



Risk Management Annual Report

April 2010 – March 2011



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1 Introduction

The Shrewsbury and Telford Hospital NHS Trust (the Trust) is committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate programme and that responsibility for implementation is accepted at all levels of the organisation. The Trust manages risks across the full range of its responsibilities in line with its corporate objectives and national standards.

The Trust Board recognises that risk management is an integral part of good, effective and efficient management practice and to be most effective should become part of the Trust's culture and strategic direction.

This annual report reflects the risk management activities and developments in the Trust for the period 1 April 2010 to 31 March 2011. The purpose of the report is to:

- Summarise the key activities relating to risk management undertaken during the year.
- Highlight the progress in the ongoing development of the Trust's risk management arrangements
- Outline the risk management objectives for the coming year.

This report should be read in conjunction with the Trusts 2010/11 Annual Report and the 2010/11 Quality Account.

2 Executive Summary

Trust Boards need to be confident that systems and policies are operating in a way that is effective, focussed on key risks and driving the delivery of objectives. This summary report is intended to be part of that process and assist in providing assurance that key risks are being identified, measured and managed. During the year, a new Chief Executive took up post which has seen changes to the management structures in the Trust.

Achievements during 2010/11 include the following:

- Compliance with the CQC Essential Standards of Quality and Safety
- Maintained CQC registration
- Continued reduction in Healthcare Associated Infections.
- A healthy culture of incident reporting with an 18% increase in reported incidents
- Appraisal completion rates for organisation at 83% (target >80%)
- Establishment of Quality and Safety Committee
- Achievement of level 1 of the revised CNST (Maternity) standards
- Compliance with all 22 key Information Governance requirements
- Appointment of Centre Chiefs to develop clinical engagement in management

3 Corporate Responsibility for Risk Management

The Boards of NHS Trusts take corporate responsibility for the strategic direction and activities of their organisations. The Trust Board is collectively responsible for providing direction and strategic leadership within a framework of reasonable and effective controls which enable risk to be identified, assessed, mitigated and managed effectively. This includes development of systems for financial control, organisational control, clinical governance and risk management and reviewing the effectiveness of Internal Controls.

The Chief Executive is the Accountable Officer for the Trust and has overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of governance.

4 Internal Review Structures

The Board must operate through a framework of effective controls to ensure that processes and changes are developed in a way which maximises the organisation's chances of achieving its objectives and at the same time minimises the associated risks. Controls are the procedures and process which ensure that the necessary actions are taken to achieve the corporate objectives.

The Trust Board is accountable for risk management and this duty has been discharged through the Management Executive which is the senior trust committee.

During the year, the following committees and groups also have responsibilities with regard to the management of risk:

- Finance and Performance Committee
- Quality and Safety Committee
- Management Executive
- Clinical Governance Executive
- Risk Group
- Health and Safety and Security Committee
- Audit Committee

4.1 Finance and Performance Committee

This Committee is a formal sub-committee of the Board and is chaired by a non-executive director. It has key responsibilities in relation to financial planning and performance management. The Committee is responsible for assessing the overall scope and effectiveness of the Trust's non clinical risk management systems; reviewing the Trust strategy for the management of business risk; and reviewing progress made in delivering key enabling strategies.

4.2 Quality and Safety Committee

This Committee is a formal sub-committee of the Board and is chaired by a non-executive director. It has key responsibilities in relation to providing assurance to the Board on clinical quality and safety; and driving an improvement culture to promote excellence in patient care.

4.3 Management Executive (Until Dec 10)

This is the senior management committee of the Trust. It is chaired by the Chief Executive. The remit of the Management Executive is to inform and implement the Trust Board's policy and strategic direction of the organisation and to reach decisions on, and monitor the progress of, the Trust's business and organisation objectives. The Management Executive is also responsible for providing leadership to the co-ordination and prioritisation of clinical, non-clinical and organisational risk, ensuring that significant risks are properly considered and communicated to the Trust Board.

4.4 Clinical Governance Executive

The Clinical Governance Executive is chaired by the Medical Director/ Associate Medical Director and reports to the Management Executive. The Executive met monthly throughout the year. The agenda of the Clinical Governance Executive reflects the forward plan developed to ensure that adequate assurance is received by

the Board on relevant areas of the Trust's work. The Clinical Governance Strategy has formed the basis of work undertaken by the corporate team and the divisions.

