RISK MANAGEMENT ANNUAL REPORT

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1.0 Introduction

The report covers the period of the 1st April 2006 to the 31st March 2007.

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.

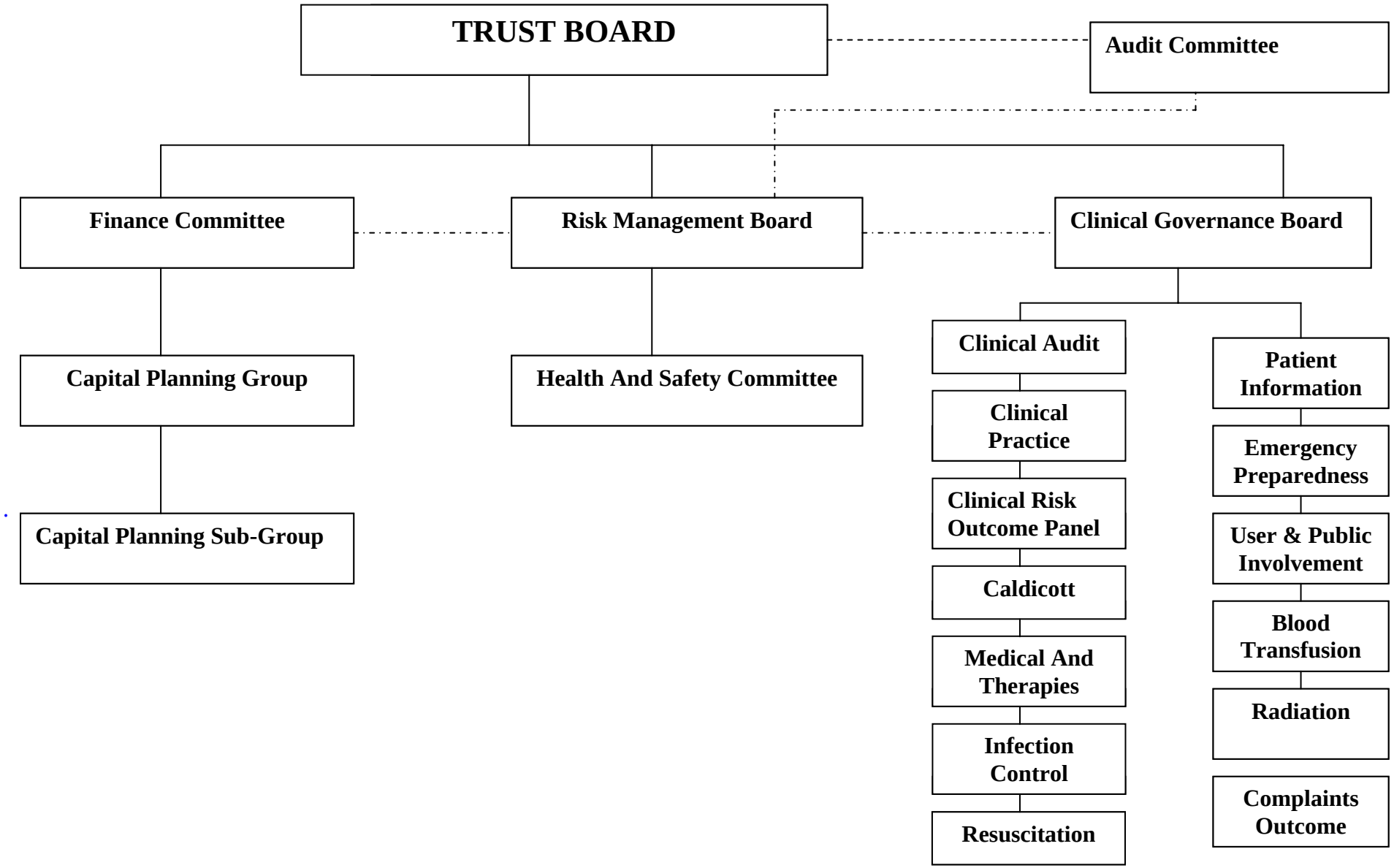
2.1.1 Key Targets: 2007 – 2008

- 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) Risk Management Standards

The NHSLA is the Authority which handles on behalf of NHS bodies all clinical negligence claims. Previously this was known as the Clinical Negligence Scheme for Trusts (CNST). Trusts had to join the scheme in order to benefit from the support with premiums that the NHSLA offered.

Trusts were assessed against the relevant risk management standards and a history of good claims. If Trusts could demonstrate that they had met the specific levels then discounts were applied to the premiums. The table below illustrates the levels and the associated premium attached

Level 1	Policy	If standards were met the premium reduced by 10%
Level 2	Practice	If standards were met the premium reduced by 20%
Level 3	Performance	If standards were met the premium reduced by 30%

The CNST standards were withdrawn at the end of March 2006 and have been replaced by the NHSLA Risk Management Standards (Acute Standards).

The NHSLA undertook a major review of the risk management standards to ensure that there was 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 the major review the following outcomes were achieved:

- Revised risk management standards have been developed
- Revised assessment process have been introduced
- Guidance to assist organizations in achieving compliance have been developed
- Changes are being shared with all organizations

- Training provided to all assessors

- Training offered to all organisations

2.2.1 Key Changes

There are now 5 specific standards for Acute Trusts (which includes specialist hospitals) each having 10 criteria to be assessed namely:

Standard 1	Governance
Standard 2	Competent & Capable Workforce
Standard 3	Safe Environment
Standard 4	Clinical Care
Standard 5	Learning from Experience

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 the Concordat.

2.2.2 The Assessment Processes

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. There are 3 main Levels with an additional Level 0 been introduced, against which Trusts can be assessed.

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

2.2.3 Scoring

In order to achieve compliance Trusts have to reach a specific score. For the initial assessment for all Trusts the minimum score required for each individual standard is 5/10. The overall score required for this years (2007) assessment is 40/50, irrelevant of which Level is being assessed.

Future assessments will also be required to meet a specific score. From 2008 onwards the minimum score required for each individual standard is 7. The overall score required will be 45/50, irrelevant of which Level is being assessed.

One of the main changes with the new assessment process is that there is the possibility of a lower Level being obtained in future reviews if a Trust performs poorly in an assessment i.e. a Trust could move from being a Level 2 to a Level 1 or even a Level 0. If this occurs then a mandatory re-assessment would occur the following year.

