1. Introduction

1.1. The Trust recognises that Risk Management must be fully embedded in order for the organisation to function safely and effectively. Robust Risk Management processes must be in place for the Board to be assured on performance and standards. To achieve this aim the Trust Board needs to be confident that the systems, policies and staff it has put in place are operating in a way that is effective, focused on key risks, and driving the delivery of the corporate objectives. To demonstrate this there is a robust Risk Management Strategy in place, which was agreed by the Trust Board in October 2011. The Risk Management Annual Report is the mechanism for measuring the progress that has been made towards achieving the strategic goals and objectives within the Risk Management Strategy.

This report presents the achievements as measured against the strategic goals within the Risk Management Strategy (2011) over the last financial year (1st April 2011 – 31st March 2012). The 2012/13 Risk Management Annual Plan is also presented (Appendix 2), to show progress against objectives at mid-year 2012/13.

2. Risk Management Strategy Objectives

2.1. The Risk Management Strategy (2011) sets out the strategic goals towards which Salisbury NHS Foundation Trust has been working with regards to Risk Management, and provides a framework which sets out clear expectations of the roles and responsibilities of all Trust staff.

2.2. Strategic Goals

The strategic goals within the Risk Management Strategy (2011) are as follows:

- To ensure that the Trust remains within its licensing authorisation as defined by Monitor and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its licensing authorisation.

- Continued development of the Assurance Framework as the vehicle for informing the Annual Governance Statement.

- To ensure that Risk Management policies are implemented ensuring that:
  - all risks, including principal risks, service development risks, and project risks, are being identified through a comprehensive and informed risk register and risk assessment process.
  - the open reporting of adverse events is encouraged and learning is shared throughout the organisation.
To monitor the effectiveness of Risk Management Policies and Procedures via the monitoring of agreed Key Performance Indicators.

To further develop the organisational safety culture and its effectiveness through implementation of Striving for Excellence and the Patient Safety First Campaign interventions.

To develop an Annual Risk Management Plan, which is agreed, reviewed and monitored by the Trust Board.

To ensure that all individuals within the organisation are aware of their role, responsibilities and accountability with regard to Risk Management.

To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually.

To ensure compliance with the NHSLA Risk Management Standards, Monitor, Care Quality Commission registration requirements and Health and Safety Standards.

3 Progress Against Strategic Goals 2011/12

3.1 Licensing Authorisation - To ensure the Trust remains within its licensing authorisation as defined by Monitor

3.1.1 Monitor has a very clear compliance framework which ensures that all NHS Foundation Trusts are able to demonstrate that they are remaining within their agreed licensing authorisation. It is imperative that the Trust is aware of any risks which may impact on its ability to adhere to this framework. The Assurance Framework, Trust risk register, and risk processes enable the Trust to identify risks which may affect the Trust’s financial and Governance ratings throughout the year and respond to these.

3.2 Assurance Framework - Continued development of the Assurance Framework as the vehicle for informing the Annual Governance Statement.

3.2.1 The Trust Board carried out an annual review of the Assurance Framework in September 2011 (ratified at the October 2011 Board Meeting). Trust Board members agreed the principal risks for inclusion in the 2011/12 framework.

3.2.2 The Assurance framework template identifies the principal risks facing the Trust, provides the linkages to the Care Quality Commission registration requirements and identifies the assurances in place to ensure risk containment is being carried out effectively. The Head of Risk Management has attended all three Assurance Committees on a quarterly basis to co-ordinate this process, ensuring the monitoring and management of principal risks is in place, as well as updating and co-ordinating the continued development of the document.

3.2.3 The Audit Committee monitors the overall Assurance Framework process biannually. The Assurance Framework process was presented to the Audit Committee in October 2011 and February 2012. The Audit Committee members were satisfied that the current process produces a compliant assurance
framework where key information and risks travel upward within the organisation and subsequent actions taken are very clear.

3.2.4 Internal audit carried out a full review of the Assurance Framework and Risk Register processes during quarter 4. This included a full documentary evidence review. The subsequent report gave an overall opinion of ‘significant assurance’ with 1 medium priority action required. The action was completed by the deadline of 30/03/12.

3.2.5 The Trust produced an Annual Governance Statement for 2011/12, which was fully compliant and evidenced through the Assurance Framework.

3.3 **Risk Management Policies - To ensure that Risk Management policies are implemented**

3.3.1 The Risk Management Strategy sets out the strategic goals and direction for Risk within the organisation. This is an overarching strategy document underneath which sits the following operational policies:

- Risk Management Policy and Procedure
- Adverse Events Reporting Policy
- Serious Incident Immediate Response Policy.
- Adverse Events: An Organisation Approach to Investigation, Analysis, and Learning
- Adverse Events: Supporting Those Involved

This suite of supporting policies provide the 'how to' practicalities for staff. All of these documents were submitted as part of the NHS Litigation Authority (NHSLA) Risk Management Standards assessment in April 2011. These policies will be reviewed during 2012/13 to ensure compliance with the new NHSLA standards published in January 2012.

3.3.2 All Directorates have risk registers which have developed over the preceding 8 years and are monitored via quarterly 3:3 meetings. During 2011/12 work has continued to ensure that monitoring within the 3:3 meetings is adequately documented within the minutes and the Trust Risk Register is updated accordingly.

3.3.3 The Adverse Events Reporting Policy was updated in 2011. Reporting across the Trust has increased again during 2011/12, which continues to reflect an environment in which staff feel able to report, and identify the process as worthwhile. There has also been an increase in the number of non-clinical staff reporting incidents.

