Agenda Item No: 66/04

West Hertfordshire Hospitals NHS
NHS Trust

Report From:	Director of Nursing, Midwifery, Quality & Risk
To:	Trust Board ~ 1st July 2004
Subject:	Risk Management
Action:	To Note Contents

Risk Management Progress Report

1. The Trust Board discussed the progress of Risk Management arrangements at its meeting on the 4th March 2004. This report provides the Board with a further up-date on progress.

2. Minutes of the Risk Management Committee held on 1 April 2004 are attached at ***Annex 1***.

3. The Trust Risk Management Action Plan has been reviewed and updated and is attached in ***Annex 2***. Work in progress is currently on target.

4. The Trust continues to implement the Datix site wide licence. To date over 2,500 incidents (mainly clinical) have been inputted and there are 109 risks on the Risk Register. These figures are likely to increase significantly as the Identification of all types of incidents from the new Single Incident Reporting Form are added to the system. Strategic Risks identified in the Trust's Assurance Framework and Estates Risks are to be added in due course. A process to ensure validity of entries on to the Risk Register has now been agreed and implemented by the Trust.

5. The Single Incident Reporting Form has now been distributed Trust wide and is currently being implemented in all Divisions. Road shows were held on each of the Trust's four sites during May 2004 to further promote this form.

6. An action plan has been produced in response to the RPST assessment attaining Level 1 in February **(Annex 3).** This will ensure 100% compliance before working towards Level 2. It has been reported there will be no Level 2 assessments for level 1 Trusts during 2005, whilst the NHS Litigation Authority revise the standards. The Trust will have an opportunity therefore to be assessed against Level 2 during 2006.

7. An Action plan is being produced following the recent CNST Level 1 assessment in February 2004 in order to take the Trust forward to achieve Level 2 in 2006.

8. The Trust has now been audited against the Controls Assurance three core standards, with the following scores being agreed:

Risk	-	94%
Governance	-	99%
Finance	-	99%

These scores are well above the 75% required as part of the Trust's returns for Controls Assurance.

The Trust submitted its Statement of Internal Control for 2003/4 to the Strategic Health Authority on 14th May 2004. This will now be published in this year's Annual Report and Accounts.

9. The Director of HR recently represented the Trust at an interview under caution with the Health & Safety Executive (HSE). David Firth of Capsticks also attended. The purpose of the interview was to answer questions from the HSE in relation to the inspection undertaken in November 2002 and provide information prior to a decision being made by the HSE on whether to take any further action. The one remaining HSE improvement notice, which relates to the year long programme of manual handling training has been further extended to 31st August 2004.

10. The Trust's Risk Manager has been appointed as the Trust's Safety Alert Broadcasting System (SABS) Liaison Officer. She will be responsible for developing and implementing a process to ensure key safety alerts issued by the Department of Health are appropriately cascaded to relevant individuals in the organisation and that appropriate action taken is fed back and then reported back to the Department of Health by the SABS Officer.

11. A risk assessment facilitated by Britannia was piloted within the Acute Medical Care Division during week commencing 5th April 2004. Subject to post pilot changes to the proforma used, assessments will be rolled out across all Divisions within the very near future.

12. All Risk Leads have been booked on to Root Cause Analysis training workshops to be hosted by the National Patient Safety Agency (NPSA) during the course of the year.

13. The Trust's draft Complaints Policy and Procedure was ratified at the Trust Risk Committee on 1st April 2004, and is available on request.

14. The next Risk Management Committee is scheduled to meet on 29th July 2004 and will report to the Board in December 2004.

The Trust Board is asked to note the above.

