RISK MANAGEMENT ANNUAL REPORT

Date: May 2006

Author: **Michelle Nolan** **Risk Manager**

CONTENTS

FIGURES

TABLES

1.0 Introduction

The report covers the period of the 1st April 2005 to the 31st March 2006.

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 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.

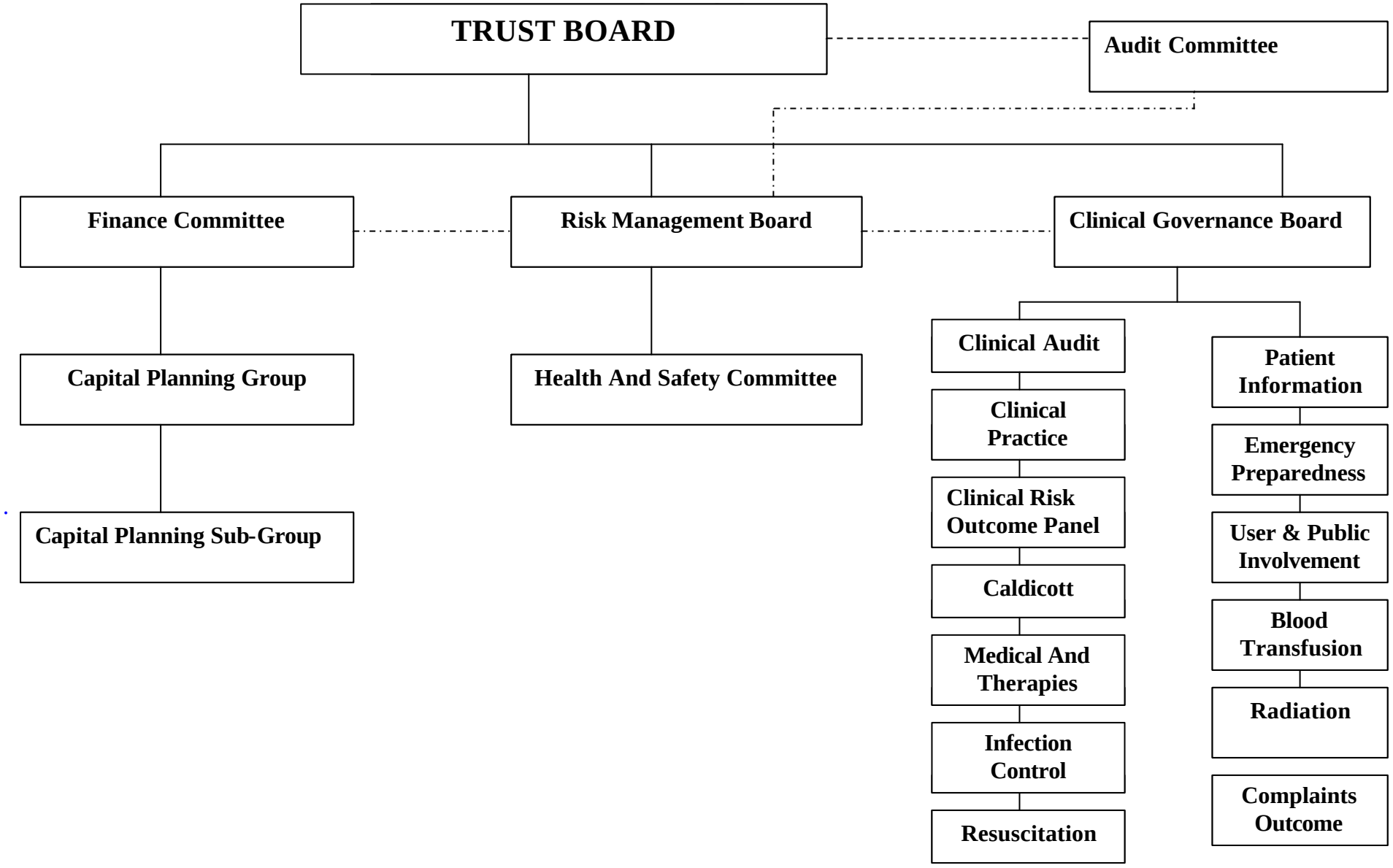
2.1.1 Key Targets: 2006 – 2007

- 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.

- 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.

Figure One: Organisational Structure For Managing Risk Within The Trust



2.2 Risk Pooling Scheme For Trusts (RPST)

The RPST Risk Management Standard which assessed NHS bodies' general approach to risk management was withdrawn by the NHSLA at the end of March 2005. However, key elements of the Standard will be incorporated into the revised approach to NHSLA standards and assessments.

2.2.1 Key Targets: 2006 – 2007

- Continue to monitor the progress of the NHSLA in the implementation of the new standards and assessment process through the NHSLA website.

- 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

2.3 Clinical Negligence Scheme For Trusts (CNST)

Formal assessment for CNST level 2 took place on the 1st and 2nd December 2004. Every Trust had to be assessed against the Standards at least once in any two-year period however, the NHS Litigation Authority are currently changing the way that CNST is assessed. The assessments will now take place within a three year period and standards will incorporate a broader criteria, (for example, including RPST). The standards for CNST assessments are therefore changing and should be available for all Trusts in the next few months. A pilot assessment for the new standards has been offered to some Trusts. The Royal National Orthopaedic Hospital has been successful in its application to trial this pilot, and await progression from the NHSLA.

2.3.1 Key Targets: 2006 - 2007

- To undertake a pilot assessment in preparation for level 3 assessment.

- To work towards achieving CNST level three.