- The 2011 Staff Survey results showed that the Trust was better than average when compared with Trusts of a similar type nationally for reporting errors or near misses. This is an improvement from 2010 when the survey identified that the Trust had fallen below average in this area. The Trust was also higher than average for staff feeling that there were fair and effective procedures in place for the reporting of errors and near misses.
- The National Patient Safety (NPSA) National Reporting and Learning System report for April 11-Sept 2011 identified the Trust to be in the highest 25% of the cluster group with 8.2 incidents per 100 admissions.
It is important to note that the NPSA state that a high reporting rate of actual incidents as well as near misses indicates a strong reporting and learning culture and therefore is a positive measure.

3.3.4 The process for commissioning and carrying out a Clinical Review/Serious Incident Inquiry is also set out in the Adverse Events Reporting Policy. During 2011/12 there were 18 Serious Incident Inquiries and 10 Clinical Reviews. These figures compare with 20 Serious Incident Inquiries, and 12 Clinical Reviews in 2010/11.

Of the 18 Serious Incident Inquiries, 12 were grade III and IV pressure ulcers.

All Clinical Reviews/Serious Incident Inquiries are reported to the Trust Board, detailing the nature of the incident, the key findings and subsequent recommendations. The Head of Risk Management also provides the Clinical Governance Committee with a quarterly report on compliance with the recommendations from these reviews. The themes arising from such reviews during 2011/12 have led to some key pieces of work being undertaken including:

- Review of the WHO stop moment documentation
- Review of MDT meetings in Gastroenterology
- Implementation of the Skin Care Bundle
- Improvement of infection prevention and control practices

3.3.5 The Trust has continued to uphold the principles of being open and recognises that promoting a culture of openness is essential to improve the safety and quality of services and benefits staff, patients and families. Families and patients are encouraged to identify questions that can be addressed within the review and this contributes to learning for staff. Ongoing support and communication with a key point of contact within the Risk Management team takes place for staff, patients and families whilst they go through the Clinical Review process, as per the “Adverse Events: Supporting Those Involved Policy”.

3.3.6 The Risk Report Card is reviewed monthly by the Clinical Risk Group and quarterly by the Clinical Management Board and Clinical Governance Committee. Key themes and trends are identified along with feedback on work streams being taken forward to improve patient safety and reduce risk.

Directorate Management Teams receive a quarterly Report Card for dissemination with their teams as well as a mid and end of year report which identifies key themes for inclusion into service plans and objectives. The report cards now also include the numbers of adverse incidents that have been closed by Risk Management, open NPSA alerts and outstanding recommendations from clinical reviews and serious incident inquiries. The quality meetings aim to draw together the themes of education, service development, risk, complaints, patient and public involvement and governance in conjunction with the quality walks to provide an overarching view of quality within the directorates and will continue to be developed in 2012/13.

There have been notable successes in sharing incident information via the Report Card. Some examples are:

- Review of the drapes used in SDU
- Development of a root cause analysis tool for investigating fractures following a fall
Groups are able to utilise the incident report cards to review and analyse incident data in more detail. The reports can be structured depending on the requirements of the group. This is exemplified by sharps and needlestick incidents for the Needlestick Action Group, medication errors for the Medicines Governance Group, security incidents for the Security Management Committee and medical records incidents for the Medical Records Committee.

A bi-annual Complaints, Litigation and Incident Partnership (CLIP) report is produced for each Directorate. This provides aggregated information from Risk, Customer Care and Litigation which is intended to inform Directorate Service Plans by identifying key areas for focus. These reports have been refined in 2011/12 to provide more detailed aggregation of themes and trends which can then be combined to provide an overall Trust wide view of corporate themes. Further development of these reports will continue in 2012/13.

Ongoing developments have taken place in 2011/12 to meet the requirements of quality in line with the contracts, and the Quality Account. This work will continue in 2012/13 as part of the Quality Meetings.

A project to develop a new risk management system to replace the existing Datix system has been identified for 2012/13. This development is to be lead by IT requiring collaborative working with Risk, Customer Care and Litigation to ensure successful implementation. This includes a system that will allow the reporting of adverse incidents via the intranet. This work will form a major part of the work plan for the Risk Management Team in 2012/13.

3.4 Key Performance Indicators (KPIs) - To monitor the effectiveness of Risk Management Policies and procedures via the monitoring of agreed Key Performance Indicators

3.4.1 The following KPIs are reported by Directorate within the Mid and End of Year Risk Management Report Cards and consist of the following:

3.4.2 All Departments report incidents across all staff groups. The level of reporting is high across the Trust as a whole and continues to increase. The numbers of major and catastrophic category incidents has declined within this increase, which is positive. There is also an increase in the number of incidents identifying no harm which is an encouraging indicator of reporting within the Trust. All departments and staff groups in the Trust report incidents although some more frequently than others. There is continued work to encourage reporting in these areas and the following staff groups increased reporting rates substantially in 2011/12: Ancillary, Allied Health Professionals, Administration and Secretarial staff.

3.4.3 A selection of departmental risk registers were reviewed as part of the NHSLA assessment in April 2011 and were identified as compliant. A planned programme of work with the Trust departments is to be included in the risk work plan for 2012/13. This is to ensure that the department risk registers are robust and in line with the Trust Risk Management Policy and Procedure and to support staff in understanding this process.

3.4.4 The Risk Management Strategy in 2011 introduced a KPI to achieve 100% compliance with the Trust policy following a needlestick or sharps injury.
During 2011/12, there have been 33 reported needlestick injuries and 29 reported sharps injuries. Of these, there has been 1 incident where a member of staff had not complied with the Trust policy. This is currently being followed up by the Occupational Health Services.

Work during 2011-12 included an audit of safe sharp practice via the Trusts Online System for Clinical Audit (OSCA) and review of the use of Sharps Bins following an audit by the main provider to the Trust.

Work planned for 2012-13 includes exploring alternative IV cannula, more robust action planning resulting from audits (both local via OSCA and external from the sharps bin provider) and the review of membership to include more representation from Facilities Directorate.