Gary Etheridge
Director of Nursing, Midwifery, Quality & Risk

9th June 2004

Annex 1

West Hertfordshire Hospitals NHS
NHS Trust

MINUTES

RISK MANAGEMENT COMMITTEE

THURSDAY, 1st April 2004

Present:	Robin Douglas	Non-Executive Director (Chair)
	Howard Borkett-Jones	Medical Director
	Vince Doherty	Acting Director of Finance
	Gary Etheridge	Director of Nursing, Midwifery, Quality and Risk
	David Law	Director of Strategic Planning
	Nicola Moore	Trust Risk Manager
	Jane Wright	Non-Executive Director
In attendance:	Jacqui Mallard	Divisional Risk Lead, Women's and Neonatal Services
	Jacki Oughton-Hughes	Modern Matron, SCBU
	Lynne Shepherd	Practice Development Nurse, SCBU

		ACTION
1.	**Apologies** Rob Allan, Director of Human Resources, Nigel Coomber, Director of Operations, Celia Richards, Clinical Governance Manager	
2.	**Minutes of Previous Meeting** Minutes from the meeting held on 22nd January 2004 were agreed as correct.	
3.	**Matters Arising**	
	♦ **Consent to Treatment Policy** It was confirmed that the appendix covering Post Mortem, Organ and Tissue retention had been removed from the Consent to Treatment Policy in order to achieve CNST compliance. It was agreed that Nicola Moore and Howard Borkett-Jones should take forward the development of a separate policy to reflect current Department of Health Guidance, with Nicola agreeing to present the policy at the next Risk Committee.	**HBJ/NM**
	♦ **ROCA** It was confirmed that the new controls assurance reporting tool (ROCA) from the DoH was now operational and being utilised by the Controls Assurance leads.	

♦ **Divisional Risk Leads**

It was reported that no further progress had been made on establishing whether or not there should be dedicated risk leads in place throughout all Divisions. Nicola Moore expressed the view that provision of dedicated Divisional Risk Leads across the Trust was key to the organisation meeting its long-term objectives and achieving compliance against the standards set by Controls Assurance, CNST and RPST. This was supported by Gary Etheridge. It was agreed that Nigel Coomber would explore this further with Divisional Managers who did not have a designated Divisional Risk Lead. **NC**

4. **Brief Overview of the Progression of the Risk Agenda**

♦ **Datix**

Nicola Moore reported that the site-wide licence had now been received and the system was currently being implemented across the Trust. There were currently over 2,300 incidents populating the database, with all Divisions having access to the system. A training session to cover advanced reporting had taken place with the Divisional Risk Leads on 24th March 2004. It was noted that a further training session would be required to cover the Version 7 Upgrade to the Datix software.

It was reported that entries on to the Risk Register were growing. Concerns were raised over risks, which were being deleted, and the importance of having a clear audit trail of this process was highlighted. It was requested that an overview of the range of risks on the risk register should be readily accessible to the Executive Team. It was agreed that Nicola Moore would facilitate system training with both Executive and Non-Executive Directors. **NM**

Nicola Moore tabled a graph illustrating the breakdown of incidents currently on the system. It was agreed that this should be an agenda item for the next Divisional Risk Leads Meeting.

It was confirmed that identified risks could be linked to the Trust's strategic objectives on the Datix system.

The Committee agreed that there should be a process of regular reporting by Sub-Risk Committee Chairs at the Risk Committee. It was agreed that this would take the form of written reports, with the first of these being produced for discussion at the next meeting. It was agreed that Nicola Moore would facilitate this process **NM**

♦ **Single Incident Reporting Form**

Nicola Moore updated the Committee on the status of the new Incident Reporting Form. It was confirmed that this would be formally launched Trust-wide within the next few weeks. It was noted that the new form was already being promoted within mandatory risk management training sessions. In addition, posters were being produced and roadshows scheduled across all 4 sites to publicise the launch.

♦ **Quality & Risk Folder**

It was confirmed that the Quality & Risk Folders had arrived in the Trust and would be circulated in May 2004. **NM**

5. **Statutory Responsibilities**

♦ **Controls Assurance**

It was confirmed that Belinda Thompson would be auditing standards during April/May 2004. All Controls Assurance Leads had been advised that action plans should be completed by 30th April 2004.

Concern was raised in relation to Standard 3, Decontamination of re-useable medical devices, where scores had still not been received. Nicola Moore was requested to progress with Rachel Fysh who was confirmed as the new Controls Assurance Lead for this standard. **NM**

It was reported that the Controls Assurance Framework document had been endorsed by the Executive Board on 1st April 2004 and would be submitted subject to review by Belinda Thompson.