2.4 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 2.5.) This enables NHS organisations to bring together good risk management practice and link it directly to continuous quality improvement and improve patient care.

The Trust decided to undertake a self assessment against each of the controls assurance standards this year, so that progress could be monitored. Table Two provides details of the scores for each standard and compares them with previous years scores.

Table One: Comparison Of Controls Assurance Scores (2001 – 2006)

Standard	Score 2001	Score 2002	Score 2003	Score 2004	Score 2005	Score 2006
Buildings, land, plant and non-medical equipment	50	68	70	74	82	85.3
Catering and food hygiene	56	92	100	96.2	98.1	98.8
Decontamination of re-usable medical devices	49	34	88	87.1	92.1	
Emergency planning	89	31	72	67.5	84.2	79.6
Environmental management	65	60	39	45	67.5	83
Financial management		87	85	85.4	81.6	82.5
Fire safety	63	74	78	88.5	88.5	89.3
Fleet and transport management	3	12	32	43.7	41.3	54.7
Governance		72	75	81.4	85	86.7
Health and safety management	52	73	79	83.5	88.8	91.6
Human resources	63	82	86	91.1	94.4	96.5
Infection control	82	76	67	85.7	93	83.9
Information management and technology	70	91	96	97.8	61.1	
Medical devices management	75	75	75	75.6	70.3	74.9
Medicines management	88	81	77	73.7	71.4	74.7
Professional advice and services	36	48	52	54.4	57.2	57.2
Management of purchasing and supply	40	60	62	59.3	57.9	57.9
Records management	63	46	31	50.9	51	35.5
Research governance				73.2	76.2	79.4
Risk management	77	66	86	95.6	96.3	97
Security management	13	28	85	90.8	91.3	90
Waste management	90	84	91	93.3	87.3	86
Overall (all standards)	59	64	73	78.4	79.7	79.2

2.4.1 Key Targets: 2006 - 2007

- Continue to work towards implementing the action plan associated with each of the twenty-two standards.

2.5 Standards For Better Health

The Healthcare Commission has developed a new system for assessing public and private Health Services in England. The system aims to reduce regulatory burden, while giving the public a more accurate picture of performance. It will for the first time offer patient and public representatives a formal role in judging the quality of services.

The new system, or annual health check, looks at a much broader range of issues in the assessments, enabling the focus to be on measuring what matters. The aim is to paint a richer picture than ever before of what is happening in healthcare – putting the onus on the healthcare organisation to make sure that they are meeting the expected standards of performance, while also checking assessments with others in the local community and beyond. The annual health check has replaced the old 'star rating' assessment system.

2.5.1 Purpose

Each Trust must complete a declaration of their performance against 24 Core Standards. This will be cross checked against a range of data sets that have national coverage and information from other regulators and 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.

For 2005/2006 Trusts were required to complete a draft declaration in October 2005 and the final declaration in April 2006. The aim of the draft declaration was to ensure that:

2.5.2 Standards Not Met/Insufficient Assurance

Of the 24 Core Standards the Trust believes it has met 20 standards. However the Trust plan to report that we have not met 3 standards.

2.5.2.1. Standards Not Met

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 action plan to meet compliance for this standard is addressed in the plan for the Strategic Development of Paediatric Services.

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

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

The action plan to meet compliance with this standard is the redevelopment of the Trust.

2.5.2.2 Insufficient Assurance

C6 Healthcare organisations cooperate with each other and social care organisations to ensure patients' individual needs are properly managed and met

This relates to the Trusts current networking assessment as identified by Sir John Temple. Directors of the Trust are meeting with the SHA Directors to determine the way forward. Subsequently an action plan will be developed.

However progress has been made and the in the April 2006 the Trust will declare that they have met this Standard.

2.5.3 Conclusion

The Trust has undertaken a comprehensive review of its performance against the 24 Core Standards for the period April 2005 –March 2006. The evidence collected has been and is being discussed widely with internal and external stakeholders. Overall the self assessment along with the recent Sir John Temple report confirms that the Trust continues to provide a high quality and safe clinical service.

2.5.4 Key Targets: 2006 - 2007

- Ensure that the core standards 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.

- Develop action plans to progress compliance with the developmental standards.

2.6 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; -

- All key users have received training to use the database. The training has included extractor training.
- The previously used databases for training, clinical incidents, non-clinical incidents, PALS, claims and complaints have being transferred to Safeguard.
- All reported incidents have being entered onto the database since 1st April 2005.
- The incident form to be used for e-reporting has being designed.
- The process of cascading access to the database out throughout the organisation has begun.

2.6.1 Key Targets: 2006 – 2007

- Transfer the Trusts corporate risk register to the Safeguard database.
- Transfer the assurance framework to the Safeguard database.
- Arrange training for the risk module for the executive team and their nominated deputies.
- Launch e-reporting throughout the Trust and support with workplace training.
- Ensure that all wards/departments have access to Safeguard.
- Facilitate the development of local risk registers.

2.7 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) and the Board itself (quarterly).

2.7.1 Key Targets: 2006 - 2007

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

- Ensure that the assurance framework is fully embedded.

- Implement the associated action plans.

2.8 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 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.

2.8.1 Key Targets: 2006 – 2007

- Transfer the current corporate risk register onto the Safeguard risk management database and arrange training for key users.

- Implement the integrated risk management system throughout the organisation to facilitate the development and ownership of local risk registers.