3.4.5 The Risk Management Strategy 2011 set a 100% target of sign off via the Managed Learning Environment (MLE) of departmental induction across all departments and staff groups. The MLE has the functionality to follow up any new members of staff who do not complete induction (copied to their line manager).

For the NHSLA assessment in April 2011, the Trust was compliant with the standard relating to departmental induction of permanent staff. However, only 72 staff (24% of new starters), had been signed off by their line managers on the MLE as completing departmental induction. This compared to 74 staff (20% of new starters) in 2010/11. The Education Department have been undertaking further work to ensure managers are aware of their responsibility to sign off within the MLE completion of Departmental Induction.

3.4.6 The Risk Management Strategy 2010 introduced a target of 100% compliance with Venous ThromboEmbolism (VTE) assessment across the Trust. This audit is carried out on all patients and is monitored via the Clinical Management Board. The range of compliance for the Trust during 2011/12 has been between 90% and 95%. This confirms that there has been sustained improvement during the year.

3.4.7 The Risk Management Strategy 2010 introduced a reduction in grade III and IV pressure sore development and set a target for evidence of reduction which remained as a key performance indicator for 2011/12. In 2011/12, 12 patients experienced a grade III or grade IV pressure ulcer as an in-patient. This is a decrease in comparison with 2010/11 when 19 patients experienced a grade III or IV pressure ulcer compared with 46 patients in 2009/10. This confirms a continuing decrease. A Trust wide action plan is maintained for 2012/12 to ensure that work in this area continues to see a reduction in pressure area care.

3.4.8 The Risk Management Strategy in 2011 introduced a new KPI to evidence 100% completion of a full root cause analysis for all fractures following a fall. This has lead to the development of a root cause analysis tool by the Risk Department that was piloted in 2011 and is now being implemented across the Trust. The falls RCA tool allows consistent capture of data and analysis of this information to identify any key issues.

A total of 29 fractures were reported in 2011/12. The RCA tool was introduced in September and in this period 17 fractures were reported. Of these 14 have been subject to RCA. This was because initially it was planned that only fractures resulting in major injuries would be subjected to an RCA. It has since been decided that any patient fall which results in a fracture or major harm would be subject to an RCA to increase the opportunities for learning. This continues to be a focus of the Risk work plan for 2012/13.
The risk management process for the review of all falls incidents was reviewed by both Internal Audit and the Audit Commission in March 2012. It confirmed that there were sound methods of collecting the data. An action was required to ensure accuracy of reporting data and this was rectified immediately.

3.4.9 The Risk Management Strategy 2010 introduced the requirement to maintain NHSLA level 2 status for both Maternity and General during 2011. The Maternity NHSLA assessment took place in February 2011 and achieved a pass on 49 of 50 standards. The General NHSLA assessment took place in April 2011 and achieved a pass on 44 of 50 standards. Both maintained NHSLA Level 2 status.

The NHSLA standards published in January 2012 identified changes to the way in which the NHSLA assessment will be undertaken with respect to the evidence reviewed for certain standards. The Trust will be subject to review for Maternity and General in February 2014. Work has already commenced in preparation for this visit and has included an interim visit on the 8th and 9th March 2012. There has also been a Trust NHSLA Workshop in April 2012. Further work forms part of the Risk Work Plan for 2012/13.

3.5 Implementation of Patient Safety Interventions - To further develop the organisational safety culture and its effectiveness through implementation of Striving for Excellence, and the Patient Safety First Campaign.

3.5.1 During 2011/12 there has been continued focus on patient safety which forms one of the Trust’s Quality Account priorities. Although the South West Quality and Safety Improvement Programme finished in March 2012 we continue to use the extranet site to post data and monitor compliance. The programme was made up of the following work streams:
- Leadership for Safety
- General Ward
- Perioperative Care
- Critical Care
- Medicines Management

3.5.2 The Leadership intervention was led and coordinated by the Executive Lead for Risk and the Deputy Director of Nursing (Programme Manager) whilst each of the other work streams had an identified clinical lead responsible for implementation in practice.

Achievements to note in 2011/12 are:

3.5.3 Leadership for safety

- Monthly meetings of the Safety Steering Group to oversee and coordinate the work streams
- Sustained retrospective notes reviews using the global trigger tool – giving valuable insight into our harm events and allowing us to commission focussed work.
- Amalgamation of the Safety Walks with the Quality Walks following an evaluation with key stakeholders

3.5.4 General Ward
Implementation across the Trust of the revised observation chart which has been produced with the aim of improving compliance with observations and escalation for patients who have triggered EWSS. Compliance with documented patient observations following this launch has been very good and we are seeing an improvement in clear escalation for patients who are deteriorating.

Our safety data has shown an upward shift in calls to the Critical Care Outreach team as a result of patient deterioration with a corresponding downward shift in cardiac arrest calls. This work has been presented regionally.

Safety briefings are reliably implemented across all inpatient wards

The peripheral vascular cannula care bundle (insertion and ongoing care) has been a focus of pilot work within an acute medical ward and the Acute Medical Unit this year. The current post holder has recently retired and this work is going to continue through the Infection Control Nurses

The SKIN care bundle has been implemented across all ward areas with an improving compliance across the year. This care bundle aims to reduce the incidence of hospital associated pressure ulcers. This work has been complimented by focussed retraining and awareness on use of the Braden scoring methodology as a risk assessment tool when patients are admitted to hospital. Again the year has seen an improving compliance in terms of assessment being completed and completed accurately. We have seen a decrease in the number of grade 3 and 4 pressure ulcers this year with a static picture in grade 2s. Our aim is to achieve further reductions going forward into 2012/13.

