Trust Risk Management Department

Annual Risk Management Report 2007/8*

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*The report was produced in August 2008 and therefore contains some information for 08/09.
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### Appendix 1: Risk Management Structure

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### Appendix 4: Division of Acute Medical Care

### Appendix 5: Division of Surgery and Anaesthetics

### Appendix 6: Women’s and Children’s Services Division

### Appendix 7: Clinical Support Division

### Appendix 8: Facilities & Estates Division
1. Introduction

The aim of this report is to highlight the progress that the Trust has made, towards all aspects of Risk Management, during the past 12 months (1st April 2007 – 31st March 2008). It outlines the role, structure, work programme and achievements to date. It will also set out the aims of the department for the forthcoming 12 months.

The report is broken down into several sections; the main body of the report provides an overview of the whole Trust in relation to risk management whilst the divisional appendices provide a more in depth analysis of each division.

As this report has been compiled during the month of August 2008 so some aspects of the report may extent past March 2008.

1.1 Role

The role of the Risk Management Department is to coordinate and support the Trust to effectively manage risk through reactive, proactive and contemporaneous means. This is achieved through the identification, prioritisation and management of risk from a variety of sources. Examples of these include incident reporting, risk assessment, performance management and compliance with external assessments.

The department’s focus covers all areas of the Trust including patients, staff, contractors, visitors, volunteers and the environment/infrastructure.

An essential underlying task for the department is to advise the Trust of the principles, requirements and implications of risk and the most effective means of management. It also ensures that the systems and processes are in place to manage risk, gaining assurance by continual monitoring.

The Risk Management Department interfaces with all departments across the Trust, to ensure uniformity of approach and compliance against a number of performance measurement standards. Predominantly, these have focused on the National Health Service Litigation Authority (NHSLA) Risk Management Standards and Standards for Better Health (SFBH).

1.2 Departmental and Trust Philosophy

Risk is inherent in all corporate and personal activities. Everyone continuously manages risk. Our aim is to embed risk management into the organisation, to the extent that is becomes ‘second nature’ to all staff.

A formal and systematic approach to risk management represents sound business practice. Within the West Hertfordshire Hospital NHS Trust, the Risk Management Strategy provides the formal statement of approach to risk management.

In most scenarios it is not possible to eliminate risk, therefore risks are managed holistically in order to maximise positive change and minimise negative outcomes.
The goal is to reduce risk to its lowest possible level.

Effective risk management requires:

1. Forward thinking and a proactive approach

2. Achieving a balance between the costs of managing a risk and the resultant benefits

3. A clear framework for operation

2. Structures and Communication

The Risk Management Department (See Appendix 1) covers all three hospital sites (Watford, Hemel and St Albans). The Department works along side Quality Assurance, Litigation and Claims. The Associate Director for Integrated Governance manages Quality Assurance, Claims and Patient Advocacy Liaison Service (PALS). This ensures effective use of resources and encourages intra professional/departmental collaboration.

The Trust is currently recruiting to the position of Head of Clinical Governance and Risk and as such the reporting structure may change through 2008 – 2009.

The success of Risk Management throughout the Trust is dependant upon an alliance between all departments, both Divisional and Corporate. The co-operation and support of all staff throughout the Trust is also required. Principally this involves incident reporting and participation in risk awareness and risk assessment. These responsibilities are clearly defined during mandatory update sessions, which are attended annually by all staff.

The Risk Manager liaises with Divisional Risk Leads and service heads in each Division to ensure uniformity of approach, data quality and information sharing. The Risk Systems Administrator assists in these endeavours by undertaking regular spot-check audits of completed incident forms and reviewing the corresponding Datix entry. In addition, risk register entries are assessed to ensure that actions plans and review dates are appropriate and current.

3. Work Programme

The Risk Management Department’s work programme can be categorised into a variety of elements, as follows:

1. Frameworks
2. Structures
3. Policies and Procedures
4. Training
5. Implementation
6. Measuring/Monitoring
The Trust Risk Management Action Plan (Appendix 2) covers all the above disciplines and charts present and future initiatives. The action plan has been written with specific targets to bring all elements of risk to the forefront of the organisation, thus embedding it into the culture of the Trust. The plan is updated annually to provide an up to date view of activity and achievement.

3.1 Frameworks

3.1.1 Standards for Better Health (SFBH)

The annual health check was introduced 2005. Its key objectives are to:

- Provide assurance that NHS healthcare services in England are meeting essential quality and safety standards for everyone.
- Ensure that healthcare organisations always seek improvement and provide value for money.
- Bring together information on the performance of healthcare services and make it available to patients, the public and NHS staff, including clinicians, so that they can make better-informed decisions.

At the end of April 2007, the Trust submitted its third declaration against the Standards for Better Health.

Since March 2008 the department has been regularly updating the Trust Board on its compliance with the SFBH on a rolling basis. As a result, this provides assurance to the Trust Board on the accuracy of its yearly declaration to the Health Care Commission (HCC).

The newly developed Clinical Quality and Governance Committee (CQuaC) and Clinical Standards Executive, will be kept updated on progress made against the SFBH whilst specific committees will have SFBH as a set agenda item:

- Medical Devices Committee
- Senior HR Meeting
- Divisional Clinical Executive Meetings
- Complaints, Litigation, Incidents and PALS Group
- Health and Safety Committee
(The list may include other committees not listed)

The department has also put together a SFBH Implementation Strategy for the 2008-2009 declaration to ensure all standard leads understand the processes, systems and actions that are required, enabling the Trust to make an informed decision on the 08/09 declaration.

http://wghintra01/risk_management/standards.htm

Final Trust Position - April 2008

Overview of the Trust's compliance against the Core Standards as of April '08:

Standards Compliant 39/43 (including 4 achieving compliance at end of year)
The 4 end of year compliance standards were:

**C3 NICE interventional procedures**  
End date of non compliance – 18.02.08

**C5a NICE technology appraisals**  
End date of non compliance – 18.02.08

**C10a Employment Checks**  
End date of non compliance – 30.07.07

**C22a and C Improve Public Health and local partnerships**  
End date of non compliance – 31.01.08

Number of Standards Insufficient / Not Met (4) including:

**C4c Decontamination**

**C20a Safe and Secure Environment**

**C20b Environment, which provides effective care and patient privacy**

**C23 Systems to manage disease prevention/health promotion**

On Thursday 26th June 2008 the Trust was inspected by the HCC on the following core standards:

- C4b Medical Devices
- C8a Whistleblowing
- C10a Employment Checks
- C11c Professional Development
- C16 Suitable and Accessible information

The results of the declaration will be made available to the Trust on Tuesday 14th October 2008.

### 3.1.2 Assurance Framework

The Assurance Framework continues to undergo regular review by the Executive Directors at the Delivery Support Group meetings. It is a standing item on the Audit Committee and is reported at least quarterly to the main Trust Board. The work is led by the Director of Corporate Affairs ensuring the Trust is managing the risks that threaten the achievement of its strategic objectives.
3.1.3 NHSLA Risk Management Standards

**Acute Trust**

West Hertfordshire NHS Trust was assessed by the National Health Service Litigation Authority in March 2008. The Trust was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 1, the Trust was required to pass at least 40 of these criteria, with a minimum of five criteria being passed in each individual standard.

The result showed that the Trust successfully demonstrated compliance (84% - 42/50 against the standards) with Level 1, as presented below:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Governance</th>
<th>Competent &amp; Capable Workforce</th>
<th>Safe Environment</th>
<th>Clinical Care</th>
<th>Learning From Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Compliance Achieved per Standard</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Overall Compliance Achieved</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Benefits For Achieving Existing Assessment Levels**

Achieving compliance at Level 1 for the standards in March 2008 means that the Trust has now received a 10% reduction against the NHSLA insurance contribution. Since this pilot assessment, there has been clear intention for the Trust to focus on achieving Level 2 by March 2010 in order to secure a further 20% discount against its insurance contribution.

**Maternity**

In February 2006, Maternity Services successfully achieved CNST Level 2.

Since the inspection, the CNST assessments were suspended for 2007/08 whilst the pilot manual of the new NHS Litigation Authority (NHSLA) Maternity Standards was being implemented.

The NHSLA have now subsequently just released the pilot standards for maternity, however even though they are currently ‘pilot’ it is unlikely that there will be any significant changes to the final version when it is released later this year.
The Trust is now booked to undertake the level 2 assessment in December 2009. Documentation will need to be submitted around September 2009 and will need to contain 1 years retrospective evidence.

The standards have significantly changed from the previous version, including more on areas such as postnatal and neonatal care including admissions to NICU. Other major changes include increases to required Labour ward cover by Obstetric Consultants (this is at level 1), training for neonatal resuscitation and examination of the newborn.

There are now 5 standards subdivided into 8 different criteria, within each standard there are 2 ‘core’ mandatory criteria that must have full compliance, in addition the maternity services would need to achieve at least 4 of the other 6 criteria within each standard to achieve a pass of 30 out of the 40 possible marks available. For the next assessment the Trust will be assessed at level 2 however, with the new scoring system it is now possible to lose both levels 1 and 2 during an assessment if the scores achieved are insufficient, hence the need to ensure full compliance is achieved and maintained at level 1. The maternity services will be required to have the required evidence for level 1 available during the assessment for the assessor during their visit.

Another major change to level 2 assessment is that for all criteria staff will be required to be interviewed, where as previously staff were only interviewed about certain aspects such as the risk strategy and risk structure and how to escalate incidents.

Areas of particular concern following initial review of the standards:

**IT Access**
All the evidence will have to be submitted electronically on a specific template, which at present the Trust computer system does not allow us to access for security reasons. This has been referred to the IT help desk but at present is yet to be resolved.

**Standard 1 Criterion 3 level 1 Midwifery and nursing staffing levels**
Requires that the maternity service have safe staffing levels for all midwifery, nursing and support staff, which are line with national recommendations, and that they are audited on an annual basis.

**Standard 1 Criterion 4 level 1 Obstetric staffing levels**
This is a mandatory criterion, which for a pass will require full compliance to achieve a pass. The criterion requires that maternity services with 5000 to 6000 births has 60 hour consultant presence on Labour ward by April 1st 2008, and 98 hour presence by April 1st 2009. This will need to be evidenced using consultant cover rotas backdated to April 2009 for 98 hours cover and back to April 2008 for 60-hour cover.

**Standard 4 Criterion 7 Level 1 and Level 2 Systematic Approach to Training**
In this criteria a training needs analysis will need to be carried out, but unlike previous standards this will now include anaesthetic and neonatal medical workers. It will require systems to ensure all staff attend, follow up for staff that do not attend and a system for the co-ordination of training records.

A number of Registrars have attended some clinical training this year but there is generally still very poor uptake by medical staff of recognised mandatory training both
clinical and non-clinical.

**Coordination of CNST**

There is an urgent need for a coordinator with clinical knowledge (as these are all clinical standards) to be appointed. For the 2 previous assessments there was a CNST Coordinator in post (the job was combined with complaints management), who prepared and coordinated the action plans in conjunction with the Risk Lead. Although previously successful in achieving CNST levels 1 and 2, in order to meet the requirements for these new standards will be a huge undertaking and require effective coordination and team working across the maternity services (including NICU), it cannot be reliant on 1 or 2 people to ensure that compliance is achieved. Because of the amount of audit required at level 2 and then at level 3 an ideal compromise would be a CNST/audit midwife.

There also needs to be adequate administrative support, which has previously been a problem in the past. The CNST clerk whom currently works with the Risk Lead is due to go on maternity leave in December 2009. In her role she has responsibility for Datix input and support, including extrapolating reports and ensuring clinical incident forms are completed and entered, maintaining the training data base with the clinical facilitators, this includes allocating staff to dates and then informing them etc.

**Patient Records Retrieval**

There is a significant problem with obtaining patients records for the purpose of audit. At present the CNST clerk will pull notes for audits that are connected to CNST on the Watford site, but there is no way of obtaining notes from Hemel or SACH. We have been informed that this is because of lack of clerical staff on these sites. This is having an impact on the quality of audit that can be undertaken and is a major concern, as audit should be an ongoing process in improving clinical care.

