Report to:	Trust Board (Public)	**Agenda item:**	**SFT4120**
Date of Meeting:	4th October 2018		

Report Title:	Risk Management Annual Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		**X**	
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Executive Sponsor (presenting):	Lorna Wilkinson			
Appendices (list if applicable):				

Recommendation:

Information - The Board is asked to note the achievements for 2017/18 within the Annual Risk Management Report.

Executive Summary:

The Risk Management Annual Report focuses on the progress that has been made against the strategic goals as set out in the Risk Management Strategy ,the lessons that have been learnt as a result of incident reviews undertaken, changes within the risk (particularly incident reporting) processes over the 2017/18 year and ongoing progress against agreed key performance indicators.

The report also confirms that accountability and responsibility arrangements are in place within the organisation and monitored on a regular basis and compliance is maintained with national standards and requirements including CQC regulations, NHS England Patient Safety Alerts and reporting to the National Reporting and Learning System.

Key items to note:

- Continued improvements to the Board Assurance Framework (BAF) and risk register processes
- The Trust continues to benchmark positively on rate of incidents reported as well as staff

feeling that the process is fair

- There has been a drop in the total incidents reported on previous year (although still above average nationally) and this needs to be understood during 2018/19
- New Head of Risk Management commenced in post Q4
- The Trust continues to network with the Wessex Patient Safety Collaborative and NHSI on key patient safety workstreams

SALISBURY NHS FOUNDATION TRUST

Risk Management Annual Report 2017/18

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 Risk Management Strategy in place, which was agreed by the Trust Board in December 2017. 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.

Good risk management has the potential to impact on performance improvement, leading to:

- Improvement in service delivery
- More efficient and effective use of resources
- Improved safety of patients, visitors and staff
- Promotion of innovation within a risk management framework
- Proactive management of incidents and a reduction in time spent 'firefighting'
- Assurance that information is accurate and that controls and systems are robust and defensible.

This report presents the achievements as measured against the strategic goals within the Risk Management Strategy (2017) over the last financial year (1st April 2017 – 31st March 2018).

2. Risk Management Strategy Objectives

2.1 The Risk Management Strategy (2017) 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.

2.2.1 Strategic Goals

The strategic goals within the Risk Management Strategy (2017) are as follows:

- To ensure that the Trust remains within its licensing authorisation as defined by NHSI 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 provider licence.

- 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 Sign up to Safety and Patient Safety Collaborative interventions.

- To ensure that the Trust can demonstrate compliance with the statutory Duty of Candour ensuring that it maintains a consistent open and honest culture, involving patients and families in investigations where appropriate.

- 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 NHSI, Care Quality Commission registration requirements, and Health and Safety Standards.

3 Progress against Strategic Goals 2017/18

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

3.1.1 NHS Improvement (NHSI) 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 Board Assurance Framework (BAF) is aligned to the strategic objectives in the Trust's Strategy, Shaping the Future, which was approved by the Trust Board in December 2017. The BAF documents the Trust's six strategic priorities, progress on delivery, and the associated risks, controls, gaps and mitigation plans.

3.2.2 The BAF format was reviewed and relaunched following Board ratification in December 2017. The BAF and Corporate risk register processes have been strengthened and both are presented to sub committees and public Trust Board Bimonthly.

3.2.3 The Audit Committee monitors the Assurance Framework process overall. It is the responsibility of the Assurance Committees (sub committees of Trust Board) to review the BAF and Corporate Risk Register to ensure breadth and depth of information and for assurance that actions are being taken to control and mitigate the risks cited. The assurance committees subsequently report to the Trust Board any new risks identified, and/or gaps in assurance/control. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this is reported immediately via the Executive.

The Board Assurance Framework and Risk management processes have been subject to review by Internal Audit during 2017/18 .This included a full documentary evidence review. The subsequent report gave an overall opinion of 'substantial assurance'. The conclusion of the auditors was:
'*the 2017/18 Board Assurance Framework (BAF) is embedded within the governance structure of the Trust processes to ensure that it is continually updated (for controls, assurances, risks and gaps) and therefore operates as a 'live' document. The overall rating given was of 'Substantial Assurance'.*

The BAF was reviewed as part of the well led review in January 2018 and the developments were noted and described positively.