Intentional Rounding to decrease falls has been introduced into 3 ward areas. This intervention is aimed at patients who are at high risk of falls, and ensures that they are seen every hour and offered a drink, or help with anything that they may need. This work will continue to be rolled out across all areas during 2012/13

3.5.5 Perioperative Care

- WHO Safe Surgery Checklist launched June 2009 across all theatres and we have seen improving compliance in 2011/12
- The perioperative care team continue to work on the Surgical Site infection bundle
- List pre briefings and debriefings were introduced across theatres and compliance continues to be monitored.

3.5.6 Critical Care:

- Reliable compliance (>95%) with care bundles (central lines, peripheral lines, and ventilator) all with the aim of reducing complications and infection.
- Reliable compliance with blood sugar control (>95% within guideline limits every month)
- Sustaining of Daily goals and multidisciplinary rounds with the aim of minimising length of time on a ventilator and stay on the ICU.

3.5.7 Medicines Management

- Medicines Reconciliation process has been spread to another acute medical ward beyond the pilot area with success
- Monthly monitoring and review of patients on warfarin therapy with an INR>6 continues.

3.6 The Annual Risk Management Plan - To develop an Annual Risk Management Plan, which is agreed, reviewed, and monitored by the Trust Board.
The 2011/12 Annual Risk Management Plan was developed by the Risk Management Team and agreed and monitored by the Clinical Risk Group and Clinical Governance Committee (See Appendix 1). It was presented to the Trust Board in October 2011 as part of the Annual Report. All objectives have been completed or are ongoing. Notable successes are:

- Combining of Quality and Safety Walks since October 2011
- Successful maintenance of NHSLA Level 2
- Continued improvement and approval of PCA document for Outcome 2 (Consent)
- Internal staff survey of patient safety completed
- Improvement in the tracking of recommendations from internal reviews
- Positive staff survey results regarding management of incidents
- Significant assurance from internal audit review 2011/12

The 2012/13 Annual Risk Management Plan has been agreed at the Clinical Risk Group and is enclosed in Appendix 2 for Trust Board Approval.

3.7.1 **Accountability and Responsibility Arrangements** - To ensure that all individuals within the organisation are aware of their role, responsibilities, and accountability with regard to Risk Management.

3.7.2 The Head of Risk Management continues to work closely with Directorate Management Teams to ensure they understand their accountabilities and responsibilities for managing risks in their areas, This is formalised through the quarterly 3:3 meetings and twice yearly reviews with the Executive Directors.

3.7.3 Incidents reported within the Directorates are reviewed quarterly at the 3:3s via the Risk Management Report Cards. This has allowed the capture of themes and pieces of work have been commissioned as a result. Some examples have been discussed in 3.3.6

3.7.4 Patient Safety and Risk Management continues to be integral to the educational programme for junior doctors as part of the Foundation Programme.

3.8 **Organisational Arrangements and Risk Management Structure** - To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually.

3.8.1 There have been no major changes to the Risk Management Structure during 2011/12.

3.9 **Ensuring Compliance with National Standards** - To ensure compliance with the NHSLA Risk Management Standards, Monitor and Health and Safety standards

3.9.1 The Trust achieved Level 2 NHSLA Risk Management Standards in April 2011, this exercise which covers 50 standards around organisational governance, a competent and capable workforce, maintaining a safe environment, clinical care, and learning, is coordinated by the Risk Department but requires input from right across the organisation

3.9.2 The Risk Management Team continues to work with the Chief Executives Office in order to demonstrate compliance with the Care Quality Commission’s regulations.
The Trust was subject to a successful CQC inspection in May 2011. The Head of Risk Management is responsible for Outcome 2 (Consent). The PCA document for this standard is updated within each year and has been submitted to the Trust Board in February 2012.

3.9.3 The Head of Risk Management works in close collaboration with the Head of Clinical Governance, Head of PPI, Head of Litigation, Head of Customer Care, Information Governance Manager, to ensure an integrated approach to clinical governance, safety, and service improvement.

3.9.4 The Risk Management Team continues to collaborate with the National Patient Safety Agency. This includes the Trust’s participation in the National Reporting and Learning System as well as co-ordinating a Trust response to the national alerts/notices/rapid response reports. This activity is co-ordinated by the Clinical Risk Group and monitored by the Clinical Governance Committee.

There have been 3 Patient Safety publications requiring action published by the NPSA during 2010/11. These include:

**Alerts:**

- No alerts were issued

**Notices**

- No notices were issued

**Rapid Response Alerts:**

- Keeping newborn babies with a family history of MCADD safe in the first hours and days of life
- Harm from flushing of nasogastric tubes before confirmation of placement
- Minimising risks of mismatching spinal, epidural, and regional devices with incompatible connectors

An expected completion date is issued with all NPSA publications. All of the above have an identified lead and action plan in place to work towards compliance.

Those that have been completed in year can be seen by the green arrows.

Those with an amber arrow reflect where action is underway towards compliance within the specified timeframe.

Those denoted by a red arrow show publications which have a lead and an action plan and are deemed but compliance has been a challenge within the specified time frame, this can be due to the scope and size of the action required.

All those with a red arrow have a risk assessment undertaken within the national closure timeframe and are closed on the CAS website.

During 2010/11 there were 13 Patient Safety Publications and of those 9 were non-compliant at the time of the 2010/11 annual report. Of these 9 there are now 8 that remain non-compliant but closed with a risk assessment and ongoing actions, as identified by the red arrows. There is 1 that is still in date as identified by the amber arrow.
Alerts:

- Safer spinal (intrathecal), epidural and regional devices part A (updated)
- Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants
- The adult patient’s passport to safer use of insulin

Rapid Response Alerts:

- Safer administration of insulin
- Reducing treatment dose errors with low molecular weight heparins
- Prevention of over infusion of intravenous fluid and medicines in neonates
- Preventing fatalities from medication loading doses
- Safer ambulatory syringe drivers
- Essential care after an inpatient fall

The Trust has a robust system in place for dealing with patient safety alerts to ensure that these are acted on appropriately and that any changes provide sustained improvement. To do this properly the Trust puts in place a detailed and comprehensive action plan to cover all the points that it feels it needs to meet all the requirements within the alert.