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

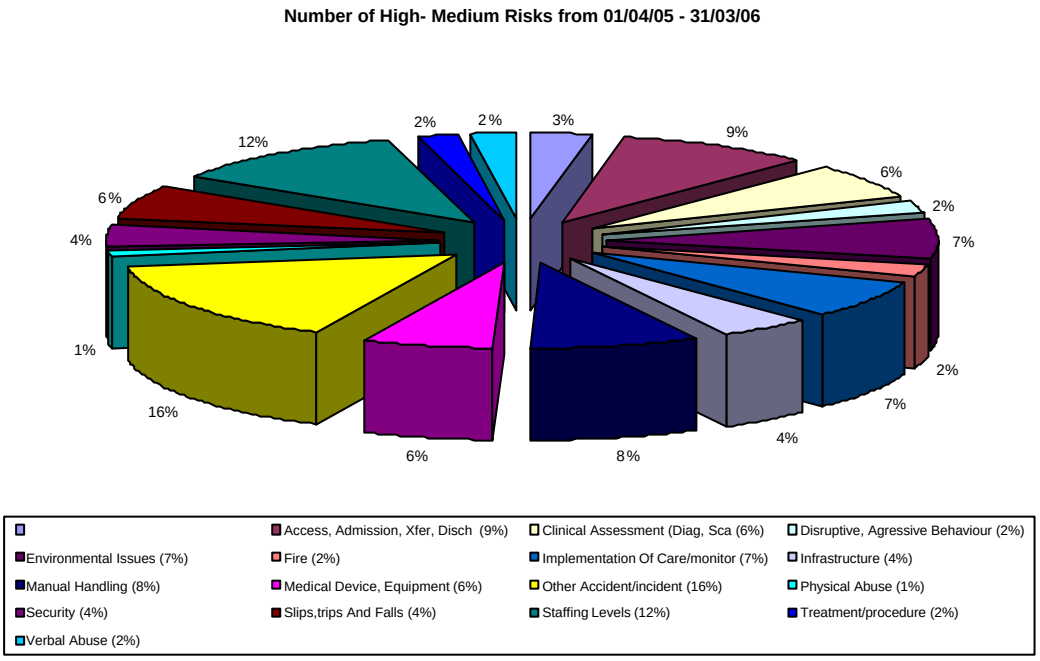
- Ensure that all staff are aware of how to submit items for inclusion on the risk register and that they are provided with adequate information as to the progress of action plans. Excellent two way communication is essential.

2.9 Incident Reporting

In all 3487 incidents were reported between 1st April 2005 and 31st March 2006. There was one reported category red clinical incident which relates to the reporting of

x-rays and there have been 94 reported amber incidents. 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.

Figure Two



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.

2.9.1 Key Targets: 2006 – 2007

- To successfully promote and nurture the new Ulysses database within the Trust, using the opportunity to re-launch incident reporting.

- 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.

- 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.

2.10 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 Seven Steps to patient safety, and Root Cause Analysis.

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).

One of these Alerts highlighted to the Trust the problems with the insertion of nasogastric tubes, which has led to changes in policies and procedures. They have also advised the Trust on Correct Site Surgery procedures which have been distributed to all consultants and are being discussed by Medical Directors and consultants for any changes in practice. The NPSA advised the Trust to develop a Latex policy and a Being Open policy, which are currently being written.

The NPSA have also set up their National Reporting and Learning System (NRLS), whereby all clinical incidents are reported to this centralised database to study trends nationally. So far the Trust have reported 2200 incidents nationally and will continue to do well in the coming year.

2.10.1 Key Targets: 2006 - 2007

- To continue Trust-wide audit and inspection of all clinical areas.
- To deliver a Root Cause Analysis workshop for all senior staff within the Trust.
- To undertake clinical audit as required.
- To implement all NPSA recommendations and participate in the central reporting of clinical incidents.

2.11 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 a non-diagnosis of osteomyelitis, psychological injury, clinical outcome to shoulder surgery, and paralysis caused as a result of a nerve root block injection. Themes in Employers Liability Personal Injury claims this year were manual handling, assault on staff, equipment failure, burns and scalds and falls/slips/trips. We received very few Public Liability claims, the main theme being falls/slips/trips.

The Risk Management Board reviews all claims. All new medical negligence claims are taken to the Clinical Risk Outcome Panel.

The Customer Care Manager is also responsible for complaints handling co-ordination throughout the Trust. The Trust has an established Complaints Procedure Policy based on the NHS Complaints Procedure Directions. The Trust emphasises local ownership of complaints and offers staff comprehensive training and advice on complaints handling through Customer Care Training, 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. Commencing April 2005 all Complaints and Claims are risk classified through the Trust's Risk Classification Matrix.

2.11.1 Key Targets: 2006 – 2007

- 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.

- 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.

- 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.

2.12 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 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.