Nicola Moore highlighted the effectiveness of the Controls Assurance Forum, highlighting the positive support mechanisms this had established for all Controls Assurance Leads. An updated Risk Management Organisational Structure, including the new CA Forum, was requested by the Chair. Gary Etheridge to review and circulate with the minutes. **GE**

The Committee discussed requirements for incorporating risk management into all job descriptions. Nicola Moore and Rob Allan to progress. **RA/NM**

♦ **CNST & RPST Update**

Nicola Moore provided an overview of the recent CNST Level 1 pass giving a detailed breakdown of scores and areas of high achievement. It was noted that the scoring for medical records standard had improved considerably. Additionally, the work provided by Ian Brookes in formulating the new Medical Devices Policy was recognised by the Committee. A full copy of the CNST Assessment report together with an updated action plan would be distributed with the minutes.

The achievement of RPST Level 1 was briefly reviewed, with it being confirmed that there were approximately 200 Trusts across the country that had still not achieved RPST Level 1. It was agreed that Terms of Reference and membership of the Risk Management Committee should be reviewed in line with RPST guidance and presented at the next Risk Committee. **GE/NM**

The Committee was advised that Willis were in the process of reviewing all RPST standards. As a result assessment at level 2 would not take place until 2006.

The Committee expressed its gratitude to Nicola and all involved in achieving compliance against these two key assessments.

6. **Policies and Procedures**

♦ **Draft Complaints Policy and Procedure**

Gary Etheridge tabled the Draft Complaints Policy and Procedure. Minor amendments to the policy produced for CNST Level 1 had been made by Lynn Hill to reflect local information. Comments to Lynn Hill were requested by 19th April 2004. The Policy was ratified subject to final comment. **ALL**

- **Procedure for the investigation and Root Cause Analysis of Incidents, Complaints and Claims**

  It was confirmed that this Policy had been produced for the RPST assessment and was RPST compliant. It was confirmed that the paper would be circulated to all Divisional Risk Leads for any further comments before seeking ratification at the next meeting.

  GE/NM

- **Validation of Entries on Risk Register**

  Nicola Moore reported that the procedure for validating entries onto the risk register had been agreed with the Divisional Risk Leads. This would now be appended to the Risk Management Strategy and Guidance on the Risk Scoring Matrix. It was agreed that the amended Risk Management Strategy would be presented for final ratification at the next meeting. **NM**

7. Risk Assessment Update

Nicola Moore reported on the progress with the Trust Wide Risk Review currently being progressed by National Britannia. It was confirmed that the assessment was currently being piloted within the Acute Medical Care Division w/c 5th April 2004. The templates would be reviewed before implementing a Trust-wide review. It was noted that there would be analysis of data at Ward, Divisional and Corporate levels. **NM**

8. Women's and Neonatal Services ~ Risk Update

Jacqui Mallard and Jackie Oughton-Hughes gave a presentation on progression of risk management within their Division and tabled two reports summarising key issues and recent developments. The new 'hats on' policy in response to a growing trend of babies being admitted to SCBU with hypothermia was a particular focus of the presentation.

9. Items for Noting

- **Divisional Risk Leads Minutes ~ 24th February 2004**
  The appropriateness of Divisional Risk Leads attending the various Risk Sub-committees in order to raise pertinent issues was discussed. The Committee agreed that they should be actively involved in all relevant sub-committees. Gary Etheridge to progress for discussion at the next meeting. **GE**
- **Controls Assurance Forum Minutes ~ 19 January 2004 and 27 February 2004**
- **Trust Risk Action Plan ~ March 2004**

10. Any other business

The appointment of Lisa Savage as Risk Co-ordinator was confirmed.