During the year a number of developments were overseen by the Executive including:

- Continued reductions in Healthcare Associated Infection
- Revised Serious Incident Policy with devolution of root cause analysis to Lead Nurses
- Incidents reported weekly to the National Reporting and Learning Scheme (NRLS).

The Quality Account provides more detailed information on the activities in this area.

4.5 Risk Group

The Risk Group is tasked with collating risk assessments from throughout the Trust and presenting them in a coherent and robust corporate risk register. The group ensures that assessments are normed and that the information gathered is complete and up-to-date. The group reports to the Clinical Governance Executive for approval of clinical risks and directly to the Management Executive for ratification of risk scoring and prioritisation with the register informing the Audit Committee and the Trust Board. The corporate risk register also informs the decision of the Capital Planning Group in allocating resources to mitigate risks.

The Risk Group is chaired by the Medical Director and meets at least six times a year. During 2010/11 the group met nine times during the year to review risks.

4.6 Health, Safety and Security Committee

To ensure adequate consultation the Trust has a Health and Safety Committee which meets quarterly. It is chaired by the Director of Compliance and Risk Management. The committee reviews health and safety performance and develops local health and safety policies.

4.7 The Audit Committee

The Audit Committee is chaired by a Non-Executive Director and the terms of reference have been reviewed in line with the updated Audit Committee Handbook to reflect its role as the senior Board committee taking a wider responsibility for scrutinising the risks and controls which affect all aspects of the organisations business. The Committee met six times during the year.

Audit Committee attendance at the seven meetings held during the year included members of the executive team, heads of service, Divisional General Managers, representatives of internal and external audit, and, as required, the local counter fraud specialist. Overall attendance by members was **88%**, with all individuals attending at least two-thirds of meetings.

The Divisional General Managers Divisions 2 and 3, plus the Head of IT were invited to attend Audit Committee over the year to present an update on the risk and governance framework in their area of responsibility.

5 Risk Management Processes

5.1 Risk Management Strategy

The purpose of the strategy is to define the Trust's policy and strategy for risk management. It clearly defines the roles and responsibilities of key managers and

Committees and sets out the specific responsibilities for the directors in the effective management of risk.

In line with national requirements the strategy is subject to annual review. The last review took place in February 2010 with version 9 of the strategy being ratified by the Trust Board in March 2010. The strategy will be reviewed again in June 2011 following the implementation of new management arrangements.

5.2 Risk Management related Policies and Procedures

A number of key documents were reviewed or developed during the year: (issue date)

- Serious Incident Policy (April 10; Feb 11)
- Development and Training Support (April 10)
- Preceptorship (October 2010)
- Whistleblowing (March 11)
- Actioning safety alerts (September 10)
- Safeguarding policies: Safe discharge of children; Children who fail to attend appointments (September 2010)
- Information Asset management Policy (March 2011)
- Information Sharing Policy (March 2011)
- Control of Contractors Policy (March 2011)
- Information and Information Systems Security Policy (March 2011)
- Network Security Policy (March 2011)

5.3 Risk Assessment Programme

The risk management strategy requires an ongoing programme of risk assessment and review using the guidance, tools, and matrices in the Risk Management Strategy, the guidance for ongoing risk assessment, and the risk register procedure. Risk assessment is covered on induction and in sessions held by the integrated risk and safety team throughout the year. In addition refresher training was provided to the Trust Board led by the Internal Auditors.

5.4 Risk Registers

Each Division and Service Delivery Unit, as well as Corporate Functions, maintains a local risk register, with staff evaluating identified risk using the agreed risk matrix. Divisional Managers and Heads of Service are responsible for reviewing the risks identified by their teams. Risks graded as high or very high (with a score of 15-25) are escalated to the risk group for further discussion using the processes detailed in the risk management strategy.

Over the year, the corporate risk register has been transferred to a web-based system. Each month the corporate risk register is reviewed and updated by the risk register group to include new risks identified; to ensure appropriate actions are taken to resolve risks and to remove resolved risks. In addition the Risk Group norms the risk scores, in agreement with managers, to ensure consistency and equity. These scores are then ratified by the Management Executive before presentation to the Trust Board. The Audit Committee and Clinical Governance Executive also discuss the Corporate Risk Register.

The management of the Trust Risk register enables all risks identified within the Trust to be effectively managed in order for decisions to be made with regard to resource allocation and risk reduction. Both the medical devices group and the capital planning group require bids for funding to be supported by an entry on the risk register.