2.2.4 Contributions

Another major change is that discount to contributions will be applied more quickly following the introduction of the new standards. Discounts will be given in the Quarter following successful assessment.

Unfortunately the RNOHT failed its pilot assessment based at Level 2 however procedures have been put in place in order to be better prepared for the next formal assessment in November 2007.

2.2.5 Key Targets 2007 - 2008

- 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.

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 this year.

2.4 Annual Health Check (Standards For Better Health)

The Healthcare Commission is an independent body responsible for reviewing the quality of healthcare and public health in England and Wales. It developed a new system of assessment for NHS organisations – the annual health check. This replaced the previous system of 'Star Ratings' and provides a much richer picture of health and healthcare in England. It is an entirely new information-led and risk-based approach to assessing and reporting on the performance of NHS organisations.

In 2005/2006 the annual health check 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.

2.4.1 Purpose of the Assessment Process

Each Trust is responsible for the standards of healthcare in their organisations and it has to complete and provide a self-declaration of their performance against 24 Core Standards as well as a number of Developmental Standards. These standards cover seven 'domains' of activity:

- Safety
- clinical and cost effectiveness
- governance
- patient focus
- accessible and responsive care
- care environment and amenities
- public health

Healthcare organisations are also assessed against the use of resources and national targets set by the Government.

This year 2006/7, the Trusts 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. 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.

2.4.2 Standards Met/Not Met/Insufficient Assurance

Of the 24 Core Standards the Trust believes it has met 22 standards. However the Trust is reporting that it has once again not met 2 standards in relation to its hospital

buildings and environment but has now met standard C11 which in the previous year the Trust declared as not met.

Standard not met in 2005/2006 but met in 2006/2007 Standard C11

C11 Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:
(a) are appropriately recruited, trained and qualified for the work they undertake

The Trust reported a "not met" for C11 in 2005/2006 in light of our assessment of weaknesses identified in the Paediatric Nursing Workforce. However, since then significant progress has been made in ensuring that the Trust can provide 24 hour paediatric nursing cover throughout the patient journey.

The following actions have been achieved or are ongoing in relation to Standard C11:

- On the paediatric unit there are at least two paediatric trained nurses on duty
- Paediatric nurses are rotating onto the Private Unit when children are present
- Agency Paediatric Nurse are regularly employed in ITU/HDU
- A paediatric nurse has been seconded to outpatients four days a week and this covers the paediatric pre-admission clinic
- The Clinical Support Nurse spends one day a week working with the nurses on the Private Unit
- A mandatory training programme for Paediatric Life Support has commenced
- A Paediatric Clinical Nurse Specialist for Pain has been appointed
- The paediatric pain assessment tool has been re-launched with all staff having a 1:1 teaching session on the use of this tool
- The Anaesthetic team are working on a post-operative pain management protocol for children
- A sub group of the Children's Services Group was established to look into the feasibility of a joint appointment for Child Psychology with the Tavistock Clinic and an appointment has been made
- The Trust Board have appointed Stecia Laddie as the Non Executive Director to take specific responsibility for ensuring accountability for the structures of Children's Services
- The Patient Forum have identified a lead for Children
- There is a monthly Paediatric Review meeting which is multidisciplinary

- The matron chairs a weekly MDT meeting

- HR maintains a database of CRB checks for all staff coming into contact with children and the required renewal date. All new starters on the Paediatric Ward have an enhanced check prior to starting

- The Child Protection Policy was approved in February 2006

- Child Protection Training is well established

- Staff are accessing the Adolescent module as part of degree pathway

- Learning Disability Nurse students are on placement within the children's wards

- A sub group of the Children's Services Group has been established to develop a day case model

- A sub group of the Children's Services Group has been established to lead on developing a paediatric outreach service

- The Paediatric Clinical Support Nurse has undertaken Paediatric Advanced Life Support training

- The Matron is a member of the SHA Child Health Network which meets quarterly

- The Matron and Clinical Support Nurse are members of the Paediatric Orthopaedic Special Interest Group (National Network)

2.4.2.1 Standards Not Met

C20 (a) Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:

a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation

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.

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
- Submitted a Business Case to recruit a Fire Safety Officer / Security Management Specialist

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 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.

C21 Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises

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:

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 five 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.

2.4.3 Assessing Performance in Relation to the Developmental Standards

The developmental standards outline a framework for improvement in NHS Trusts that is broader than the requirements set out in the core standards. The standards are designed to stretch the performance of even the best performing Trust.

Trusts' will be assessed on a four-point scale from ***'limited'*** to ***'excellent'*** developmental progress. Trusts will be expected to declare increasingly improved levels of performance to reflect continuous improvement in the services they provide.

In 2006/2007 the assessment will be undertaken in shadow form. Therefore the results of the assessment will not be included within the aggregated quality of services component of the annual rating.

The domains being assessed in Acute Trusts for 2006/2007 are

- ***Safety - Developmental standard D1***

Healthcare organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another

The Trust declares that is has made **fair** developmental progress on the basis that it has declared 'met' for core standards C1, C2, C3 and C4.

- ***Clinical and cost effectiveness – Developmental standard D2, part (a)***

Patients receive effective treatment and care that conform to nationally agreed best practice, particularly as defined in national service frameworks, NICE guidelines, national plans and agreed national guidance on service delivery

The Trust declares that it has made **fair** developmental progress on the basis that it has declared 'met' for core standards C5 and C6.

2.4.4 Hygiene Code 2006

On 1 October 2006, the Health Act 2006 introduced a statutory duty on NHS organisations to observe the provisions of the Code of Practice on Healthcare Associated Infections. Given the importance of this national priority to improve the prevention and control of healthcare associated infections, the Secretary of State agreed that the Healthcare Commission should take account of the performance of all trusts with respect to the Code as part of the Annual Health Check 2006/2007.

In order that performance against the Code is taken into account the Healthcare Commission requires all Trusts to:

- consider the extent to which they have been meeting the duties set out in the Code from 1 October 2006 in our declarations of performance against the core standards. The Healthcare Commission has amended its criteria for standards C4a, C4c and C21 to include reference to the Code.

- Provide a short statement outlining whether the Trust considers it has appropriate measures in place to ensure the provisions of the Hygiene Code are being observed as of 31 March 2007. This statement will not contribute directly to our quality of services rating, rather it will sit alongside our declaration for the core and developmental standards. This statement is intended to provide assurance to patients and the public that we have taken due account of our new duties under the Code.