**Benchmarking**

A benchmarking tool for levels 1 and 2 has now been prepared, once leads for each standard have been identified and agreed this tool will need to be sent to them for completion. Thereafter a strategy for achievement and action plans will need to be prepared and agreed within the Division with regular meetings to update and ensure that agreed time frames are adhered to.

3.1.4 **Maternity Healthcare Commission Inspection**

This report is presented in the Maternity Annual Report

3.1.5 **Safety Alert Broadcasting System**

The Safety Alert Broadcast System (SABS) is an electronic system that has been developed by the Department of Health (DH), the Medicines and Healthcare Products Regulatory Agency (MHRA) and the National Patient Safety Agency (NPSA). There is also an estates and facilities management section produced by the DH.

SABS is a means of sending important safety and device alerts to a named SABS Liaison Officer within the Trust electronically in a streamlined and consistent way by e-mail.
During the period from 1\textsuperscript{st} April 07 – 31\textsuperscript{st} March 08 Clinical Informatics handled the SABS process.

On Monday 14\textsuperscript{th} April 2008 the SABS process was handed back to the Risk Management and Governance Department. An email was sent out to all staff within the SABS distribution network informing them of this change.

1\textsuperscript{st} April 07 – 31\textsuperscript{st} March 08
During this period the Trust received 112 safety alerts

<table>
<thead>
<tr>
<th>Safety Alerts received from Apr 07 - Mar 08</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No action is required</td>
<td>57</td>
</tr>
<tr>
<td>Assessing relevance of alert</td>
<td>17</td>
</tr>
<tr>
<td>Action is necessary: on going</td>
<td>8</td>
</tr>
<tr>
<td>Action is necessary: not yet started</td>
<td>6</td>
</tr>
<tr>
<td>Action completed and matter resolved</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>112</td>
</tr>
</tbody>
</table>

The table shows that at the end of March 08 the Trust had 31(28%) alerts that are currently unclosed (Assessing relevance of alert, Action is necessary: ongoing, Action is necessary: not yet started)

81 (72%) alerts have been closed, as being not relevant to the Trust and therefore no action is required or have been closed as action completed.

Of the 31 that were unclosed 24 were past the deadline date for completion.

As the SABS review demonstrates that the majority of affected areas have delivered a
reasonable standard of quality in ensuring that the well being of patients and staff were paramount when important safety notices required actions. With continued developments on the horizon, the Trust is well placed to further meet the Standards for Better Health for C1b SABS.

The majority of the outstanding alerts have now been closed or action is almost complete.

**Key Developments as from July 08 Include:**
- The approval of the SABS policy.
- The continued development of the Trust’s SABS tracker database.
- Each division having a nominated SABS lead and an assistant to act as a “nearest point of contact” to ensure effectiveness and cover.

West Hertfordshire Hospital Trust has taken the initiative to put in place a robust framework that will be monitored according to quality standards. It is hoped that the SABS process will be audited to further reinforce the process.

### 3.1.6 NICE Guidance

Since February 2008 the Trust has had an approved policy for the dissemination, monitoring and implementation of NICE guidance, which is reviewed as part of the Divisional Clinical Standard Executives.

The Governance Department currently holds a database of all guidance received and the current position on implementation.

The Trust’s Public Health Forum currently reviews all NICE public health guidance.

### 3.1.7 National Patient Safety Agency (NPSA)

With effect from 1\textsuperscript{st} April 2005, the Trust adopted the Common Classification System (CCS) on Datix, for recording incidents. This enables the Risk Management Department to benchmark incident statistics against other Trusts. It also enables the department to produce more meaningful data analysis, as all areas of the Trust will be recording uniformly.

The NPSA now produce feedback reports that will allow our Trust to compare incident type and frequency with other organisations in the same cluster (the trust is grouped with other large acute trusts).

The last feedback report received was from April 07 – September 07 and the following extracts have been taken from this report:
- In each of the six months the risk management department submitted patient safety incidents to the NPSA
- The Trust fell in the middle range of incidents per one hundred admissions (within the cluster)
- Under type of incident the Trust had slightly less patient accidents but slightly
more treatment, procedure incidents (within the cluster)

- Under Specialty the Trust had a similar number of A&E incidents, a higher number of Obs and Gynae incidents and slightly lower medical and surgical incidents (within the cluster)
- The Trusts medication incidents mirror the numbers reported by the rest of the cluster (by type of medication incident)

The full report is available on the intranet site: http://wghintra01/risk_management/pubrep.htm

3.1.8 Health and Safety

The primary focus of H&S activity this year (07/08) has emanated from the 3 day audit undertaken by the HSE at the end of March 2007. This resulted in improvement notices, initially just six, but some of these were later divided to improve subject focus making the final tally 8. The Trust has worked well and a great deal of hard work has been put in to ensure that the requirements of notices have now been completed.

The HSE still visits on a regular basis to both monitor our progress on continued compliance with the notices and to provide support on specialist areas such as workplace stress.


The Health & Safety Plan for 2008/09 addresses the key issues that need to be addressed by the Trust in order to improve its safety climate and to ensure that H&S is driven down through the management structure as required by HS(G)65.

Benchmarking, using the HSE’s Corporate Health and Safety Performance Index (CHaPSI) tool will be undertaken during July 2008 and will help to identify further target areas for future Safety Plans.

Following up on the Improvement Notices served in 2007, the H&S Plan recognises that that these notices served to highlight areas that were not being addressed by the Trust to the satisfaction of the HSE. The plan therefore identifies key areas to address its obligation for continuity and consolidation and progress will be monitored by the Health & Safety Committee.

Risk Assessments

The Trust carried out a risk assessment audit in March 08 with initially poor results indicating only a 54% compliance level. Further pressure on departmental managers and encouragement to both review existing and undertake new risk assessments finally produced a 100% return in June 08.

Investigations into the March audit revealed the common factor for this was a lack of managers/supervisors attending Risk Management training. It also revealed that many who had attended were confused by the different types of assessment.
A new programme of training commenced June 10th 2008 that selects 5 basic risk assessment tools and provides a focus on one tool per month, each with 12 opportunities for managers and supervisors to attend. This will allow delegates to concentrate on one tool at a time and have a month in which to practice and become more familiar with it before examining the next tool.

The risk assessment audit will be conducted again in August and in December 2008 to monitor the effects of this training and ensure that a greater variety of assessment types are being conducted.

This will help monitor the effects of the new training modules as well as encourage a more comprehensive and compliant response when the annual audit is repeated for the Standards for Better Health declaration (specifically Core Standards C7c and C20a) in March 2009.

**Moving and Handling**

Further to the work carried out in 2007 the Trust has appointed a Back Care Manager who started in May 2008. The post holder will:

- Carry out review of services offered and requirements for advice and training provision.
- Continue contract Manual Handling training/service to ensure new Back Care Advisors are brought to autonomous level of competence.
- Review the system for tracking of manual handling devices/equipment.
- Monitor compliance with the relevant NHSLA Risk Management Standard.

**Health & Safety Conclusion**

A great deal of excellent work has been undertaken during 2007 to relieve the pressures imposed by improvement notices. However, whilst the Trust can feel rightly proud of what it has achieved over the past year, this can only be regarded as the beginning.

The H&S Plan for the current year seeks to continue and develop this work and provide a structured way forward. Key to the success of this is the review of H&S Management arrangements and ensuring that resources are commensurate with the spread and complexity of the organisation.

Recognising the importance of consistent H&S Management at all levels is critical to the success of the H&S plan if it is to be achieved uniformly across the Trust. A devoted 'Top down' emphasis is required to raise the profile, ensure attention to H&S management duties and to achieve the reliable and sustainable level of compliance that will be required to satisfy the HSE, NHS Standards and the requirements for achieving Foundation Status.
3.2  Structures and Communication

3.2.1  Reporting Structures

Several changes took place during 2007/2008 to the reporting structure.

The following four committees/groups have the responsibility for ensuring that all aspects of risk and governance are monitored and reviewed:

**Clinical Quality and Governance Committee (CQuaC)**
This Committee was only set up in June 2008 and replaces the previous Clinical Governance Committee, which ceased in 2007.

CQuaC will assure the Trust Board that it is delivering safe and competent clinical care, optimising patient safety and clinical outcomes.

**Clinical Standard Executive (CSE)**
The Clinical Standard Executive Business Meetings and Divisional Clinical Standard Executives took over the role of the old Clinical Governance Committee.

The purpose of the CSE is to seek assurance that the Trusts clinical services are continually developed and improved through the implementation of robust systems and processed whilst fully supporting the objectives of clinical, corporate and research governance.

Except for the CSE Business Meeting, the CSE committees are broken down by division (Acute Medical Care, Women’s & Children’s Services, Surgery & Anaesthetics and Clinical Support), with each division having a CSE meeting on average once a quarter.

The meeting is chaired by the Associate Medical Director of Clinical Governance and the agenda’s comprise of the following elements:

- The clinical audit programme
- Key clinical issues and risks for the division
- Identification and monitoring of the clinical performance indicators
- Implementation of national recommendations and noting changes in practice
- Reporting and progressing serious clinical incidents
- Monitoring compliance with clinical policies
- Public Health
- Complaints
- Aspects of NHSLA Risk Management and Standards for Better Health

**Complaints, Litigation, Incidents and PALS (CLIP) Group**
This group has taken the place of the Risk Management and Complaints Advisory Group and was set up in July 2008.

The purpose of the Complaints, Litigation, Incidents and PALS (CLIP) Group is to ensure that the Clinical Quality and Governance Group (CQuaG) has a sound
assessment of the trends and themes and mitigating action arising out of complaints, litigation, incidents and PALS and that the Trust has adequate plans, processes and systems for both identifying and managing these issues.

This group reviews the CLIP report which is a quarterly report of trends and actions following complaints, litigation, incidents and PALS concerns.

**Health and Safety Committee**

The Trust’s Health and Safety Committee has been established, in accordance with the Safety Representatives and Safety Committees Regulations to promote and secure the co-operation of all employees in the promotion of health, safety and welfare.

The main objectives of the committee are to:

- Establish and maintain standards of health and safety in keeping with legal requirements, Trust policy and Risk Management.
- Develop and monitor the effectiveness of these standards in order to ensure the health, safety and welfare of all Trust employees and contractors.

The organisational reporting structure is illustrated in Appendix 3

### 3.2.2 Divisional Risk Leads

Risk Leads have responsibility for all risk related issues, including incident analysis to identify themes and trends. There have been dedicated risk leads in place for the Divisions of Surgery and Women’s and Children’s Services. Within Acute Medical Care and Estates, Facilities and Clinical Engineering the Risk Lead role is a ‘bolt-on’ duty. Within Clinical Support, the role is undertaken by each of the Divisional Service Heads.

Divisional Risk Lead meetings are undertaken quarterly, with additional representation by the Health and Safety Adviser and Clinical Governance Manager. These have encompassed discussion of generic and specific risk related issues; the sharing of practice; cross-divisional learning and ensured contribution to the corporate agenda and action plan.

### 3.2.3 Communication

The Risk Management intranet web pages were launched in 2003, with regular reviews and updates. These are designed to provide staff with useful and easily understandable information on such topics as:

1. CNST/NHSLA Risk Management Standards
2. Datix
3. Incident Reporting/Incident Reports
4. Root Cause Analysis
5. Standards for Better Health
3.3 Policies and Procedures

The following policies, produced by the Risk Department, have been reviewed and ratified by the appropriate Committee during 2007/8.

- Incident Reporting and SUI Policy
- Datix System Specific Security Policy
- Risk Management Strategy
- Being Open Policy
- Procedure for a Systematic approach to Incidents, Complaints and Claims Management, Analysis and Sharing Safety Lessons
- Policy For The Implementation Of Clinical Guidance From The National Institute Of Clinical Excellence & Recommendations From National Clinical Governance Reports

All policies ratified by the Trust now adhere to the Policy Development Framework, which outlines the format and procedure for policy ratification ensuring all policies are standardised.

3.4 Training

The Risk Department continues to present a regular risk management session at general induction and mandatory staff updates.