During the year, 18 risks were added to the corporate risk register and 19 risks were removed owing to them having been mitigated or resolved. The total number of risks (scoring 15 or above) on the register at the end of March 2010 was 49

As at 31 March 2011, there were 12 principal risks on the corporate risk register compared with 10 at the end of March 2011.

The Corporate Risk Register and the associated controls and assurances have been overseen by the Audit Committee throughout the year and have been formally reported to the Trust Board in November 2010 and February 2011.

The risk matrix used to evaluate risks is subject to regular review to ensure that scoring is consistent and proportionate. During the year, the risk matrix was regularly revised and updated.

5.5 Board Assurance Framework

At a Board Development seminar, the Board highlighted potential risks to achievement of the Corporate Objectives in order to develop the 2010/11 assurance framework.

The first iteration of the assurance framework was reviewed by the Trust Board at its meeting in June 2010 in line with the requirement for the full framework to be reviewed twice yearly by the Board. The Board reviewed the framework again at the November 2010 and January 2011 meeting.

The Audit Committee reviewed the framework at meetings in April, June September and December 2010, and February 2011. In line with year-end reporting requirements, the Audit Committee reviewed the final version of the 2010/11 assurance framework at its April 2011 meeting.

Internal Audit reported that the Assurance Framework and related processes and found that "Taking account of the issues identified, the Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective"

The Board identified 12 principal risks which have been linked to five risk groupings identified in the Integrated Business Plan. The first four risks are 'umbrella' risks covering a number of known risks. The 12 principal risks were:

5.5.1 We don't provide the right clinical care (resulting in poor clinical outcomes)

A plan of work has been drafted, which will form the basis of a patient safety strategy over the next three years. The Chief Executive hosted a Leading Improvement in Patient Safety (LIPS) taster event in March 2011 with a further event planned for June 2011 so that a significant number of clinical staff can be trained.

5.5.2 We don't respond to patient needs and views (resulting in poor patient outcome)

Interventions are being targeted at wards with higher than average numbers of complaints, pressure ulcers and falls with the aim of providing support and development to improve quality to patients.

5.5.3 We don't deliver the Trust Improvement Programme (resulting in inability to invest in quality)

This is controlled through measures to manage pay and agency costs, introducing strengthened robust business planning processes and financial reviews.

5.5.4 We have poor information systems and processes (resulting in poor decision making and planning)

It has been recognised that there is a lack of resource, knowledge and infrastructure for IT and performance management. There were problems in relation to patient waiting times which arose from this risk. A project is being developed by Innovations Group to enhance performance reporting.

5.5.5 We don't have enough suitably trained or supervised staff delivering care (resulting in poor quality and patient experience)

The nurse recruitment strategy has been successful in reducing the numbers of nursing vacancies. However, it is proving more challenging to fill medical posts. The reconfiguration options currently being discussed will mitigate some of these risks if successful. There are particular risks in obstetrics linked to insufficient staffing to provide dedicated obstetric and anaesthetic cover to the labour ward and to sustain midwifery levels in line with the recommendations of 'Safer Childbirth'. Recruitment is in progress for these posts.

5.5.6 We don't have sufficient clinical leadership across the organisation (resulting in lack of improvement in safe patient care)

Senior Clinicians have been appointed to the role of Centre Chiefs and a development programme is in place to support the transition to clinical management.

5.5.7 The Health Economy fails to deliver the QIPP agenda (resulting in financial risk across the Health Economy and deteriorating patient experience)

Both PCTs have made very challenging assumptions as part of the QIPP agenda (Quality, Improvement, Productivity and Prevention). These schemes are intended to provide savings in the latter half of the year however have not delivered the promised savings.

5.5.8 The public consultation on 'keeping it in the county' fails to deliver on the agreed way forward (resulting in loss of local services to patients)

The public consultation on 'Keeping it in the County' took place between January and March 14th and accepted the reconfiguration plans.

5.5.9 We don't have enough capital to upgrade estate and equipment (resulting in substandard environment and poor patient experience)

Requests for capital expenditure are risk assessed and must be included within a divisional risk register in order to be considered for capital investment.