Continued work is on-going with departments and directorates to review their risk registers and ensure that all relevant risks are identified and recorded and that the directorates have processes in place to escalate risks where support is required.

3.2.4 The Trust produced an Annual Governance Statement for 2017/18, which was fully compliant and evidenced through the Assurance Framework and supporting documentation.

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 Requiring Investigation Policy.
- Duty of Candour and Being Open Policy

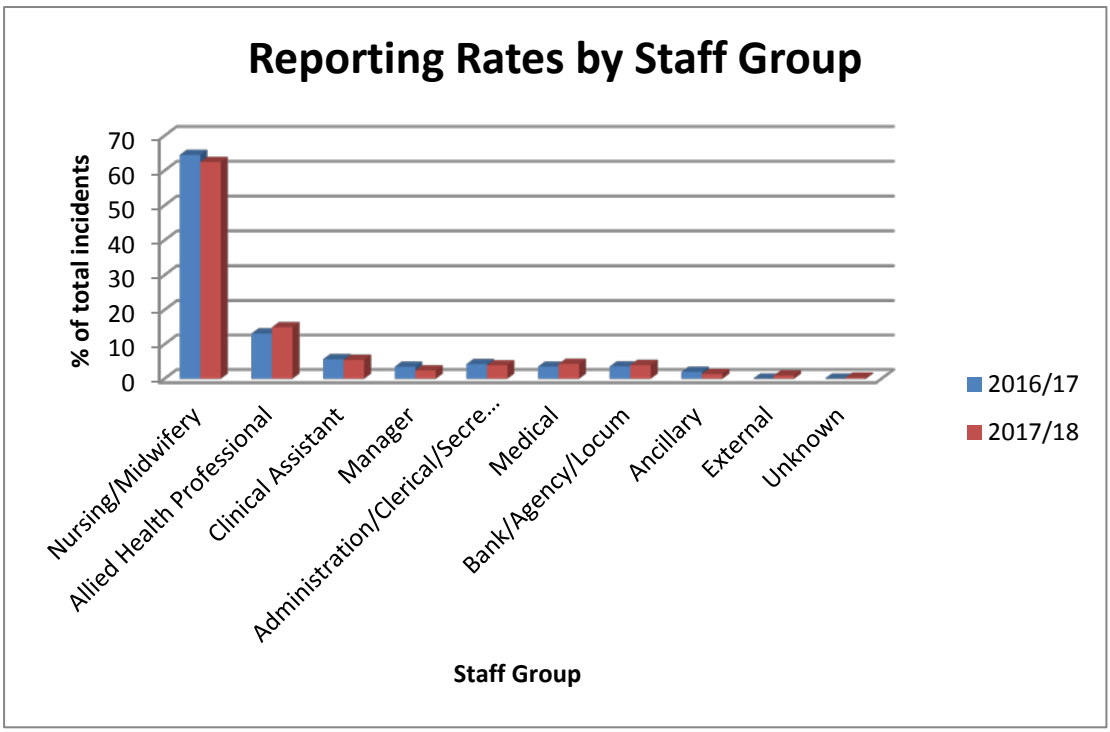
This suite of supporting policies provide the 'how to' practicalities for staff and are all within their renewal dates.

3.3.2 All Directorates have risk registers, high risks (12+) and those requiring executive support are reported and monitored via the executive performance meetings. During 2017/18 work has continued to ensure that monitoring within the performance meetings is adequately documented within the minutes and the Trust Risk Register is updated accordingly. Following publication of the Trust's Accountability and Integrated Governance frameworks the process has been strengthened.