The Director of Nursing/Director for Infection Prevention and Control has considered Core Standards C4a and C4c and can confirm we remain compliant following legislative change.

The Director of Estates and Facilities has considered Core Standard C21 and has confirmed that the Trust remains non-compliant as the Trust requires to be redeveloped.

2.4.5 Process for Evidence Gathering

The process for planning the self assessment was agreed by the Trust Board in November 2006. As a result of this a senior clinician was identified to lead on the

collection of the evidence bringing together information from governance of clinical quality, information, research, finance and other organisations. Over 100 senior internal members of staff both clinical and non-clinical were involved in reviewing each of the Core Standards and identifying evidence to support the Trusts assessment. In the cases where the standards had not been fully met action plans were developed. The Trust obtained CNST level 2 in December 2004 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. The completed table was reviewed and revised at the weekly executive meeting. 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:

- Exec Directors Meetings
- Clinical Directors Meetings
- Executive Board
- Trust Board
- Overview and Scrutiny Committee
- Patient Forum meetings

The Trust also undertook a Trust wide Nursing audit based on the core standards which formed the basic minimum standard of care that patients should expect to receive. The results demonstrated that the Trust was meeting minimum standards in all domains and key areas audited and demonstrated a high level of compliance in Domain 1 Safety.

2.4.6 Conclusion

The Trust has undertaken a comprehensive review of its performance against the 24 Core Standards for the period April 2006 – March 2007 and the two developmental standards. 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.

2.4.7 Key Targets: 2007 – 2008

- 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; -

- The corporate risk register and assurance framework have been transferred to the database.

- The risks identified on the corporate risk register have been linked to the principal objectives within the assurance framework..

- A number of members of the executive team have received training on the risk module.

- One directorate has attended a Risk Register Workshop. The objective of this session was to raise awareness amongst senior managers regarding the risk register and assurance framework and to ensure that a holistic approach is taken within the directorate when identifying and managing risks.

- An “accepted” risk register has been developed which is reviewed and approved by Risk Management Board at each meeting. A copy of the “accepted” risk register is also provided to the Board.

- Reporting templates have been designed and introduced for the corporate, directorate, Audit Committee and accepted risk registers. These registers are ordered by risk rating.

- Training on the Risk Standards module has been attended by key staff.

- Report design training has been attended by key staff.

- Scheduler has been set up so that each director receives via e-mail a copy of their directorate risk register on a monthly basis. The Chief Executive receives a copy of all directorate risk registers.

- The Trust Board receives a copy of the high risk section of the corporate risk register every six months.

- The assurance framework is formally reviewed by the Board at every second meeting.

- The Audit Committee reviews it’s risk register and the assurance framework at each meeting.

- E-reporting forms have been re-designed and installed onto the web. There are four forms in all – general incidents, medication, fire, security.

- All trainers have access to Safeguard.

- A revised incident report summary has been designed and installed.

- Work has commenced to develop local risk registers e.g. within theatres.

2.5.1 Key Targets: 2007 – 2008

- 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.

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

- Programme scheduler so that incident summary reports are automatically distributed to all wards / departments for formal review at team meetings every two weeks.

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: 2007 - 2008

- 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.

- Implement the associated action plans.

- Develop a new assurance framework report template which displays links with the corporate risk register.

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 of meetings (Clinical Governance Board, Infection Control Committee, Finance Committee, Audit Committee) that are received by the Risk Management Board.

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.

It is anticipated that the introduction of the integrated risk management database will facilitate the development of local risk registers and allow all stakeholder the ability to review their individual action plans.

The following has been achieved this year:

- The corporate risk register has been transferred onto the Safeguard risk management database and training has been arranged for key users.

- 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.

- 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.

- Work has commenced to implement the integrated risk management system throughout the organisation which facilitates the development and ownership of local risk registers.

- Work continues to ensure that the risk register is holistic and comprehensive by widening the information sources used to compile the data.

- The risk register has been linked to the assurance framework . The links can be observed through Safeguard as a report template has not yet been designed.

2.7.1 Key Targets: 2007 – 2008

- 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.

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

- Update the Risk Management Strategy to reflect changes in systems of work.

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

- Produce a report template which details the links between the assurance framework and the risk register.

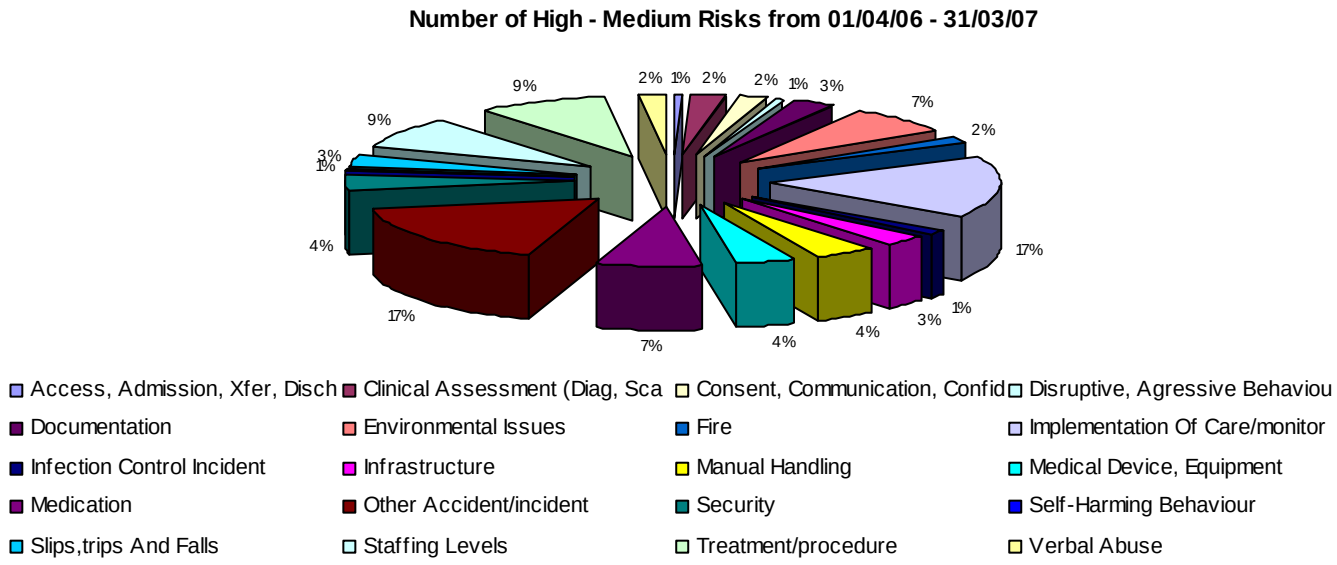
- Produce a report template which arranges risks by target dates.