5.5.10 We don't deliver an I&E surplus (resulting in inability to invest in quality)

Scrutiny of plans takes place through Programme Board and Finance & Performance Committee. The Trust achieved a small surplus at year end; however, this was following £5M support from the SHA. The main reasons for this variance are as follows:

- £14m over performance in activity
- The ability to deliver the Trusts CIP of £7m was hindered by the significantly above-plan emergency activity
- Medical staff agency costs of £5m
- £3.5m of non funding emergency activity due the emergency threshold adjustment

- Escalation costs (related to emergency activity) of £700k

5.5.11 We don't deliver national priorities (resulting in a loss of confidence in the service)

The Infection Control targets for 2010/11 were met. Although the Trust achieved most of the access targets last year, sustaining and improving performance remained a concern. The Trust worked with the Department of Health Intensive Support Team to identify areas for improvement.

5.5.12 We deliver national targets through poor management processes (resulting in unintended consequences e.g. development of outpatient pending lists)

The Intensive Support Team (IST) has visited the trust and made a number of recommendations to improve performance in respect of cancer waits and management of outpatients.

There were some issues which caused particular problems in year including issues with cancer waiting times, 18 week waiting times and outpatients. These are reflected in the risks above, in particular risks 4, 11 and 12. There were gaps in control which were not immediately apparent. The Trust had placed an overreliance on management assurances. More robust controls have now been put into place and independent assurances sought alongside management assurance. There is an ongoing review into the circumstances of the gaps in the control process. The Trust is also reviewing its performance reporting processes to ensure that there is clear evidence-based reporting to the Board.

5.6 *Sub certification process to inform Statement on Internal Control*

In line with best practice, a system of sub certification was introduced to inform the development of the Statement on Internal Control (SIC). Divisional General Managers were asked to certify that the Divisional Risk Register was complete and up-to-date, and that actions were taken if lapses were identified.

5.7 *Statement on Internal Control*

The Chief Executive, as Accountable Officer, is required to make an annual Statement on Internal Controls (SIC) alongside the accounts of the Trust and in accordance with guidance issued by the Treasury and Department of Health. The SIC is a high level summary of the system of internal control which requires disclosure of any significant control issues.

There were some issues which caused particular problems in year including issues with cancer waiting times, 18 week waiting times and outpatients. There were gaps in control which were not immediately apparent. The Trust had placed an overreliance on management assurances. More robust controls have now been put into place and independent assurances sought alongside management assurance. There is an ongoing review into the circumstances of the gaps in the control process.

The Trust is also reviewing its performance reporting processes to ensure that there is clear evidence-based reporting to the Board. The Trust had a financial plan to achieve a surplus of £2.6m but delivered a small surplus of £26k following support of £5m from the SHA.

With the exception of the internal control issues highlighted above, the SIC concluded that The Shrewsbury and Telford Hospital NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and those control issues have been or are being addressed

6 Health and Safety

In the year 2010/ 2011, the H&S Team has continued to focus attention on the Trust's response to reported incidents, including root cause analysis of the majority of RIDDOR-reportable incidents. The Team has worked with staff and management to identify improvements to work environments and working practices with a view to reducing the likelihood of a recurrence.

The Team has also supported Trust management through a major HSE management inspection focusing on slips and trips, workplace transport, infection control, management of work-related stress and violence and aggression, control of asbestos and legionella, and moving and handling. This resulted in a single improvement notice, but no further enforcement action.

The H&S Team's training programme, which aims to equip line management, link workers and staff representatives with suitable H&S-related knowledge and skills, continued. In the year, the Team trained a total of 160 delegates in courses and workshops covering COSHH and Display Screen Equipment assessments, general risk assessment, first aid and work-related stress management, and the nationally recognised IOSH: Risk Management in Healthcare course.

7 National Standards / External Review

7.1 *NHS Litigation Authority (NHSLA) Risk Management Standards*

The NHSLA is a Special Health Authority responsible for handling negligence claims made against NHS bodies in England. In addition to dealing with claims when they arise, the NHSLA has an active risk management programme to help raise standards of care in the NHS and reduce the number of incidents leading to claims.

The core of the NHSLA's risk management programme is provided by its standards and assessment. NHS trusts and other healthcare organisations are regularly assessed against risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA. For the Trust two sets of standards: general risk management standards and maternity standards apply.

The Trust achieved a pass at level 2 of the new NHSLA Risk Management standards during December 2008. The Trust is not required to be reassessed until quarter 3 2011. The Trust achieved level 1 against the revised CNST (Maternity) Standards in June 2010 and is due to be assessed at level 2 during 2011/12.