Risk Management Training Attendance 1st April 07 – 31st March 08

<table>
<thead>
<tr>
<th>Session</th>
<th>Maximum capacity</th>
<th>Number of delegates booked</th>
<th>Number of delegates attending</th>
<th>Number of DNA’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Management</td>
<td>3793</td>
<td>2101</td>
<td>1542</td>
<td>559</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Induction Attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session</td>
<td>Maximum capacity</td>
<td>Number of delegates booked</td>
<td>Number of delegates attending</td>
<td>Number of DNA’s</td>
</tr>
</tbody>
</table>
Risk Management has also been incorporated as a 30-minute presentation to the Foundation Year 1 and 2 intakes in February and August, at both Hemel Hempstead and Watford hospitals.

The August 2008 FY1 and FY2 training has now taken place.

### 3.5 Measuring and Monitoring

#### 3.5.1 Datix

The Trust’s electronic risk management database is Datix, comprising the following modules:

1. Incident reporting  
2. Risk Register  
3. Complaints Handling  
4. Claims Management  
5. Patient Advice and Liaison Services (PALS)  
6. Standards Module (Library of evidence against Standards for Better Health)

Use of the system continues to grow and develop, particularly integration between the modules and the production of reports.

#### 3.5.2 NHSLA Risk Management Standards Level 2

As the Trust works towards Level 2 all risk management policies will be assessed to ensure that they are embedded into the Trusts culture and are being followed in all circumstances.

#### 3.5.3 Incident Review 1st April 07 – 31st March 2008

The Risk Management department provides a quarterly incident report to the following committees for review and action:

- Drugs and Therapeutics Committee  
- Health and Safety Committee  

The reports contain an overview of incident data and then specific quarterly data on medication incidents within the Drugs and Therapeutics report and security/personal injury/RIDDOR incidents within the Health and Safety Report.

In 2008 the Trust, following agreement by the Board merged the Complaints Advisory and Risk Management Groups. In their place is now a single Complaints, Litigation, Incidents and PALS (CLIP) Group. This group will be responsible for reviewing incident data on a quarterly basis for each division, this report, its findings and actions will be reviewed at the Clinical Quality and Governance Committee (CQuaC) before being
The following incident review will provide an overview of Trust incidents. Each separate divisional risk management report will look at its own incidents in further detail.

The incident data presented in the following graphs is from those incidents that occurred from 1st April 07 – 31st March 08 and incorporates all types of incidents (unless otherwise stated).

**Total Number of Reported Incidents 2004 - 2008**

Total Number of Incidents Over Previous Four Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-5</td>
<td>7577</td>
</tr>
<tr>
<td>2005-6</td>
<td>7268</td>
</tr>
<tr>
<td>2006-7</td>
<td>7593</td>
</tr>
<tr>
<td>2007-8</td>
<td>7005</td>
</tr>
</tbody>
</table>
Over the last four years the graph identifies that the Trust reported between 7,000 and 7,600 incidents per year. From 06-07 to 07-08 there has been a fall of 588 incidents as 7,005 were reported in 07-08.

Following further investigation many of the individual divisions have reported a small fall from the previous year apart from Women’s and Children’s Services which have seen an increase. These changes in the numbers of incidents reported will be reviewed further in the divisional risk management reports.

**Number of reported incidents 1st April 07 – 31st March 08**

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>562</td>
</tr>
<tr>
<td>May</td>
<td>571</td>
</tr>
<tr>
<td>Jun</td>
<td>644</td>
</tr>
<tr>
<td>Jul</td>
<td>715</td>
</tr>
<tr>
<td>Aug</td>
<td>611</td>
</tr>
<tr>
<td>Sept</td>
<td>548</td>
</tr>
<tr>
<td>Oct</td>
<td>500</td>
</tr>
<tr>
<td>Nov</td>
<td>566</td>
</tr>
<tr>
<td>Dec</td>
<td>584</td>
</tr>
<tr>
<td>Jan</td>
<td>633</td>
</tr>
<tr>
<td>Feb</td>
<td>525</td>
</tr>
<tr>
<td>Mar</td>
<td>496</td>
</tr>
</tbody>
</table>

The table identifies that the number of incidents occurring each month has fluctuated between 500-700 per month.
Each division reported the following number of incidents:

- Acute Medical Care Division – 2795 incidents
- Surgery and Anaesthetics Division – 1481 incidents
- Women’s and Children’s Services – 1728 incidents
- Estate and Facilities Division – 317 incidents
- Clinical Support Division – 640 incident

The remaining incidents came under other divisions.

**Number of Serious Untoward Incidents (SUI’s)**

<table>
<thead>
<tr>
<th>DATE OF INCIDENT</th>
<th>NATURE OF SUI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-07</td>
<td>Unexpected neonatal death post delivery</td>
</tr>
<tr>
<td>Aug-07</td>
<td>Blood transfusion Incident. Patient died but not as a consequence of the incident</td>
</tr>
<tr>
<td>Aug-07</td>
<td>Magnesium sulphate prescribing and administration error. Child's condition stabilised and was subsequently transferred to WGH from Hemel A &amp; E</td>
</tr>
<tr>
<td>Sep-07</td>
<td>Unexpected labour outcome ~ stillbirth</td>
</tr>
<tr>
<td>Nov-07</td>
<td>Alleged sexual assault. Police advised WHHT that the Crown Prosecution Service would not uphold the case, therefore charges had been stopped. Internal disciplinary procedure.</td>
</tr>
<tr>
<td>Dec-07</td>
<td>No patient involvement. Dr stole/self injecting drug. Referred to GMC. Trust Disciplinary Procedure followed.</td>
</tr>
</tbody>
</table>

During the period from 1st April 07 – 31st March 08 the Trust reported 6 SUI’s to the East of England Strategic Authority.

All of these incidents were investigated by the Trust and have had appropriate action plans to prevent as reasonably practicable a reoccurrence of the incident.
**Number of Incidents by Stage of Care**

All incidents completed are processed onto the Trusts Risk Management System (Datix) and are attributed a category as to the type of incident.

The highest occurring incident was ‘accidents that may result in personal injury’ this is commonly incidents involving patient falls, this category reported 1583 out of a total 7005 incidents (23% of the total). The second highest occurring incident was ‘infrastructure or resources’ with 1142 (16% of the total). The third highest occurring incident was ‘labour or delivery’ which reported 881 incidents (13% of the total).
Number of Incidents by Adverse Event (Top 10)

This table identifies the actual adverse event of the incident, for example an incident categorised as ‘labour or delivery’ will have an adverse event category of ‘third or fourth degree tears’.

From the above table it is apparent that the highest reported stage of care incidents are represented in the adverse event table.

Due to the number of different adverse events only the top 10 are represented in this table.

The highest occurring adverse event was ‘lack of suitably trained or skilled staff’ this is reported 750 out of a total 7005 incidents (11% of the total). The second highest occurring incident was ‘fall on level ground with 591 (8% of the total). The third highest occurring incident was ’fall from a height, bed or chair’ which reported 443 incidents (6% of the total).
Days taken from Incident Date to Processed Date

Over the past 12 months the Risk Management Department has been producing incident data (graphs and tables) for various committee’s based on the date that the incident was processed onto Datix.

Whilst this method ensures that all incidents are collected it will mask any specific incident trends, for example if 20 incidents occur during the space of 1 month but are processed on one particular day, if the graph uses the date the incident was processed then it would identify that there was a problem with 20 incidents on one day when in fact these incidents occurred over a month.

Although this represents a significant problem with the reports, in the majority of the graphs a good representation of data would still be provided (i.e. the type of incident occurring).

The reason for the Risk Management Department using the date that the incident was added/processed onto Datix was due to significant delays in processing incidents and incidents then being missed off reports. The following table highlights this problem.

![Number of Days from Incident Date to being Entered onto Datix](chart)
It is evident from the table that a high proportion of incidents are processed onto Datix almost a month after they have occurred. There were 2401 (out of 6960 incidents from the 5 main divisions) processed on or over 31 days following the incident occurring. This represents 34% of incidents.

- Acute Medical Care Division processed 1033 (37%) of its total incidents (2795) after 31 days
- Surgery and Anaesthetics processed 589 (40%) of its total incidents (1481) after 31 days
- Women’s and Children’s processed 523 (30%) of its total incidents (1728) after 31 days
- Clinical Support processed 170 (27%) of its total incidents (640) after 31 days
- Estates and Facilities processed 86 (27%) of its total incidents (317) after 31 days

It is important to note that these incidents are being reviewed and actioned before being processed which is the most important aspect, however the Trust needs to improve the efficiency of incident processing to ensure accurate incident reports are provided throughout 2008 – 2009.

The table only represent the four largest divisions hence the total number of incidents is only 6960.

**Number of Incidents reported by Staff Groups (Top 10)**

![Incident Reporting by Staff Groups (Top 10)](image)
76% of all incidents reported had the staff group data entered. From the table it is easy to identify that the majority of incidents were reported by midwives and nurses and there is a distinct lack of reporting by clinicians.

Number of Incidents by Time of Day

![Number of Incidents by Time of Day](image)

71% of all reported incidents had the time of occurrence stated (the department can only assume that this was the time of the incident as opposed to the time of the incident discovered or reported)

The majority of the incident occurred during the day with 2882 (58%), 1168 (23%) incidents occurred from 1800 – 2359hrs whilst 936 (19%) occurred in the early morning.
The table identifies the day of the week the incident occurred, there is no significant difference from Monday to Thursday with Friday showing a small fall in the reported number of incidents. At weekends there are considerably less incidents. This table should provide more detail when used in the divisional reports.
Number of Incidents by Patient Age

Only 54% of the incidents had the patient’s age recorded and of these incidents the majority of incidents occurred to those patients aged between 71-90. This may be in direct correlation to the high number of patient fall incidents.

Number of Incidents by Patient Gender
47% of patient incidents had the patients gender recorded and of those female patients were involved in more incidents than male patients.

**Number of Incidents logged as ‘other’**

Over the last 12 months the Risk Management Department has been concerned with the number of incidents graded as ‘other’. 143 incidents were graded as other during the period 1st April 07 – 31st March 08, this represents 2% of all incidents.

This figure represents those incidents that had ‘other’ stated in more than one category box. Many more incidents would have had ‘other’ stated in the adverse event category only.
3.5.4 Risk Review 1st April 07 – 31st March 2008

All major risks affecting each division are presented at the Clinical Standards Executive ensuring that:

- The Trust gains a wider perspective of the risk issues facing the organisation
- There is the opportunity to escalate issues as a strategic risk
- There is greater monitoring of risk entries to ensure they are accompanied by detailed action plans to achieve mitigation

All the risks, which are scored 16+, are also presented at the Health and Safety Committee for review.

The Trust has a risk management database (Datix) which contains the Trusts risk register. The Risk Register enables the Trust to identify and prioritise its risks and provides an integrated approach to clinical and non-clinical risk management. Datix is fully networked, allowing individual Divisions to maintain their own Risk Registers. Information from each Division feeds into the Trust-wide Register, giving a prioritised portfolio of risks across the entire Trust.

The risk department endeavours to gain assurance from the Divisions that issues are addressed prior to incidents or risks being closed. Feedback suggests that serious incidents are fully investigated, with practice changes implemented and lessons learned as appropriate. Many incidents relate to recurring themes and as such individual cases will not be pursued, as there will be separate Risk Register entries to tackle the overarching issues.

As each Risk Register entry must be accompanied by a detailed plan, with individual actions assigned, there is a clear audit trail to evidence completion and mitigation.

**Number of Risks Opened**

The table below highlights that the majority of the risks opened are from the division of Facilities and Estates.

Of the 419 new risks opened 259 (62%) related to Estates and Facilities.
Risks Opened During 2007-8 by Division

Opened Risks Passed Review Date

Risks Which were Opened 2007/8 and Have Passed the Review Date by End of July
(Top 5 Divisions)
A number of risks that have been opened in 07-08 have passed the review date (by the end of July) and now need to be reviewed.