2.8 Incident Reporting

In all 3979 incidents were reported between 1st April 2006 and 31st March 2007 compared to 3487 last year.. There was one reported category red incident which relates to a death on site of a member of staff within accommodation. 138 incidents have been categorised as medium risk. Refer to Figure Two. In all, 14 incidents have been reported to the HSE in accordance with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) These incidents have been investigated and appropriate action plans agreed, in line with the Trusts incident reporting policy.

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.

Figure Two



2.8.1 Key Targets: 2007 – 2008

- To review the Incident Reporting Policy.

- To develop an Serious Untoward Incident Policy.

- To ensure that all wards and 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 updated.

- 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 NPSA has enjoyed close links with the Trust this year and has invited members of the Trust to attend a number of workshops promoting the National Reporting and Learning System (NRLS) and Being Open. 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 2006-7 these have included

- **'Safer Practice with High Dose Ampoules of Diamorphine and Morphine'**- Action Completed.

- **'Improving Compliance with Oral Methotrexate Guidelines'**- Action Completed

- **'Right Patient Right Blood'**- Action is currently underway

- **'Colour Coding Hospital Cleaning Materials and Equipment'**- Guidance is currently being reviewed

- **'Early Identification of Failure to Act on Radiological Imaging Reports'**- Guidance is currently being reviewed

- '**Using Bedrails Safely and Effectively'**- A policy is currently being written

The NRLS is now well developed and the NPSA are sending quarterly reports to all Chief Executives and Director's of Nursing/Governance. In 2006-7 the Trust have reported approximately 3000 patient safety incidents to the NRLS and have been commended for a good reporting culture. The RNOHT have been compared with a cluster group of other Acute Specialist Trusts and have reported more incidents than any other.

2.9.1 Key Targets: 2007 - 2008

- 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 continues to receive a low volume of claims of negligence. 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 include clinical outcome to shoulder surgery, and spinal surgery. Themes in Employers Liability Personal Injury claims this year were manual handling, equipment failure, and falls/slips/trips. We received very few Public Liability claims, the main theme being falls/slips/trips.

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: 2007 – 2008

- 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 to ensure local ownership of complaints, 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; -

- The Safe Handling Of Patient Valuables Policy has been reviewed and approved by the Board.

- Safes have been installed in all wards and at Main Gate. Workplace training has been provided.

- A safe register and reconciliation folder have been introduced to all ward areas.

- A lost property procedure has been introduced throughout the Trust.

- The Security Policy has been reviewed and approved by the Board.

- The Procedure For The Management And Care Of Patients And Visitors Who Are Violent, Abusive And Disorderly has been reviewed and approved by the Board.

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

- The business case to recruit a Fire And Security Officer has been approved by the Board. The recruitment process has commenced but has been unsuccessful to date.

- Conflict resolution training sessions have been scheduled to run throughout the year.

- A programme of Crime Reduction Site Surveys has commenced. Surveys are undertaken by Lynne Wilson and Michelle Nolan.

- A programme of night inspection visits has commenced.

- The Trust participated in the Security Awareness Month (SAM) in conjunction with the CFSMS during June 2006.

- Zero tolerance posters, disclaimer signs, ten steps to keeping safe awareness leaflets and a leaflet detailing the role of the LSMS's have been distributed to

all wards/departments and displayed appropriately throughout the organisation.

- The Director (Mark Masters) and Non-Executive Director (Morton Creeger) who lead and promote security management have attended training provided by the CFSMS.

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

- Weekly meetings are held in conjunction with a representative from the Security Team and one of the LSMS's.

- Monthly meetings are held between both LSMS's and the Security Team.

- A Lone Worker Policy has been written and approved by the Board.

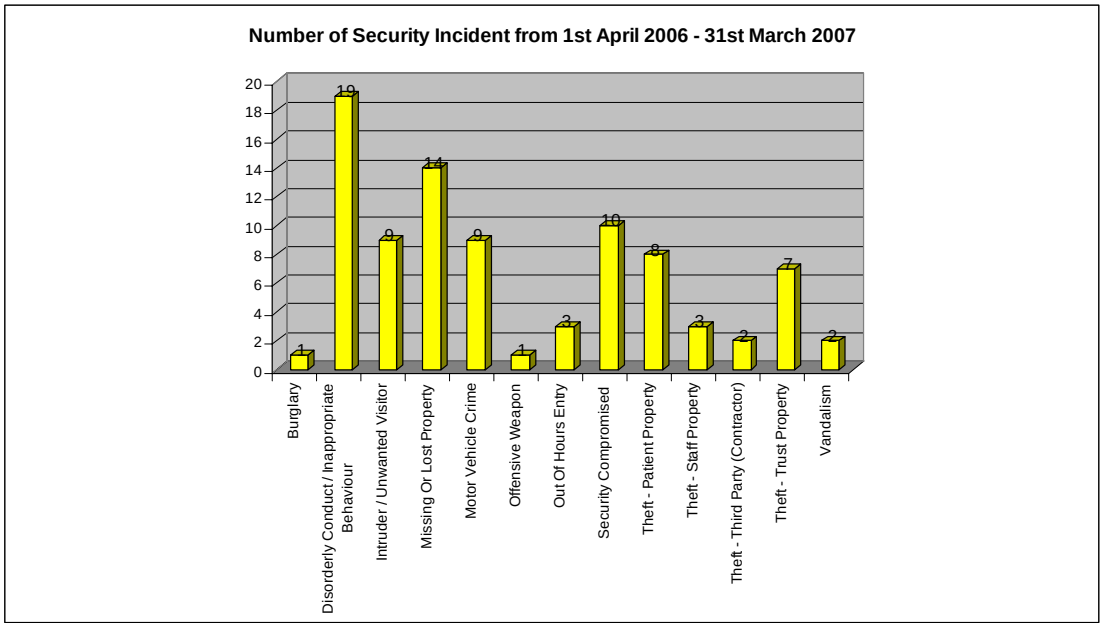
- Local lone working procedures have been reviewed with the Community Liaison Department.