7.2 *CQC Essential standards of Quality and Safety*

The Trust is registered with the CQC without conditions and is compliant with the essential standards of quality and safety. Internal Audit reviewed the process of monitoring compliance with the CQC standards and gave an opinion of substantial assurance.

7.2.1 *Responsive review*

The CQC carried out a responsive review during 2010. The overall judgment of the CQC is that they had minor concerns in two outcome areas – outcome 4 'care and welfare of people who use services' and outcome 13 'staffing'. The CQC judged the Trust compliant with outcomes in seven additional areas.

The CQC concluded that people who use services were receiving the right care, at the right time, from the right people. However, they found some inconsistencies in the planning and delivery of care, particularly around the prevention and management of pressure sores. The Trust was already aware of this problem and has developed a plan of work to improve prevention and management of pressure sores.

The CQC also judged that there were areas within the trust where there is not a sufficient number of qualified and experienced staff in post to meet the needs of the service. This related particularly to staffing in the maternity unit. Again, the Trust was aware of this issue and is in the process of recruiting additional medical and midwifery staffing in obstetrics and gynaecology.

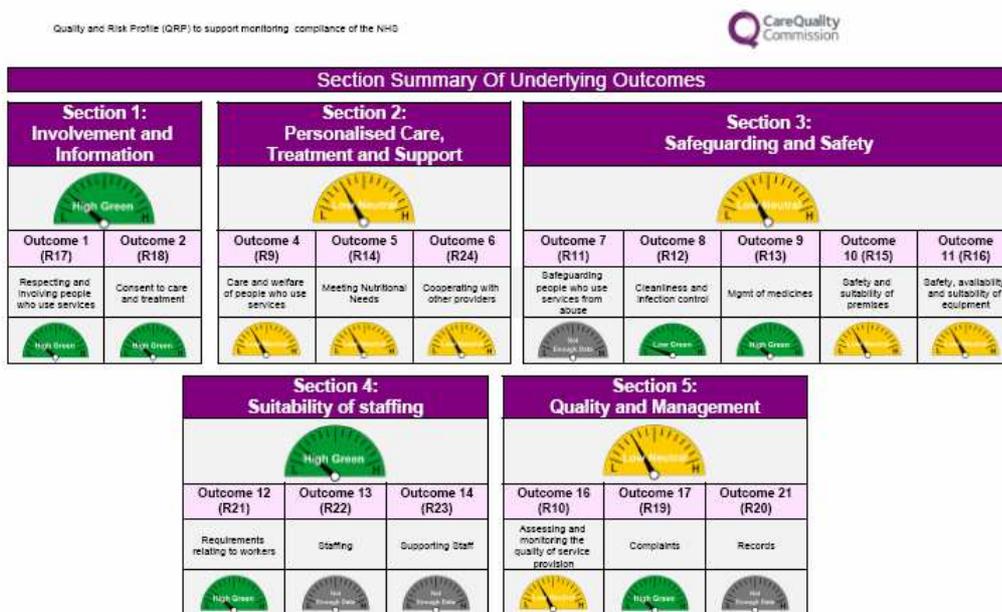
7.2.2 CQC visit - Dignity and Nutrition standards

The CQC carried out a number of randomly chosen inspections across the country during March 2011. The inspection reviewed standards relating to dignity in care and nutrition. The CQC judged that there was a minor concern about care at the Trust in relation to the treatment of vulnerable adults. Although a formal report has not been received from the CQC yet, a number of actions have already taken place to improve this area of care. A formal action plan will be submitted to the Trust Board early in 2011/12.

7.2.3 Quality and Risk Profiles

The CQC Quality and Risk Profile (QRP), first issued in January 2010 was updated monthly from September 2010. The CQC will use the QRPs to help assess where risks lie within an organisation and will act as a prompt for implementing front line regulatory activity, such as inspection. They will play an important role in helping the CQC to assess whether trusts comply with regulatory standards.

The QRP has evolved to include over 600 separate pieces of data drawn from a number of sources, including patient and staff surveys, data returns and comments from NHS choices. The data is grouped to give a dashboard style indicator for each of the outcomes. The dashboard issued in March is shown below:



The QRP is monitored monthly and there are actions in place for all indicators which are negative.