3.3.3 Reporting of incidents across the Trust decreased by 14.5% during 2017/18. However despite this decrease the NRLS report for April 2017 - September 2017 identified that there was no evidence of the Trust under reporting with 41.99 incidents

per 1000 bed days reported. The median for Acute (non specialist) organisations is 40.02 incidents per 1000 bed days.

Due to the decrease in incidents being reported there will naturally be a decrease in the reporting rate of various staff groups however there has been an increase in the number of Medical staff, Allied health and bank/agency and locums reporting incidents which is positive.



The 2017 Staff Survey indicated one question where Salisbury NHS Foundation Trust compared less favourably against other trusts. This was on the percentage of staff reporting errors, near misses or incidents witnessed in the last month (88% vs national average of 90%). However the Trust compares favourably when benchmarked against others in the same national staff survey on fairness and effectiveness of procedures for reporting errors, near misses and incidents, and staff confidence and security in reporting unsafe clinical practice. This is therefore quite complex to understand and should form part of the listening events within the staff engagement programme.

78% of reported incidents resulted in no harm to patients compared with 72% the previous year. The number of near misses has increased by 53% from the previous year. It is important to note that a high reporting rate of near misses as well as actual incidents indicates a strong reporting and learning culture and therefore is a positive measure.

3.3.4 The process for commissioning and carrying out reviews (Clinical Reviews and Serious Incident Inquiries) is set out in the Adverse Events Reporting Policy. During 2017/18 there were 23 Serious Incident Inquiries commissioned and 2 Clinical Reviews. These figures compare with 47 Serious Incident Inquiries and no Clinical Reviews in 2016/17. There has been a reduction in the number of Serious Incident Inquiries due to falls due to a change in local contract agreement with the CCG regarding falls incidents. This change was to release clinical time to be proactive on the actual falls improvement programme embedding learning following a fall rather

than using resources to write numerous RCA's. This has been received positively and has allowed for the embedding of SWARMs and the share and learn sessions.
If learning identified through a SWARM review, following a fall, is already known then recommendations and actions will be put in place with strict target dates being set to implement the learning and provide evidence this has been done. The CCG are still to be informed of the incident and that it does not meet the STEIS requirement. However, where new learning has been identified through the SWARM a full Serious Incident Investigation is undertaken and follows the existing process. Updates were still provided for all falls resulting in fracture or major harm via the quarterly falls report.

Of the 23 Serious Incidents there were the following themes:

- 6 were falls resulting in fractures, (5 were fractured hips, 1 distal femur fracture). This is a reduction on previous year
- 2 were hospital acquired grade III pressure damage (there were no grade IV hospital acquired pressure ulcers). This compares to the same number of 3 grade III hospital acquired pressure ulcers in the previous year. Monthly 'share and learn' reviews continue to identify areas where 'clusters' of hospital acquired grade 2 pressure ulcers are identified to promote a proactive approach to learning and prevention.
- 3 'Never Events' were reported during the year. All were perioperative events. All patients recovered well and did not require further treatment.
- 5 incident investigations related to delays/errors in the cancer pathway – in this group the underlying causes are varied but commonly associated with the cancer pathway and processes, or clinical judgements. An aggregated review across the whole patient pathway has been commissioned by the Cancer Board.

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 Management Board and Clinical Governance Committee with a quarterly report on compliance with the recommendations from these reviews. The themes arising from such reviews during 2017/18 have led to some key pieces of work being undertaken including:

- A full waiting list validation exercise and review of capacity commissioned. The Cancer Lead Clinician is coordinating a full review of the pathways and the key area of risk as evidenced by the cancer related serious incident investigations. Learning is being aggregated from these reports and will be shared widely across the organisation.
- ED referral reference guideline for suspected lung cancer referrals.
- Intensive support for theatres is being provided by the Directorate Management Team which is overseen by fortnightly meetings with executive directors. Part of this support has included listening exercises and the development and implementation of a theatres improvement plan.
- New Intra-operative burn protocol to include British Burn's Association guideline for first aid management for burn injury and management options, enhanced by SIMulation training in the theatre.
- Regular SIM training in emergency situations, based in Day Surgery Unit theatre environment
- Standard operating policy written for Decontamination processes within theatres.