- The Security Management Action Plan 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 been established with the Local Community Police Team. The team participate in Corporate Induction.

In total, 89 security related incidents were reported between the 1st April 2006 and the 31st March 2007 compared to 108 during the 1st April 2005 – 31st March 2006. The number and categories of incidents are detailed in Figure Three.

Figure Three:



2.11.1 Key Targets; 2007 – 2008

- Update the Incident Reporting Policy to incorporate the requirement to report incidents of physical assaults to the appropriate CFSMS operational managers.

- Review the Handling Of Controlled Drugs Policy. Seek Board approval and implement.

- Review security related risk assessments.

- 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.

- A security awareness handbook will be developed and distributed to all staff as part of the induction process.

- 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.

- Continue the recruitment process to employ a Fire And Security Officer.

- Continue to raise the profile of the Security Officers and review their work routines.

- Hold a fire and security awareness roadshow.

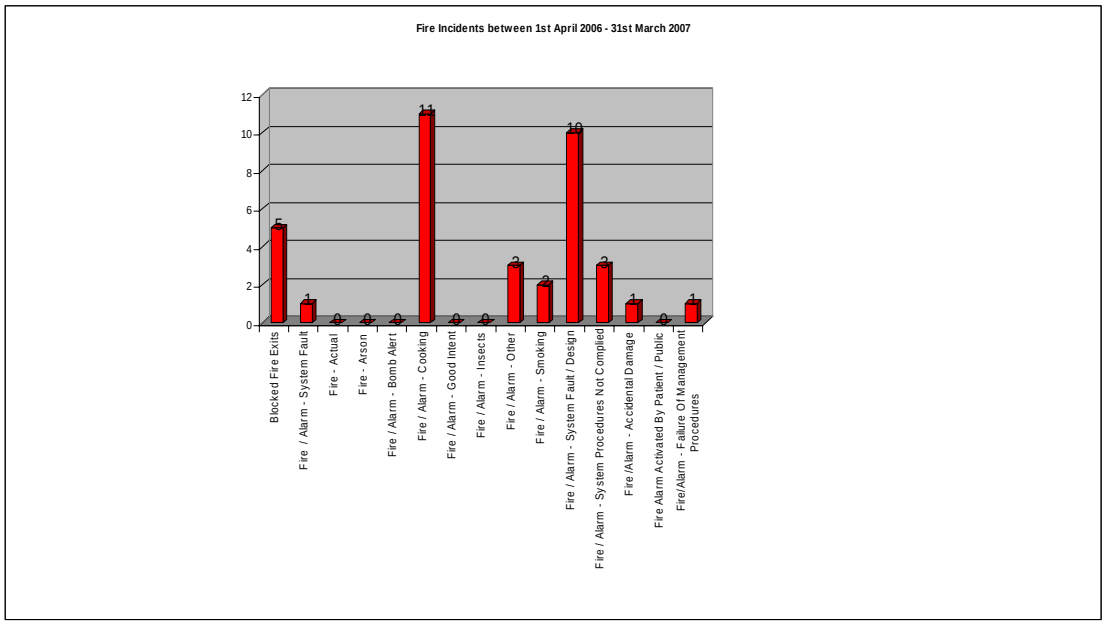
2.12 Fire

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; -

The number of reported unwanted fire signals has reduced throughout the year as illustrated in Figure Three. During the 1st April 2002 – 31st March 2003 there was a total of 156 unwanted fire signals, during 1st April 2003 – 31st March 2004 there was a total of 139 unwanted fire signals reported. During 1st April 2004 – 31st March 2005 36 and between 1st April 2006 and 31st March 2007, 37 unwanted fire signals were reported through incident reporting. However, according to Medirest records 134 unwanted fire alarms were activated.

Figure Four: Reported Unwanted Fire Signals



2.12.1 Key Targets: 2007 – 2008

- Recruit a Fire Safety Officer / Local Security Management Specialist.
- Develop a programme of increasing fire precaution awareness and instil a fire safety culture within the organisation.
- Assess current management procedures and review competencies.
- 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 "year two" action plan (07/08) financial year and submit to the LFEPA for approval and comments.

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, but has stressed that the Trust needs to continue to embed the safety culture within the Estates

Department and that work must continue to document disaster recovery / business continuity plans. To ensure that risk is kept as a priority issue the following work has continued; -

- The Director Of Estates And Facilities and the Risk Manager have developed a comprehensive action plan for the HSE addressing areas such as training, risk management strategy, policies and procedures, emergency preparedness and capital expenditure which is being implemented and carefully monitored. The majority of this action plan has been implemented.

- The Director Of Estates updates the Risk Management Board at all meetings.

- The Risk Manager meets with the Chargehands on a fortnightly basis to develop risk assessments.

- A specific assessment tool has been designed and one to one training with all staff has been undertaken.

No decision has been reached to date by the HSE regarding prosecution. However, the Director Of Estates represented the Trust at an interview under caution on the 21st December 2006.

2.13.1 Key Targets: 2007 – 2008

- 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 Planning Group continues to use the Controls Assurance Standards to monitor progress. The Trust has joined "PageOne", this is where the NHS London on-call officer contacts all NHS organisations across London if there is a major incident or an alert that the Trust needs to receive urgently.

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

2.14.1 Key Targets: 2007 – 2008

- To review the Bolsover Street Major Incident Policy

- To review the Stanmore Major Incident Policy

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 July 2006, and results were presented to the Nursing Advisory Committee. A second audit will be undertaken in July - August 2007.

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.

The Manual Handling Advisor has devised a form to be completed by the Pre Admission clinic staff. The form called the Patient Handling Information Group (PHIG) is sent out electronically to appropriate members of staff to inform them of a patient being admitted with complex manual handling needs. Early feedback from the group members as to the usefulness of the form is favourable.

General patient handling training courses are now undertaken with a mix of nurses and therapy staff. The only specific courses held are for Paediatrics and Theatre staff. The Corporate Induction programme has now incorporated Manual Handling Theory and practical sessions. This has been running successfully since January 2006.

Load Handling courses for non-clinical staff are now to be attended on a two yearly basis. Introduction to Manual Handling for Medical Staff courses have resulted in 23 members of the medical staff being trained since April 2006.

