corporate Induction.

- A review has commenced of the card access control system.

- Work has continued with prison officers in completing pro-active risk assessments prior to a prisoner attending site.

- A security awareness handbook has been developed and is distributed to all staff as part of the induction process.

- Work has commenced in tidying up the card access system. Cards of leavers are being deactivated.

- LSMS's attend the local community meetings organised by Cannons Safer Neighbourhood Team

In total, 122 security related incidents were reported between the 1st April 2007 and the 31st March 2008 compared to 89 during the 1st April 2006 – 31st March 2007. This may be due to the work that has been undertaken in raising awareness regarding incident reporting throughout the organisation and by encouraging Security Officers to report. The number and categories of incidents are detailed in Figure Three.

Figure Three: Number And Category Of Security Incidents

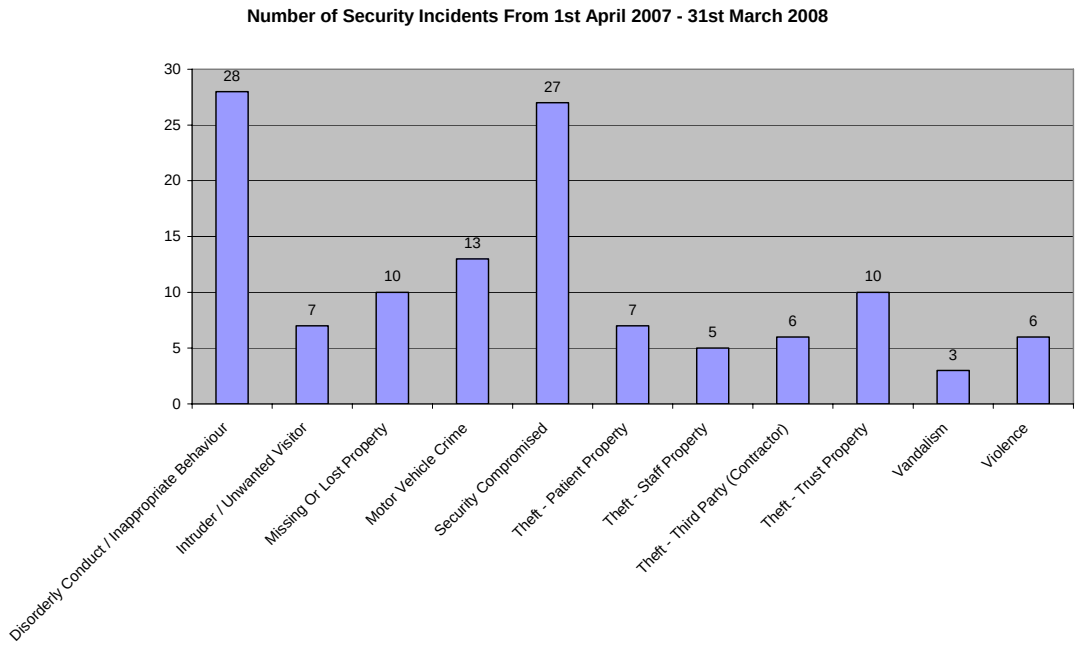
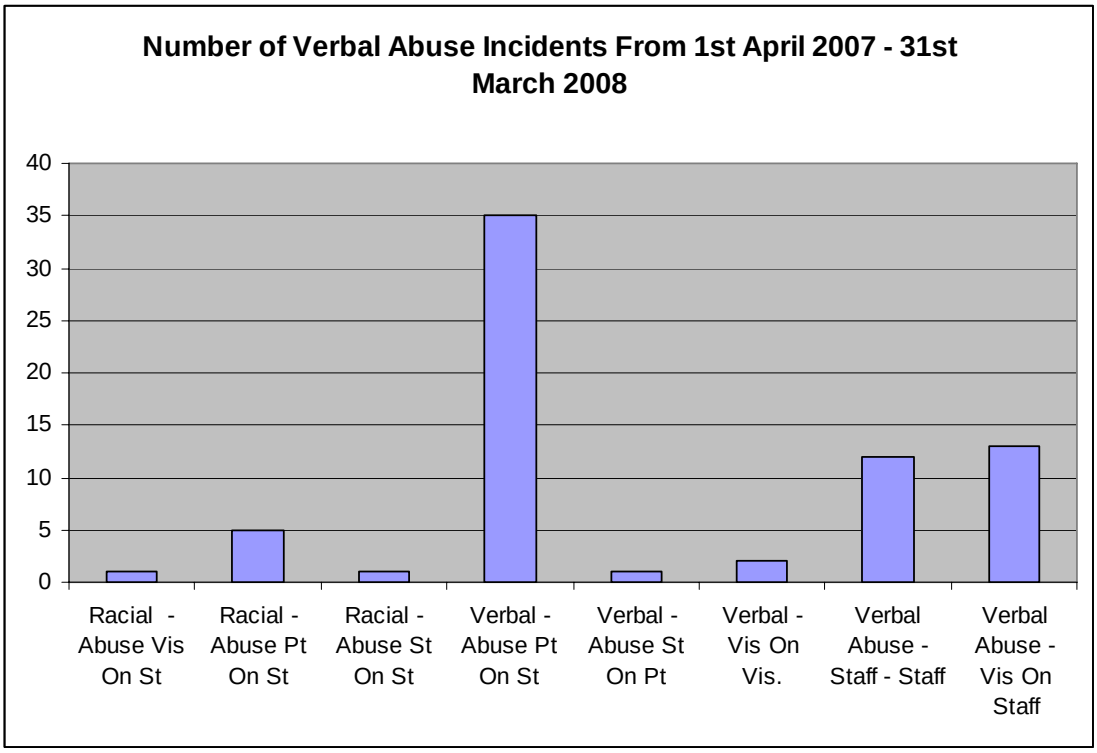


Figure four details that 71 verbal abuse related incidents were reported during the 1st April 2007 – 31st March 2008. The pervious year 87 incidents were reported.

Figure Four: Verbal Abuse Statistics



2.11.1 Key Targets; 2007 – 2008

- Continue to raise staff awareness about the importance of reporting security related incidents through workplace training and the launch of e-reporting.

- Continue to develop profile of Security Officers on site. Initiatives to be introduced to facilitate Security Officers to be more pro-active e.g. introduce trend analysis, articles in Articulate, proactive use of e-mail.

- Continue the recruitment process to employ a Fire And Security Officer on a full time basis.

- Hold a fire and security awareness roadshow.

- Review the Annual Security Management Action Plan.

- Develop and implement "Prisoner Visit Risk Assessment Template" for both Bolsover Street and Stanmore sites.

- Review the Corporate Security Policy.

- Review the Handling Of Patients Property Policy

- Review the Lone Workers Policy and facilitate the development of local procedures.

- Review security alarm installations across the Trust and ensure all are linked to Main Gate.

- Review key management across the site.

- Introduce staff access groupings on the card access control system.

- Introduce a 69 point dyster system across the Trust.

- Develop and implement a capital project plan

- Continue to raise awareness regarding the handling of difficult patients.

- Tender card access control system.

- Local police to join risk management executive walkabout during October 2008 to help raise security awareness

- LSMS's to continue to attend the local community meetings organised by Cannons Safer Neighbourhood Team

- Link all security alarms to a central location and review local procedures.

- Tender for the maintenance of the card access system.

2.12 Fire

The Regulatory Reform (Fire Safety Order) gives the London Fire & Emergency Planning Authority (LFEPA) wider jurisdiction to enforce fire compliance. The overall result will have a major impact on every Healthcare Trust in terms of corporate governance, personal liability and devolved competence throughout every level of an organisation. All this underlines the vital necessity for Trusts to develop high level strategies that incorporate both Health and Safety, and Fire Safety issues. It also creates the need for a methodological approach, to devolved management, required competencies, training needs analysis and definition of detailed procedures – with easily traceable audit trails that can demonstrate that a fire incident was a genuine accident rather that negligence.

The following has been achieved this year; -

- A Fire Officer (Mukund Patel) has been seconded from the Estates Department for two days per week.