- Standard operating policy and the WHO surgical checklist revised. This included the checking for completeness and integrity of instruments as a standard check for every procedure.

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 reviews and this contributes to learning for staff. Ongoing support and communication with a nominated point of contact takes place for staff, patients and families whilst they go through the Serious Incident Inquiry process, as per the "Duty of Candour and Being Open Policy". Staff are also given details of the Trust's Staff Counsellor and Clinical Psychology Department who can be accessed independently for support.

Work continues to support clinicians in implementing the statutory 'Duty of Candour'. The Duty of Candour places a requirement on providers of health and adult social care to be open with patients when things go wrong. This requirement is built into the web incident reporting form so that compliance can be monitored at all stages of the incident process. Duty of Candour outcomes for Serious Incidents is reported regularly to the Clinical Risk Group, Clinical Governance Committee and Trust Board. Work is ongoing to ensure that compliance is achieved for events that meet the duty of candour threshold but not that of a serious incident i.e. lower level of harm.

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

Any clinical or non-clinical working group 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 Safety Group and security incidents for the Security Management Committee. Reports are also compiled for clinical areas with active risk groups so that they may review themes within incidents and use this to inform their risk registers. The introduction of the web reporting system has further enhanced this as the system has the functionality for teams and individuals to set up bespoke reports. Regular training sessions on reporting are available for staff to book on through the Datix Administrator.

1:1 sessions were also facilitated in 2017/18 by the Head of Risk Management and ward/departmental leads to identify key incident themes in their areas and actions that were being taken to address these. This was seen as a way of feeding back to staff actions that had been taken as a result of incidents reported. Whilst there was initially good engagement with this process, the focus will be sustaining it in 2018/19.

Reviews of complaints, litigation and incidents to try and triangulate data have proved unsuccessful. Whilst there are links between incidents and complaints within the timeframes reviewed, there is often disparity with claims data as there is frequently a time lag between the incident and a claim being brought. However, web reporting does support directorates and teams being able to review data independently and aggregate their own themes over differing time periods.

Ongoing developments have taken place in 2017/18 to meet the requirements of quality in line with commissioner contracts and the Quality Account. This work will continue in 2018/19.

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 Reporting across the Trust remains fairly consistent with the numbers of incidents graded major and catastrophic remaining low (0.5%) which is positive. All departments and staff groups in the Trust report incidents although some more frequently than others. There is continued work to identify low reporting areas and understand the reason for this, putting in support and education measures where required

3.4.2 All risks are held within the risk module of Datix, regardless of score, resulting in departments and directorates being able to access all risks via a central database. Work continues to ensure that risks are carefully managed to ensure appropriate and timely escalation where required to allow the Trust to build a picture of organisational risks at all levels and support the allocation of resources to mitigate Trust wide risks. This is a large piece of work and will continue to be a focus in 2018/19.

3.4.3 An ongoing KPI to evidence 100% completion of a full root cause analysis (RCA) for all fractures following a fall. This is successfully embedded in practice and used across the Trust.

There has been a reduction in the number of falls resulting in a fracture from 33 in 2016/2017 to 25 in 2017/2018, representing a 15% overall reduction in falls resulting in harm. The rate of falls resulting in patients fracturing their hip showed a small reduction from last year. We have found that these patients often have delirium as a result of their illness, surgery or medication. Some patients, who were admitted following a fall at home, had recovered, and were ready to go home, but were waiting for a care package when they fell and suffered a fracture. This reduction has been achieved by taking a fresh look at our approach to falls prevention and the introduction of a new risk assessment. This focused on a wider range of risks including removing trip hazards around the patient's bed space and putting the beside locker and belongings on the same side as the patient gets out of bed at home. There has been focus on taking a patient's blood pressure when lying down and standing up to spot whether the blood pressure falls when the patient stands up. If so, medication that could be causing it is reviewed. The introduction of double grip slipper socks on every ward to help prevent a patient slipping on the floor. We wanted to improve the observation of patients with delirium and have successfully tested an updated pressure sensor mat on one ward to alert staff when a patient gets out of bed or stands up from a chair. New updated pressure sensor mats will be in place in early 2018/2019. We also plan to introduce a delirium care bundle which is a set of practices to investigate, manage and plan care and treatment in early 2018/2019. This work remains a priority in order to sustain the improvement during 2018/19