Historically the Trust would not formally close an alert unless it was satisfied that the process was completed. However, new guidance in December 2010 from the NPSA identified that alerts can be closed with ongoing actions as long as there is a risk assessment and action plan in place. This process is now in place for all alerts and notices and has not changed during 2011/12.

The process for monitoring the ongoing work identified in risk assessments for alerts will be further developed in 2012/13 via the Clinical Risk Group and 3:3 meetings with the Directorate Management Teams.

4 Future Developments

The Risk Management Team will continue to ensure implementation of the revised Risk Management Strategy through the Annual Risk Management Plan 2012/13 (appendix 2).

4.1.1 2012/13 will see ongoing development of the Assurance Framework to ensure that it is providing the Trust Board with intelligent information during increasingly challenging times.

4.1.2 The Risk Management team shall continue to support the delivery of the safety programme (Patient Safety First Campaign and NHS South West Quality and Safety Improvement Programme).

4.1.3 The Risk Management team shall actively support ongoing work regarding the Care Quality Commission regulations.

4.1.4 The Risk Management team shall continue to co-ordinate activity ensuring improved compliance with the NHSLA general standards.
4.1.5 The Risk Management team shall continue to ensure that risk information is provided to the commissioners as per the 2012/13 contract requirements.

4.1.6 The Risk Management Team will continue to develop the RCA tool for falls.

4.1.7 The Risk Management Team will work with Trust departments to support the development of robust local risk registers.

4.1.8 The Risk Management Team will work with IT to implement a replacement system for Datix that also includes Customer Care and Litigation and will provide an intranet adverse event reporting process.

4.1.9 The processes and structures for effective Risk Management are firmly established within the organisation but continue to evolve in response to national and local directives. There is a continued drive towards maintaining a safety culture whilst responding to the challenge of efficient management of resources.
# Risk Management Plan 2011/12 (with end of year review)

<table>
<thead>
<tr>
<th>Step 1. Building a Safety Culture – create and environment where staff are confident to use the Risk Management processes in supporting decisions</th>
<th>Objective</th>
<th>Recognised Outcome/Measure</th>
<th>Progress Against Objective</th>
<th>Person(s) Responsible &amp; Target for Completion</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| Reassess the safety culture within the Trust through the validated Staff Survey | | • Results analysed and presented following completion in Jan 2011  
• Repeat survey in Jan 2012 | Results collated and awaiting analysis  
Results reported to Clinical Risk Group in December 2011 and March 2012. Due to low numbers of responses the Safety Survey is to be reviewed in 2012. | DM/SK CRG  
September 2011  
Jan 2012 | December 2011  
Survey to be reviewed prior to repeating. For 2012/13 work plan |

<table>
<thead>
<tr>
<th>Step 2. Lead and Support Staff – Risk Management Department will exhibit strong leadership and ensure that all staff have access to or are competent in using the Risk Management processes</th>
<th>Objective</th>
<th>Recognised Outcome/Measure</th>
<th>Progress Against Objective</th>
<th>Person(s) Responsible &amp; Target for Completion</th>
<th>Completion Date</th>
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</table>
| Maintain high quality data capture and audit trail of actions taken as a result of the Executive Safety Walk Rounds | | • Identify key issues for safety that require Executive Lead  
• Ensure regular review and updates to outstanding actions  
• Consider function of walk rounds alongside Quality Walks | Actions for departments and Executives now clearly defined  
Ongoing monitoring in 3:3  
Quality and Safety Walks combined in October 2011. | Risk – All walks  
DM Quarterly  
DM with Quality Leads Dec 2010 | Completed (ongoing)  
Completed (ongoing)  
Completed October 2011 |