**Closed Risks During 07-08**

Of those risks opened during 07-08 several have been closed during this period with the division of Estate and Facilities opening and closing the highest number.
3.5.5 Incident and Risk Auditing

The Systems Administrator continues to conduct regular audits of incident forms before they are centrally filled. Some of the issues that have arisen are:

- Inaccurate coding (identifying the use of ‘other’ codes and reclassifying the incident)
- Inaccurate entry of the incident date
- There are cases where incidents are logged on Datix but did not occur within our Trust. These incidents should therefore be logged as *External* patient safety incidents; sometimes this has not been the case.
- Incidents have been entered more than once therefore the relevant member of staff has been approached and the duplicated incident has been deleted from the database
- Staff entering the incidents have omitted the appropriate trigger
- The notify field is not always used.

The audit process is further enhanced by a fortnightly submission of all patient safety incidents, regardless of consequence, to the NPSA National Reporting and Learning System (NRLS). Where mandatory fields are omitted or incorrectly completed, the data submission is returned by the system, with errors highlighted.

4. Future and Ongoing Developments

Again, this has been a challenging year for the Trust. The Trust must now move forward on strengthening its risk management culture ensuring risk management truly becomes a fundamental part of all Trust business. The Risk Management Department will continue to monitor the effectiveness of the systems and processes through the newly formed Complaints, Litigation, Incident and PALS Group and subsequent quarterly report.

Work programme already identified for the year ahead is:

1. Continue the implementation of a paperless incident reporting system (Datix e-form)
2. Work towards the achievement of the NHS Litigation Authority Risk Management (NHSLA RM) Standards assessment at Level 2
3. Work towards achievement of CNST/NHSLA Maternity Level 1/2
4. Maintain compliance with the Core Standards for Standards for Better Health that relate specifically to incidents, risks and governance (Core Standards C1a, C7a and c)

4.1 Implementation of DatixWeb

From the 1st January 2008 the Risk Management Department has been working on the implementation of DatixWeb, this is an electronic version of the incident form which enables staff to complete the online form using the intranet.
This section of the Annual Report will give an analysis of the Datixweb system. The aim of the system is for the paper incident reporting forms to be replaced by an electronic incident form, which will be accessible to all staff via the Intranet Home Page.

The benefits of implementing the system are listed below:

♦ quick response times, due to rapid reporting
♦ the ability to spot trends
♦ the ability to identify the severity of incidents quickly
♦ increased reporting of incidents
♦ the ability to mitigate risks, putting preventative practices into place
♦ greater clinical effectiveness
♦ ability to meet mandatory reporting requirements
♦ reduced processing of incidents (once the information has been approved by the appropriate manager the information will automatically be transferred into the the main Datix system whereas before a member of staff would need to manually enter the information on the incident form onto the system.

The implementation of the system will be gradual and structured in order to identify and troubleshoot any teething problems. It is therefore envisaged that the system will not be used Trust Wide until Summer/Autumn 2009.

The Women’s and Children’s division was the first division where the system was introduced, in May ’08, and thus this analysis will only focus on incidents for this division which occurred in the first three months, May – July 08.

Summary

A total of 192 incidents were reported via DatixWeb within the first three months of using the system and 181 have been approved and are on the main application. The report will only focus of the 181 incidents, which have been approved, unless otherwise stated.

Electronic Incident Reports Completed

The table below plots the use of the intranet forms in comparison to the paper forms; there has been a marked increase in the number of electronic incident forms completed.

The overall decline in reported incidents in July is due to the late processing of incidents.
E-Reported Incidents by Location Exact and Incident Date

The below graph shows that Delivery Suite was the location, which reported the highest number of incidents via the online system – reporting 107 incidents out of 181 (59% of the total) for the division during the first three months.
In July 2008 82% of incidents for that month were reported electronically, however it must be borne in mind that the inputting of paper forms for this month is probably going to continue until mid August. 45% of incidents for the month of June were reported electronically and in May this figure was 34%

**E Reported Incidents by Staff**

Of the 181 electronic incidents reported 85 were completed by different members of staff - 60% of these staff only reported one incident.

**Time of Incident**

By reviewing the number of electronic incidents that had the time of the incident recorded highlights the benefits of the electronic form, as staff need to complete mandatory fields to submit the form essential information which could be excluded from the paper version now has to be included.

<table>
<thead>
<tr>
<th>Type of Form</th>
<th>Total Number of Forms</th>
<th>Number of Forms with Time Recorded</th>
<th>Number (as a Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Form</td>
<td>181</td>
<td>157</td>
<td>87%</td>
</tr>
<tr>
<td>Paper Form</td>
<td>182</td>
<td>56</td>
<td>31%</td>
</tr>
</tbody>
</table>

The above table clearly highlights an advantage of Electronic Reporting – the time of day is more likely to be recorded.

**Recommendations / Actions**

Following the implementation of DatixWeb there are still several areas that require improvement:

1. To encourage staff within the division to continue reporting on line.
2. Liaise with IT department to update the versions of Internet Explorer which are used by staff so that the Datix Web system will be quicker to load
3. Risk Management department to look into providing more support and training to staff
4. The Maternity division have noticed a fall in the overall number of reported incidents with the introduction of the electronic version, this will be investigated to ensure all staff are aware of the new system and have appropriate access.
5. Conclusion

The corporate management of risk during the last year has been a particularly demanding one. With the Divisions stretched due to a significant reduction in capacity and resource and the need to improve performance against DoH targets, lateral thinking and initiative Trust wide have been required to drive forward the risk management agenda. Despite this, the Trust has maintained its healthy reporting culture, improved its risk management performance and was successful in attaining NHSLA Risk Management Standards Level 1 (General). Additionally, the number of initiatives implemented by the divisions has been outstanding. The following risk management reports complied by the respective Divisions is evidence of this.

The year ahead will be a no less challenging one. The Risk Management Department will concentrate its own objectives on meeting Level 2 of the NHSLA Risk Management Standards the relevant Standards for Better Health whilst facilitating the remainder of the Trust to meet theirs.
Appendix 1

Trust Risk Management Structure 2007-2008

Graham Ramsay
Medical Director

Vacant
Head of
Clinical Governance & Risk

Nick Egginton *appointed
March 08
Clinical Governance Manager

Vacant
Trust Risk Manager

Shakeel Oozeerally
*appointed May 08
Standards Co-Ordinator

Heidi Buckell
Systems Administrator

Pamela Mudie
PA

Vacant
Divisional Risk Lead
Acute Medical Care Services

Richard Simon
Divisional Risk Lead
Estates

Mel Withero *appointed
Nov 07
Divisional Risk Lead
Surgery & Anaesthetics

Service Managers
Clinical Support

Jacky Jones
Divisional Risk Lead
Facilities

Jacqui Mallard
Divisional Risk Lead
Women’s & Neonatal Services
### Appendix 2

**Trust Risk Action Plan (Present and Future)**

<table>
<thead>
<tr>
<th>ACTION REQUIRED</th>
<th>LEAD DIRECTOR (S)</th>
<th>PERSON (S) RESPONSIBLE (* Lead)</th>
<th>START DATE</th>
<th>TIMESCALE</th>
<th>DATE ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FRAMEWORKS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.1 NHSLA Risk Management Standards (NHS Litigation Authority)  "The Trust has a separate NHSLA Risk Management Standards Implementation Plan  
  Paper to be presented to the Clinical Quality and Governance Committee (CQuaC) this paper will include a strategy to help the Trust in its work towards achieving level 2.  
  Facilitate progress towards level 2compliance for all standards and criterion within the assessment and those specifically relating to governance, risk and incidents.  
  CQuaC to make a decision on the level at which the Trust be should be assessed (the Trust will need to be assessed prior to March 2010)  
  | Associate Director for Integrated Governance  
  | Clinical Governance Manager (Risk Manager once appointed)  
  | June 08  
  | August 08  
<p>| August 08  | | | | |</p>
<table>
<thead>
<tr>
<th>ACTION REQUIRED</th>
<th>LEAD DIRECTOR (S)</th>
<th>PERSON (S) RESPONSIBLE (* Lead)</th>
<th>START DATE</th>
<th>TIMESCALE</th>
<th>DATE ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.2 STANDARDS FOR BETTER HEALTH (SFBH)</strong>&lt;br&gt;*The Trust has a separate Implementation Plan for the Standards for Better Health</td>
<td>Director of Patient Safety</td>
<td>Clinical Governance Manager</td>
<td>June 08</td>
<td>August 08</td>
<td></td>
</tr>
<tr>
<td>Implementation Plan for the 08/09 SFBH declaration</td>
<td>Director of Clinical Governance Manager</td>
<td>June 08</td>
<td>August 08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitate review of the SFBH and ratification by Trust Board/CQuaC/CSE on a quarterly basis.</td>
<td>Director of Patient Safety</td>
<td>Clinical Governance Manager</td>
<td>April 08</td>
<td>March 09</td>
<td></td>
</tr>
<tr>
<td>Facilitate progress towards 08/09 compliance for all standards and those that specifically relate to governance, risk and incidents.</td>
<td>Director of Patient Safety</td>
<td>Clinical Governance Manager</td>
<td>April 08</td>
<td>March 09</td>
<td></td>
</tr>
<tr>
<td><strong>1.3 CNST/NHS LA Maternity Standards</strong></td>
<td>Head of Midwifery</td>
<td>Divisional Risk Lead/CNST Maternity Lead</td>
<td>August 08</td>
<td>November 08</td>
<td></td>
</tr>
<tr>
<td>Benchmarking Process (criterion leads and action plans to be put in place by Dec 09)</td>
<td>Head of Midwifery</td>
<td>Divisional Risk Lead/CNST Maternity Lead</td>
<td>August 08</td>
<td>November 08</td>
<td></td>
</tr>
<tr>
<td><strong>1.4 NPSA</strong></td>
<td>Associate Director for Integrated Governance</td>
<td>Clinical Governance Manager / Datix Administrator</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Review the next NPSA feedback report and action as required</td>
<td>Associate Director for Integrated Governance</td>
<td>Clinical Governance Manager / Datix Administrator</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td><strong>1.5 Safety Alert Broadcast System (SABS)</strong></td>
<td>Associate Director for Integrated Governance</td>
<td>Standards Coordinator</td>
<td>April 08</td>
<td>March 09</td>
<td></td>
</tr>
<tr>
<td>Ensure all SABS alerts are actioned within the required timescales (for 08/09)</td>
<td>Associate Director for Integrated Governance</td>
<td>Standards Coordinator</td>
<td>April 08</td>
<td>March 09</td>
<td></td>
</tr>
</tbody>
</table>

**2. STRUCTURES**

**2.1 RISK LEADS**
<table>
<thead>
<tr>
<th>ACTION REQUIRED</th>
<th>LEAD DIRECTOR (S)</th>
<th>PERSON (S) RESPONSIBLE (* Lead)</th>
<th>START DATE</th>
<th>TIMESCALE</th>
<th>DATE ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure a Risk Lead is appointed with Acute Medical Care</td>
<td>N/A</td>
<td>General Manager for AMCD</td>
<td>August 08</td>
<td>November 08</td>
<td></td>
</tr>
<tr>
<td>Ensure a Risk Manager is appointed</td>
<td>Director for Patient Safety</td>
<td>Associate Director for Integrated Governance</td>
<td>June 08</td>
<td>November 08</td>
<td></td>
</tr>
</tbody>
</table>

### 2.2 REPORTING STRUCTURE

- Maintain the CLIP group schedule
  - Associate Director for Integrated Governance
  - Clinical Governance Manager/ Complaints Manager
  - July 08
  - March 09

- Review organisational structure in relation to risk and governance
  - Associate Director for Integrated Governance
  - Associate Director for Integrated Governance
  - August 08
  - November 08

### 3. COMMUNICATION

- Update the Trust Risk Management intranet site
  - Associate Director for Integrated Governance
  - Clinical Governance Manager
  - April 08
  - August 08
  - August 08

- Continue the Risk Newsletter/ Incorporate risk feedback into generic Trust newsletters
  - Associate Director for Integrated Governance
  - Clinical Governance Manager (Risk Manager once appointed)
  - April 08
  - March 09
## 4. POLICIES & PROCEDURES

### 4.1 RISK MANAGEMENT STRATEGY

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Responsible</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update the Risk Management Strategy</td>
<td>Associate Director for Integrated Governance</td>
<td>April 08</td>
<td>March 09</td>
</tr>
<tr>
<td>Update the Policy Development Framework</td>
<td>Associate Director for Integrated Governance</td>
<td>August 08</td>
<td>November 08</td>
</tr>
</tbody>
</table>