- A programme for undertaking fire risk assessments has been developed and the following assessments have been completed:
    - Angus Mackinnon Ward

    - Pain Management Offices

    - Aspire

- Alan Bray Unit
- Adolescent Ward

- Fire safety awareness training is provided on a rolling basis each month. In order to support this practical fire evacuation training sessions were arranged during February 2008. These sessions were attended by 179 staff. Attendees were given the opportunity to put to the test fire evacuation techniques and use specialist fire evacuation equipment within a simulated fire emergency situation.

- Fire evacuation straps have been ordered for all clinical areas.

- The Trust has met with the LFEPA to discuss the development of the Trust's fire safety plan for 2008 / 09 in light of the approval from the SHA to re-develop the site.

- A fire drill programme ahs been developed and implemented. A report is forwarded to all areas involved summarising how individuals responded as well as detailing any actions that need to be implemented to improve the fire safety culture.

- Fire hydrant documentation has been reviewed.

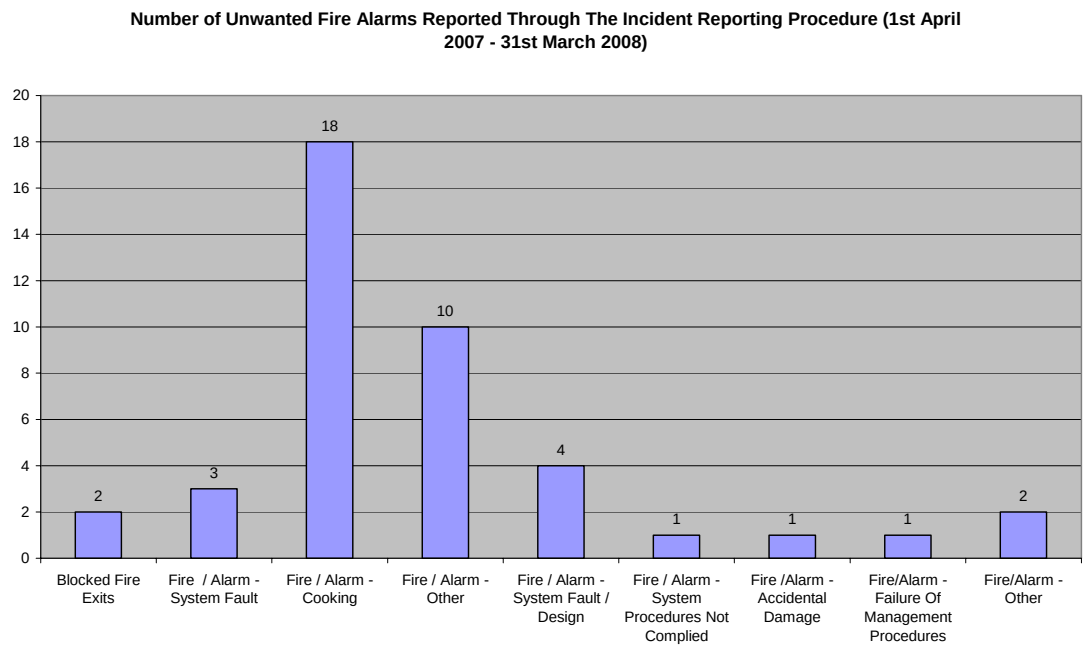
- The Fire Officer has worked closely with the Bolsover redevelopment team.

- Incident reports detailing fire / unwanted fire alarm activation are followed up by the Fire Officer or Risk Manager.

- Key staff have been trained in the newly installed fire panels.

- The number of reported unwanted fire signals has remained stable throughout the year as illustrated in Figure Three. The number of unwanted fire signals that have been reported through the incident reporting procedure is only 42, but the figure from Medirest's records indicate that the actual figure is approximately 142. The Fire Officer has begun to monitor where unwanted fire alarms are occurring so that appropriate action can be taken to reduce their occurrence.

Figure Four: **Unwanted Fire Signals Reported Through The Incident Reporting Procedure**



2.12.1 Key Targets: 2008 – 2009

- Develop a programme of increasing fire precaution awareness and instil a fire safety culture within the organisation.
- Assess current management procedures and review competencies.
- Continue to systematically review and update fire risk assessments.
- Review all internal and external escape routes. Clearly define routes and update plans accordingly.
- Assess lighting levels on external escape routes and upgrade as required.
- Develop action plan (08/09) financial year and submit to the LFEPA for approval and comments.
- Further develop the fire drill programme to include clinical areas.
- Introduce fire wardens to all areas.
- Review the Fire Safety Policy.
- Develop a priority works list in relation to capital expenditure.
- Work towards reducing the number of unwanted fire calls.

2.13 Health And Safety Executive (HSE) – Steam Pressure Systems

During 2005 the HSE issued an improvement notice relating to the Trusts failings to effectively manage and operate the steam pressure systems on site in line with statutory requirements. The failings were highlighted after an accident which resulted in a member of the Estates staff being scalded. The incident was reported to the HSE as the individuals injuries resulted in more than three days off work. The HSE investigation which followed resulted in an improvement notice.

The HSE revisited the department on the 9th November 2005 and were satisfied that the Trust has fulfilled the requirements of the Improvement Notice.

The Trust was prosecuted during 2007 and received a fine of £15,000 + costs.

2.13.1 Key Targets: 2008 – 2009

- Continue to monitor compliance against the HSE action plan.

- Continue to nurture and embed a safety culture within the Estates Department.

2.14 Emergency Planning

The Major Incident Procedure (Stanmore Site) has been reviewed and approved by the Board.

The content of the emergency boxes at Main Gate and X-Ray have been reviewed as have all contact numbers for key staff.

The Risk Manager and the Acting Clinical Governance Manager have attended MAJAX training.

A communication exercise has been undertaken out of hours. The response by staff was reassuring.

A member of staff from the Local Police Counter Terrorism Unit has provided Security Officers with awareness training.

Posters have been sent to all areas to raise awareness regarding terrorism.

The Facilities Manager has attended the loggist training provided by the Department Of Health.

All wards have been provided with emergency torches.

All Estates staff have been involved in a tabletop exercise.

Links have been developed with the local police and Counter Terrorism Unit.

The Risk Manager and Facilities Manager have attended training provided by Operation Argus on business continuity.

A policy for the management of Pandemic flu has been included in the Trusts Business Continuity Plan.

2.14.1 Key Targets: 2008 – 2009

- To review the Bolsover Street Major Incident Policy
- To provide appropriate training to all staff who may be involved in a major incident.
- To undertake a communication exercise every six months.
- To provide the Risk Management Board with regular updates regarding the implementation of the Major Incident Plan.
- To undertake a tabletop exercise.
- Develop business continuity plans.
- Ensure additional staff attend loggist training.

2.15 Manual Handling

The income generation work is continuing with a Higher Education Institution.

An audit of the Patient Handling Risk Assessment Tool which was launched on July 1st 2005 to all areas that admit patients to the Trust was undertaken in August 2007. Results showed a significant improvement on the 2006 audit results. A third audit will be undertaken in July - August 2008.

The Occupational Health Department are continuing to refer staff with musculoskeletal injuries to the Manual Handling Service. Individual ergonomic work place risk assessments have been carried out, thus allowing the injured member of staff to undergo a graduated return to work where appropriate.

Clinical staff are continuing to contact the Manual Handling Advisor for advice when they come across patients with complex handling needs.

Two new policies have been completed, The Safer Handling of Heavy Patients and the Bed Rails Policy. They can be located on the 'K' drive, along with an updated version of the Safer Handling of Patients Policy

The Patient Handling Information Group form (PHIG) is still being used extensively by pre admission staff to inform wards, appropriate departments and individual members of staff who will be involved in the planning of care for patients with complex manual handling needs admitted to the Trust.

General patient handling training courses are now undertaken with a mix of nurses and therapy staff. Specific courses held are for Theatre staff, Medical Staff, Porters and Domestic staff. The Corporate Induction programme incorporates Manual Handling Theory and Practical sessions.