Date and Time of Next Meeting

29th July, 14.00-16.30 hrs, Gurney Lecture Theatre, Postgraduate Centre, HHGH

Annex 2

WEST HERTFORDSHIRE HOSPITALS NHS ~ TRUST RISK MANAGEMENT ACTION PLAN

(INCORPORATING RELEVANT HEALTHCARE COMMISSION, RPST, CNST and HSE TARGETS)

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
1.	**FRAMEWORKS**						
1.1	**RPST LEVEL 1 (Risk Pooling Scheme for Trusts)**						
	Prepare for RPST Level 1 Assessment	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Oct '02	February '03	Feb '03	N/A
	Re-Prepare for RPST Level 1 Assessment	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June '03	Dec '03	Dec '03	N/A
	Undertake RPST Level 1 Assessment	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Feb '04	February '04	Feb '04	N/A
	Prepare for RPST Level 2 Assessment	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Feb '04	Feb '05 Interim visit		
1.2	**CONTROLS ASSURANCE**						
	Submit Controls Assurance returns for 01/02	Director of Finance	*N Moore	March '02	31 July '02	July '02	N/A
	Statement of Internal Control to be signed by Chief Executive to be included in Trust Annual Report 01/02	Director of Finance	*N Moore	June '02	31 July '02	July '02	N/A
	Submit Controls Assurance returns for 02/03	Director of Finance	*N Moore	March '03	15 May '03	15 May '03	N/A
	Obtain verification from Internal Audit that the Trust is complying on 3 core standards (Risk Management, Financial Management and Governance)	Director of Finance	*N Moore	March '03	15 May '03	15 May '03	N/A
	Statement of Internal Control to be signed by Chief Executive ~ 02/03	Director of Finance	*A Bettridge	March '03	15 May '03	15 May '03	N/A

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
	Submit Controls Assurance returns for 03/04	Director of Finance	*N Moore	April '03	15 May '04	May '04	N/A
	Establish a CA Forum for CA Standard Leads	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '04	Jan '04	Jan '04	N/A
	Develop a schedule for progressing CA framework & CA action plans ~ 2004/05	Director of Nursing, Midwifery, Quality & Risk & Director of Finance	*N Moore	May '04	July '04		
1.3	**CNST**						
	Achieve CNST Level 1	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '01	February '02	Feb '02	N/A
	Review progress against CNST Level 1	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '03	February '03	May '03	N/A
	Prepare for re-assessment CNST Level 1 ~ Acute	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Feb '03	February '04	Feb '04	N/A
	Prepare for CNST Level 1 Maternity Standard	Director of Nursing, Midwifery, Quality & Risk	*N Moore B Harlev-Lam	April '03	Dec '03	Dec '03	N/A
	Prepare Maternity evidence and action plan for submission to Willis prior to inspection	Director of Nursing, Midwifery, Quality & Risk	*N Moore B Harlev-Lam	May '03	August '03	Aug '03	N/A
	Re-prepare for CNST Level 1 Maternity Standard	Director of Nursing, Midwifery, Quality & Risk	*N Moore J Mallard	Jan '04	Nov '04		
	Prepare for CNST Level 2 ~ Acute	Director of Nursing, Midwifery, Quality & Risk	*N Moore	March '04	Feb '05		
1.4	**HEALTHCARE COMMISSION (CHAI)**						
	Review progress against CHAI Action Plan targets. Thereafter, review progress 6 monthly	*Medical Director	*C Richards	May '03	Sept '03	Sept '03	Mar '04 Sept '04 March '05
	Benchmark against CHI framework for risk management	Director of Nursing, Midwifery, Quality & Risk	*N Moore	May '04	June '04		

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
1.5	**HEALTH & SAFETY**						
	Develop local HSE Action plan following HSE visit & Review quarterly	Director of HR	*Rob Allan	May '03	May '03	May '03	Quarterly
1.6	**NPSA**						
	Achieve NPSA compliance	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '01	Winter 2001	2001	N/A
	Benchmark against NPSA s 'Seven Steps to Patient Safety	Director of Nursing, Midwifery, Quality & Risk	*N Moore	May '04	June '04		
2.	**STRUCTURES**						
2.1	**RISK LEADS**						
	Identify Clinical Risk Leads for all Divisions	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June '01	June '01	Nov '01	N/A
	Following the convergence of Risk & Non-Clinical ~ identify Risk Leads for all Divisions	Director of Nursing, Midwifery, Quality & Risk	*N Moore	March '03	April '03	April '03	N/A
	Establish a training programme for Divisional Risk Leads	Director of Nursing, Midwifery, Quality & Risk	*G Etheridge	Feb '04	4 training sessions arranged during '04	January '04	Jan '05
	Establish quarterly Divisional Risk Lead Meetings	Director of Nursing, Midwifery, Quality & Risk	*G Etheridge	Feb '04	Quarterly meetings arranged	Jan '04	N/A
2.2	**REPORTING STRUCTURE**						
	Establish a new Trust Risk Management Group	Chief Executive	*Non-Executive	Jan '03	Feb '03	Feb '03	N/A
	Establish Risk sub-groups reporting to Trust Risk Management Group	Director of Nursing, Midwifery, Quality & Risk	*G Etheridge	Jan '03	February '03	May '03	N/A
	Converge Clinical & Non-Clinical Risk-Risk Dept	Director of Nursing, Midwifery, Quality & Risk	*G Etheridge	Feb '03	March '03	March '03	N/A