Monitor Risk Management training attendance in line with training needs analysis | | • Evidence of review by Clinical Risk Group and H&S Committee  
• Dissemination to Directorates | Risk Management Training reviewed and updated in 2011/12.  
Risk assessment training now delivered with H & S Manager.  
Investigation training now delivered with Customer Care and Litigation.  
Figures to be presented in Q1 2012/13. | Committee Chairs  
CRG Oct 2011  
H & S Nov 2011 | CRG June 2012  
H & S Committee July 2012  
Directorates Q1 2012 Quality 3:3 |
<table>
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<tr>
<th>Objective</th>
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<th>Person(s) Responsible &amp; Target for Completion</th>
<th>Completion Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Step 3. Integrate Risk Management Activity</strong> – <em>All components of Risk Management (clinical, financial, organisational) are integrated in such a way as to support corporate decisions</em></td>
<td></td>
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</tbody>
</table>
| Following Level 2 compliance April 2011, ensure action plan in place to work towards maintaining level 2 April 2014. | • Wash up meeting with standard leads  
• Review publication of updated standards January 2012  
• Meeting with NHSLA assessor Feb 2012  
As above | Completed – action plan to follow Interim visit booked for March 2012 | DM August 2011  
DM January 2012  
DM February 2012 | August 2011  
January 2012  
March 2012 |
| Maintain compliance with Maternity NHSLA Risk Management Standards | | | DM August 2011  
DM January 2012  
DM February 2012 | August 2011  
January 2012  
March 2012 |
| Ensure compliance with the CQC Regulations and associated Outcomes (Outcome 2 Consent to Care and Treatment and Outcome 20 Notification of Other Incidents). | • Monitor completion of work identified in action plans to ensure continuous improvement  
• Patient survey and consent  
• Maintain updated PCA document | | DM Dec 2011  
DM Dec 2011  
DM March 2012 | December 2011  
Pilot completed Dec 2011  
February 2012 |
| Ensure risk and safety reporting requirements as per the contract are reported to commissioners | • Reporting requirements met  
• Maintain timeliness of SII reports to meet national and local targets and Commissioner input as required | Ongoing  
All current SII within time limits agreed with Commissioner | DM March 2012 | March 2012 |
| Produce an Annual Report clearly illustrating progress made in 2010/11 on the management of Risk within the organisation | • Risk Management Annual Report presented to Trust Board | Report completed September 2011 for Trust Board October 2011 | DM October 2011 | October 2011 |
| Review the Risk Management Strategy | • Risk Management Strategy revised and ratified by Trust Board  
• Following meeting with the NHSLA Feb 2012, consider if further Trust review of Risk Management process required | Revised September 2011 for Trust Board October 2011  
Risk Strategy to be updated as required by September 2012. Changes as identified in April 2012 Trust NHSLA workshop | DM October 2011  
March 2012 | October 2011  
March 2012 and ongoing for 2012/13 |
<table>
<thead>
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</tr>
</thead>
</table>
| Continue to develop and embed the Assurance framework ensuring its status as a key document in steering the focus of the Trust Board and Assurance Committees with a clear audit trail of actions taken to reduce strategic risk. | - Dynamic assurance framework in evidence  
- Assurance framework deemed compliant by Internal audit review 11/12 | Regular updates continue | DM March 2012 | March 2012 |
| Continue to develop the risk management links within service development and project planning processes within the Trust | - Risk reviews incorporated into these processes giving clarity of purpose, associated risks, and monitoring of mitigation activities | Ongoing input to Theatre Management System Group  
Ongoing membership to Order Comms group | DM Ongoing | Ongoing |
| Contribute to the development of clinical dashboards and the Quality Account in relation to risk and patient safety information | - Continue to identify data that can be incorporated into the development of dashboards using current safety data from Datix  
- Ongoing data input to KQIs  
- Input to review of the previous Quality Meetings to identify Directorate strengths and weaknesses for Risk Management and Patient safety | Applicable data has been discussed. Pending future work on Dashboards  
Review ongoing  
In line with work by Head of Clinical Effectiveness | DM/SK  
March 2012  
DM/AK  
DM Dec 2011 | Completed  
Completed |
| **Step 4. Promote Reporting – clinical and non clinical incidents** | | | | |
| Work with IT to complete the capital bid for the introduction of the Datix web system covering incident reporting, risk management and complaints. If capital bid successful, have a pivotal role in implementing this system as part of a Trust wide project plan and ensure that other objectives related to incident reporting are sustained | - Completion of capital bid  
- Identification of project plan to commence in April 2012 | Completed and submitted  
Capital bid unsuccessful. Trust IT project bid accepted. Collaborative working commenced. | DM August 2011  
DM March 2012 | 18/08/11  
April 2012 ongoing |
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<tr>
<td>Continue to monitor themes and trends from reported adverse events via the Risk Report Cards and Clinical Governance Report cards. Maintain a robust monitoring report of progress against recommendations from Clinical Reviews and SIIs</td>
<td>• Directorate and Trust wide Risk Report cards evidenced with emerging themes/trends and actions  • Never events added to report card  • Outstanding actions from CR/SI monitored via 3:3  • Timely closure of incidents monitored via 3:3  • Timely upload of incident data to the Datix system  • Evidenced through Annual Report</td>
<td>Ongoing quarterly reports</td>
<td>DM/CG March 2012</td>
<td>All reports completed for 2011/12</td>
</tr>
<tr>
<td>Through the Risk Report Cards monitor reporting by Department and Professional group with focussed work resulting in those areas showing low engagement.</td>
<td>• Directorate and Trust wide report cards to show reporting by Department and staff group  • Actions taken as a result of above data  • Maintain levels of reporting identified by staff survey and national data</td>
<td></td>
<td>DM/CG March 2011</td>
<td>All reports completed for 2011/12</td>
</tr>
<tr>
<td>Maintain staff awareness of incident reporting, feedback mechanisms and shared learning</td>
<td>• Maintain comparison levels with other Trusts regarding reporting  • Continue improvement of staff perception and understanding of incident reporting</td>
<td>Ongoing review of NRLS reports To be picked up within the implementation of the replacement datix system</td>
<td>DM/CG October 2011 DM/CG March 2012</td>
<td>October 2011 and March 2012 For 2012/13</td>
</tr>
<tr>
<td>Implement changes to external reporting mechanisms as systems become available. This will be impacted by the restructure of the NPSA and SHA</td>
<td>• Implementation of systems as they arise</td>
<td>No significant changes in 2011/12</td>
<td>DM March 2012</td>
<td>March 2012</td>
</tr>
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<td><strong>Step 5. Involve and Communicate with Patients and the Public</strong></td>
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| Continue to maintain and strengthen Trust Being Open policy with ongoing promotion of an open culture with families, patients and staff when patient safety incidents have occurred | • Clinical Governance session regarding being open and patient stories  
• Patient and family support | Written submission for Clinical Governance newsletter  
Ongoing support to families and patients | Jan 2012  
DM ongoing | Feb 2012  
March 2012 ongoing |
| **Step 6. Learn and Share Safety Lessons** – *sound investigative techniques are applied and robust solutions are implemented as a result* | | | | |
| Continue to work with the NPSA ensuring that patient safety lessons learnt on a national level are incorporated into the Trust’s working practices | • NPSA Alerts quarterly progress report  
• Review of new processes required for SIGNALS alerts and any changes to reporting from the reduction of the NPSA | Ongoing  
Discussed at CLIP and CAS meetings. Discussed at CRG. To be managed via CLIP and circulation to interested parties. Reports not required. | CG  
DM/CG March 2012 | March 2012 ongoing  
Dec 2011 |
| Provide integrated training for Directorate Management teams on use of RCA across both incidents and complaints in conjunction with the Customer Care Manager | • Training sessions to be rolled out and evaluated  
• Attendance to be monitored as detailed in Step 1 | Directorate sessions completed.  
Ongoing programme advertised.  
For further development in 2012/13 | CLIP  
March 2012 | March 2012 ongoing |
| Further embed and sustain electronic solution to the follow up of Clinical Review/Serious Incident Inquiry recommendations to ensure a robust, timely, and effective procedure | • Follow up process in place and working using Datix software  
• Reporting of progress on actions from reviews and inquiries added to report cards  
• Tracking system of recommendations to be improved | Ongoing  
Ongoing | DH/SK  
March 2012 and ongoing  
DM/DMTs Oct 2011 | Completed  
Completed |
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| Continue Trust participation in NHS South West Quality and Patient Safety Programme | • Further development of metrics associated with each intervention to evidence improvement  
• Monitoring of impact through extranet reports presented at the Safety Steering Group and CGC  
• Provide ongoing links to Safety project from Risk Department including involvement in the General Ward stream.  
• Continued development across the work streams despite changes to external influences | SW Quality and Safety Programme no longer exists – data still posted on extranet and compliance monitored                                                                                                                        | TN/LW March 2012                                                                                                                                            | March 2012         |
| Maintain the profile of the Safety project within the Trust during strategic changes within the SHA |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                           | CG/DM March 2012 | March 2012         |
|                                                                           |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                           | LW/DM March 2012 | ongoing            |
Risk Management Plan 2012/13 (with mid-year progress)