Table Four: Manual Handling Training

Patient Handling Full Day (Min4/Max8)

Courses Offered	Places Offered	Places Booked	Places Attended	DNA rate of places booked but not attended	Places offered but not booked
5	40	36	27	9 (25%)	4 (10%)

Patient Handling Refresher (Min 4/Max6)

Courses offered	Places offered	Places booked	Places attended	DNA rate of places booked but not attended	Places offered but not booked
44	268	246	195	51 (20%)	22 (9%)

Load Handling (Min 3/Max12)

Courses offered	Places offered	Places booked	Places attended	DNA rate of places booked but not attended	Places offered but not booked
11	132	56	30	26 (46%)	76 (57%)

Domestics staff Load Handling (Min 4/Max 12)

Courses offered	Places offered	Places booked	Places attended	DNA rate of places booked but not attended	Places offered but not booked
12	144	65	56	9(14%)	79(55%)

Portering staff Patient Handling (Min 4/Max 6)

Courses offered	Places offered	Places booked	Places attended	DNA rate of places booked but not attended	Places offered but not booked
3	18	15	12	3 (20%)	3 (17%)

Medical staff (Min 4/Max 8)

Courses offered	Places offered	Places booked	Places attended	DNA rate of places booked but not attended	Places offered but not booked
8	50	40	34	14 (35%)	10 (20%)

Corporate Induction Theory (Min 4)

Courses offered	Places offered	Places booked	Places attended	DNA rate of places booked but not attended	Places offered but not booked
9	N/A	148	130	18 (12%)	N/A

Corporate Induction Practical (Min 4/Max 8)

Courses offered	Places offered	Places booked	Places attended	DNA rate of places booked but not attended	Places offered but not booked
17	136	130	100	30 (23%)	6 (4%)

2.15.1 Key Targets: 2008– 2009

- To undertake a third audit of the Patient Handling Risk Assessment Tool
- To continue to undertake Income Generation work for the Trust
- Continue facilitating Individual, Ward and Departmental risk assessments
- To review the teaching presentations and handouts given to attendees
- To review teaching sessions and to further develop ways of increasing attendance figures

2.16 Risk Identification Tools

The risk identification tools are monitored and reviewed as required and continue to be implemented throughout the Trust. Risk identification involves examining all sources of risk from the perspective of all stakeholders, both internal and external. Hazards are systematically identified using a number of sources; -

Internal

- Hazard spotting.
- Local workplace inspections.
- Audits.
- Risk assessments.
- Incident, complaints and claims reporting.
- Backlog maintenance.
- Brainstorming workshops.
- Controls assurance baseline self assessments.
- Patient satisfaction surveys.
- Staff surveys.
- Process analysis.
- Media reviews.
- Risk profiling processes.
- SWOT analysis.
- Training evaluation forms.
- Unions.
- Whistleblowing Policy

External

- Coroner reports.
- Media.
- National reports.

- New legislation and guidance.
- NPSA survey.
- Reports from assessments / inspections undertaken by external bodies.

2.16.1 Key Targets: 2008 – 2009

- Continue work to embed the use of the risk identification tools throughout the organisation.

- Ensure that all staff are aware of how to manage risks that have been identified and encourage/support local ownership of risk.

- Continue to develop local risk registers.

2.17 Audits / Inspections

A rolling programme of risk management audits and inspections has been introduced. The audit covers a number of areas; -

- Departmental risk management organisation.

- Departmental risk assessments.

- Local arrangements (fire, hazard/safety notices, contingency planning, first aid, general)

- Specific hazards and topics.

- Security awareness.

The workplace inspections give consideration to:

- Maintenance standards.

- Workplace practices.

- Housekeeping standards.

- Employee involvement.

- Safe systems of work.

In all fourteen departments have been audited during 1st April 2007 and 31st March 2008 and six inspections have been completed.

Table Five: Completed Audits And Inspections

Audits	Inspections
Alan Bray Unit Adolescent / Coxen Ward Angus Mackinnon Ward Centralised Booking Information Technology Margaret Harter Ward Theatres Pathology Private Patients Unit X-Ray Medirest Histopathology Rehabilitation Ward Outpatients Department	Alan Bray Unit Clinical Engineering Jackson Burrows Ward Private Patients Unit TSSU Theatres

Each department that is audited is provided with a summary report and a comprehensive action plan. Progress made against the action plan is reviewed during the workplace inspection.

2.17.1 Key Targets: 2008 – 2009

- Review the audit / inspection tool on an annual basis.

- Ensure that a minimum of one inspection and one audit is undertaken each month. Table Three exhibits the audit / inspection schedule for 2008.

Table Six: Audit And Inspection Schedule For 2008

Anticipated Month of Visit	Inspections	Audit
January	Ward 4	Phillip Newman Ward Medical Records
February	The Coleman Unit	Community Liaison
March	Orthotics	Clinical Engineering
April	Histopathology	Angus Mackinnon Ward
May	Margaret Harte	JBW
June	Outpatients	Finance
July	Motion Analysis Lab	Medirest
August	Rehab Ward	Teaching Centre
September	Theatres	Pharmacy
October	Limb Fitting	Pathology
November	Coxen / ADU	Estates
December	Social Work	IT

Each department that is audited is provided with a summary report and a comprehensive action plan. Progress made against the action plan is reviewed during the workplace inspection.

2.18 Key Indicators

A number of key indicators have been identified and developed that are capable of indicating improvements in the management of risk. These include; -

- Number of reported incident, claims and complaints.
- Risk register
- Number of fire alarm activations.
- Number of staff attending training sessions.
- PALS – number of enquiries, and number per 100 inpatients / outpatients, top five themes for the past three months.

- Complaints – number of complaints, number of issues, number of complaints per 100 inpatients / outpatients and top five issues over the past three months.
- Number of requests for independent review.
- Number of new medical negligence claims.
- Number of trips / falls.
- Number of deaths.
- Missing notes and x-rays – number per 100 inpatients / outpatients
- Infection control – number of MRSA cases.
- Audit – number of audits registered per month.
- Pre-assessment cancellation rates (for clinical reasons), absolute numbers seen in Pre-Assessment Clinic and proportion of all inpatients, most frequent reasons for cancellations.
- Cancellation rates due to unavailability of surgeon.
- In-patient satisfaction survey and main issues arising.
- Budget monitoring.
- Break even.
- Capital resource limit.
- External financing limits.
- PSPP – Public Sector Payment Policy.
- Backlog maintenance.
- Estates risk profile.
- PEAT – Patient Environment Assessment Team.
- Number of unwanted fire signals (FR11)
- ERIC (Estates Reconciliation Information And Collection)

2.18.1 Key Targets: 2008 – 2009

- Review and where necessary develop key indicators so that all risks are considered equally and an integrated approach is taken.

2.19 Training

The provision of information, instruction and training is an important means of achieving competence and helps to ensure safe working practices are adhered to. It contributes to the Trust's risk management culture and is needed at all levels, including senior management and the Board.

The on-going risk assessment process is an aid to determining the level of information, instruction and training needed for each type of job.

The provision of adequate advice, support and development is identified through the staff development and review process, identification of training needs and production of training plans.

Records of attendance at training are maintained and inadequate attendance rectified. A system to follow up individuals who do not attend training sessions has been introduced. All records are entered onto the Safeguard training module to ensure that records are linked to claims, complaints, incidents and risk assessments.

A range of risk related training sessions are available throughout the organisation. These sessions include; -

- *Managing Risk*
  A one day course for all staff but in particular Risk Officers/Risk Facilitators. After attending the course, individuals will have an understanding and working knowledge of; -
  - Health and safety legislation
  - Risk management strategies throughout the organisation.
  - Be capable of undertaking risk assessments.

- *Risk Assessment Workshop*
  This course should be attended by all staff a year after participating in Managing Risk. The aim of the session is to remind staff of the risk assessment process and to develop multi-disciplinary assessments applicable to the areas where participants are employed.

- *Fire Safety Awareness*
  All staff must attend this session on an annual basis to ensure that they are aware of the Trust's policies and procedures regarding fire and the measures that can be taken to prevent fire spread.

  Fire evacuation training sessions have been run during 2008. Attendees were given the opportunity to put to the test fire evacuation techniques and use

specialist fire evacuation equipment within a simulated fire emergency situation

- *Display Screen Equipment*
  This training is undertaken with individuals at their workstations. The session aims to ensure that all staff are aware of how to arrange their workstations ergonomically.