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
	Review Risk Management Group's Terms of Reference to include monitoring role of key practice indicators	Director of Nursing, Midwifery, Quality & Risk	*G Etheridge	June '03	July '03	July '03	July '04
	Review Risk Sub-committee's Terms of Reference to include identification of key practice indicators capable of showing improvement in the management of risk	Director of Nursing, Midwifery, Quality & Risk	*G Etheridge	June '03	July '03	July '03	July '04
3.	**COMMUNICATION**						
	Establish Risk Intranet web-page to combine clinical/non clinical/organizational risk	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June '03	Ongoing	Ongoing	N/A
	Produce 12-Point Plan for Patient Information (guidance for clinicians wishing to produce patient information). Such patient information being a standard for CNST	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '03	July '03	July '03	July '04
	Formal ratification of 12 point plan	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '03	August '03	July '03	July '04
	Launch Patient information database on Intranet to provide a comprehensive catalogue of all patient information available within the Trust (CNST 2 requirement)	Director of Nursing, Midwifery, Quality & Risk	*Pt Info Group	Jan '03	August '04		
4.	**POLICIES & PROCEDURES**						
4.1	**RISK MANAGEMENT STRATEGY**						
	Develop Risk Management Strategy	Director of Nursing, Midwifery, Quality & Risk	*N Moore	March '01	March '01	March '02	N/A
	1st Review Risk Management Strategy (combined clinical/non-clinical)	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '03	Feb '03	Feb '03	N/A
	2nd Review of Risk Management Strategy in line with CA, RPST and CNST	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Feb '03	July '03	July '03	Refer to 3rd review

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
	3rd Review of Risk Management Strategy in line with CA, RPST and CNST	Director of Nursing, Midwifery, Quality & Risk	*N Moore	July '03	Nov '03	Nov '04	Nov '05
	Develop a Risk Management Strategy for Maternity Services	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Winter '03	Winter '03	Winter '03	Nov '05
	Develop Divisional Risk Management Strategies	Director of Nursing, Midwifery, Quality & Risk	*Risk Leads N Moore	April '04	June '04		
4.2	**INCIDENT REPORTING POLICY**						
	Develop Incident Reporting Policy	Director of Nursing, Midwifery, Quality & Risk	*N Moore	March '01	May '01	May '01	N/A
	2nd Review Incident Reporting Policy in line with CA, RPST and CNST and cross reference with Raising Concern Policy & Risk Strategy and RIDDOR	Director of Nursing, Midwifery, Quality & Risk	*N Moore	May '03	Nov '03	Nov '03	Nov '05
	Audit Incident Reporting Policy	Director of Nursing, Midwifery, Quality & Risk	*N Moore	May '04	Dec '04		
4.3	**HEALTH & SAFETY POLICIES**						
	Review all Trust Health & Safety Policies	Director of H.R	*R Allan	Feb '03	Ongoing		
4.4	**CONSENT TO TREATMENT POLICY**						
	Devise and implement Consent to Treatment policy	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '01	Sept '01	Sept '01	N/A
	Implement Consent to Treatment Workshops	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Sept '03	Dec '01	Dec '01	N/A
	1st Review Consent to Treatment Policy in light of DoH model	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Nov '02	Dec '02	Dec '02	Dec '04
	2nd Review Consent to Treatment Policy in light of CNST recommendations	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Dec '02	Jan '04	Feb '04	Feb '06
	3rd Review Consent to Treatment Policy	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Dec '05	Feb '06		
	Audit Consent to Treatment Policy	Director of Nursing, Midwifery, Quality & Risk	*Tracey Moran N Moore	May '04	Aug '04		
	Re-launch Consent to Treatment Workshops on to a rolling programme	Director of Nursing, Midwifery, Quality & Risk	*N Moore	July '03	Ongoing	Ongoing	N/A