### 4.2 INCIDENT REPORTING POLICY

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Responsible</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update the Incident Reporting Policy to comply with EoE SUI policy</td>
<td>Associate Director for Integrated Governance</td>
<td>April 08</td>
<td>March 09</td>
</tr>
</tbody>
</table>

### 4.4 CONSENT TO TREATMENT POLICY

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Responsible</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement Consent to Treatment Training</td>
<td>Associate Director for Integrated Governance</td>
<td>September 08</td>
<td>November 08</td>
</tr>
</tbody>
</table>

### 4.5 SAFETY BROADCASTING POLICY

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Responsible</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Produce a Safety Alert Broadcasting System Policy and implement Trust-wide</td>
<td>Associate Director for Integrated Governance</td>
<td>May 08</td>
<td>August 08</td>
</tr>
</tbody>
</table>

## 5. TRAINING

### 5.1 RISK TRAINING
Continue risk awareness as part of Trust’s Induction, training programme to include junior doctors

| Continue risk awareness as part of Trust’s Induction, training programme to include junior doctors | Associate Director for Integrated Governance | Clinical Governance Manager Standards Coordinator | April 08 | March 09 |

### 6. MEASURING/MONITORING

**Ensure the continuation of the CLIP Reports reviewing themes and trends**

| Ensure the continuation of the CLIP Reports reviewing themes and trends | Associate Director for Integrated Governance | Divisional Risk Leads | April 08 | March 09 |

**Implementation of DatixWeb**

| Implementation of DatixWeb | Associate Director for Integrated Governance | Clinical Governance Manager / Systems Administrator | May 08 | November 09 |

**Incident Analysis to include Which Doctor information. (The incident data provided in reports should be based on number of patient admissions, bed spells)**

| Incident Analysis to include Which Doctor information. (The incident data provided in reports should be based on number of patient admissions, bed spells) | Risk Manager | Risk Manager | November 08 | March 09 |

| Reduced Incident processing time and other categories used | Risk Manager | Divisional Risk Leads | November 08 | March 09 |

| Increase incident reporting by clinicians | Risk Manager | Divisional Risk Leads | November 08 | March 09 |

Original Action Plan devised December ‘02 (see previous annual reports)

**Reviewed & Updated:**

August 2008

Mark Jarvis  
Associate Director for Integrated Governance

Nick Egginton  
Clinical Governance Manager
Appendix 4

Division of Acute Medical Care

Annual Risk Management Report 2007/08

Author: Simon Green
Authors Job Title: General Manager
Division: Division of AMCD
Manager Responsible for Review: Simon Green
Manager Job Title: General Manager
E-mail Address of Manager: simon.green@whht.nhs.uk
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</tr>
<tr>
<td>4.</td>
<td>Risk Register Review</td>
<td>56</td>
</tr>
</tbody>
</table>
1. Introduction

The Acute Medical Care Division has had a Risk Lead throughout 07/08 although the role was combined with other responsibilities. As of April 08 the member of staff who was carrying out the role of divisional risk lead has changed roles internally within the Trust and at present the division is currently recruiting to this post.

Throughout 07/08 the division held regularly monthly Risk Management Forums, which reviewed the divisional risk register, any Serious Untoward Incidents or significant incidents, complaints and health and safety matters. The Divisional Manager, Risk Lead, Head of Nursing and Matrons regularly attended the meeting.

The division also held nine Clinical Governance ½ day sessions, three of these sessions were joint sessions and included all specialties within the division the remaining 6 were held by each specialty.

2. Serious Untoward Incident (SUI) Analysis

During 07/08 the division reported two SUI’s to the East of England Strategic Health Authority.

<table>
<thead>
<tr>
<th>DATE OF INCIDENT</th>
<th>DATE STHA INITIAL REPORT</th>
<th>NATURE OF SUI</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.08.2007</td>
<td>30.08.2007</td>
<td>Blood transfusion Incident</td>
<td>Level of patient harm categorized as moderate. Patient died but not as a consequence of the incident</td>
</tr>
<tr>
<td>26.11.2007</td>
<td>29.11.2007</td>
<td>Alleged sexual assault</td>
<td>Police advised WHHT that the Crown Prosecution Service would not uphold the case, therefore charges were stopped. Internal disciplinary procedure followed.</td>
</tr>
</tbody>
</table>

Both these incidents have been fully investigated with final reports sent to the East of England Strategic Health Authority.

Recommendations following the Blood Transfusion Incident

**Blood Transfusion Training & Education**

There needs to be an urgent evaluation of the existing blood transfusion education programme directed at nursing staff, to ensure the focus relates to the safe administration of blood. The programme would benefit by providing teaching in a step-by-step approach thus ensuring the key steps such as collecting, checking and administrating are clearly described and reinforced.

**Overnight Blood Transfusion**

The Trust needs to be assured that relevant Blood Transfusion Guidelines and best
practice, particularly in relation to overnight blood transfusion are implemented and widely understood throughout the organisation.

**Shift Management Skills**
The Trust needs to explore the appropriateness of developing a more pragmatic approach to shift management education and training, for example ward based learning linked to competencies.

**Blood Collection System**
There needs to be an urgent evaluation of the current blood storage systems to ensure parity and best practice throughout the organisation.

**Handover**
The need for a patient to have a blood transfusion should be seen as a variance and communicated verbally supported by documentation.

The on-call Medical Team should be aware of all patients that are expected to receive blood transfusion overnight.

**Blood Transfusion Policy**
A simple flowchart should be developed to provide a quick reference guide for staff to reinforce the checking steps prior to administration.

**Shared Learning**
The contents of this report should be shared in a facilitated manner for both Nurses and Doctors in order that lessons can be learnt in a constructive environment

**Recommendations following the alleged sexual assault**

As briefly stated on Thursday 29 November 2007 the Police Service advised West Hertfordshire Hospitals NHS Trust that the Crown Prosecution Service would not uphold the case therefore charges had been stopped. However, the internal disciplinary procedure continued and the Staff Nurse remained suspended until the conclusion of the disciplinary investigation.

The practice of using public areas (Aldenham Day Room) to discuss clinical care or conduct team meetings is inappropriate and the Investigation Team recommends that this practice cease immediately.

Senior Nursing Management Teams need to ensure that Senior Sisters receive formal briefing, support and direction when they involved in the management of a Serious Untoward Incidents.

The investigation recommendations should be presented to the Acute Medical Care Senior Nursing Team.
3. **Incident Review 1st April 07 – 31st March 08**

**Number of Incidents from 1st April 07 – 31st March 08**

```
<table>
<thead>
<tr>
<th>Month</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 07</td>
<td>244</td>
</tr>
<tr>
<td>May 07</td>
<td>242</td>
</tr>
<tr>
<td>Jun 07</td>
<td>224</td>
</tr>
<tr>
<td>Jul 07</td>
<td>263</td>
</tr>
<tr>
<td>Aug 07</td>
<td>246</td>
</tr>
<tr>
<td>Sep 07</td>
<td>170</td>
</tr>
<tr>
<td>Oct 07</td>
<td>309</td>
</tr>
<tr>
<td>Nov 07</td>
<td>223</td>
</tr>
<tr>
<td>Dec 07</td>
<td>239</td>
</tr>
<tr>
<td>Jan 08</td>
<td>252</td>
</tr>
<tr>
<td>Feb 08</td>
<td>186</td>
</tr>
<tr>
<td>Mar 08</td>
<td>187</td>
</tr>
</tbody>
</table>
```

From the table it is clearly evident that there was a fall in the number of reported incidents during the summer months with a peak in Oct 07.

The division reported 2795 incidents during this period.

The increases were most significant on Stuart Ward which reported 12 incidents in Aug, 20 in Sept and 25 in Oct, whilst Aldenham ward reported 12 in Aug, 26 in Sept, and 48 in Oct. The main reason for this increase was a lack of suitably skilled or trained staff which was reported 25 times in Aug, 33 in Sept and 68 in Oct.

The only other major increase came from patient falls from heights, falls on a level.
The majority of the incidents were logged under the specialty of General Medicine and Sub specialties 1238 (44% of the total), Care of the elderly reported 742 (27%) and Emergency Care reported 196 (7%).

Once a new risk manager has been appointed to the AMCD they will need to review the incidents logged under the general medicine and sub specialties category to ensure that that have been processed correctly and should not come under the other specialties listed.
Accidents that resulted in personal injuries was the highest reported incident categorised under the Stage of Care, this is mainly made up of patient falls and represents 35% of the total number of incidents.

Infrastructure or resources (staffing, facilities and environment) made up 21% of the total number of incidents.
### Number of Incidents by Adverse Event

<table>
<thead>
<tr>
<th>Incidents</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of suitably trained/skilled staff</td>
<td>427</td>
</tr>
<tr>
<td>Fall from a height, bed or chair</td>
<td>387</td>
</tr>
<tr>
<td>Fall on level ground</td>
<td>365</td>
</tr>
<tr>
<td>Missing, inadequate or illegible healthcare record</td>
<td>155</td>
</tr>
<tr>
<td>Patient not isolated due to lack of side rooms</td>
<td>148</td>
</tr>
<tr>
<td>Accident of some other type or cause</td>
<td>88</td>
</tr>
<tr>
<td>Absconder / missing patient</td>
<td>49</td>
</tr>
<tr>
<td>Suspected fall</td>
<td>48</td>
</tr>
<tr>
<td>Physical abuse, assault or violence</td>
<td>45</td>
</tr>
<tr>
<td>Unsafe / inappropriate clinical environment</td>
<td>43</td>
</tr>
</tbody>
</table>

This table clearly illustrates the high number of reported incidents concerning a lack of suitably trained/skilled staff 427 (15% of the total).

Patient falls on a height and on the level were also highly reported.

Throughout 07/08 the recruitment and retention of staff was an issue for the division.
Number of Incidents by Staff Group

The above table clearly illustrates that the majority of the incidents were reported by the nursing staff with a very small proportion reported by junior doctors.

Number of Incidents by Time
89% of the top ten incidents had the time stated.

Of the incident locations that recorded a time it can clearly be seen that all the wards have a similar pattern of when the incidents happened.

Aldenham Ward reported the highest number of incidents by location and a significant number of these related to staff shortages.

**Number of Incidents by Day of the Week**

This table illustrates the day of the week that the incident occurred. There is no significant trend in the table apart from most of the wards exhibit similar reporting on the same days.
63% of the top 10 locations had the age of the patient stated

Lancaster, Stuart and Sarratt Ward are all Care of the Elderly and as such a higher proportion of their incidents relate to older patients.
Risk Management Department
Annual Risk Management Report 2007/8
Date of report: August 2008

Number of Patients by Gender

Incidents by Gender of Patient

62% of the top ten locations had the gender of the patient stated

Number of Incidents using ‘other’ categories

Frequency which ‘Other’ Codes are used within the Top 5 Care Stages

- Accident that may result in personal injury: 67
- Infrastructure or resources (staffing, facilities, environment): 32
- Implementation of care or ongoing monitoring/review: 19
- Patient Information (records, documents, test results, scans): 8
- Treatment, procedure: 5
The above table reports on the number of incidents that have been processed using ‘other’ as the code best used to describe the incident.