- *Excellence In Customer Care*
  This course has run successfully for several years. All Trust staff (particularly those in the frontline dealing with customers) are invited to attend this session. The session ensures that all staff have an understanding of the standards of service expected by the Trust, giving them the skills and support necessary to maintain these standards. The programme is now being revised to further enhance staff skills in dealing effectively with our patients. A separate session on handling complaints is currently in design stage.

- *Introduction to Clinical Governance*
  This session forms part of the mandatory training schedule. The day-long course includes clinical audit, PALS, the management of complaints, root cause analysis, incident reporting, the principles of Caldicott and risk assessments.

- *Manual Handling: Patient Handling Inductions/Refreshers*
  Manual Handling – Load Handling
  These sessions raise awareness amongst staff as to the correct way in which to handle patients/loads as well as the principles of ergonomic assessments.

- *Conflict Resolution Training*
  In accordance with the Counter Fraud and Security Management Service, (CFSMS) conflict resolution training is provided for all front line staff.

- *Corporate Induction*
  An extensive induction programme has been designed for both clinical and non-clinical staff. This programme incorporates a series of mandatory training sessions including fire, patient handling, basic life support and corporate induction.

- *Risk Officer Seminars*
  In order to support Risk Officers seminars are held once a month. The intention is that each session is interactive and facilitate the Risk Officers in their role of embedding the risk management strategy within their area.

Table Seven: Attendance On Mandatory Training (1st April 2007 – 31st February 2008)

Course	Total Number Of Participants Involved	Participant's Cancellation	Attended	Course Cancelled (Number Of Participants)	Unattended
Managing Risk	34	6	25	1	12
Patient Handling Induction	212	49	111	34	18
Theory of Patient / Load Handling	213	16	155	6	36
Patient Handling Refresher	431	85	217	100	29
Load Handling	51	8	31	5	7
Patient Handling Full Day	61	12	41	2	6
Patient Handling For Porters	22	0	22	0	0
Fire Training	650	124	358	40	128
Fire Training – Ward Evacuation	238	9	178	0	52
Customer Care	19	6	12	0	1
Clinical Governance	76	16	29	31	5
Infection Control (includes attendance at annual update)	533	37	413	80	53
Conflict Resolution	166	30	86	22	28
Basic Life Support	232	52	136	13	31
Basic Life Support Paediatrics	241	53	154	8	26
Valuing Diversity	204	34	110	31	29

2.19.1 Risk Awareness Training For the Executive Team

A highly successful and well attended risk awareness training event was held on the 29th October 2007 for the executive team, non-executive directors and the Chairman.

The annual training event was organised and presented by Andy Dwyer (Clinical Risk Manager) Michelle Nolan (Risk Manager) and Jo Hillier (Patient Safety Manager for the National Patient Safety Agency)

The session was interactive and included an opportunity for the attendees to reflect on the Trusts safety culture using the nationally promoted Manchester Patient Safety Framework (MaPSaF) Other topics included Being Open, the Incident Decision Tree, Root Cause Analysis as well as Board accountability and the risk management organisational structure.

2.19.2 Key Targets: 2008 - 2009

- Develop a system to highlight and deliver training needs of those acting up or those who have been promoted.

- Ensure that all senior staff are attending mandatory training.

- Provide an annual risk awareness training event for the executive team.

2.20 First Aid Arrangements

Refresher training has been arranged for all first aiders. The training will be provided by St. John's Ambulance. As one of the first aiders has commenced maternity leave an additional first aider has been identified and training arranged.

Three first aiders have been identified for Bolsover Street and training has been arranged.

2.20.1 Key Targets: 2008 – 2009

- Seek agreement on the out of hours procedure. This will involve reviewing and defining the role of the Site Managers and providing formal training.

- All first aiders to have attended their refresher training.

- First aider posters to be updated and distributed to all wards / departments.

2.21 Policy Development

Each ward / department have a set of policy folders so that documents are easily accessible to all staff. Copies of all policies are also available on the K drive (Corporate / Policies / Health and Safety)

The following risk management policies have been reviewed / developed and approved by the Board;

- Risk Management Strategy 2008 (and associated summary document)

- Risk Management Strategy 2007 (and associated summary document)

- Policy for responding to the recommendations and requirements of external agency visits, inspections and accreditations
- Major Incident Policy
- Serious Untoward Incident Policy
- Root Cause Analysis Policy
- Local Induction Policy
- Induction Policy
- Temporary Staff Induction Policy

2.21.1 Key Targets 2008 – 2009

The following policies will be reviewed / developed this year; -

- Risk Management Strategy 2008
- Risk Management Strategy Summary 2008
- Lone Workers Policy
- Major Incident Procedure
- Pregnant Worker and Nursing Mothers Policy
- Security Policy
- Smoke Free Policy
- Handling of Patients Valuables Policy
- Fire Safety
- COSHH – Control of Substances Hazardous to Health

2.22 Safety Alert Broadcast System

SABS is an electronic system developed by the Department Of Health, with the Medicines And Healthcare Products Regulatory Agency (MHRA), NHS Estates and the National Patient Safety Agency (NPSA) The nominated SABS Officer is the Risk Manager – Michelle Nolan. Details of all alerts are provided in summary form to the Risk Management Board and the Health And Safety Committee.

SABS has two elements; -

1. It is simply a means of e-mailing new safety alerts to nominated leads in Trusts and PCT's who are asked to disseminate the message to those who need

to take action. The system will replace distribution of alerts by fax, post or other means which have been relied upon up until now.

If a Trust is unable to acknowledge an alert within two working days, an e-mail will automatically be generated, sent to the Trust and copied to the Strategic Health Authority.

2. There is now a feedback function. SABS Liaison Officers are responsible for completing a feedback form to confirm that action has been taken within the organisation in response to each alert.

In light of the introduction of SABS the procedure for distributing safety alerts has been modified within the Trust. Alerts are no longer sent via mail to all wards and departments. The new procedure is as follows; -

- The SABS e-mail account is checked on a daily basis by both the Clinical and Risk Manager. Alerts that are clinical in nature are dealt with by the Clinical Risk Manager, whilst those that are non-clinical are dealt with by the Risk Manager.

- Each alert is acknowledged, and details of the action that is required to implement the guidance is provided to the SHA.

- Alerts and audit forms are distributed to those listed on each alert.

- All alerts are stored on the K drive, so that they are easily accessible to all staff.

- The Clinical / Risk Manager updates the SABS system at regular intervals to ensure that the SHA is aware of progress that is being made in the implementation of the action plan that relates to each alert.

2.22.1Key Targets: 2008- 2009

- Continue to monitor the broadcast system, distribute alerts and facilitate and report on the implementation of each action plan.

2.23.1 Estates Related Risks

The estates related risks remain significant and are reflective of a site which has backlog maintenance estimated at £54 million. However, improvements have continued in complying with the following standards:

- HTM 02 Medical gases

- HTM 03 Heating and ventilation systems

- HTM 04 Water systems (Legionella)

- HTM 06 Electrical services

Many estates related policies have been reviewed / updated and approved by the Trust Board. These are now viewable on the Trusts intranet system.

Staff have been supported to attend training. Two members of staff have been nominated the appointed person with regards to legionella and have attended appropriate training. One member of staff has attended high voltage training for appointed person and another has attended confined space training for appointed person.

A new fire alarm maintenance and support contract has been approved and implemented.

2.23.1 Capital Projects

A number of projects have been completed. These include:

- Refurbishment of the hydrotherapy pool which had been closed due to compliance and environmental issues.
- Replacement of the floor within Ward 4.
- Refurbishment of the roof above the Outpatients Department and replacement of defective skylights.
- £100,000 has been spent repairing and replacing poor quality roads.
- Car park improvements have been undertaken at the rear of Orchard Court.
- The Kitchen Block Parents Accommodation has been upgraded following its closure due to non compliance with fire safety regulations.
- All wards have been deep cleaned and a number of wards have been refurbished prior to cleaning. Refurbished areas include ITU, Plaster Theatre and SCIC.
- Fire panels have been upgraded in key areas such as Eastgate House and Orchard Court.