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
4.5	**DATIX POLICY**						
	Develop a Datix Security Policy	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Dec '03	Jan '04	Jan '04	Jan '06
4.6	**TRUST QUALITY & RISK FOLDER**						
	Produce and circulate Trust Quality & Risk Folder	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '04	Implement Trust-wide by June '04		
5.	**TRAINING**						
5.1	**RISK TRAINING**						
	Implement Basic Risk Awareness training workshops	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Dec '02	Ongoing	Feb '03	Ongoing
	Establish risk awareness as part of Trust's Induction training programme to include junior doctors	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Feb '04	Ongoing		
	Provide Risk Matrix training	Director of Nursing, Midwifery, Quality & Risk	*N Moore	August '02	Ongoing		
	Review Risk Matrix training and re-launch workshops	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan'03	Ongoing		
	Implement Datix Risk Management training prior to system going live	Director of Nursing, Midwifery, Quality & Risk	*N Moore	March '03	June '03	June '03	Ongoing
	Implement Root Cause Analysis (RCA) training	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June '03	Nov '03	Nov '03	Ongoing
	Identify a robust Risk training programme for all staff & Mandatory Induction Training Programme	Director of Nursing, Midwifery, Quality & Risk	*S Whiterod J Barrett N Moore	Sept '03	Nov '03	Nov '03	Nov '05

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
6.	**MEASURING/MONITORING**						
6.1	**RISK DATA REPORTING & COLLECTION**						
	Establish individual Divisional Clinical Risk databases	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June 2000	July '01	July '03	N/A
	Establish single Risk Management database (Datix)	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Dec '02	Sept '03	Oct '03	Ongoing
	Devise/implement and launch a single form for Incident/Accident reporting, relating to staff and patients in line with RPST requirements and to include capture of incidents of violence and aggression	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Winter '03	Spring '04	Launched April '04	N/A
6.2	**TRUST RISK MATRIX AND REGISTER**						
	Develop and apply Trust Risk Matrix to: - Business Planning process - ERNS reporting - Backlog maintenance schedules - Medical equipment - Ward departmental risk assessments	 Director of Strategic Planning Director of Strategic Planning Director of Strategic Planning Medical Director Director of Nursing, Midwifery, Quality & Risk	 *Exec Team *N Moore *N Moore *G Savage *N Moore & Joyce Wong	 Feb '02 April '02 April '02 April '02 April '02	 March '03 February '03 February '03 February '03 February '03	All Achieved	Ongoing
	Update Risk Scoring Matrix document in line with revised organisational structure and Incident Reporting Policy	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '03	October '03	July '03	Oct '04
	Establish Trust Risk Register capable of recording clinical, financial and organizational risks and initial risk rating and risk treatment plans	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June '03	Nov '03	Nov '03	Ongoing
	Amalgamate various risk registers in to Trust Risk Register	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June '03	April '04	April '04	N/A