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<tr>
<td><strong>Step 1. Building a Safety Culture</strong> – <em>create and environment where staff are confident to use the Risk Management processes in supporting decisions</em></td>
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| Reassess the safety culture within the Trust through the validated Staff Survey | • Undertake literature review  
• Redesign patient safety survey and gain approval from CRG prior to use  
• Undertake Staff Safety Survey | Competed and being reviewed | FH July 2012  
FH Oct 2012  
Dec 2012 | July 2012 |
| **Step 2. Lead and Support Staff** – *Risk Management Department will exhibit strong leadership and ensure that all staff have access to or are competent in using the Risk Management processes* | | | | |
| Ongoing development of Patient Safety and Quality Walkrounds. | • Maintain clear action leads and identify on Datix  
• Monitor compliance with actions via 3:3  
• Provide annual report to CGC | | FH March 2013  
FH March 2013  
FH August 2013 | |
| Monitor Risk Management training attendance in line with training needs analysis and review current training | • Evidence of review by Clinical Risk Group and H&S Committee  
• Dissemination to Directorates | Data being collected | Committee Chairs/FH  
CRG June 2012  
H & S Committee July 2012  
FH/ CH March 2013 | |
| **Step 2. Lead and Support Staff** – *Risk Management Department will exhibit strong leadership and ensure that all staff have access to or are competent in using the Risk Management processes* | | | | |
| Work with across Trust Departments to ensure that robust departmental risk registers are in place in line with the Trust Risk Management Policy | • Identify Trust wide work plan  
• Work with DMTs to identify non-compliant/low uptake areas and monitor at 3:3s  
• Identify further work plan for 2013/14 in light of NHSLA requirements | Scoping work of current local risk registers and review of Trust risk register | FH/CG Sept 2012  
FH/CG Dec 2012  
FH/CH March 2013 | |
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| Update suite of Risk policies in line with NHSLA requirements and any changes to process | ● Policies to be submitted to CRG and approval boards:  
- Adverse Event Reporting  
- Adverse Events – supporting those involved  
- Learning from incidents, complaints and claims  
- Risk Management Policy and Procedure | Reviewed July 2012  
Reviewed July 2012 – updates being made | FH Dec 2012 |

**Step 3. Integrate Risk Management Activity** – *All components of Risk Management (clinical, financial, organisational) are integrated in such a way as to support corporate decisions*