2.23.2 Estates - Key Targets: 2008- 2009

- Develop a Steering Group For Legionella. This may be a stand alone committee or it may be integrated into a current committee as the Infection Control Committee.
- Ensure that key staff attend relevant legionella training.
- Review, seek approval and implement legionella policies and procedures throughout the organisation.
- Zone plans are to be reviewed and displayed adjacent to all fire panels.

2.23.3 Capital Projects – Key Targets 2008 - 2009

- Complete the Building Management System (BMS) upgrades.

- The focus this year is on legionella. £35,000 has been agreed from the capital budget and an action plan has been agreed. One of the top priority jobs is the installation of new heat exchangers with paediatrics. A programme of tank cleaning will be undertaken and alarms are to be fitted to the water boilers.

- Develop and implement a programme of fire precautions.

- Continue to implement works associated with the HSE action plan which relates to a steam incident.

- Continue to implement a programme to improve cleanliness and infection control.

2.24. Waste Management

There has been a comprehensive review of legislation in clinical waste handling with the introduction of the Hazardous Waste Regulations (2005) and the Department of Health's 'Safe Management of Healthcare Waste' guidance document (2006).

The RNOH NHS Trust commissioned Catalyst Waste Solutions to carry out a waste audit in June 2007 to identify the key issues/areas that have a direct effect on the way the Trust handle clinical waste.

An action plan has been developed and the key issues are being addressed.

Due to compliance legislation problems with their autoclave processing plant, Polkacrest were unable to collect or dispose of the Trust's clinical and anatomical waste for an eight week period and the Trust were forced to source an alternative provider. This resulted in additional disposal costs and manual handling issues.

The following has been achieved:

- Full waste management audit completed by Catalyst Waste Solutions Ltd.

- Duty of Care audit carried out with current off site disposal contractors (Polkacrest)

- Action plan submitted to Risk Management and Trust Boards.

- Tender for waste services commenced

- Specification for waste support submitted

- 2 day training course to Senior Managers carried out

2.24.1 Key Targets: 2008- 2009

- Finalise tender process and award new contract for all waste services by 1st October 2008.

- 2 day waste support to implement action plan recommendations and carry out on site training.

- Change to new colour coded sharps bins and bags

- Continue with Duty of Care audits

- Implement better segregation of waste and recycling initiatives

- Ensure contingency plans are in place for collection and disposal of all waste streams.

2.25 Re-Development

2.25.1 Stanmore site

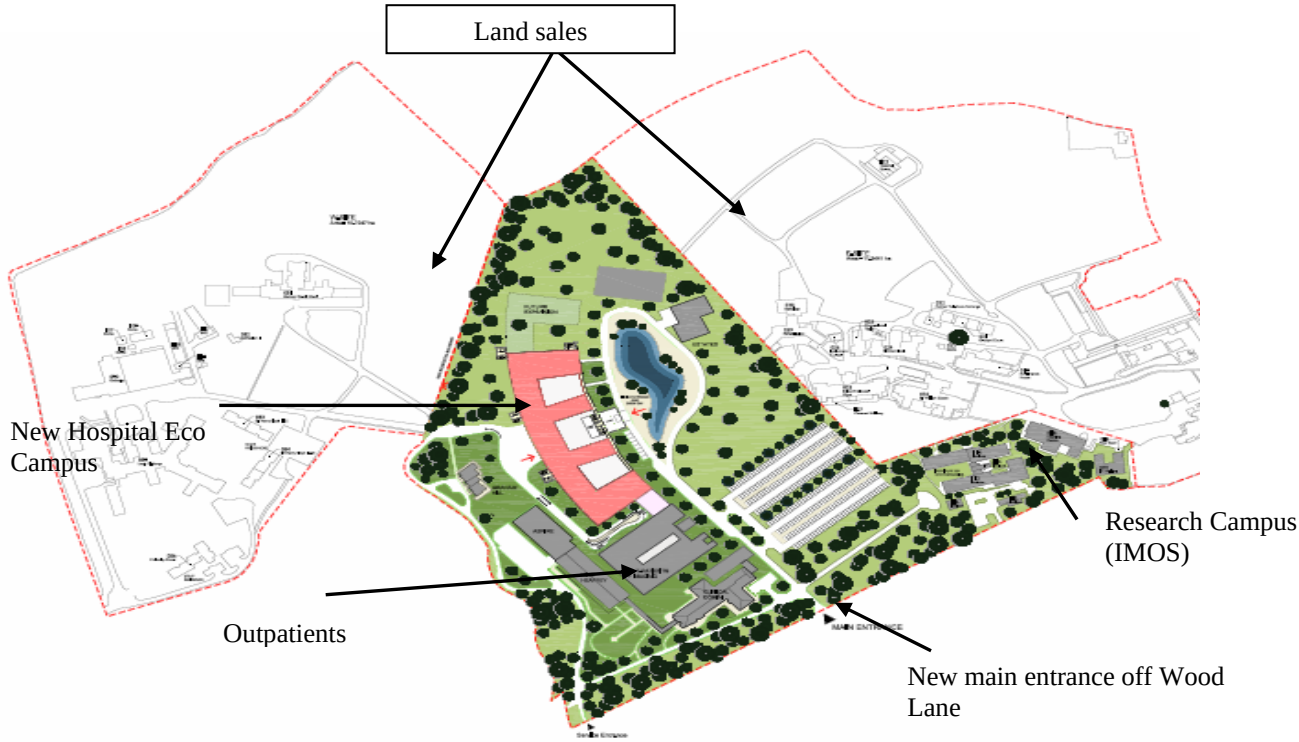
The London Strategic Health Authority has agreed that, subject to the approval of a business case, the RNOH can redevelop the Stanmore site to provide new wards, theatres and a range of refurbished areas.

Andrew Woodhead, Chief Executive, stated "*this shows a vote of confidence in the long-term future of the Trust and gives us the opportunity to plan for redevelopment without having to consider other options*".

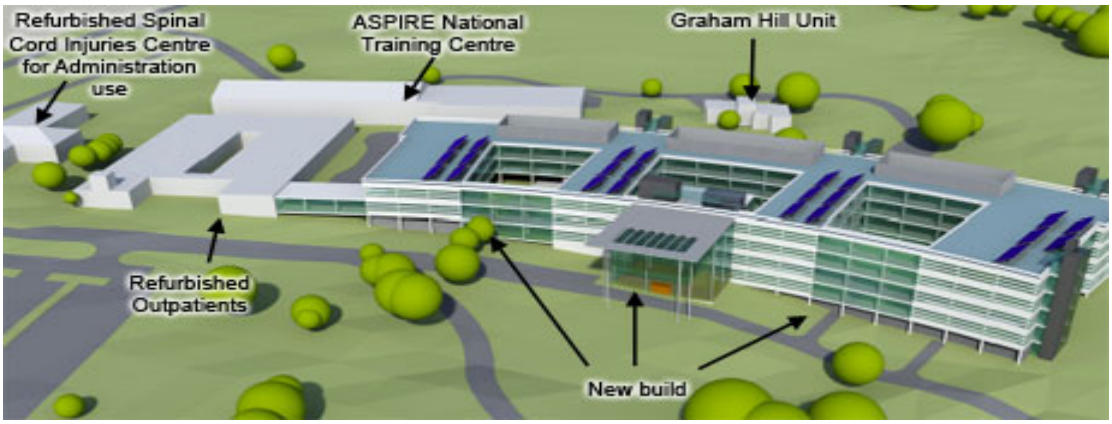
2.14.1 **Overview Of Site Plans**

The redevelopment will replace all of the clinical buildings currently spread around the site with a new single building adjacent to the Aspire National Training Centre and the Institute of Musculoskeletal Science (IOMS). This can be achieved within a single building phase that leaves the existing hospital unaffected and operating at full capacity. New inpatient and diagnostic facilities will be built adjacent to the existing outpatient building which will be expanded and refurbished to meet demand. The Trust will also use this opportunity to improve the facilities provided for the IOMS, in particular bringing together the currently dispersed range of research activity on the campus. The main principle behind the development is that the Trust will consolidate its services on the centre zone of the site, freeing up the east and west ends for land sales. This is illustrated in the master plan overleaf

Figure Six: Masterplan of Stanmore Site Re-development



The new RNOH will provide a patient centred environment, built to the very latest healthcare standards, improving still further the quality of care our clinical teams can provide. With wards and theatres under one roof, services can be organised in the most efficient and effective way to provide patients with the best and quickest possible care provided precisely when and where it is required. The new hospital will enable new ways of working that benefit both patients and staff. The specialist teams will be able to accelerate their service improvements whilst continuing to meet or exceed national standards and setting and achieving the highest clinical standards as a focused neuro-musculoskeletal centre.