2.15.1 Key Targets: 2007– 2008

- To undertake a second audit of the Patient Handling Risk Assessment Tool
- Continue to provide ergonomic input into the redevelopment plans for the new PFI hospital build
- Continue to further develop the PHIG referral system whereby Pre Admission Clinic staff can refer patients to the Manual Handling Service if they think the patient has specialist handling needs
- To develop and implement a Safer Handling of Heavy Patients Policy
- To develop and implement a Bed Safety Sides Policy
- Continue facilitating Individual, Ward and Departmental risk assessments

Table One: Manual Handling Training Statistics 2006

Patient Handling Induction (Min 4/Max 8)

Courses offered	Places offered	Places booked	Places attended	DNA rate on bookings	Places offered but not booked
16	128	81	58	23 (27.7%)	47 (36.7%)

Patient Handling Refresher (Min 4/Max 8)

Courses offered	Places offered	Places booked	Places attended	DNA rate on bookings	Places offered but not booked
39	312	260	214	46 (17.6%)	98 (31.4%)

Load Handling (Min 3/Max 12)

Courses offered	Places offered	Places booked	Places attended	DNA Rate on bookings	Places offered but not booked
19	152	96	70	26 (27%)	56 (36.8%)

Doctors trained: 15 SHO's and 1 SPr

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: 2007 – 2008

- 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 fifteen departments have been audited during 1st April 2006 and 31st March 2007 and thirteen inspections have been completed.

Table Two: Completed Audits And Inspections

Audits	Inspections
Angus Mackinnon Ward	Adolescent / Coxen Ward
Commissioning	Clinical Engineering
Estates	Coleman Unit
Finance	Commissioning
Human Resources	Estates
Jackson Burrows Ward	Finance
Medirest	Physiotherapy
Medical Engineering	Plaster Theatre
Medical Records	Purchasing
Pathology	Rehabilitation Ward
Pharmacy	TSSU
Purchasing	Ward 4
Teaching Centre	X-Ray
Theatres	
Ward 4	

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: 2007 – 2008

- 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 2007.

Table Three: Audit And Inspection Schedule For 2007

Anticipated Month Of Visit	Audit	Inspection
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	Jackson Burrows Ward
June	Outpatients	Finance
July	Motion Analysis Lab	Medirest
August	Rehab Ward	Teaching Centre
September	Theatres	Pharmacy
October	Limb Fitting	Pathology
November	Coxen / Adolescent Unit	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: 2007 – 2008

- 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.

- *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.

Table Four: Attendance On Mandatory Training (1st April 2006 – 31st February 2007)

Course	Total Number Of Participants Involved	Participant's Cancellation	Attended	Course Cancelled (Number Of Participants)	Unattended
Managing Risk	70	13	34	13	10
Patient Handling Induction	87	11	63	0	13
Patient Handling Refresher	304	65	161	19	59
Load Handling	99	23	38	19	19
Fire Training	475	56	303	22	94
Excellence In Customer Care	25	3	14	6	2
Clinical Governance	40	8	7	22	3
Infection Control	316	25	219	19	53
Conflict Resolution	92	16	59	6	11
Basic Life Support	194	41	118	0	35
Basic Life Support Paediatrics	100	21	53	0	26
Valuing Diversity	167	27	90	0	50

2.19.1 Key Targets: 2007 - 2008

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

- Review training needs of Site Managers and deliver.

2.20 First Aid Arrangements

Twelve members of staff have completed training with St. John's Ambulance.

Details of first aiders and contact numbers have been distributed to all wards / departments.

An in-house refresher workshop has been attended by the first aiders. Formal training will be attended during 2008 as this is a statutory requirement.

2.20.1 Key Targets: 2007 – 2008

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

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 / Health And Safety / Policies)

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

- Risk Management Strategy 2006
- Procedure For The Management And Care Of Patients And Visitors Who Are Violent, Abusive And Disorderly.
- Security Management Policy
- Lone Workers Policy
- Stress Management Policy
- Root Cause Analysis Procedure

The documents listed below are currently in draft form; -

- Incident Reporting
- Slips, Trips, Falls
- Risk Management Strategy 2007
- Mobile Telephone And Handset Policy

2.21.1 Key Targets 2007 – 2008

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

- To develop a robust programme of policy review and development.

2.23 Financial Risk

During the year the financial position of the Trust remained a cause for concern. In 2004/5 the Trust implemented a financial recovery plan but ended the year with a £3.8m Income and Expenditure deficit. The recovery plan has continued over the last two financial years with the deficit reduced to £0.5m in 2005/6 and £0.3m in 2006/7. The Trust was originally targeting a surplus of £0.952m in 2006/7. Despite meeting cost improvement targets and activity targets for the year the continued shift towards more complex clinical case mix during the year resulted in cost growth exceeding income growth – a symptom of the Payments by Results funding system under which half of the Trust's clinical income is funded (see below).

2.23.1 Actions taken to date

The Trust agreed a Provider Sustainability Plan (2006/07 – 2009/10) last year with the SHA. This year the plan was updated to an Annual Plan (2007/8 – 2009/10) which has been agreed with the NHS London Provider Agency. These plans have included measures to deliver cumulative breakeven over 5 years by 2008/9 and establish recurrent financial stability. The plan targets income and expenditure surpluses for 2007/8 and 2008/9 which are considered deliverable. However, there remain significant risks to the Trust under the Payments by Results funding system whereby income received for complex cases at a national average tariff rate is significantly less than the previous funding system which allowed for local flexibility to recognise complex casemix.

The Trust is working closely with the Department of Health and other Specialist Trusts who face similar issues with the national tariff under Payments by Results. In particular, the Trust is part of the Specialist Orthopaedic Alliance of Trusts which is recommending specific changes to the tariff to protect specialist orthopaedic Trusts from the significant funding reductions in 2008/9 that could be experienced if no further changes are implemented. In 2009/10 a new tariff structure is being implemented (HRG version 4) which should assist with tackling this issue as there is a significantly increased number of tariff categories to appropriately reflect activity complexity.

However, the Trust recognises that it cannot rely entirely on issues with the funding system being completely resolved. Therefore, the Executive team continues to implement a challenging programme of cost reductions that have been agreed by the Board. Procedures have been put in place to more closely monitor income and expenditure against the financial plan across the Trust so issues can be highlighted and acted upon before they impact on underlying financial stability. In particular, costing systems are being developed to move the Trust towards service line reporting so that the impact of projected clinical casemix changes on both income and costs can be forecast in advance and appropriate management action taken.