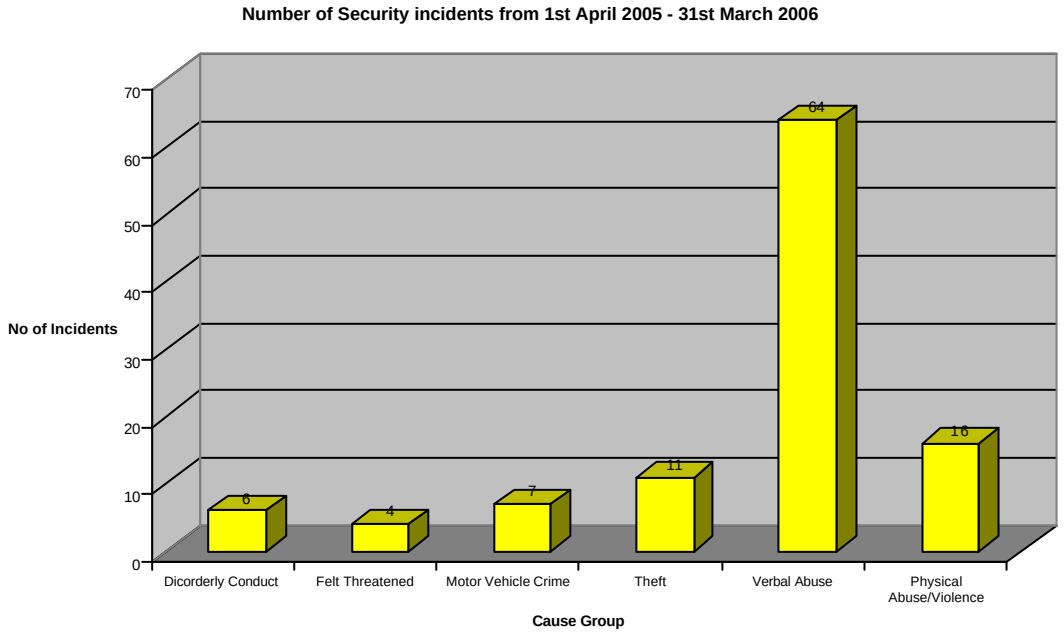
- The Safe Handling Of Patients Valuables Policy has being reviewed. (awaiting Board approval)

- Funding for the provision of ward safes has been ring fenced.

- The patients valuables receipt book has been reviewed and amended.
- Security issues are addressed during the induction process.
- Personal alarms are available to all staff.
- Security Officers have received training in line with statutory requirements.
- The two nominated Local Security Management Specialists have attended training (4.5 week accreditation course) provided by the Counter Fraud And Security Management Service.
- Conflict Resolution training sessions have continued and are available for frontline staff.
- The Trust is a member of the NPAG Security Benchmarking Club.
- The business case to appoint a Fire And Security Management Specialist has been approved.
- Work has commenced to develop the profile of the Security Officers.

In total, 108 security related incidents were reported between the 1st April 2005 and the 31st March 2006 compared to 102 during the 1st April 2004 – 31st March 2005. The number of categories of incidents are detailed in Figure Three.

Figure Three: Number And Type Of Security Related Incidents Reported.



2.12.1 Key Targets; 2006 – 2007

- Review and seek Board approval of the corporate Security Management Policy.
- Review and seek Board approval for the Zero Tolerance Policy.
- Develop a Lone Worker Policy.
- Review the Handling Of Controlled Drugs Policy. Seek Board approval and implement.
- Update security section of the local risk management handbooks.
- Update the Incident Reporting Policy to incorporate the requirement to report incidents of physical assaults to the appropriate CFSMS operational managers.
- Review security related risk assessments.
- Continue to collate information to develop a comprehensive asset register.
- Hold a security awareness roadshow to raise awareness throughout the Trust.
- Launch a Hospital Watch scheme.
- Provide all wards with their own safe to ensure the safety of patients valuables.
- Install CCTV along the slope corridor.
- Recruit a Fire Safety And Security Management.
- Develop key indicators, monitor and review.
- Liaise with the Redevelopment Team and the Crime Prevention Unit to ensure that "Security By Design" principles are considered when planning the new hospital.

2.13 Fire

From October 2006 it is anticipated that the Regulatory Reform (Fire Safety Order) will give 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.

In line with these changes to legislation the LFEPA implemented an entire site inspection programme and subsequently issued the Trust with an Enforcement Notice. The summary of the notice is as follows:

The main areas of concern are:

- Accommodation – both staff and guests fall below acceptable standards.
- Control measures for fire varies between departments.
- Poor standards of services and lighting on external escape routes

The following action has been taken and the LFEPA have signed off the enforcement notice; -

Strategic Fire Safety Review
Lawrence Webster Forrest (Fire Engineering and Fire Risk Management Consultants) were appointed to develop a strategic fire safety review. The purpose of the review was to establish the fire risk exposure levels throughout the organisation and to prepare an indicative fire risk prioritisation of fire risk management measures.

The report defines priorities for physical and management fire precautions which are given in terms of immediate, medium and longer term. The report recommends that aggregated fire risk (physical and management) considered as high are implemented within three months and fire risks considered medium are implemented within eighteen months. Other moderate fire risks are to be addressed as soon as logistics and budget allow.

Fire Safety Officer / Local Security Management Specialist
Executive approval has been obtained to recruit a Fire Safety Officer / Local Security Management Specialist. The purpose of this role can be summarised as:

- To manage all aspects of fire safety and security management throughout the Trust.
- To provide training to all staff and to provide expert advice and guidance regarding security issues and fire safety with regards to fire safety legislation, Firecode, Places Of Work (Fire Precautions), Regulatory Reform (Fire Safety) Order.
- To act as the Trusts specialist for all fire safety matters and contribute to the development of Trust strategy and implementation of effective processes and systems.

Ring Fencing of Capital
It has been agreed that year on year 20% (approximately £200k) will be ring fenced from the capital programme. This money will be used to improve passive and active fire precautions throughout the organisation. In order to facilitate the development of a comprehensive action plan the Trust will employ a specialist to develop specifications which will detail the actions required to bring all areas of the site within the Trusts control up to benchmark standards.

Fire Risk Assessment
The fire risk assessment relating to Bolsover Street has been reviewed in line with a request from the LFEPA which was received on the 3rd February 2006.

A programme of fire risk assessment review will commence when the Fire Safety Officer / Local Security Management Specialist has been recruited. It is anticipated that the recruitment process will take approximately three months. The review will commence with the residential areas and then the healthcare provision departments and finally any other remaining departments.