The Proposal will:

- Completely eliminate nightingale wards in the hospital

- Provide 50% single rooms
- Maximise the provision of ensuite facilities in wards
- Improve the quality of the environment
- Meet the NHS Estates rationalisation agenda
- Provide modern flexible buildings specifically designed for modern healthcare
- Separation of inpatient and outpatient activity
- Address the investment need to meet statutory requirements
- Provide future expansion space should there be a need to increase activity to take on increased orthopaedic work from within London.
- Rationalise and consolidate car parking.
- Improve the accessibility and quality of the site

2.25.3 Bolsover Street

The redevelopment of the Bolsover Street outpatient facility has commenced. The scheme, which will result in a lease back of circa 2,074 m^2 (gross internal area) and is expected to be fully operational by December 2009.

2.25.4 Key Targets: 2008- 2009

- Approval of Outline Business Case by NHS London SHA
- Preparation of documentation to go to the market to identify a preferred
- partner for the Stanmore Redevelopment
- Construction of the Ronald McDonald Children's Charity House
- Commence work on land sale receipt for the Stanmore site
- Preparation for the commissioning of the new Bolsover Street Facility

2.26 Executive Risk Management Walkabouts

A monthly programme of risk management walkabouts commenced during January 2008. The walkabouts are lead by Michelle Nolan (Risk Manager), Andy Dwyer (Clinical Risk Manager) and they are accompanied by one of the executive team members who are responsible for risk management – namely Andrew Woodhead (Chief Executive) Mark Vaughan (Director of Human Resources and Corporate Affairs) and Kathryn Corder (Acting Director of Nursing) The intention is that all wards and departments are visited on a rolling basis and staff have an opportunity to discuss any risk management issues.

The risk management walkabout programme is detailed in Table Eight:

Table Eight: Risk Management Executive Walkabouts

Date	The Risk Manager and Clinical Risk Manager will be accompanied by
27th February	Chief Executive
5th March	Acting Director of Nursing
16th April	Chief Executive
7th May	Director of Human Resources and Corporate Affairs
4th June	Chief Executive
8th July	Director of Human Resources and Corporate Affairs
9th September	Chief Executive
6th October	Local Security Management Specialists (Michelle Nolan / Lynne Wilson) and Canons Safer Neighbourhood Team
5th November	Chief Executive
3rd December	Acting Director of Nursing

2.26.1 Key Targets: 2008- 2009

- Continue the monthly executive Risk Management walkabouts – ensure all areas are visited.

2.27.1 Manchester Patient Safety Framework

The safety of both patients and staff in a healthcare organisation is influenced by the extent to which safety is perceived to be important across the organisation. This "safety culture" is a new concept in the health sector and can be a difficult one to assess and change. The Manchester Patient Safety Framework (MaPSaF) has been produced to help make the concept of safety culture more accessible. It uses ten dimensions of safety and for each of these it describes what an organisation would look like at five levels of safety culture. The framework helps staff to:

- Recognise that safety is a complex multidimensional concept.
- Facilitate reflection on safety within the Trust and their individual departments
- Stimulate discussion about the strengths and weaknesses of the safety culture within the organisation and their department
- Highlight differences in perception between staff groups

- Help understand how an organisation with a more mature safety culture may look.

- Help evaluate any specific intervention to change the safety culture of the organisation and / or local teams.

Work has commenced in working through the ten dimensions of the MaPSaF framework. To date the first three dimensions have been reviewed by Risk Officers, the Executive Team and members of the Health and Safety Committee. It has been interesting to find that very similar responses have been given by each group.

2.27.1 Key Targets: 2008- 2009

- Continue to work with the Executive Team, Risk Officers and Health and Safety Committee to ensure that all dimensions of safety culture as detailed within the framework are reviewed. The results are to be shared and discussed between the groups.

- Cascade this work out to other areas e.g. as part of local workplace training.

3.0 Progress Against Action Plan For 2007 – 2008

Table Nine provides a summary of the progress made against the Trust's Risk Management Action Plan (2007 – 2008)

Table Nine: Progress Made Against Of Risk Management Action Plan (2007 – 2008)

Action	Responsible Person / Lead
• Continue to monitor and review the risk management organisational structure to ensure that the strands of governance such as financial, clinical, research and risk are brought together in a coherent way. (ON-GOING) • Review the work of the Risk Management Board on an annual basis, to ensure that the group continues to meet it's terms of reference and is receiving and reviewing information on risks of all types. (ON-GOING) • Develop a template for the assurance framework report which demonstrates the links to the risk register. (OUTSTANDING) • Continue to facilitate the development of local risk registers. (ON-GOING) • Continue to monitor and review the assurance framework so that it is maintained as a dynamic document. (COMPLETED) • Continue to ensure that the assurance framework is fully embedded. (ON-GOING) • Implement the associated assurance framework action plans. (ON-GOING) • Produce a report template which orders the risk register by target dates. (COMPLETED) • Ensure that all staff are aware of how to submit items for inclusion on the risk register and that they are provided with adequate information as to the progress of action plans. Excellent two way communication is essential. (COMPLETED) • Key members of staff to attend template report training. (COMPLETED) • Update the Risk Management Strategy (annually). (COMPLETED)	Mark Vaughan Director of Human Resources and Corporate Affairs

Action	Responsible Person/Lead
• Review the audit / inspection tool on an annual basis. (COMPLETED) • Ensure that a minimum of one inspection and one audit is undertaken on a monthly basis. (COMPLETED) • Review the key indicators and develop where necessary so that all risks are considered equally and an integrated approach is taken. (COMPLETED) • Develop a system to highlight and deliver training needs of those acting up or those who have been promoted. (OUTSTANDING) • Review training needs of Site Managers and deliver. (OUTSTANDING)	Mark Vaughan Director of Human Resources and Corporate Affairs
• To liaise closely with the Trusts NHSLA assessor (COMPLETED) • To ensure that all relevant staff are aware and comply to the updated NHSLA guidance in April 2007 (COMPLETED) • To be successful with a formal assessment in November 2007 (COMPLETED) • To work towards achieving level 2 of the new standards (COMPLETED) • Undertake clinical audit as required. (ON-GOING) • Continue to report to the NRLS. (ON-GOING) • Implement all NPSA recommendations and guidance. (ON-GOING)	Kathryn Corder Acting Director of Nursing

Action	Responsible Person/Lead
• Develop and implement a Safer Handling Of Heavy Patients Policy. (COMPLETED) • Develop and implement a Bed Safety Sides Policy. (COMPLETED)	Kathryn Corder Acting Director of Nursing
• Pilot e-reporting and cascade out throughout the Trust. (OUTSTANDING) • Continue facilitating individual, ward and departmental risk assessments. (ON-GOING) • Programme scheduler so that the incident summary reports are automatically distributed to all wards / departments for formal review at team meetings every two weeks. (ON-GOING) • Develop a Serious Untoward Policy. (COMPLETED) • Ensure that all wards / departments receive a summary report of all their reported incidents on a fortnightly basis. These reports should be reviewed as part of team meetings and appropriate feedback provided to the Clinical / Risk Manager in order that Safeguard can be updates. (OUTSTANDING) • Review and re-launch CROP – Clinical Risk Outcome Panel. (OUTSTANDING) • Continue work to embed the use of the risk identification tools throughout the organisation. (ON-GOING) • Ensure that all staff are aware of how to manage risks that have been identified and encourage / support local ownership of risk. (ON-GOING) • Continue to monitor the Safety Alert Broadcast System, distribute alerts and facilitate and report on the implementation of each action plan. (ON-GOING)	Mark Vaughan Director of Human Resources and Corporate Affairs / Kathryn Corder Acting Director of Nursing