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
	Audit monitoring and effectiveness of Risk Register	Director of Nursing, Midwifery, Quality & Risk	*N Moore	April '04	July '04		
	Develop a process for controlling, validating & monitoring entries onto Risk Register	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Oct '03	Jan '04	Feb '04	Feb '05
6.3	**ROOT CAUSE ANALYSIS**						
	Develop and implement Root Cause Analysis template	Director of Nursing, Midwifery, Quality & Risk	*N Moore	June '01	Dec '01	Dec '01	N/A
	Expand Root Cause Analysis template to include all aspects of risk (clinical, non-clinical and organizational)	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '02	May '03	May '03	May '04
	Develop local guidance on conducting a RCA to be appended to Root Cause Analysis tool (to include Complaint and Claims requirements)	Director of Nursing, Midwifery, Quality & Risk	*N Moore Lynn Hill	June '03	Nov '03	Nov '03	Nov '05
6.4	**REPORTS**						
	Produce monthly Clinical Governance data reports	Medical Director	*C Richards	Oct '02	Monthly	Ongoing	N/A
	Produce Trust Clinical Governance Annual Report ~ '01/02	Medical Director	*C Richards	Dec '02	January '03	Jan '03	N/A
	Produce Trust Clinical Governance Annual Report ~ '02/03	Medical Director	*C Richards	Jan '03	June '03	June '03	N/A
	Produce annual Divisional Risk Reports	Director of Operations Director of Nursing, Midwifery, Quality & Risk	*Divisional Risk Leads N Moore	Jan '04	June '04		
	Produce annual Risk Report	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '04	June '04		
	Produce Trust Clinical Governance Annual Report	Director of Nursing, Midwifery, Quality & Risk	*C Richards N Moore	Sept '03	June '04		

	ACTION REQUIRED	LEAD DIRECTOR	PERSON (S) RESPONSIBLE (* Lead)	START DATE	TIMESCALE	DATE ACHIEVED	REVIEW DATE
6.5	**TRUST TRIGGER LIST**						
	Produce Trust trigger list for risk for the generic identification and cataloguing of all incidents within the Trust (NPSA and CNST 2 requirements)	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '01	Dec '01	Achieved Dec '01	N/A
	Review Trust trigger list and launch Trust wide in line with NPSA coding	Director of Nursing, Midwifery, Quality & Risk	*N Moore	Jan '03	August '03	Achieved June '03	June '04

Original Action Plan devised December '02
Reviewed & Updated ~ Jan, Feb, March, April, May, June, August & November '03
Revised & Updated ~ January, March & May 2004

Gary Etheridge
Director of Nursing, Midwifery, Quality & Risk

Nicola Moore
Trust Risk Manager

Annex 3

Local Action Plan for Achievement of RPST Risk Management Standards ~ Level 1

Crit	Criterion Description	Lead Officer	Risk Assessment of Continued Non Compliance Impact (I)	Likelihood (L)	Risk Rating (I x L)	Action Required	Target Date	Actual Date	Review Date
2	**The Risk Mgt Strategy**	GE/NM/ Risk Leads	**5**	**5**	**25**	*Risk Management Policy and Strategy must be embedded throughout the organisation.*	Dec '04		
3	**The Risk Management Organisational Structure**								
3.3.1	Terms of reference indicate that the relevant Executive Directors described under criterion 1.2 are members of the committee(s)	GE/NM	1	1	1	*Terms of reference of the Risk Management Committee to be amended. Membership should be clearly defined by listing the titles of each of the members.*	July ' 04		
4.	**The Reporting and Management of Incidents**								
4.8.5	The guidance clearly details when external agencies need to be involved in the investigation process.	GE/LH/ NM	4	2	8	*Incident Reporting Policy and Procedure for the investigation and Root Cause Analysis of Incidents, Complaints and Claims to be revised detailing when external agencies need to be involved in the investigation process and who is responsible for contacting and involving external agencies.*	July '04		
4.9.2	The Serious Untoward incident reporting procedure is explicit about responsibility for informing staff or the public.	GE/NM/ NC	4	2	8	*Serious Untoward Incident Policy and Media Relations Policy to be revised to incorporate expansion on who would be responsible for informing staff and the public about any incidents that they may have been affected by.*	July '04		
4.9.3	The Serious Untoward incident reporting procedure requires any information given to staff or the public to be documented.	GE/NM NC/SF	4	3	12	*Serious Untoward Incident Policy to be revised.*	July '04	April '04 Awaiting ratification by exec team	
4.9.4	The incident reporting procedure is explicit that those directly affected by the event must be notified before the media.	GE/NM/ NC	4	3	12	*Serious Untoward Incident Policy to be revised.*	July '04	April '04 Awaiting ratification by exec team	