A quarterly report of all falls root cause analysis undertaken continues to be discussed at the Falls Group, Clinical Risk Group, and Clinical Management Board and fed back through the Contract Quality Review Meeting. This report has been revised recently in order to provide a more comprehensive overview of all the falls related work across the Trust and now also includes full numerical trends (including

no harm falls), aggregated themes from the quarters, sign up to safety, falls work stream, and the new falls trust wide action plan. Key findings from these aggregated reports have demonstrated:

- A number of the patients are frail and elderly;
- Many have a history of falls including this being their reason for admission;
- Many of the patients are fit for discharge and awaiting either a package of care for support in their own home or placement to a residential setting with care.

3.4.4 The Trust continues to complete the monthly Safety Thermometer return and utilises this data for internal quality improvement

3.4.5 The Sign up to Safety programme has continued and is reported via the safety steering group. The Director of Nursing is currently chair of the Wessex Patient Safety Collaborative Steering Group and the Trust has been an active participant in regional events

3.4.6 A robust process is in place for the receipt and management of NHS England Patient Safety Alerts which is managed via the Clinical Risk Group

3.5 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.*

3.5.1 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 risk and governance executive performance meetings and stocktakes with the Executive Directors.

3.5.2 Incidents reported within the Directorates are reviewed quarterly at the risk and governance executive performance meetings via the Risk Management Incident data.

3.5.3 Patient Safety and Risk Management continues to be integral to the educational programme for junior doctors, student nurses, specialist staff groups, staff development programmes and the induction of all new staff.

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

3.6.1 It was recognised that additional Patient Safety Facilitator hours were required to support the risk agenda, particularly falls. A business case was submitted for 0.6 wte hours which was supported by the board and agreed in April 2017. Recruitment to this post has been successful. It is important to note that the Risk team have experienced some instability this year in that there has been a high level of maternity leave which is covered by temporary secondments and a new Head of Risk commenced in post during Q4. Despite this the team haver continued to function well and ensure that all contractual requirements are met.

3.7 Ensuring Compliance with National Standards - To *ensure compliance with the Care Quality Commission, NHSI and Health and Safety standards*

3.7.1 The Risk Team continues to work with the Chief Executive's Office and Directorate management Committees in order to demonstrate compliance with the Care Quality Commission's regulations and provide additional information where requested from the CQC.

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

3.7.3 The Risk Team continues to collaborate with NHS Improvement. This includes the Trust's participation in the National Reporting and Learning System as well as co-ordinating a Trust response to the NHS Improvement Patient Safety Alerts. This activity is co-ordinated by the Head of Risk and Patient Safety Facilitator and overseen by the Clinical Risk Group. The Trust currently has no open NHS England Patient Safety Alerts, which are beyond their due date.

4 Future Developments

4.1 2018/19 will see the continued development of Datixweb to support the Trust in its risk management processes and provide accurate and timely information to staff, managers and the Trust Board.

4.2 The Risk Team shall actively support ongoing work regarding the Care Quality Commission regulations and inspection.

4.3 The Risk Team shall continue to ensure that risk information is provided to the commissioners as per the 2018/19 contract requirements.

4.4 The Risk Team will take a lead role in the falls prevention work, including participation in NHSI Falls Collaborative.

4.5 The Risk Team will work with departments and Directorate Management Committees to support the development of robust local risk registers, with appropriate risks escalated for Directorate/Board awareness.

4.6 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.

4.7 A review of staff requirements and training available will be undertaken to ensure that the needs of staff at all levels of the organisation are being met.