Action	Responsible Person/Lead
• Review security related risk assessments. (ON-GOING) • Encorporate PARS reporting into the Incident Reporting Procedure. (COMPLETED) • Liaise with the IT department to ensure that there are appropriate IT security policies and procedures in place, that are regularly updated and that the implementation of these procedures throughout the Trust is monitored. (ON-GOING) • A security awareness handbook will be developed and distributed to all staff as part of the induction process. (COMPLETED) • Continue to develop profile of Security Officers on site. (ON-GOING) • Continue to raise staff awareness about the importance of reporting security related incidents through workplace training and the launch of e-reporting. (Security related incident report form to be launched) (ON-GOING) • Continue the recruitment process to employ a Fire And Security Officer. (SECONDED FOR TWO DAYS PER WEEK) • Continue to raise the profile of the Security Officers and review their work routines. (ON-GOING) • Hold a fire and security awareness roadshow. (COMPLETED) • Develop a programme of increasing fire precaution awareness and instil a fire safety culture within the organisation. (ON-GOING)	Mark Masters Director of Estates and Facilities and Projects

Action	Responsible Person/Lead
• Assess current management procedures and review competencies. (ON-GOING) • Systematically review and update fire risk assessments. (ON-GOING) • Review all internal and external escape routes. Clearly define routes and update plans accordingly. (ON-GOING) • Assess lighting levels on external escape routes and upgrade as required. (ON-GOING) • Develop "year two" action plan (07/08) financial year and submit to the LFEPA for approval and comments. (COMPLETED) • Continue to monitor compliance against the HSE action plan. (ON-GOING) • Continue to embed and nurture a safety culture within the Estates Department. (ON-GOING) • Complete the Building Management System extension. (ON-GOING) • Undertake more steam improvements when new capital is released. Work will be agreed using reports that have followed the HSE visit. High risk areas have been completed, so work will focus on medium to low risk areas. (COMPLETED)	Mark Masters Director of Estates and Facilities and Projects
• At appropriate intervals monitor and review the work of the Audit Committee to ensure that it continues to take a holistic approach to the monitoring and review of risks and controls which affect the Trust's business.	Rob Hurd Director of Finance

Action	Responsible Person/Lead
• Develop costing systems to allow the Trust to implement service line income and expenditure reporting so that the impact of projected clinical case mix changes on both income and costs can be forecast in advance and appropriate management action taken. (SYSTEM COMPLETED. IMPLEMENTATION ON-GOING) • Agree specialist Orthopaedic tariff adjustments for 2008/9 with Department of Health and model implications for 2009/10 of move to new HRGv4 tariff; (COMPLETED) • Implement 6 point Turnaround Action Plan o Accelerate cost improvement initiatives that are already being implemented o Continue the case mix review and curtail activity where marginal costs exceed tariff o Clinical Workforce Review – shifting from non-income generating activity to clinical income generating activity. This will include ▪ Confirmation that all clinical activity is captured and counted ▪ Shifting from academic, training, education & research activities to clinical o Increase income generating areas that make a positive contribution o Continue implementation of contracting, coding and costing strategy to maximise income o Find new areas of savings through service reconfiguration (set in the context of all of the above) – including Clinical Systems Improvement Plan initiatives. Continue to embed non-pay expenditure controls through the Trust's approved Procurement Strategy work plan." (COMPLETED)	Rob Hurd Director of Finance

4.0 Summary Of Action Plan For 2008 - 2009

Table Ten provides a summary of the risk management action plan for 2008 - 2009

Action	Responsible Person /Lead
• Continue to monitor and review the risk management organisational structure to ensure that the strands of governance such as financial, clinical, research and risk are brought together in a coherent way. • Review the work of the Risk Management Board on an annual basis, to ensure that the group continues to meet it's terms of reference and is receiving and reviewing information on risks of all types. • Continue to facilitate the development of local risk registers. • Continue to monitor and review the assurance framework so that it is maintained as a dynamic document. • Continue to ensure that the assurance framework is fully embedded. • Continue to implement the associated action plans. • Develop a new assurance framework report template using the Safeguard Risk Management database which displays links with the corporate risk register as well as the standards for better health. • Develop and implement a programme to ensure that local risk registers are compiled, monitored and reviewed by all wards and departments. • Schedule departmental risk registers (current and accepted) so that they are received by each ward / department on a regular basis. • Each director to progress the work in consolidating and monitoring their risk registers	Mark Vaughan Director of Human Resources and Corporate Affairs

Action	Responsible Person / Lead
• Recruiting sufficient staff to ensure capacity in place to meet 18 week target e.g. in theatres • Continue to reduce staff costs in line with trust CIP (cost improvement programme) • High levels of perceived bullying & harassment in trust – achieve reduction. • Continue to improve appraisal rates • Introduce Bradford Scoring Index for recording sickness absence and reduce levels across trust • Ensure membership rates for FT (foundation trust) are maintained and improved. • Ensure governance arrangements are in place for FT status including election of Council of Governors • Ensure plan is developed, agreed and in place for EWTD (European working time directive) 48 hour target in 2009 • Develop robust workforce strategy and plan for hospital redevelopment plans • Launch fundraising campaign for new hospital • Review the audit / inspection tool on an annual basis. • Ensure that a minimum of one inspection and one audit is undertaken each month. Table Three exhibits the audit / inspection schedule for 2008. • All first aiders to have attended their refresher training.	Mark Vaughan Director of Human Resources and Corporate Affairs

Actions	Responsible Person / Lead
• Seek agreement on the out of hours procedure. This will involve reviewing and defining the role of the Site Managers and providing formal training. • First aider posters to be updated and distributed to all wards / departments. The following policies will be reviewed / developed this year; - • Risk Management Strategy 2008 • Risk Management Strategy Summary 2008 • Lone Workers Policy • Major Incident Procedure • Pregnant Worker and Nursing Mothers Policy • Security Policy • Smoke Free Policy • Handling of Patients Valuables Policy • Fire Safety • COSHH – Control of Substances Hazardous to Health • Continue the monthly executive Risk Management walkabouts – ensure all areas are visited.	Mark Vaughan Director of Human Resources and Corporate Affairs

Actions	Responsible Person / Lead
• To liaise closely with the Trusts' NHSLA assessor • To ensure that all relevant staff are aware and comply with updated guidance from the NHSLA • To work towards achieving Level 2 status of the new standards and assessment criteria. • The Trust will require another formal assessment before November 2010, however future assessments will require a minimum score of 7/10 for each standard and a total score of at least 45/50 irrelevant of which level is being assessed. An NHSLA action plan has since been development and is under review to address the areas that the Trust could improve. • Ensure that the core standards continue to be met. This is not optional as they do not set out new expectations but are based on a number of standards and requirements that already exist. • To continue to report to the NRLS • To undertake clinical audit as required • To implement all NPSA recommendations and guidance • Continue to develop and implement action plans to progress compliance with the developmental standards. • Add the Standards For Better Health data into the database. • Root cause analysis's to be completed within 60 days. • Improve attendance at infection control training	Kathryn Corder Acting Director of Nursing

Actions	Responsible Person / Lead
• To provide the Risk Management Board with regular updates regarding the implementation of the Major Incident Plan. • To undertake a tabletop exercise. • Develop business continuity plans. • Ensure additional staff attend loggist training. • To undertake a third audit of the Patient Handling Risk Assessment Tool • To continue to undertake Income Generation work for the Trust • Continue facilitating Individual, Ward and Departmental risk assessments • To review the teaching presentations and handouts given to attendees • To review teaching sessions and to further develop ways of increasing attendance figures • Continue work to embed the use of the risk identification tools throughout the organisation. • Ensure that all staff are aware of how to manage risks that have been identified and encourage/support local ownership of risk. • Continue to develop local risk registers.	Kathryn Corder Acting Director of Nursing