Crit	Criterion Description	Lead Officer	Risk Assessment of Continued Non Compliance Impact (I)	Likelihood (L)	Risk Rating (I x L)	Action Required	Target Date	Actual Date	Review Date
5.	**The Reporting and Management of Complaints and Claims**								
5.1.3	A minute evidences that the complaints procedure has been considered and approved by the Board	GE(LH)	4	5	20	*Complaints Procedure complete with review date to be revised and ratified by the Trust Board.*	July 04		
5.8.3	The guidance clearly details when external agencies need to be involved in the investigation process.	GE/LH/ NM	4	2	8	*See 4.8.5*	July '04		
5.9.2	The organisation is able to demonstrate that managers/ clinicians have been made aware that the conduct and control of all claims is the responsibility of the Claims Manager.	GE/LH	2	2	4	*Distribute global staff email informing Managers and Clinicians of the role and responsibilities of the Claims Manager in relation to claims.*	May '04		
5.10.2	A Board minute evidences that the claims procedure(s) has been Board approved	GE	4	5	20	*Claims Policy to be approved and noted by the Trust Board.*	Sept '04		
5.12.3	The guidance clearly details when external agencies need to be involved in the investigation process	GE/LH/ NM	4	2	8	*See 4.8.5*			
6.	**The Risk Mgt Process**								
6.1.1	The organisation has clearly defined and documented the systems, procedures and staff responsible for the identification of hazards.	GE/NM	4	4	16	*Revise paper on Risk Register and Risk Matrix to ensure expansion of the risk identification systems used to populate the risk register, and staff responsible for them are identified and provided with full training.*	May '04		
6.1.10	Strategic risks and underlying hazards are systematically identified, assessed and analysed, and included on the Trusts risk register.	GE/NM	4	2	8	*Ensure that risks identified as part of the Assurance Framework are placed on the risk register.*	May '04		
6.1.11	There is evidence of the Board regularly reviewing the risk on the organisation-wide risk register.	GE(NM)	4	2	8	*Ensure Board Minutes demonstrate that the Board has received and reviewed risks from the risk register.*	Sept '04		

Crit	Criterion Description	Lead Officer	Risk Assessment of Continued Non Compliance Impact (I)	Likelihood (L)	Risk Rating (I x L)	Action Required	Target Date	Actual Date	Review Date
6.2.1	On the basis of risk evaluation, the organisation has produced risk treatment plans for all strategic risks.	GE/NM	4	3	8	*Ensure that strategic risks on the risk register have been adequately risk scored and have accompanying action plans.*	May '04		
6.3.3	There is evidence of the Board taking decisions on risk treatment options	GE(NM)	2	2	4	*Ensure that where risks are reviewed by the Board, minutes provide a true and accurate reflection of the discussions and decisions that have taken place.*	Sept '04		
7.	**Risk Management Training**								
7.2.2	The organisation has a procedure for rectifying non-attendance at mandatory and statutory training courses and can provide evidence that it is used in practice.	RA/SW	5	3	15	*Ensure that the procedure for rectifying attendance at mandatory and statutory training is formalised and can be provided as evidence that it is used in practice.*	July '04		
7.3.3	The organisation can demonstrate that 60% of all staff attend a specific local induction, which includes risk management and is appropriate to the area in which they are working.	RA/SW	5	3	15	*Ensure a system is developed whereby local induction attendance records can be collated centrally enabling the Trust to demonstrate that 60% of all staff are attending.*	July '04		
7.4.1	Course evaluation sheets are issued to staff attending mandatory and statutory training course.	RA/SW	4	2	8	*Reinstate course evaluation sheets.*	April '04	March '04	
8.	**Independent Assurance**								
8.2.2	There is evidence that the audit plans are drawn up with full consideration of all risks as detailed within the risk register.	VD/SG/ CR	4	3	12	*Ensure that the Risk Register is used to inform the next audit plan.*	April '05		

Note: Risk Scores calculated using the Trust's Risk Scoring Matrix. In all cases scores are based on worst-case scenario of consequence multiplied by likelihood as a result of continued non-compliance.

Lead Officer Key

CR	Celia Richards
GE	Gary Etheridge
LH	Lynn Hill
NC	Nigel Coomber
NM	Nikki Moore
RA	Rob Allan
SF	Sue Fay
SG	Sue Gunn
SW	Sue Whiterod
VD	Vince Doherty

Plan written April 2004
Plan reviewed May 2004

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