4. **Divisional Risks**

**Risks opened from 1st April 07 – 31st March 08**

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Opened</th>
<th>Rating (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to comply with cardiac arrest audit</td>
<td>It is a national requirement that all cardiac arrest are reported to Resuscitation Officers to facilitate national audit and local feedback. 1) staff members are not completing cardiac arrest forms 2) due to the lack of resource within the resuscitation office, forms that are completed are not logged onto the database for analysis</td>
<td>13-Sep-2005</td>
<td>16</td>
</tr>
<tr>
<td>Insufficient trust resource to implement WHHT emergency planning</td>
<td>Insufficient resource to manage Emergency Planning within the Trust, including major incident planning (review, updates and testing), training &amp; awareness, CBRN preparedness (Chemical, Biological, Radiological &amp; Nuclear incidents), and the statutory requirements laid out in the new Civil Contingencies Act (e.g. audit, Business Continuity, EP risk assessments).</td>
<td>4-Mar-2005</td>
<td>16</td>
</tr>
<tr>
<td>Incident</td>
<td>Description</td>
<td>Date</td>
<td>Rating</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>Unsafe Nurse Staffing Levels</td>
<td>Incidents of unsafe staffing levels are occurring, and will occur for some time due to (1) inability of NHSP to identify a bank staff member (2) confirmed bank member of staff cancels the booking shortly before shift commences, impacting on the ability of senior nurses to identify internal cover (3) staffing establishments are minimal, not providing a 'buffer' should a shift need cover</td>
<td>10-Feb-2005</td>
<td>20</td>
</tr>
<tr>
<td>HTM2030 Compliant Decontamination Equipment</td>
<td>HTM2030 (European standard BS EN ISO 15883) defines the legal requirements for the supply and use of washer-disinfector's for cleaning surgical instruments. Failure to bring equipment to standard has the potential for service closure (HSE). Existing equipment/wash rooms within West Hertfordshire Hospitals Trust fails to comply, despite recent considerable investment in new endoscope washers/disinfector's (Lancers) and extensive refurbishment of the endoscopy suites. Nationally there is a significant level of non-compliance however non-compliance has resulted in the HSE closing an endoscopy service within one organisation.</td>
<td>6-Oct-2004</td>
<td>25</td>
</tr>
<tr>
<td>Lack of power sockets to support clinical care</td>
<td>Non HDU bays have no more than 2 sockets per bed. The removal of extension leads due to a HSE directive has impacted on the ability of ward staff to ensure safe and appropriate clinical support (cardiac monitoring, pump infusion etc) for patients requiring more than two pieces of equipment at one time. (Please see Incident forms 037013 and 037002, 037023)</td>
<td>18-Jul-2004</td>
<td>16</td>
</tr>
</tbody>
</table>

The AMCD continues to review its risks on a regular basis, which are also presented at the Divisional Clinical Standards Executives.

Once the AMCD have appointed a divisional risk lead they will be able to monitor risks and incidents more closely and ensure actions to reduce risks and incident reoccurrences are implemented.
Appendix 5

Division of Surgery & Anaesthetics

Annual Risk Management Report 2007/08

Author
Mel Withero

Authors Job Title
Risk Lead

Division
Division of Surgery

Manager Responsible for Review
Maxine McVey /Elaine Odlum

Manager Job Title
Head of Nursing / Divisional Manager

E-mail Address of Manager
Maxine.McVey@whht.nhs.uk
Elaine.Odlum@whht.nhs.uk
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<td>62</td>
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<td>Overview of Governance and Risk in Surgery &amp; Anaesthetics</td>
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</tr>
<tr>
<td>6.</td>
<td>Incident Analysis</td>
<td>65</td>
</tr>
</tbody>
</table>
1. Introduction

The Surgery & Anaesthetic division is spread across all three sites, and during this period of time maintained 7 wards, 2 ITUs, 3 theatre complexes, and 3 pre-op assessment units. The division is then split into specialties such as General Surgery, Trauma, Orthopaedics, Vascular, and Ophthalmology, ENT and Oral Surgery. Each specialty has a clinical governance lead who is the ‘link’ between the risk lead and the specialty and is responsible for ensuring the specialty is kept up to date on governance issues from within the trust and also from wider sources, such as Royal Colleges, NICE, NPSA.

During the period concerned (2007/08) the division underwent some significant changes, greatest of these was the opening of the new day surgery unit on the St Albans Site. This was designed to relieve some of the pressure from HHGH and WGH and takes patients suitable for day surgery from all sites. Suitability for day surgery referral is assessed by the pre-operative assessment team, and is linked to general health, existing medical conditions and the procedure to be undertaken. Separating elective and trauma work also has infection control benefits as all elective patients are screened for MRSA prior to admission; if they return positive results then they are treated before admission (dependant on clinical urgency of procedure to be undertaken)

In preparation for this, the configuration of the wards changed with Cleves Ward closing at HHGH and opening on the Watford site and becoming a Trauma Ward in order to support the centralising of Trauma work at Watford.

2. SUI Review Summary

The division of Surgery and anesthetics has only reported one SUI during the year 2007/08. This concerned an incident of suspected self-administration of medication. This was reported as an SUI and also reported to the police. The Clinical Director was appointed as the investigator and the Business Manager for Anaesthetics was the contact for police liaison.

Following a police investigation no charges were bought. The division reported this to the Strategic health Authority under the SUI Policy and carried out an internal investigation.

Following divisional review, there were no changes in practice necessary. The drug was stored appropriately and kept locked, but the staff group of the individual concerned meant that they had unrestricted access to the drug.

3. Risk Register Review

The risk register is maintained and monitored by the risk lead, however the population and ownership of the risks within the register remains with the staff in the division. Rights of access to the register are restricted in that only certain staff have access to change entries but all staff can access to review. Staff will contact the risk lead to add items, this will facilitate a discussion around risk, control and grading and then a mutual decision is then taken as to entry on the register is necessary. This is usually the case when the risk will be mitigated fairly easily by easy to achieve actions within the specialty/ward and also within a short space of time. Staff remain responsible for mitigation of the risk and production and monitoring of any
associated action plans, although the risk lead will provide assistance when necessary.

Increasingly, the risk register is being used to document necessary bids for equipment via capital planning. This is a useful and effective way of documenting the need for the equipment and carries a formal appraisal of the risks associated with continuing with the old equipment (where appropriate) or risks associated with having no equipment in place.

Items added to the risk register for surgery and anaesthetics during the past year range from high-level organisational risks such as non-compliance in decontamination (graded at 25) to a build up and ongoing problems with achieving all the necessary trauma cases on the Watford site.

The top 5 issues on the risk register during the year are detailed below in a table

<table>
<thead>
<tr>
<th>Risk description</th>
<th>Grade</th>
<th>Actions</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ventilators in ITU</strong> - The make and model of ventilator used in ITU has become obsolete, the manufacturer would not be able to repair or supply parts for in the event of a breakdown. This would result in closure of ITU beds and transfer of patients to other units and potentially have clinical outcomes for a patient if the ventilator were in use when it malfunctioned.</td>
<td>25</td>
<td>Business case and quotes written/sent to Capital Planning.</td>
<td>New ventilators were purchased for the unit and the risk closed.</td>
</tr>
<tr>
<td><strong>Sterile Services at SACH and HHGH</strong> - Sterile department is non-compliant with HTM 2010 2030 and HBN 13. Has been non-compliant since 31st March 2007.</td>
<td>25</td>
<td>WHHT is joining consortium HBNL for decontamination super centre. Estimated opening date is now 2009. The Divisional Decontamination Lead sits on the Trust wide Decontamination Compliance Group which meet monthly to steer the trust toward compliance</td>
<td>This risk is ongoing.</td>
</tr>
<tr>
<td><strong>Medical Devices Lack of Training</strong> - Risk to patient safety due to user error through lack of training in the safe use of medical equipment. Although Infusion Device training is organised by Clinical Engineering the attendance is low and there is no evidence that divisions are disseminating it to their staff</td>
<td>25</td>
<td>Following the identification of this risk, all departments/units were asked to review their systems of recording staff training details.</td>
<td>This risk is ongoing. The staff training is up to date but the recording and monitoring of this is not.</td>
</tr>
<tr>
<td><strong>Steris Machine in DSU WGH</strong> - 2 Steris machines using steris 70 solution are in use in day surgery unit. They are used for decontamination of theatre equipment such as flexible gastro and endoscopes and light leads. They are used on a daily basis. Machines are non compliant with regulations HTM 2030 from April 2007.</td>
<td>25</td>
<td>Risk controlled by DSU staff who monitor final printed check that sterilisation has taken place. Decontamination group in Trust meet every other month chaired by Strategic plan for decontamination is that it will take place off site at a central unit, for most equipment but not flexible scopes, which will have to be decontaminated on site.</td>
<td>This risk is ongoing.</td>
</tr>
<tr>
<td>Risk description</td>
<td>Grade</td>
<td>Actions</td>
<td>Outcome</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dirty and clean should be segregated and rinse water not accessible for weekly</td>
<td></td>
<td>decontamination lead for Trust. External reviews have been undertaken</td>
<td>Ongoing discussion re changes to service to allow flexible endoscopy work to be relocated to endoscopy unit. Centralisation of day surgery to SACH in September meant that steris machines were decommissioned. This risk is now closed</td>
</tr>
<tr>
<td>testing. Alternative would be to use endoscopy but their system is also non</td>
<td></td>
<td>yearly.</td>
<td></td>
</tr>
<tr>
<td>compliant. Other option would be to purchase a new system, which is not feasible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>because of building regulations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laser Equipment in Ophthalmology WGH - The lease on the current laser in the</td>
<td>20</td>
<td>After trying three different models, the consultants have now</td>
<td>The company has agreed to extend their free trial on the promise that the Trust will purchase the equipment from them. The piece of equipment has now been purchased and the risk closed.</td>
</tr>
<tr>
<td>outpatient department expired two months ago. The equipment is currently on loan</td>
<td></td>
<td>chosen the laser that is most suitable to their out-patient work.</td>
<td></td>
</tr>
<tr>
<td>from a company. Failure to purchase this equipment will result in the company</td>
<td></td>
<td>This equipment is the Novus Spectra Laser System manufactured by</td>
<td></td>
</tr>
<tr>
<td>withdrawing the equipment. This will have a huge impact on the numbers of</td>
<td></td>
<td>Lumenis.</td>
<td></td>
</tr>
<tr>
<td>patients receiving laser treatment in the clinic. On average the clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>performs 6-laser treatment daily, 4 days a week.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. SABS Review

The division has a solid system for circulation and monitoring of SABS and associated actions, the alerts are received by the risk lead and the secretary who then takes advice from the Head of Nursing and circulates the alert to all relevant staff. At this point, the divisional database is updated. This database records exactly who the alert was sent to and also deadlines for action etc. Responses are then collated and recorded on to the same database.

Some of those requiring action during this time are detailed in table below:

<table>
<thead>
<tr>
<th>Alert Title</th>
<th>Date of release</th>
<th>Action Taken</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detachment of spreader bar from hoist whilst in use (patient hoist).</td>
<td>31.5.07</td>
<td>Not applicable. The surgical wards use floor mounted hoists and not ceiling/mobile hoists</td>
<td>Modern Matrons (all surgical wards)</td>
</tr>
<tr>
<td>Potential for connector to crack when used to deliver Propofol (anaesthetic agent)</td>
<td>13.6.07</td>
<td>Not applicable. Device not used.</td>
<td>All theatre areas, ITU and all Anaesthetic consultants.</td>
</tr>
<tr>
<td>Risk of asphyxiation to children from potential for entrapment between wooden bed rails.</td>
<td>27.6.07</td>
<td>Not applicable. Device not used.</td>
<td>Modern Matrons and DSU Manager</td>
</tr>
<tr>
<td>Various labeling errors which can result in the use</td>
<td>2.7.07</td>
<td>Not applicable. Device not used.</td>
<td>All theatre areas.</td>
</tr>
</tbody>
</table>
of an incorrect balloon size (gastroenterology/colonic surgery).

| Inappropriate mixing of head and cup sizes due to incorrect labeling of cups (Orthopaedic hip resurfacing implants). | 29.8.07 | Not applicable. Device not used. An orthopaedic consultant reported using a faulty device, but on review of patient notes/x-rays no patients were involved. | All theatre areas and all consultant orthopaedic surgeons |
| Device may kink during use, impeding ventilation (Endotracheal tubes). | 11.9.07 | Not applicable. Device not used. | All theatre areas and ITU |
| Outer pouch seal may be compromised (Orthopaedic bone cement). | 25.10.07 | Not applicable. Device not used. | All theatre areas |
| Possibility of delivering an unintended 1.7 ml bolus if the pump door is opened (Volumetric infusion pump) | 20.12.07 | Not applicable. Device not used. | All theatre areas and Modern Matrons (all surgical wards) |
| Brake mechanism may not lock due to component failure/excessive wear (stretcher trolley) | 12.2.08 | Day Surgery Unit at SACH reported having some of the Stryker trolleys (eye surgery), but there were no reported problems. | All theatre areas, Modern Matrons and ITU |
| Foam head of oral swabs may detach from the stick during use. | 18.3.08 | All appropriate staff made aware of the problem. | Modern Matrons, ITU staff and Manager of Oral/Maxillary Surgery. |
| Multiple reports of hypodermic syringes spontaneously disconnecting from, or failing to maintain a secure connection to fittings/other devices. | 22.10.07 | SACH theatres, DSU (WGH) and Aragon and Ridge wards found the affected syringes in their areas. Syringes were discarded/returned to manufacturer. | All theatres, ITU and Modern Matrons |

5. **Overview of Risk Management and Governance in Surgery**

Risk and Governance in Surgery is led by the Divisional Risk Lead, who is employed on a part time basis. The risk lead is line managed by the Head of Nursing, but also works closely with the Clinical Director and Divisional Manager. For a considerable time (May 07 – November 07) during the year, the division was without a risk lead. During this time, crucial pieces of work were picked up by the Acting Divisional Manager and Acting Head of Nursing. In November, a Divisional Manager and Risk Lead were appointed, which enabled the division to once again, focus on proactive risk management throughout the division.
The main forum for wider discussion on risk issues is the monthly Divisional Risk Forum that is chaired by the Clinical Director. This is attended by all the above, a general surgery representative and also a business manager representative. As and when relevant or necessary, other members of the division may attend.