2.23.2 Key Targets: 2007/8 and 2008/9

- 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;

- Agree specialist Orthopaedic tariff adjustments for 2008/9 with Department of Health and model implications for 2009/10 of move to new HRGv4 tariff;

- Implement 6 point Turnaround Action Plan
    - Accelerate cost improvement initiatives that are already being implemented

    - Continue the case mix review and curtail activity where marginal costs exceed tariff

    - 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

    - Increase income generating areas that make a positive contribution

    - Continue implementation of contracting, coding and costing strategy to maximise income

    - 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."

2.24 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.

2.24.1 Key Targets: 2007- 2008

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

2.25 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.

Capital projects have included the refurbishment of the plant room for theatres five and six as well as the replacement of the main boiler house burner.

A major risk to the Trust has been reduced to the Trust by the replacement of aging burners in the main boiler house. This will enable the provision of a more reliable heating system.

A risk assessment process has been implemented with ALL requisitions, and there has been on-going risk management training for all Estates staff. An appointed person has attended appropriate confined space training.

2.25.1 Key Targets: 2007- 2008

- Complete the Building Management System (BMS) extension.

- Undertake more steam improvements when new capital 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.

3 Progress Against Action Plan For 2005 – 2006

Table Five provides a summary of the progress made against the Trust's Risk Management Action Plan (2005 – 2006)

Table Five: Progress Made Against Of Risk Management Action Plan (2005 – 2006)

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) • Continue to work closely with the Clinical Risk Manager to ensure that there is a comprehensive and co-ordinated risk management system throughout the Trust and that there is positive support for the system (ON-GOING) • Continue to monitor the broadcast system, distribute alerts and facilitate and report on the implementation of each action plan. (ON-GOING) • The following policies will be reviewed / developed this year; - Risk Management Strategy, Incident Reporting, Mobile Telephone And Handset Policy. (COMPLETED) • Develop a system to highlight and deliver training needs of those acting up or those who have been promoted. (ON-GOING) • Review and where necessary develop key indicators so that all risks are considered equally and an integrated approach is taken. (COMPLETED) • Review the audit / inspection tool on an annual basis. (COMPLETED) • Transfer the current corporate risk register onto the Safeguard risk management database and arrange training for key users. (COMPLETED)	Mark Vaughan

Action	Responsible Person / Lead
• Transfer the assurance framework to the Safeguard database. (COMPLETED) • Implement the integrated risk management system throughout the organisation to facilitate the development and ownership of local risk registers. (ON-GOING) • Ensure that the risk register is holistic and comprehensive by widening the information sources used to compile the data. (ON-GOING) • 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. (ON-GOING) • Continue to monitor and review the assurance framework so that it is maintained as a dynamic document. (ON-GOING) • Ensure that the assurance framework is fully embedded and implement the associated action plans. (ON-GOING) • Arrange training for the risk module for the executive team and their nominated deputies. (TRAINING HAS BEEN PROVIDED TO ALL DIRECTORS WHO HAVE REQUESTED IT) • Facilitate the development of local risk registers. (ON-GOING) • Ensure that a minimum of one inspection and one audit is undertaken each month. Table Two exhibits the audit / inspection schedule for 2007. (ON-GOING) • 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)	Mark Vaughan

Action	Responsible Person /Lead
• Continue to work towards implementing the action plan associated with each of the twenty-two controls assurance standards. (ON-GOING – DETAILED WITHIN CORPORATE RISK REGISTER)	Mark Vaughan
• Seek agreement on the out of hours procedure for the provision of first aid. This will involve reviewing and defining the role of the Site Managers and providing formal training. (OUTSTANDING) • To undertake a pilot assessment in preparation for CNST level 3 assessment. (COMPLTETED) • Continue to monitor the progress of the NHSLA in the implementation of the new standards and assessment process through the NHSLA website. (ONP-GOING) • To continue to report changes in policy and / or practice to staff as a result of reported incidents in Articulate or an alternative Clinical Governance Magazine. (OUTSTANDING) • Ensure that the core Standards For Better Health are 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. (ON-GOING) • Review training needs of Site Managers and deliver. (OUTSTANDING) • Develop action plans to progress compliance with the developmental standards. (ON-GOING) • Continue to provide ergonomic input into the redevelopment plans for the new PFI hospital build (ON-GOING) • Continue to further develop the patient referral system whereby Pre Admission Clinic staff can refer patients to the Manual Handling Service if they think the patient has specialist handling needs (COMPLETED) • To review the Bolsover Street Major Incident Policy. (OUTSTANDING)	Anthony Palmer

Action	Responsible Person /Lead
• Many staff have yet to attend Customer Care training and therefore the programme is being reviewed to ensure it meets the needs of all frontline staff. (COMPLETED) • The number of complainants remaining dissatisfied at the Local Resolution stage is increasing, largely due to the level of complaints being more complex. Therefore the Trust will aim to ensure the Local Resolution stage is more proactive and helpful to complainants. The complainant will initially 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. If complainants remain dissatisfied further opportunities to resolve the complaint will be achieved through meetings with the relevant staff and the complainant. This will give the Trust the opportunity to identify alternative ways to address concerns. (ON-GOING) • With the increased role of the Matrons and Clinical Leaders to ensure local ownership of complaints, it is envisaged that responses to formal complaints will become more robust. Facilitate this process. (ON-GOING) • To continue Trust-wide audit and inspection of all clinical areas. (ON-GOING) • To deliver a Root Cause Analysis workshop for all senior staff within the Trust. (COMPLETED) • To implement all NPSA recommendations and participate in the central reporting of clinical incidents. (COMPLETED)	Anthony Palmer
• To agree a process for the local resolution of risk management issues identified through incident report forms to replace the function of the former Incident Reporting Group. (ON-GOING) • Launch e-reporting throughout the Trust and support with workplace training. (ON-GOING)	Mark Vaughan / Anthony Palmer