Actions	Responsible Person / Lead
• Medical staff to have infection control updates at Medical Staffing Committee • Continue teaching re medicines policy • To review and re-launch CROP – Clinical Risk Outcome Panel. • To ensure that the backlog of clinical incidents is cleared and all incidents are added to Safeguard risk management database in a timely fashion. • The number of complainants remaining dissatisfied at the Local Resolution stage is still a concern. The Trust will continue to ensure the Local Resolution stage is more proactive and helpful to complainants. Complainant will have an opportunity to discuss outstanding grievances with the Customer Care Manager either before or after the Chief Executive's written response, depending on the complexity of the case, allowing for further opportunities to resolve the complaint through meetings with the key personnel and the complainant. This will give the Trust the opportunity to identify alternative and more successful ways to address concerns. • With the increased role of the Matrons and Clinical Leaders local ownership of complaints will be made and it is envisaged that responses to formal complaints will become more robust. • To ensure that lessons are learnt from the themes in complaints and actions taken to improve service provision through the Complaints Outcome Panel, Clinical Governance Board and local initiatives with the Matrons and General Managers. • To review the Bolsover Street Major Incident Policy • To provide appropriate training to all staff who may be involved in a major incident.	Kathryn Corder Acting Director of Nursing

Actions	Responsible Person / Lead
• To undertake a communication exercise every six months.	Kathryn Corder Acting Director of Nursing
• Develop a template for the assurance framework report which demonstrates the links to the risk register. Also link the report to the Standards For Better Health. • Pilot e-reporting and cascade out throughout the Trust. • Develop a risk register relating to root cause analysis reports. • Each director to review and consolidate their risk registers. • To ensure that all wards and departments receive a summary report of all their reported incidents on a weekly basis. These reports should be reviewed as part of team meetings and appropriate feedback provided to the Clinical / Risk Manager in order that Safeguard can be updated. • To launch e-reporting throughout the organisation. • Review and where necessary develop key indicators so that all risks are considered equally and an integrated approach is taken. • Develop a system to highlight and deliver training needs of those acting up or those who have been promoted. • Ensure that all senior staff are attending mandatory training. • Provide an annual risk awareness training event for the executive team.	Mark Vaughan Director of Human Resources and Corporate Affairs / Kathryn Corder Acting Director of Nursing

Actions	Responsible Person / Lead
• Continue to monitor the broadcast system, distribute alerts and facilitate and report on the implementation of each action plan. • Continue to work with the Executive Team, Risk Officers and Health and Safety Committee to ensure that all dimensions of safety culture as detailed within the framework are reviewed. The results are to be shared and discussed between the groups. • Cascade this work out to other areas e.g. as part of local workplace training.	Mark Vaughan Director of Human Resources and Corporate Affairs / Kathryn Corder Acting Director of Nursing
• At appropriate intervals monitor and review the work of the Audit Committee to ensure that it continues to take a holistic approach to the monitoring and review of risks and controls which affect the Trust's business. • Deliver 2007/08 annual audited accounts to national timetable • Continue work with DoH and Specialist Commissioners to mitigate PbR funding risks • Agree revised break even recovery period with SHA as part of FT application for April 2009 • Close CIP monitoring to Finance & Performance Committee and Trust Board • Asset management policies and procedures to be put in place for the new financial year • New stock control system to be in place by the end of the financial year • PCT contracts to be signed consistent with delivering 18 week access targets and financial plan	Rob Hurd Director of Finance

Actions	Responsible Person / Lead
• Document Trust objective setting process for Trust Board approval • Improve ALE rating from 1 to 2 overall with evidence of moving from 2 to 3 in some areas • Roll out patient level costing system and develop data quality.	Rob Hurd Director of Finance
• Continue to raise staff awareness about the importance of reporting security related incidents through workplace training and the launch of e-reporting. • Continue to develop profile of Security Officers on site. Initiatives to be introduced to facilitate Security Officers to be more pro-active e.g. introduce trend analysis, articles in Articulate, proactive use of e-mail. • Hold a fire and security awareness roadshow. • Review the Annual Security Management Action Plan. • Develop and implement "Prisoner Visit Risk Assessment Template" for both Bolsover Street and Stanmore sites. • Review the Corporate Security Policy. • Review the Handling Of Patients Property Policy • Review the Lone Workers Policy and facilitate the development of local procedures. • Review security alarm installations across the Trust and ensure all are linked to Main Gate.	Mark Masters Director of Estates and Facilities and Projects

Actions	Responsible Person / Lead
• Review key management across the site. • Introduce staff access groupings on the card access control system. • Introduce a 69 point dyster system across the Trust. • Develop and implement a capital project plan • Continue to raise awareness regarding the handling of difficult patients. • Tender card access control system. • Local police to join risk management executive walkabout during October 2008 to help raise security awareness • LSMS's to continue to attend the local community meetings organised by Cannons Safer Neighbourhood Team • Continue to monitor compliance against the HSE action plan. • Continue to nurture and embed a safety culture within the Estates Department. • To implement the proposed Capital Plan with consideration of the re-development of the site. • Link all security alarms to a central location and review local procedures. • Tender for the maintenance of the card access system.	Mark Masters Director of Estates and Facilities and Projects

Actions	Responsible Person / Lead
• Develop a programme of increasing fire precaution awareness and instil a fire safety culture within the organisation. • Assess current management procedures and review competencies. • Continue to systematically review and update fire risk assessments. • Review all internal and external escape routes. Clearly define routes and update plans accordingly. • Assess lighting levels on external escape routes and upgrade as required. • Develop action plan (08/09) financial year and submit to the LFEPA for approval and comments. • Further develop the fire drill programme to include clinical areas. • Introduce fire wardens to all areas. • Review the Fire Safety Policy. • Develop a priority works list in relation to capital expenditure. • Work towards reducing the number of unwanted fire calls. • Continue the recruitment process to employ a Fire And Security Officer on a full time basis. • Complete the Building Management System (BMS) upgrades.	Mark Masters Director of Estates and Facilities and Projects

Actions	Responsible Person / Lead
• The focus this year is on legionella. £35,000 has been agreed from the capital budget and an action plan has been agreed. One of the top priority jobs is the installation of new het exchangers with paediatrics. A programme of tank cleaning will be undertaken and alarms are to be fitted to the water boilers. • Develop a Steering Group For Legionella. This may be a stand alone committee or it may be integrated into a current committee as the Infection Control Committee. • Ensure that key staff attend relevant legionella training. • Review, seek approval and implement legionella policies and procedures throughout the organisation. • Zone plans are to be reviewed and displayed adjacent to all fire panels. • Finalise tender process and award new contract for all waste services by 1st October 2008. • 2 day waste support to implement action plan recommendations and carry out on site training. • Change to new colour coded sharps bins and bags • Continue with Duty of Care audits • Implement better segregation of waste and recycling initiatives • Ensure contingency plans are in place for collection and disposal of all waste streams.	Mark Masters Director of Estates and Facilities and Projects

Actions	Responsible Person / Lead
• Implement a modern data warehousing system to provide high quality information for all management and operations • Continue to improve customer service levels • Deliver a robust and resilient ICT infrastructure • Improve information security and information governance. This includes a detailed information mapping exercise. • Submit all external returns in a timely manner • Continue to maximise Trust income by maintaining a high quality clinical coding function.	Saroj Patel Director of IM&T
• Roll out wireless infrastructure in all clinical areas • Complete the implementation of the Electronic Ordering System, implement bed management system, develop the orthotics systems including process improvement, roll out voice recognition for clinical notes • Increase the use of the intranet • Develop a comprehensive and integrated IM&T strategy	Saroj Patel Director of IM&T

Actions	Responsible Person / Lead
• Review and consolidate risk register with operational management team and establish regular review process throughout the year at monthly team meetings in order to monitor and manage risk. • Revise access, booking and choice policy in line with demands of 18 week RTT. • Improve data quality to minimise need for data cleansing of 18 week pathways. • Implement 18 week patient tracking list (PTL). • Develop and implement policy reporting plain film. • Systems and training to eliminate breaches of 28 day readmission guarantee for cancelled operations.	Sheila Puckett Director of Operations and Service Improvement

5.0 Conclusion

The Royal National Orthopaedic Hospital NHS Trust is committed to the management of risk and this is clearly demonstrated by the progress that has been made during 2007 – 2008. It is recognised that the developments and progress which has been achieved throughout the last year would not have been possible without the commitment, participation and co-operation of staff. Thank you.

However, whilst the foundation stones are being laid, it must be highlighted that there is still much work to be undertaken to ensure that there are robust mechanisms in place, and that a holistic approach is always followed in order to ensure that a high degree of patient, staff and visitor safety is facilitated.