At this divisional risk forum there is a fairly regular agenda, the risk register is reviewed and actions identified, high level incidents are reported on and reviewed, all divisional MRSA Bacteraemia are also reviewed here, and any national guidance such as NCEPOD reports or NICE guidance. The forum also reviews any developing trends or themes and identifies the way forward to act on these themes. Any issues which cannot be resolved in the clinical areas also come to the forum where they will be discussed and actions identified.

In addition to this, the division has its clinical governance days. There are 12 set days across the year, 3 of these are allocated as divisional and all clinical staff in the division are expected to attend at least one of the days. At these divisional days, we invite both internal and external speakers to present topics of their choosing, these could be audit reports, general reports into areas of general interest, or feed back following Root Cause Analysis Investigations following incidents. The remaining 9 days are split across the surgical specialties and the agenda is set within the specialty. The divisional risk secretary maintains a database of dates and attendees at the clinical governance days to ensure staff attend when they can.

Also crucial to the risk management process in surgery is the role of the business managers. Each specialty has an assigned manager to ensure the day-to-day business runs smoothly. These business managers are also responsible for production of business cases for equipment, service changes etc and are usually the link between the consultants and the risk lead for keeping the register up to date and accurate.
6. Incident Analysis

Number of Incidents from 1st April - 31st March 08

The 1st four months of the year saw a steady increase in numbers of incidents reported, climbing from 124 in April up to a yearly high of 181 in July. Following this there was an unexpected drop in numbers down to 84. This could be partially explained by higher numbers of staff taking annual leave, to accommodate this there were theatre closures for 2 weeks.

Following this drop, the numbers started to rise again. Around September time, the division made drastic changes to service delivery, separating trauma/orthopaedic and elective work and designating St Albans as the elective site. The new Day Surgery Unit opened on the St Albans site and we expected the numbers of incidents reported to rise slightly reflecting ‘teething troubles’ with the new configuration. In actual fact, numbers remained consistent around this time.

(The number of surgical procedures, carried out within the division during the year was 20136.)
Over the last year, Surgery & Anaesthetics reported 1471 incidents; these were fairly well spread amongst 3 specialties, Trauma and Orthopaedics (406), Anaesthesia (395) and General Surgery (384). Trauma and Orthopaedic specialty reported more than any other specialty, this is not surprising, the patients which come in as a result of trauma are less fit than elective patients and to a certain extent you would expect more adverse events to happen in this care group.

You could also explain the amount of incidents within the orthopaedic care group when you consider the patients. Many of them have had major joint surgery, and to some extent have suffered a certain amount of loss of mobility following their procedure. Regaining this mobility and independence is part of the rehabilitation of the patients and a number of them would experience slips, trips and falls whilst regaining this independence.

The second most reported specialty was Anaesthesia, for the period 2007/08 incidents occurring in ITU were classified as anaesthesia. We have now separated ITU from Anaesthesia on Datix so we would expect to see a difference next year. Also, it is worth
remembering that Anaesthesia will be a part of nearly all surgical procedures from other specialties, increasing the probability of incident.

General Surgery also reported 384 incidents, much higher than any other specialty, this is because they are a larger specialty and, in general, have older sicker patients in their care. General Surgery encompasses colorectal and breast surgery, 2 very large surgical areas.

**Number of Incidents by Stage of Care**

![Diagram showing numbers of incidents by care stage]
By far the most reported incident per care stage was ‘accident that may cause personal injury’, (343) this would include slips trips and falls amongst staff and patients, lifting and handling incidents, or events such as needle stick/sharps injuries.

The division also reported 140 incidents in the category of ‘Access, admission, transfer, and discharge’, these would include incidents of cancelled procedures, non-clinical transfers across sites, or delayed discharges from clinical areas such as ITU to wards, or discharges delayed due to non-clinical reasons. As a result of this, we have developed systems within the division for better reporting and analysis of such incidents and these issues have been escalated outside of the division to the Clinical Standards Executive meeting. Many of these admission/discharge incidents are reporting delays in transferring ITU patients into wards throughout the Trust. Our ITU matrons work closely with the bed managers to try and ensure that patients receive timely transfers/discharges, which support best practice. Consistent and accurate reporting of these occurrences is crucial to enable analysis at a later date.

The division also reported 30 incidents of ‘abusive, violent, disruptive or self-harming behaviour’. Nursing staff on our wards are often exposed to unacceptable behaviour from patients that could be either physical or verbal. Sometimes, this can be attributed to a clinical reason, such as head injury or side effects of medication; with this in mind we are reviewing existing guidelines concerning patients with mental health issues or those that present with disruptive behaviour. This includes ensuring our staff are equipped and empowered to challenge such behaviour in patients whose behaviour does not have a clinical indicator.

Number of Incidents by Adverse Event

<table>
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<th>Numbers of Incidents by Adverse Event (Top 10)</th>
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<tr>
<td>Missing, inadequate or illegible healthcare record</td>
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<tr>
<td>Fall on level ground</td>
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<tr>
<td>Lack of suitably trained/skilled staff</td>
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<tr>
<td>Transfer - delay/failure</td>
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<tr>
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<td>Delay</td>
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<td>Treatment, procedure - other adverse event</td>
</tr>
<tr>
<td>Other medication incident</td>
</tr>
<tr>
<td>Fall from a height, bed or chair</td>
</tr>
<tr>
<td>Lack of/delayed availability of beds</td>
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</table>
It is somewhat surprising that the highest actual adverse event reported (222) was ‘missing, inadequate or illegible healthcare record’. Many of these concern patients attending for pre-op assessment or out patients’ clinic without case notes. This results in temporary sets of notes being made, or doctors reviewing patients without having a full history to review beforehand. There are widespread issues with the quality of note keeping and records maintenance that are being addressed through many different avenues.

There have also been episodes where patients have indwelling devices such as venflons, catheters or CVC lines and there is no current/up to date care plan in the notes. A growing issue within the division is lack of/delayed availability of beds; over the last year we reported 35 incidents, this links with work already ongoing on the establishment of ITU across WGH and HHGH.

**Number of Incidents by Staff Groups**

Unsurprisingly, the two staff groups who reported a huge majority of the incidents were Sister/Charge Nurse (500) and Staff Nurse (488). This equates to just over 70% of reported incidents. This is reassuring, as these 2 staff groups would be involved at every stage of a patient’s journey through the division. It is more disappointing to see that Consultants reported only 32 of 1406 incidents although many of the incidents were reported by nursing staff on behalf of Consultants. Many of the incidents filled in by the nursing staff have had...
input from the consultants in immediate management of the incident, such as reviewing patients after a fall, or detailing further treatment necessary as a result of the incident. This shows that whilst they may not be reporting the incident, they are fully informed and consulted by nursing staff to manage them. Hopefully, the reporting by Consultants may improve when the on-line reporting becomes available throughout the Trust. It was also pleasing to see that Health Care Assistants are directly reporting some incidents and obtaining nursing input onto the report.

**Number of Incidents by Time of Day**

![Numbers of Incidents by Time of Day (Top 10 Locations)](image)

The graphical representation of times of incident occurring is interesting. You can see that in most of the clinical areas, the incident occurred between 0800-1759. This is unsurprising as it is the timeframe when most patients are undergoing procedures and are at their most active. Outside of the regular hours, ITU reported the most incidents, 91 opposed to the next highest of 32 and 31 on Cleves Ward and Ridge Ward respectively. Many of these incidents in ITU can be attributed to Out of Hours discharges, these are reported as incidents as they contravene ‘Best Practice in ITU’ Guidelines. These discharges occur out of hours for a number of reasons. Sometimes ward beds are requested for patients within daytime hours but are not available until later in the day, at other times a night time discharge is necessary because a sicker patient in A&E or a deteriorating patient on a ward has greater clinical need for the bed. These cannot be avoided, but as per policy they are recorded as clinical incidents.

The areas which reported a significant number of incidents between the hours of 00:00 and
0759 were Boleyn Ward and Cleves Ward. This can perhaps be rationalised by noting that there are less staff on duty over night, and a certain group of patients who would be on these wards can be confused and anxious when they wake over night, also they are reluctant to use a call bell in case they disturb other patients. This means that they do not always ask for assistance when they should. Cleves Ward also takes every patient admitted with a fractured neck of femur; these patients are at higher risk of fall or injury than other care groups. Whilst Cleves is an orthopaedic ward, Boleyn is a general surgical ward and reported 23 incidents between 0000 and 0759 opposed to 17 during day time hours.

In some areas, the split of incidents over the 3 timeframes (0000-0759, 0800-1759 and 1800-2359) reflects the working practice, i.e. there were no incidents reported in Day Surgery before 0800 and only 4 incidents reported during 1800-2359, there is a similar pattern in the operating theatre complexes.

**Number of Incidents by Day of the Week**

In general there was an equal split across clinical areas and incidents occurring during Mon-Friday. In nearly all clinical areas, there were less incidents occurring at weekends than during the week. The exception to this was ITU, this can perhaps be explained by the fact that the ITU patient is generally sicker than a patient on a ward and so the unit is as busy seven days a week. ITU activity does not change at weekends as the wards and theatres are affected by the Mon-Fri elective activity.
Number of Incidents by Age of Patient

In most clinical areas the patients most affected by the incidents were within the 81-90 age bracket. The exceptions to this were Day Surgery and Operating theatres, where the age bracket of most affected patients was 41-50 and 31 to 40 respectively. This age range 31-50 perhaps find the lack of independence hard to manage, and so possibly fail to take nurses advice regarding assistance and staying in bed etc. In day surgery we can rationalise this by noting that, in general, the older the patient the less likely they are to be suitable for day surgery. This could be due to a variety of reasons such as general fitness or other existing medical conditions. Only the fittest patients are deemed suitable for Day Surgery, this is due to the likelihood of complications and lack of ITU on site at St Albans. All patients are assessed in pre-op as to suitability for day surgery and assessed for anaesthetic risk according to the ASA Scale (Anaesthetic Scoring Assessment).

The most common age of patients effected by incidents on our orthopaedic wards is between 71 and 90, again this can be explained by ages of people receiving joint replacement or
undergoing major joint surgery being higher.

These figures may be affected when you consider that only 66% of logged incidents have recorded the age/DoB of the patient. Staff are asked to use a patient label form notes on the incident form which will give us all the information necessary, but sometimes this is unavailable. In these circumstances we rely on the hand written information to enable us to record age. It is unclear if the reasons for non-recording of age are due to information supplied on the form, or incomplete logging onto the Database.