Fire Instruction Signs
In order to facilitate the provision of clearly defined escape routes, fire instruction signs have been replaced throughout the site.

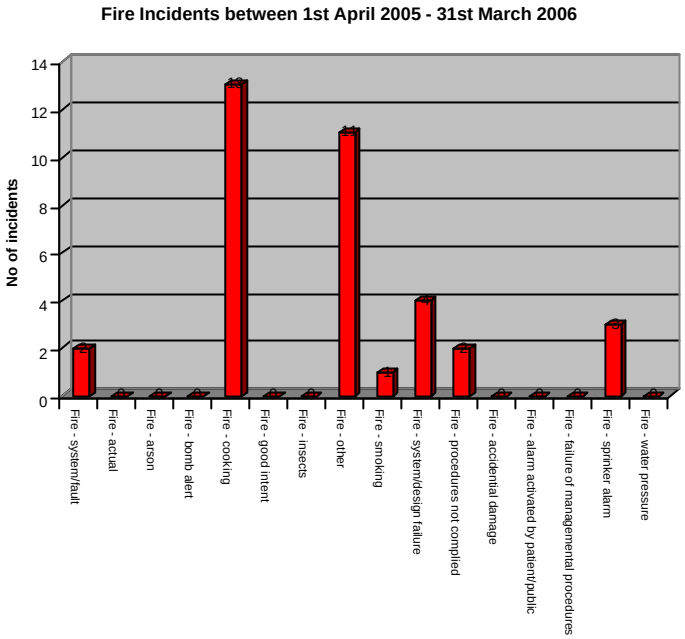
Fire Drill Programme
A fire drill programme for 2006 and record log has been agreed.

Night Site Visits
The Risk Manager and Accommodation Manager will undertake a night site visit every three months. The first visit was scheduled for the 31st March 2006. These visits will also include fire drills within accommodation blocks.

Letter Of Intent
Harrow Council visited Louis Fleishmann Nursing Home on the 5th January 2006 and served a letter of intent. The Trust has fulfilled the requirements of this letter and the Environmental Health Officer with whom we were liaising has closed the file. As a result of this letter of intent battery operated smoke detectors have being fitted in residences where there was no fire detection as an interim measure and security patrols have been increased.

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 2005 – 31st March 2006 36 unwanted fire signals reported through incident reporting, but according to Medirest records 134 unwanted fire alarms were activated.

Figure Four: Reported Unwanted Fire Signals



2.13.1 Key Targets: 2006 – 2007

Implement a programme of physical improvement works. Develop the scope of works for active and passive improvements. Tender project and carry out works.

- 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.

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

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 has been agreed; -

- The Estates Manager provides the Risk Management Board (meets every eight weeks) with a progress report at each meeting. The extracts from the minutes of the meetings will be forwarded to the HSE for their information.

- 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.

2.14.1 Key Targets: 2006 – 2007

- Continue to monitor compliance against the HSE action plan.

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

2.15 Emergency Planning

The Major Incident Procedure for the Trust has been reviewed and revised following the Major Incident Planning Group meetings and staff training. The Major Incident Planning Group continues to use the Controls Assurance Standards to monitor progress.

The Major Incident Procedure was put into place on 7th July 2005 when the London Transport system was attacked by Terrorists. The Trust stopped all elective surgery for the day and declared that it was able to receive ITU patients from other hospitals if required. The Major Incident Procedure was reviewed again following this.

2.15.1 Key Targets: 2006 – 2007

- To review the Bolsover Street Major Incident Policy.

2.16 Manual Handling

The income generation work has continued and has secured a contract with a Higher Education Institution.

The Patient Handling Risk Assessment Tool was launched on July 1st 2005 to all wards. Teaching sessions were undertaken for link nurses and other multi-disciplinary team workers. The link nurses then trained their own ward staff, the Manual Handling Team supported all parties during this time by attending ward meetings as requested.

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 Pre Admission clinic staff contact the Manual Handling Department by e-mail to inform them of patients with complex handling needs.

General course for patient handling 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.

2.16.1 Key Targets: 2006– 2007

- To undertake an 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 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
- Provide each Ward / Department with a manual handling file. This file will contain appropriate polices and procedures, product information, training records etc.
- Plan and deliver manual handling training programme for Doctors
- Continue facilitating Ward and Departmental risk assessments

2.17 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.

2.17.1 Key Targets: 2006 – 2007

- 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.

- Develop local risk registers.

2.18 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 eight departments have been audited during 1st April 2005 and 31st March 2006 and eight inspections have been completed.

Table Two: Completed Audits And Inspections

Audits	Inspections
• Ward 4 • Theatres • TSSU • Clinical Neurophysiology • Orthotics • Physiotherapy • Purchasing • SIU (Spinal Injury Unit)	• DOG (Duke Of Gloucester Ward) • PPU (Private Patients Unit) • Clinical Neurophysiology • Purchasing • Orthotics • Occupational Therapy • SIU (Spinal Injury Unit) • Ward 9

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.

2.18.1 Key Targets: 2006 – 2007

- 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 2006.

Table Three: Audit And Inspection Schedule For 2006

Anticipated Month Of Visit	Audit	Inspection
January	Phillip Newman Ward	Supplies
February	Community Liaison	ADU
March	Clinical Engineering	Coxen
April	Angus Mackinnon Ward	Rehab Ward
May	CT Scanning	SIU

Anticipated Month Of Visit	Audit	Inspection
June	Finance	Ward 4
July	Medirest	TSSU
August	Teaching Centre	Physiotherapy
September	Pharmacy	Theatres
October	Pathology	X-Ray
November	Estates	Bolsover Street
December	IT	JBW

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.