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| Following Level 2 compliance April 2011, ensure action plan in place to work towards maintaining level 2 April 2014. | ● Trust NHSLA tabletop workshop  
● Organise interim visit with NHSLA for 2012/13  
● 2nd Trust tabletop workshop date to be organised  
● Review of NHSLA standards on publication Jan 2013 | Completed  
No interim visit due to no assessment in 2013/14 year | DM April 2012  
FH June 2012 | April 2012  
July 2012 |
| Maintain compliance with Maternity NHSLA Risk Management Standards | | | | |
| Ensure compliance with the CQC Regulations and associated Outcomes (Outcome 2 Consent to Care and Treatment and Outcome 20 Notification of Other Incidents). | ● Monitor completion of work identified in action plans to ensure continuous improvement and maintain PCA document  
● Patient survey and consent to be completed  
● Survey results to be presented to CMB  
● Confirm with CMB if further data collection to continue  
● Review of Consent Policy | Updated June 2012  
Survey data collection May 2012. Delayed due to poor response | FH Quarterly during 2012/13 | |
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| Ensure risk and safety reporting requirements as per the contract are reported to commissioners | - Reporting requirements met  
- Maintain timeliness of SII reports to meet national and local targets and Commissioner input as required |                                                                                             | FH                                                             | March 2013        |
| **Step 3. Integrate Risk Management Activity** — *All components of Risk Management (clinical, financial, organisational) are integrated in such a way as to support corporate decisions* |                                                                                             |                                                                                             |                                                                  |                   |
| Produce an Annual Report clearly illustrating progress made in 2012/13 on the management of Risk within the organisation | - Risk Management Annual Report presented to Trust Board                                 | Report for CGC September 2012                                                              | FH                                                             | October 2012      |
| Review the Risk Management Strategy                                      | - Risk Management Strategy revised and ratified by Trust Board                           |                                                                                             | FH                                                             | October 2012      |
| Continue to develop and embed the Assurance framework ensuring its status as a key document in steering the focus of the Trust Board and Assurance Committees with a clear audit trail of actions taken to reduce strategic risk. | - Dynamic assurance framework in evidence  
- Assurance framework deemed compliant by Internal audit review 12/13 | Agreed July 2012                                                                            | FH present at Assurance Committees 2012/13                  | FH March 2013      |
<p>| Continue to develop the risk management links within service development and project planning processes within the Trust | - Risk reviews incorporated into these processes giving clarity of purpose, associated risks, and monitoring of mitigation activities |                                                                                             | FH                                                             | ongoing           |
| Contribute to the development of the Quality Account in relation to risk and patient safety information | - Ongoing data input to KQIs                                                           |                                                                                             | FH                                                             | ongoing           |</p>
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<td>Work with IT to contribute to the development of a replacement system for Datix to include: Web based adverse event reporting and investigation system Risk Assessment Module Contacts Module Administration and reporting requirements Executive Safety Walkaround Module Customer Care Module Litigation Module</td>
<td>• Link with project manager (Carol Perren) to confirm workstreams required • Development of replacement system • Project plan and implementation</td>
<td>Work ongoing to develop electronic sheet 1 and 2 to be available via the intranet. Aim for roll out November 2012</td>
<td>FH and Risk Team Ongoing IT – project plan not yet in place</td>
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<tr>
<td>Work with IT, Customer Care and Litigation to identify implementation plan for:</td>
<td></td>
<td></td>
<td>FH/Risk Team, Customer Care, Litigation No current time frame available</td>
<td></td>
</tr>
<tr>
<td>Continue to monitor themes and trends from reported adverse events via the Risk Report Cards. Maintain a robust monitoring report of progress against recommendations from Clinical Reviews and SII</td>
<td>• Directorate and Trust wide Risk Report cards evidenced with emerging themes/trends and actions • Ongoing work with Directorates via DMT 3:3 pre-meetings • Ongoing development of mid and end of year CLIP reports • Evidenced through Annual Report</td>
<td></td>
<td>FH/CG March 2013</td>
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<td>Through the Risk Report Cards monitor reporting by Department and Professional group with focussed work resulting in those areas showing low engagement.</td>
<td>• Directorate and Trust wide report cards to show reporting by Department and staff group for mid and end of year • Actions taken as a result of above data • Maintain levels of reporting identified by staff survey and national data</td>
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<td><strong>Step 4. Promote Reporting – clinical and non clinical incidents</strong></td>
<td>Maintain staff awareness of incident reporting, feedback mechanisms and shared learning</td>
<td>● Maintain comparison levels with other Trusts regarding reporting</td>
<td>FH and Risk Team</td>
<td>March 2013</td>
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<tr>
<td></td>
<td>● Continue improvement of staff perception and understanding of incident reporting (to be reviewed with the Datix replacement project)</td>
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<td>Implement changes to external reporting mechanisms as systems become available. This will be impacted by the restructure of the NPSA and SHA</td>
<td>● Implementation of systems as they arise</td>
<td>FH March 2013</td>
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<td>Review the Trust scoring matrix to reflect the most up-to-date guidance from the NPSA regarding grading of harm</td>
<td>● Update Matrix and approval from CRG</td>
<td>FH/CG Sept 2012</td>
<td></td>
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<td><strong>Step 5. Involve and Communicate with Patients and the Public</strong></td>
<td>Continue to maintain and strengthen Trust Being Open policy with ongoing promotion of an open culture with families, patients and staff when patient safety incidents have occurred</td>
<td>● Clinical Governance session regarding being open and patient stories</td>
<td>FH/TN/CB Dec 2012</td>
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<td><strong>Step 6. Learn and Share Safety Lessons – sound investigative techniques are applied and robust solutions are implemented as a result</strong></td>
<td>Continue to work with the NPSA ensuring that patient safety lessons learnt on a national level are incorporated into the Trust’s working practices</td>
<td>● NPSA Alerts quarterly progress report</td>
<td>CG March 2013</td>
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<td></td>
<td>● Implement process for follow up and review of risk assessments linked to NPSA alerts</td>
<td>Ongoing</td>
<td>CG/FH July 2012</td>
<td>Ongoing</td>
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<td>Raised through 3:3 process with DMT, if appropriate action not taken for escalation through CRG</td>
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| Review all risk management training and ensure compliance with NHSLA standards                                                                     | ● Incident reporting  
      ● Risk Assessment Training  
      ● Investigation (joint training)  
      ● Attendance to be monitored as detailed in Step 2                                                                                     | Training to be further reviewed with implementation of new incident reporting system                                                                         | CG/FH Jan 2013  
      Committee Chairs/FH  
      CRG June 2012  
      H & S Committee July 2012                                                                                                                     |                 |
| Continue to implement the RCA tool for falls and identify key issues for learning                                                                      | ● Key issues/learning from completed RCAs to be presented at Trust Falls Group to agree actions  
      ● Present to CRG as part of falls reporting                                                                                                      |                                                                                                                                                             | CG Oct 2012  
      CG Quarterly 2012                                                                                                                                       |                 |

**Step 7. Implement Solutions to Prevent Harm** — includes identification of local solutions, system redesign (proactively and reactively)

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| Continue Trust participation in NHS South West Quality and Patient Safety Programme  
      Maintain the profile of the Safety project within the Trust during strategic changes within the SHA | ● Further development of metrics associated with each intervention to evidence improvement  
      ● Monitoring of impact through extranet reports presented at the Safety Steering Group and CGC  
      ● Provide ongoing links to Safety project from Risk Department including involvement in the General Ward stream.  
      ● Continued development across the work streams despite changes to external influences                                                                 | NHS South West Quality and Safety Programme no longer exists however use of the extranet site continues for posting data and monitoring compliance. Safety Steering Group dissolved and reports made directly to appropriate monitoring groups. | Ongoing                                                                                                           |                 |