7.3 *Head of Internal Audit's Opinion*

The Head of Internal Audit Opinion is that based on the work undertaken in 2010/11, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk

7.4 *Review of outpatients*

During 2010/11 the Board received information through Incident reports of incidents occurring in outpatients (January, July, and October 2010). However management assurances were relied upon that subsequently proved to be inadequate. The Board approved an external review by the Intensive Support Team (IST) of systems and processes which has resulted in an action plan led by the Chief Operating Officer to improve standards and performance. The Board has also asked for a review of the current reporting suite with a greater focus on evidence to support assurances.

7.5 *West Midlands Quality Review Service*

During 2010/11 the health economy was reviewed by the West Midlands Quality Review Service (WMQRS). This process identified a number of immediate risks which are being addressed by an action plan monitored by the Strategic Health Authority. The Trust's Director of Compliance and Risk Management oversees the development and effectiveness of the Trust's governance structure, although it is acknowledged that governance is a responsibility of the entire Board.

7.6 *Health and Safety Executive*

The Trust received two inspections from the HSE during 2009/10. One was a formal visit in October 2010 to inspect the Microbiology Labs at RSH. On the day the HSE threatened to raise a prohibition notice, and then improvement notices, but due to prompt remedial action taken these did not materialise.

The second inspection consisted of a full management audit at PRH. One improvement notice was issued on workplace transport. Actions are being implemented in response to this visit.

The HSE prosecuted the Trust following the death of a patient on Ward 8 in 2007. The main arguments against the Trust were staffing levels, and failure to implement the bed-rails policy. The Trust was fined £50000 + £8500 costs.

7.7 *2010 Staff Survey – Safety at Work*

The percentage of work related injuries and stress has increased since 2009 when compared with acute Trusts in England. The perception of effective action from the Trust towards violence and harassment was rated as 3.55 which is similar to the acute trust average.

The Trusts score of 75% was above average when compared with Trusts of a similar type for the availability of hand washing materials.

The percentage of staff reporting that they witnessed a potentially harmful error, near miss or incident had increase from 40% to 43% which was higher than the acute

Trust average of 37%. However, 99% of staff said they had reported incidents compared with the acute trust average of 95%.

8 Risk Management Training

Training is designed to demonstrate the processes and tools available to enable staff to identify and treat risk and to explain how risk is escalated through teams to the Trust Executive and Board. Risk management awareness training was provided throughout 2010/11 at all levels of the organisation, including the Board.

Some elements of risk management training are mandatory and attendance at these sessions continues to be recorded with follow-up by service managers and heads of services on those staff who have not attended the appropriate training sessions. During 2011, the statutory training programme includes a session on vulnerable adults.

In addition the Trusts corporate induction programme includes awareness sessions on risk related areas including incident reporting, Health and Safety, Governance, Information Governance, Fire, Moving and Handling and Security.

9 Risk Management Support

Sources of specialist advice and assistance available for managing risk include Head of Risk and Assurance, Patient Safety Team, Health and Safety Team, Security Manager, Investigations Team. Vulnerable Adults Lead, Head of Patient and Corporate Services, and Information Governance Manager.

10 Claims

10.1 Medical Negligence Claims

During 2010/11, 67 medical negligence claims were opened against the Trust. In the same period 55 claims were closed*.

New claims are categorised according to financial risk as follows:

Risk Grouping	Potential Loss	Number of new claims 2010/11	Number of new claims 2009/10	Number of new claims 2008/09	Number of new claims 2007/08
1	Potential Small loss (> £100)	0	0	1	0
2	Potential Loss > £1,000	5	2	8	5
3	Potential Loss > £10,000	48	34	22	32
4	Potential Loss > £100,000	14	38	33	11
5	Potential Loss > £1,000,000	0	7	12	6
	TOTAL	67	81	76	54

*Cases are closed on the advice of the NHSLA when no further action is likely. This category also includes cases, which are withdrawn by the claimant or discontinued.

During 2010/11 there were 55 cases closed. The date of the incident ranged from occurring in 1993 to 2009 and financial liability would be assumed by the Existing Liabilities Scheme (pre 1995) or the NHS Litigation Authority.

Medical Negligence Closed Claims 2010/2011

Division	Withdrawn	Settled
1	13	10
2	18	13
3	0	1
Total	31	24

The number of cases settled or withdrawn reflects national performance.

At the end of the financial year there were 218 medical negligence cases open.

10.2 *Other Claims*

During 2010/11 three Public Liability (PL) and 18 Employee Liability (EL) claims were opened against the Trust.