2.19 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.
- Controls assurance scores.
- 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)

2.19.1 Key Targets: 2006 – 2007

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

2.20 Training

The provision of information, instruction and training is an important means of achieving competence and help 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 will be 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
    - Role of the Health And Safety Executive.
    - Role Of The Medicines And Healthcare Products Regulatory Agency
    - Risk management strategies throughout the organisation.

- *Risk Officer Seminars*
  Each session is aimed to providing support and guidance to Risk Officers / Risk Facilitators in implementing the risk management strategy.

- *Fire Safety Awareness*
  All staff must attend this session on an annual basis to ensure that they are aware of the Trusts 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.

- *Clinical Risk Management And An Introduction To Clinical Audit*
  This course is open to all clinical staff and aims to give a broad overview of the Trust's clinical risk strategy and incident reporting system and to help people understand the importance of clinical risk management.

- *Excellence In Customer Care*
  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.

- *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 loads as well as the principles of ergonomic assessments.

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

- *Corporate Induction*
  Corporate induction has been extended to one week and includes all mandatory training sessions.

Table Four summarises the attendance on mandatory training between the 1st April 2005 and the 31st February 2006.

Table Four: Attendance On Mandatory Training (1st April 2005 – 31st February 2006)

Course	Total Participant Involved	Participant Cancellation	Attended	Course Cancelled (No of participants)	Unattended
Managing Risk	68	18	21	16	13
Patient Handling Induction	181	42	111	19	9
Patient Handling Refresher	284	46	153	14	71
Load Handling	71	13	30	15	13
Corporate Induction	356	22	165	0	169
Fire Training	545	86	261	61	137
Excellence in Customer Care	173	30	68	50	25
Clinical Governance	33	5	16	12	2
Infection Control	553	61	377	8	107
Conflict Resolution	12	4	6	0	2
Basic Life Support	552	68	155	155	106
Valuing Diversity	119	7	63	21	28

2.20.1 Key Targets: 2006 - 2007

- 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.

2.21 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.

2.21.1 Key Targets: 2006 – 2007

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

2.22 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;

- D.S.E. – Display Screen Equipment Policy And Self Assessment Tool

- Fire Safety

- Risk Management Strategy

- Smoke Free Policy

- Safe Handling Of Patients Valuables

- Mercury Spillage Procedure

The documents listed below are currently in draft form; -

- Procedure For The Management And Care Of Patients And Visitors Who Are Violent, Abusive And Disorderly.

- Security Management

2.22.1 Key Targets 2006 – 2007

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

- Risk Management Strategy

- Incident Reporting

- Mobile Telephone And Handset Policy

2.23 Introducing A Smoke Free Environment

The public health white paper, "Choosing Health" makes a clear commitment to a smoke free NHS by the end of 2006.

The Trust had a staggered implementation plan, with the introduction of two external designated areas for smokers from the 1st November 2005. However, the blanket ban was introduced on the 1st January 2006.

To facilitate the implementation of this initiative, the following action has been taken; -

- A Smoke Free Policy has been approved by the Board.
- Two champions have been nominated – Director Of Human Resources, Mark Vaughan (non-clinical champion) and the Medical Director, Nan Mitchell (clinical champion)
- Resource and information folders have been developed and provided to all wards.
- The Smoke Free Working Party met on a monthly basis throughout the implementation period.
- Harrow PCT Smoking Cessation Services provide smoking cessation support sessions for staff.

2.24 Financial Risk

Following a significant over spend in the financial year 2004/05 of £3.8m the Trust faced the significant challenge of not only breaking even in 2005/6 but also repaying the accumulated deficit. The overspend compounded historic cash flow pressures which continued to put at risk the ability of the Trust to pay suppliers on a timely basis.. A balanced financial plan was eventually agreed in the autumn of 2005/6. This was dependent on delivering significant NHS activity above previous years to meet the 6 month inpatient access target as well as a £2.4m cost improvement programme which included reduced capacity such as the closure of 1 ward from Christmas onwards.

Audit reports have highlighted issues Managers have with the financial information provided and these are being addressed in order to ensure the highest quality information to support the delivery of statutory financial duties. This has been supported by more detailed work on longer term financial planning issues which have provided the strategic context within which detailed budgets are set on an annual basis.

2.23.1 Key Targets: 2005/6 and 2006/7

- 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

- Agree the financial plan and budget prior to the start of the financial year to ensure cost improvement programmes are delivered on time

- 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.

- Continue roll out of budgetary control policies such as

    1. Bank & Agency staffing review groups
    2. Vacancy Control Panel to ensure all appointments are within establishment
    3. Escalate non-pay authorisation limits in overspending areas

- 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

- Establish developmental plans and training programmes for Finance staff.

2.25 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.

2.25.1 Key Targets: 2006- 2007

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

2.26 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 2040 Control Of Legionaires Disease

- HTM2025 Piped Medical Gas Systems

- PEAT

- HTM 2011 Generator Testing

- HTM 2025 Ventilation Systems In Healthcare Premises

Many estates related policies have been reviewed / updated and approved by the Trust Board. These are now viewable on the Trusts intranet system. Last years capital programme was frozen due to financial pressures and therefore the only major project completed was Adolescent Ward extension and refurbishment using donated funding.

2.26.1 Key Targets: 2006- 2007

- Implement the energy reduction measures.

- Carryout physical fire improvement work to residences.

- Maintain the Trusts “green” status for PEAT inspections.