Action	Responsible Person /Lead
• To successfully promote and nurture the new Ulysses database within the Trust, using the opportunity to re-launch incident reporting. (ON-GOING) • Continue facilitating Ward and Departmental risk assessments. (ON-GOING) • Ensure that all wards/departments have access to Safeguard. (OUTSTANDING)	Mark Vaughan / Anthony Palmer
• Continue to monitor compliance against the HSE action plan. (ON-GOING) • Continue to nurture and embed a safety culture within the Estates Department. (ON-GOING) • Implement a programme of physical improvement works. Develop the scope of works for active and passive improvements. Tender project and carry out works. (COMPLETED) • Implement the energy reduction measures. (ON-GOING) • Carryout physical fire improvement work to residences. (COMPLETED) • Maintain the Trusts “green” status for PEAT inspections. (COMPLETED) • Undertake additional legionnaires disease prevention work. (ON-GOING) • Implement a car parking strategy. (ON-GOING) • Relocate IT building and dispose of surplus land and properties (COMPLETED) • Carry out toilet refurbishment works in various patient areas. (COMPLETED)	Mark Masters

Action	Responsible Person /Lead
• Improve the Trusts management of waste. (ON-GOING) • Complete HSE Action Plan (COMPLETED) • Recruit a Fire Safety Officer / Local Security Management Specialist. (ON-GOING) • Develop a programme of increasing fire precaution awareness and instil a fire safety culture within the organisation. (ON-GOING) • Assess current management procedures and review competencies. (ON-GOING) • Systematically review and update fire risk assessments. (OUTSTANDING) • 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) • Review and seek Board approval of the corporate Security Management Policy. (COMPLETED) • Review and seek Board approval for the Zero Tolerance Policy. (COMPLETED) • Develop a Lone Worker Policy. (COMPLETED) Review the Handling Of Controlled Drugs Policy. Seek Board approval and implement. (COMPLETED)	Mark Masters

Action	Responsible Person /Lead
• Update security section of the local risk management handbooks. (OUTSTANDING) • Update the Incident Reporting Policy to incorporate the requirement to report incidents of physical assaults to the appropriate CFSMS operational managers. (COMPLETED) • Review security related risk assessments. (COMPLETED) • Continue to collate information to develop a comprehensive asset register. (ON-GOING) • Hold a security awareness roadshow to raise awareness throughout the Trust. (COMPLETED) • Launch a Hospital Watch scheme. (OUTSTANDING) • Provide all wards with their own safe to ensure the safety of patients valuables. (COMPLETED) • Install CCTV along the slope corridor. (OUTSTANDING) • Recruit a Fire Safety And Security Management. (ON-GOING) • Develop key indicators, monitor and review. (ON-GOING) • Liaise with the Redevelopment Team and the Crime Prevention Unit to ensure that “Security By Design” principles are considered when planning the new hospital. (ON-GOING)	Mark Masters

Action	Responsible Person /Lead
• Further develop the Audit Committee's role 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. (ON-GOING) • Implemented clear budget management structure, budget holder accountability and responsibilities and performance management framework through budget sign off and monthly meetings between Executive Directors and Clinical Directorates (COMPLETED) • Agree the financial plan and budget prior to the start of the financial year to ensure cost improvement programmes are delivered on time (ON-GOING) • Implement robust monitoring against the financial plan, including a monthly Cost Improvement Board to ensure early warning signals are in place to address deviations from plan. (COMPLETED) • Continue roll out of budgetary control policies such as o Bank & Agency staffing review groups o Vacancy Control Panel to ensure all appointments are within establishment o Escalate non-pay authorisation limits in overspending areas (COMPLETED) • Develop and implement a variety of staff training programmes for budget managers supported by clear budget holder responsibilities and manual. This will include developing a budget holder incentives strategy to reward good financial management (COMPLETED) • Establish developmental plans and training programmes for Finance staff. (ON-GOING)	Rob Hurd

4.0 Summary Of Action Plan For 2007 - 2008

Table Six provides a summary of the risk management action plan for 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. • 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. • Develop a template for the assurance framework report which demonstrates the links to the risk register. • 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. • Implement the associated assurance framework action plans. • Produce a report template which orders the risk register by target dates. • 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. • Key members of staff to attend template report training. • Update the Risk Management Strategy (annually).	Mark Vaughan

Action	Responsible Person/Lead
• Review the audit / inspection tool on an annual basis. • Ensure that a minimum of one inspection and one audit is undertaken on a monthly basis. • Review the key indicators and develop where necessary 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. • Review training needs of Site Managers and deliver.	Mark Vaughan
• To liaise closely with the Trusts NHSLA assessor • To ensure that all relevant staff are aware and comply to the updated NHSLA guidance in April 2007 • To be successful with a formal assessment in November 2007 • To work towards achieving level 2 of the new standards • Undertake clinical audit as required. • Continue to report to the NRLS. • Implement all NPSA recommendations and guidance.	Anthony Palmer

Action	Responsible Person /Lead
• Develop and implement a Bed Safety Sides Policy. • Develop and implement a Safer Handling Of Heavy Patients Policy. • Continue facilitating individual, ward and departmental risk assessments.	Anthony Palmer
• Pilot e-reporting and cascade out throughout the Trust. • Programme scheduler so that the incident summary reports are automatically distributed to all wards / departments for formal review at team meetings every two weeks. • Develop a Serious Untoward Policy. • 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. • Review and re-launch CROP – Clinical Risk Outcome Panel. • 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 monitor the Safety Alert Broadcast System, distribute alerts and facilitate and report on the implementation of each action plan.	Mark Vaughan / Anthony Palmer

Action	Responsible Person /Lead
• Review security related risk assessments. • Encorporate PARS reporting into the Incident Reporting Procedure. • 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. • A security awareness handbook will be developed and distributed to all staff as part of the induction process. • Continue to develop profile of Security Officers on site. • 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) • Continue the recruitment process to employ a Fire And Security Officer. • Continue to raise the profile of the Security Officers and review their work routines. • Hold a fire and security awareness roadshow. • Recruit a Fire Safety Officer / Local Security Management Specialist. • Develop a programme of increasing fire precaution awareness and instil a fire safety culture within the organisation.	Mark Masters

Action	Responsible Person /Lead
• Assess current management procedures and review competencies. • 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 "year two" action plan (07/08) financial year and submit to the LFEPA for approval and comments. • Continue to monitor compliance against the HSE action plan. • Continue to embed and nurture a safety culture within the Estates Department. • Complete the Building Management System extension. • 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.	Mark Masters
• 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

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; • Agree specialist Orthopaedic tariff adjustments for 2008/9 with Department of Health and model implications for 2009/10 of move to new HRGv4 tariff; • 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."	

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 2006 – 2007. 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.