Nine EL claims were settled, and one was closed on the advice of the NHSLA. Four PL claims were settled or closed.

At the end of the financial year there were 31 EL and 5 PL claims open.

11 Incident Reporting and Management

11.1 *Incident Reports*

During 2010/11 there were 11,053 reports received compared with 9,377 during 2009/10. This is an increase of 18% in reported incidents. Of these incidents, 564 incidents are at various stages of investigation and approval; 87% of these were reported in the last quarter of the year. (There were 1,828 open incidents at year end 2009/10).

The total reports included 8,531 patient safety incidents (7,201 in 2009/10) and 2,522 incidents affecting staff, visitors, contractors and others (2171 in 2009/10).

A total of 1782 patient slips, trips and falls were reported; and of these 26 were RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)-reportable most commonly because the fall resulted in a fracture. (There were 34 patient RIDDOR reports in 2009/10) One of these occurred in the car park.

A total of 72 RIDDOR reports were submitted. 49 were staff incidents (most commonly because the incident resulted in an 'over 3 day injury') and 4 dangerous occurrences where staff were exposed to biohazards. (There were 56 staff RIDDOR reports in 09/10). Root cause analysis is undertaken on all RIDDOR injuries.

The report from the National Reporting and Learning Scheme (NRLS) covering April 2010 – September 2010 showed a reporting rate for this period of 4.05%. This was an artificially low figure related to delays in processing incidents in the early part of the year due to work on other corporate priorities, which led to a backlog of incident reports to be uploaded to the voluntary NRLS system. High risk and serious untoward incident reporting continued to be prioritised during this time. This backlog has now been cleared and it is anticipated that the next report from the NRLS (due September 11) will show a significantly increased reporting rate.

It is encouraging that 84% of incident reports resulted in no harm to the patient which remains better than the large acute trust average of 72.7%. A further 11% of incidents resulted in low harm.

11.2 Serious Incidents

Certain incidents are classified as Serious Incidents (SIs). All SIs are required to be reported to the CQC via the NRLS and to the Strategic Health Authority. This is co-ordinated by the Chief Compliance Officer.

113 SIs were reported compared to 34 in 2009/10. 14 of these were subsequently downgraded, as investigation showed that these were not reportable incidents. Of the remaining 99 incidents, 35 were grade 3 or 4 pressure ulcers (not previously reportable) and 25 related to HCAI. The increase in SIs is due, in part, to changes in reporting requirements.

12 Infection Control and the Hygiene Code

Trusts have a statutory duty to observe the provisions of the Code of Practice for the Prevention and Control of Health Care Associated Infections as set out in the Health Act 2006. The Hygiene Code is incorporated into the CQC Essential Standards of Quality and Safety for which the Trust declared full compliance.

13 Information Governance

The Information Governance Toolkit Assessment was completed and submitted by the Trust by the 31 March 2011. The overall result for SaTH was 72% (Not satisfactory). The score in October 2010 was 50%. The Information Governance Framework processes were audited by internal auditors following the October 2010 submission as recommended by DH.

The Trust attained at least level 2 in the 22 key requirements and achieved level 2 in 43/45 requirements overall. However, the mandatory requirement is for all NHS organisations to achieve level 2 compliance in all 45 requirements otherwise a 'not satisfactory' score is awarded. The two requirements scored at level one were:

8-324 - Pseudonymised and/or anonymised data is used for all secondary purposes. Currently this is not technically possible throughout most of the NHS.

8-505 - This requirement is scored by using the results from a 'clinical coding audit'. This was carried out in early March and the results of accuracy did not meet the requirement to achieve a level 2 although the score was close to the acceptable threshold.

14 Security

In accordance with the Secretary of State Directions on improving security in the NHS the Trust has a nominated Local Security Management Specialist (LSMS) who reports to the Director of Compliance & Risk Management (who is the nominated Security Managing Director). Major areas of work undertaken by the Trust's Security Manager during 2010-11 include:

14.1 Policy activity

- Security Management Policy - reviewed and amended to incorporate latest guidance from NHSLA.
- Violence and aggression - development of enhanced patient support pathway for use by nurse management teams in determining best and most appropriate support for aggressive patients.

- Publication of procedures for dealing with terrorist incidents and lock-down policy.

14.2 Incident Reporting

793 security incidents were reported and investigated in 2010-11, including violence and aggression, theft, nuisance and other adverse behaviour.