- Undertake additional legionnaires disease prevention work.

- Implement a car parking strategy.

- Relocate IT building and dispose of surplus land and properties
- Carryout out toilet refurbishment works in various patient areas
- Improve the Trusts management of Waste.
- Complete HSE Action Plan

3.0 Progress Against Action Plan For 2005 – 2006

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

Table Five: Summary Of Risk Management Action Plan (2004 – 2005)

Action	Responsible Person / Lead
• Continue to monitor and review the risk management organisational structure. (ON-GOING) • Annually review the work of the Risk Management Board, 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 towards achieving the recommendations made in the last RPST assessors report. (ON-GOING) • Monitor the progress of the NHSLA in the implementation of the new Standards For Better Health and assessment process. (ON-GOING) • Continue towards implementing the action plan associated with each of the twenty two controls assurance standards. (ON-GOING) • Continue to monitor and review the assurance framework.(ON-GOING) • Implement action plans associated with the assurance framework. (ON-GOING) • Ensure that the corporate 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. (ON-GOING) • Provide Conflict Resolution training for all frontline staff. (ON-GOING) • Review the Zero Tolerance Policy. (WORK HAS COMMENCED BUT NOT COMPLETED)	Mark Vaughan

Action	Responsible Person / Lead
• Continue with the programme of fire drills. (ON-GOING) • Review the fire risk assessments. (WORK HAS COMMENCED BUT NOT COMPLETED) • Review and implement the fire policy and procedures. (COMPLETED) • Introduce workplace specific fire training. (ON-GOING) • Continue to work towards reducing the number of unwanted fire signals. (ON-GOING) • Implement the Safeguard training module of the new integrated risk management database. (COMPLETED) • Continue to work towards embedding the risk identification tools throughout the organisation. (ON-GOING) • Review corporate induction arrangements to ensure that all mandatory training is covered. (COMPLETED) • Develop a system to highlight and deliver training needs of those acting up or those who have been promoted. (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 develop local risk registers. (WORK HAS COMMENCED BUT NOT COMPLETED) • Review the audit / inspection tools annually.(ON-GOING)	Mark Vaughan

Action	Responsible Person /Lead
• Ensure that a minimum of one inspection and one audit is undertaken each month. (ON-GOING) • Review location and content of first aid boxes. (COMPLETED) • Ensure that all wards/departments have details of who the first aiders are and how they can be contacted. (COMPLETED) • Seek agreement on the out of hours provision of first aid. (OUTSTANDING) • Review the Risk Management Strategy (annually) (ON-GOING) • Develop and implement the Smoke Free Policy. (COMPLETED) • Launch the Smoke Free Working Party. (COMPLETD) • Nominate a clinical champion in relation to introducing a smoke free environment. (COMPLETED) • 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
• Work towards achieving CNST level three. (ON-GOING) • Undertake clinical audits as required. (ON-GOING) • Implement all NPSA recommendations and participate in the central reporting of clinical incidents. (ON-GOING) • Continue to progress the Essence Of Care standard regarding the Safety Of Mental Health Patients in general / acute hospital settings. (ON-GOING)	Anthony Palmer

Action	Responsible Person/Lead
• Revise the Legal Services And Procedures Policy to include the risk classification matrix. (COMPLETED) • Revise the Complaints Procedure to include the risk classification matrix and the new directions for the Independent Review Stage. (COMPLETED) • Re-vamp the Customer Care training programme to offer a more fundamental approach. (ON-GOING) • Training awareness initiatives are to be set in all clinical areas to ensure that staff use the appropriate procedures and act upon complaints. (ON-GOING) • Review all concluded litigation claims individually by the staff involved to ensure that the Trust progresses any actions / recommendations. (ON-GOING) • Launch the revised Patient Handling Risk Assessment Tool, accompanied by staff training. (COMPLETED) • Complete and launch the Policy For Safer Handling Of Heavy Patients. (COMPLETED) • Continue to provide ergonomic input into the re-development plans for the new PFI hospital. (ON-GOING) • Develop a patient referral system whereby Pre-Admission Clinic staff can refer patients to the Manual Handling Service. (COMPLETED) • Provide each ward / department with a manual handling file. (COMPLETED) • Plan and deliver manual handling training programmes for doctors. (ON-GOING)	Anthony Palmer

Action	Responsible Person/Lead
• Continue with manual handling mandatory training in more general clinical groups and review this delivery after six months. (ON-GOING) • Continue to facilitate ward / departmental manual handling assessments. (ON-GOING) • For all Senior Mangers and Site Managers to have attended Major Incident Training. (ON-GOING) • To continue regular testing both live and tabletop run throughs. (ON-GOING) • To review the Bolsover Street Major Incident Policy. (WORK HAS COMMENCED BUT NOT COMPLETED) • Communications to review and update Staff Contact lists quarterly. (ON-GOING)	Anthony Palmer
• Ensure that the core standards within Standards For Better Health are met. (ON-GOING) • Develop action plans to progress compliance with the developmental Standards For Better Health (COMPLETED) • Arrange for data on all the current in-house built databases to be transferred to Safeguard. (COMPLETED) • Commence the entering of all incidents from the 1st April 2005. (COMPLETED) • Design and launch the e-report form. (WORK HAS COMMENCED BUT NOT COMPLETED) • Arrange Safeguard extractor training for all key users. (COMPLETED) • Promote and nurture the new Safeguard database throughout the Trust. (ON-GOING) • Continue to report changes in policy/practice to staff as a result of incident reporting in Articulate. (ON-GOING)	Mark Vaughan / Anthony Palmer