14.3 Protecting People

381 incidents involved violence and/or aggression..

Intentional:	Physical attacks 23	Non- physical (verbal/threatening) 144
Non- Intentional:	Physical attacks 140	Non- physical (verbal/threatening) 74

The Trust adopts a 3 step approach to dealing with all violence and with aggression incidents:

- 1) Use of conflict resolution training skills - 373 staff attended CRT training in 10-11.
- 2) Seeking support from security staff - Increased security staffing commenced 1st April 10;
- 3) Seeking police assistance - during 2010-11 there were 153 reported instances where police intervention and/or assistance was requested.

14.4 Sanction and Redress

During 2009-10 the Trust was one of the top ten Trusts for bringing criminal sanction against perpetrators and assailants.

14.5 Lone Working

275 Trust staff who work off-site or in high risk hospital departments are now benefiting from enhanced security using a national system that allows monitoring of adverse situations and confrontations and provides a means of dispatching emergency service assistance to staff. Once activated pagers send an immediate signal to relevant staff who can provide support or escalate a response e.g. security, CSM etc.

14.6 CCTV

A business case for additional CCTV facilities resulted in a 74K capital grant for 2011-12. Work will see additional facilities at RSH (internal and external) and the centralising of existing recording equipment to facilitate monitoring of each site by licensed security staff.

14.7 Access Control

Work was undertaken to see urgent improvements to existing card access control management system at RSH and address historical weaknesses in access control arrangements in the RSH Maternity building. A number of minor improvements to infrastructure and changes to procedures have been made to address historic weaknesses across both sites e.g. installation of electronic key pads to PRH Day Surgery Unit.

A detailed account of all activity in this area including details on security awareness training and communication for the period 2010/11 will be published in the Trust Annual Security Report 2010-11.

15 Key Achievements for 2010/11

The Risk Management Strategy lists key risk management objectives (derived from the Corporate Objectives). The following section details achievements in these areas:

15.1 **Objective 1: To manage risks to safety, effectiveness & the patient experience**

- Participation in the Leading Improvements in Patient Safety (LIPS) Programme including holding a 'taster day' for 150 members of staff in March 2011.
- Continued reduction in number of healthcare associated infections
- Establishment of Quality and Safety Committee
- Publication of Quality Account
- Revised Serious Incident process implemented
- Compliance with the CQC Essential Standards of Quality and Safety
- CQC responsive review and review of dignity and nutrition judged the trust compliant with CQC standards
- 18% increase in incident reporting compared with previous year
- Achievement of level 1 of the revised CNST (Maternity) standards

15.2 **Objective 2: To manage risk of failing to achieve national targets**

- Sustained improvement in performance management of Infection Control initiatives

15.3 **Objective 3: To manage risks to staff and subsequent risks to service quality**

- Revised Statutory Training programme implemented
- Revised Statutory Training monitoring regime with effect from 1st April 2010 which gives more detailed information to managers about the training their staff have completed
- Appraisal completion rates for organisation at 83% (target 80%) with improved quality measures in Staff Survey with SaTH remaining in top 20% of Trusts
- Appointment of Centre Chiefs to develop clinical engagement in management

15.4 **Objective 4: To manage risks to achievement of Foundation Trust Status**

- Integrated Business Plan updated
- Quarterly reviews held with Divisions and Corporate areas.
- Integrated Performance Report developed

15.5 **Objective 5: To manage risks to partnership working**

- Successful public consultation on 'Keeping it in the County'
- 'Board to Board' meetings held with Shropshire County PCT and NHS Telford and Wrekin.

15.6 **Objective 6: To manage risks embracing technology & enabling strategies**

- 'Productive Ward' continues to be rolled out across the Trust
- 'Productive Theatre' being implemented
- Web based risk register and assurance framework used by all Divisions and corporate areas
- Compliance with all 22 key Information Governance requirements

16 Key Risk Management Goals for 2011/12

- Further refinement of a dashboard of quality indicators
- Development of Improvement Board to bring together all improvement initiatives
- Holding a Leading Improvements in Patient Safety (LIPS) programme at SATH
- Embedding robust risk management arrangements in the revised management structures.

- Continue work towards NHSLA Maternity Level 2 assessment
- Continue work toward general NHSLA assessment at level 2
- Improve Information Governance Toolkit score
- Revise risk management strategies and policies to take account of revised management structures