Action	Responsible Person/Lead
• Agree a process for the local resolution of risk management issues identified through report forms to replace the function of the Incident Reporting Group. (OUTSTANDING) • Provide all users with access to the Safeguard risk management system via their PC's. (ON-GOING) • Provide training to all users and raise awareness regarding incident reporting and the development of local risk registers. (ON-GOING) • Review and where necessary develop key indicators so that all risks are considered equally. (ON-GOING) • Review training needs of Site Managers. (OUTSTANDING)	Mark Vaughan / Anthony Palmer
• Monthly attention by the user – the emergency generators should be started up once a month by a simulation of a failure of the normal power supply, and allowed to energise the fire alarm supply for at least one hour. The fire alarm system should be monitored to identify any malfunctioning caused by the use of the generator. (ON-GOING) • Implement the energy reduction measures. (ON-GOING) • Continue with the road refurbishment work. (WORK HAS COMMENCED BUT NOT COMPLETED) • Maintain the Trusts "green" status for PEAT inspections. (ON-GOING) • Undertake additional legionnaires disease prevention work. (ON-GOING) • Obtain Board approval for the reviewed estates policies and procedures. (COMPLETED) • Address the Disability Discrimination Act requirements. (OUTSTANDING)	Mark Masters

Action	Responsible Person/Lead
• Introduce a clearly defined management structure and budgetary responsibilities. (COMPLETED) • Ensure accountability and responsibility are closely aligned in relation to budget management. (COMPLETED) • Develop and implement a variety of staff training programmes for budget managers. (ON-GOING) • Establish developmental plans and training programmes for Finance staff. (ON-GOING)	Rob Hurd

4.0 Summary Of Action Plan For 2006 – 2007

Table Six provides a summary of the risk management action plan for 2006 – 2007.

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

Action	Responsible Person/Lead
• Transfer the assurance framework to the Safeguard database. • Implement the integrated risk management system throughout the organisation to facilitate the development and ownership of local risk registers. • Ensure that the risk register is holistic and comprehensive by widening the information sources used to compile the data. • 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. • Continue to monitor and review the assurance framework so that it is maintained as a dynamic document. • Ensure that the assurance framework is fully embedded and implement the associated action plans. • Arrange training for the risk module for the executive team and their nominated deputies. • Facilitate the development of local risk registers. • Ensure that a minimum of one inspection and one audit is undertaken each month. Table Four exhibits the audit / inspection schedule for 2006. • 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.	Mark Vaughan

Action	Responsible Person/Lead
• Continue to work towards implementing the action plan associated with each of the twenty-two controls assurance standards.	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. • To undertake a pilot assessment in preparation for CNST level 3 assessment. • Continue to monitor the progress of the NHSLA in the implementation of the new standards and assessment process through the NHSLA website. • 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. • 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. • Review training needs of Site Managers and deliver. • Develop action plans to progress compliance with the developmental standards. • Continue to provide ergonomic input into the redevelopment plans for the new PFI hospital build • 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 • To review the Bolsover Street Major Incident Policy.	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. • 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. • 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. • To continue Trust-wide audit and inspection of all clinical areas. • To deliver a Root Cause Analysis workshop for all senior staff within the Trust. • To implement all NPSA recommendations and participate in the central reporting of clinical incidents.	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. • Launch e-reporting throughout the Trust and support with workplace training. • To successfully promote and nurture the new Ulysses database within the Trust, using the opportunity to re-launch incident reporting.	Mark Vaughan / Anthony Palmer

Action	Responsible Person/Lead
• Continue facilitating Ward and Departmental risk assessments. • Ensure that all wards/departments have access to Safeguard.	Mark Vaughan / Anthony Palmer
• Continue to monitor compliance against the HSE action plan. • Continue to nurture and embed a safety culture within the Estates Department. • Implement a programme of physical improvement works. Develop the scope of works for active and passive improvements. Tender project and carry out works. • Implement the energy reduction measures. • Carryout physical fire improvement work to residences. • Maintain the Trusts “green” status for PEAT inspections. • Undertake additional legionnaires disease prevention work. • Implement a car parking strategy. • Relocate IT building and dispose of surplus land and properties • Carryout out toilet refurbishment works in various patient areas • Improve the Trusts management of waste. • Complete HSE Action Plan	Mark Masters

Action	Responsible Person/Lead
• 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. • Review and seek Board approval of the corporate Security Management Policy. • Review and seek Board approval for the Zero Tolerance Policy. • Develop a Lone Worker Policy. • Review the Handling Of Controlled Drugs Policy. Seek Board approval and implement. • Update security section of the local risk management handbooks. • Update the Incident Reporting Policy to incorporate the requirement to report incidents of physical assaults to the appropriate CFSMS operational managers.	Mark Masters

Action	Responsible Person/Lead
• Review security related risk assessments. • Continue to collate information to develop a comprehensive asset register. • Hold a security awareness roadshow to raise awareness throughout the Trust. • Launch a Hospital Watch scheme. • Provide all wards with their own safe to ensure the safety of patients valuables. • Install CCTV along the slope corridor. • Recruit a Fire Safety And Security Management. • Develop key indicators, monitor and review. • Liaise with the Redevelopment Team and the Crime Prevention Unit to ensure that "Security By Design" principles are considered when planning the new hospital.	
• 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. • 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	Rob Hurd

Action	Responsible Person/Lead
• Agree the financial plan and budget prior to the start of the financial year to ensure cost improvement programmes are delivered on time • 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. • 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 • 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 • Establish developmental plans and training programmes for Finance staff.	Rob Hurd

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 2005 – 2006. 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.