**Number of Incidents by Patient Gender**

![Incidents by Gender of Patient (Top 10 Locations)](image)

Again it is necessary to remark that only 68% of entries onto the database recorded a gender of the patient. In this case we can be fairly certain that this is down to incomplete entry onto the database as staff are not asked to indicate gender on the form. Of the incidents where gender was recorded there was a fairly even split of male and female. The only exception to this would be Cleves Ward where there were twice as many female incidents as male. It is useful to remember these figures include staff/patients and visitors to the ward, and not purely patients.
Within Surgery and Anaesthetics we are keen to establish correct codes for incidents entered to facilitate meaningful reporting and trend analysis. This means that wherever possible we will avoid using the ‘other’ field. The data processor works closely with the Database Administrator to establish correct codes for incidents, which she is unsure over. We have also achieved consistent categorising and logging due to the having one person responsible for inputting all incidents.

The graph shows that when we do use the other filed it is usually within ‘Accident/Personal injury’ or ‘infrastructure/Environment', these incidents represent a 2% of logged incidents.
Appendix 6

Division of Women’s and Children’s (WACS)

Annual Risk Management Report 2007/08

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Manager Job Title    Risk Lead
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1. Introduction

WACs has undergone some structural changes in the last year with Paediatrics having been brought back into the Division from PCT management. Following this the management of SCBU was moved back from maternity to Paediatrics.

In addition from June 2007 the management of risk on Elizabeth ward was also handed back to the division, although the actual management of staff remained with surgery. This will change in 2008/09 following appointment of a new substantive head of Midwifery. Management of the Gynaecology theatres remains within the surgical division and currently there are no plans for this to change.

During 2008 there will be a management restructure of the Division with clinical Directors for Obstetrics, Paediatrics and Gynaecology being identified. All the specialties within the Division are undergoing a review to ensure that the correct local risk and governance frameworks are in place to ensure that risk and governance is appropriately managed. If necessary issues can be escalated through the appropriate forums and up through the Trust Governance groups to the Board.

The division has recently written its Risk Management Strategy.

The report will focus on both WACS and the specific specialties within the division.

Women’s and Children’s Services
The following incident charts cover maternity, gynaecology and paediatrics.

2. Serious Untoward Incidents

<table>
<thead>
<tr>
<th>DATE OF INCIDENT</th>
<th>DATE SIHA INITIAL REPORT</th>
<th>NATURE OF SUI</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>05.06.2007</td>
<td>19.06.2007</td>
<td>Unexpected neonatal death 2hrs 49 mins post delivery</td>
<td>Unexpected neonatal death. Neonatal death following delivery of a baby in very poor condition. Post mortem identified acute asphyxia as the cause of death, following investigation it was identified that this outcome may have been prevented if midwives had acted differently during the later stages of labour.</td>
</tr>
<tr>
<td>09.09.2007</td>
<td>11.09.2007</td>
<td>Unexpected labour outcome ~ stillbirth</td>
<td>Still birth. The mother came in with a history of reduced fetal movements and suspicious CTG. A decision was made to induce labour, because the CTG remained suspicious the decision was made to perform an emergency C/section. Baby was a stillborn weighing 4.99kg. At post-mortem the pathologist said that the death was a result of hypoxia but could not be certain of time of death. The pathologist also suggested that the</td>
</tr>
</tbody>
</table>
mother had gestational diabetes, which is a risk factor in itself for interuterine death. It was generally felt that this was antenatal problem for the baby and that outcome probably could not have been changed.

In the first case the family have suggested that they may seek compensation as a result of the outcome. In the second case the family at this time do not appear to wish to pursue further actions.

All SUI’s within Maternity are initially discussed at the Maternity Risk Management Group, once investigations are finished and action plans have been implemented, the cases are then presented at the Maternity Clinical Governance Group which is for all staff to ensure that identified learning is shared.

In 2008 there has now been formed the Critical Incident Review Group. The aim of the group is to meet within 48 hours of a potentially serious incident being identified the group will meet to decide on whether the incident should be escalated as a serious untoward incident and how the incident should be investigated, by whom and how it should be managed. It is planned to introduce this concept to paediatrics as well in the coming year.

3. Incident Review 1st April 07 - 31st March 08

Number of Incidents

Since June 2007 there has been a very small decline in the number of incidents reported, the incidents from this period fluctuate between 129 – 182 incidents per month.
**Number of Incidents by Specialty**

The chart below details the number of incidents reported by the specialty (the category that incidents are recorded under when processed).

- Obstetrics: 1229
- Gynaecology (From 1st June '07): 145
- Children Services: 120
- Midwifery: 118
- Neonatal Intensive Care Unit: 47
- Community Midwifery: 17
- Antenatal Care: 13
- Neonatology: 11
- Paediatrics: 6
- Anaesthesia: 6
- Fertility Treatment (From 1st June '07): 1

Obstetrics has the highest number of incidents reported (see additional maternity incident graphs)

**Number of Incidents by Stage of Care**

The chart below details the number of incidents reported by the stage of care (the category that incidents are recorded under when processed).

The highest number of reported incident concerns ‘labour or delivery’, with the other categories reported considerably lower.
Numbers of Incidents by Care Stage

- Labour or Delivery: 881
- Infrastructure or resources (staffing, facilities, environment): 160
- Access, Appointment, Admission, Transfer, Discharge: 104
- Patient Information (records, documents, test results, scans): 88
- Accident that may result in personal injury: 88
- Treatment, procedure: 83
- Other - please specify in description: 80
- Medication: 65
- Medical device/equipment: 50
- Consent, Confidentiality or Communication: 45
- Implementation of care or ongoing monitoring/review: 23
- Clinical assessment (investigations, images and lab tests): 18
- Abusive, violent, disruptive or self-harming behaviour: 17
- Diagnosis, failed or delayed: 13
- Security: 19
- Anaesthesia: 4
The highest reported incident concerns ‘simple complication of treatment’. This is because it can be very difficult to fit the incident into what options are available on datix. It also needs to be remembered that the majority are not really adverse events, but are reported as a result of the maternity trigger list.

The increase in reported delay incidents relates to an attempt to record delays of over 30 minutes from decision to deliver by emergency caesarean section until actual delivery.

For CNST purposes WACS must audit all emergency c/sections from time of decision to delivery, if there is a delay of over 30 minutes WACS have to try to ascertain why and if required provide action plans. Many emergency cesarean sections with a delay of over 30 minutes could actually be reclassified as non-urgent. The incident forms are used as a trigger if there is a delay over 30 minutes.
Number of Incidents by Staff Group (Top 10)

The graph below highlights the type of staff who report incidents. It is clearly evident that the majority of the reporting is from midwives. It must be noted that if incidents are identified by the WACS risk lead having previously not been reported then these are reported and entered under midwifery staff.
Only 53% of incidents reported (in the top 10) had the time of occurrence recorded. Due to the unpredictability of natural births the incident times follow this trend with no significant different between morning, daytime and night.
Number of Incidents by Day of the Week (Top 10 Locations)

It is noticeable that there is little change in the number of incidents reported occurring at the weekend.
4. NICE Guidance Overview

The Division is currently reviewing local governance frameworks to ensure that NICE guidance is effectively disseminated and reviewed. Currently when new guidance is produced it is sent to the relevant areas within the Division for them to decide how it should be taken forward. For instance in maternity NICE will be discussed at Labour Ward Forum or the Risk Group and presented at Clinical Governance to all groups of staff.

**NICE Guidance CG55 Intrapartum Guidelines**

The guidance has suggested that women be given Syntocinon for the third stage through a route that is currently unlicensed. Another concern raised by clinicians is that the guidance recommends injecting directly into the umbilical cord for retained placenta something that the Doctors are not trained to do and have reservations on.

The guideline group have been asked to re look at this guidance with a view to changing the current protocol to bring in line with CNST requirements.

NICE recommends the SROM (spontaneous rupture of membranes) needs to be augmented within 24hrs, the Trusts present practice is within 48hrs. If the Trust adopts the 24hrs guideline then it has huge implications on capacity. Again the guideline group will need to look at this guidance, it is likely that an audit will need to be undertaken to look at how a change will impact on maternity services particularly in relation to women wanting to deliver on ABC.
NICE Guidance CG62 – Antenatal Care
WHHT does not routinely offer dating scans
One of the trained midwifery sonographers is leaving the Trust, which will mean that the
planned start date for dating scans will extend past September 08. The recruitment process
has already commenced.

This has a knock on effect on the requirement for the Trust to carry out nuchal tests, as they
cannot be done without the pregnancy being dated. However, the plans are that this will
commence in March 2009

NICE Guidance CG63 – Diabetes in pregnancy
WACS will benchmark this guidance against current practice. It is already evident that the
Trust will not be compliant with all aspects. However, the Division uses the WHO
recommendations which they consider more stringent than those recommended by NICE

5.Maternity

5.1 Healthcare Commission Report
In 2007 the Healthcare Commission (HCC) undertook a nationwide review of all maternity
services. The review assessed maternity services nationally to establish “Does the Trust
provide a high quality, value for money maternity service?”

West Hertfordshire Hospitals NHS Trust was assessed as “Least Well Performing”.

The 25 indicators used by the Healthcare Commission to assess the Trust are set within an
assessment framework grouped under three themes, ‘Clinical Focus’, ‘Women Centred Care’
and ‘Efficiency and Capability’. Data sources for the review, and which informed our final
score included data provided by the Trust, the Mothers’ Survey (externally undertaken), staff
survey (externally undertaken), and data available from national sources e.g. HES, CEMACH.

CEMACH data shows the Trust has the lowest perinatal mortality rate in NHS East of
England. This HCC assessment does not therefore reflect on the safety of our service. In
addition some of the scoring of indicators was low because we either failed to submit the
necessary data or the data quality was poor.

As a result of this rating the Trust Board required the maternity services to produce an action
plan, which would address the weaknesses identified by the review. This action plan is
regularly being reviewed and updated and has been placed on the Trust risk register until
such time that the maternity services are reassessed and obtain an improved rating.

The following list highlights the main indicators which need to be addressed as part of the
action plan:
• Women not receiving NICE recommended number of antenatal appointments
• Availability of NICE recommended screening
• Appropriate use of Caesarean sections
• Maternal Morbidity
• Postnatal care of women and babies
• Progress on implementing Mental Health NICE guidance
• Extent that the staff are trained in core maternity skills
• Teamwork and supervision
• Time between first contact and booking
• Choice and continuity of antenatal care
• % of women offered an informed choice for screening tests
• % of women attending NHS antenatal classes who wanted to
• Extent of choice in Labour
• Support for infant feeding
• Quality of support in caring for the baby after discharge (first 6 weeks)
• Stakeholder involvement in service planning and evaluation
• Staffing levels
• Integration of support workers
• Average cost per delivery
• Data Quality
• Appropriate involvement of obstetricians and midwives in A/N care.
• % of women who felt their length of stay was right

5.2 Clinical Negligence Scheme for Trusts
This is reviewed in detail in the main body of the report (page 7)

5.3 Electronic Incident Reporting
This is reviewed in detail in the main body of the report (page 31)

5.4 Maternity Specific Incident Analysis 1st April 07 – 31st March 08

Delivery Rates
The total numbers of deliveries in the period April 2007 to March 2008 was up by just 26 from the corresponding period in 2006/07. However, the spontaneous delivery rate decreased by 3% in 2007/08 but there was an increase in 2% in the overall caesarean section rate.
On further analysis the emergency caesarean section rate for primigravida women rose by 2% and 2% for multigravida women, for both groups there was no change in the elective caesarean section rates. Instrumental delivery rates also remained unchanged between the 2 periods.

**Post Partum Haemorrhages (PPHs)**

As part of the Health Care Commission Action Plan the Division is now required to monitor all PPHs over 2500mls through investigation and audit of the management of these cases. In 2007/08 there was a total of 25 cases involving blood loss over 2500mls (0.44% of all deliveries), of those 7 involved total losses of over 4000mls. Of the 7 cases 6 patients were delivered by caesarean section, of which 2 required post partum hysterectomies.

Currently one of the Registrars is undertaking an audit of cases and is due to present the findings at the July Maternity Clinical Governance Meeting. Both cases that have involved the patient having a hysterectomy have been or will be presented at Clinical Governance Meetings.

**Perineal Repairs**

Third degree tears continue to be audited on a regular basis, with the proforma that was introduced last year about to be added to the hand held notes on a permanent basis.

As part of the HCC action plan we are required to ensure that all repairs are commenced within one hour of delivery. A small audit has just been undertaken and will be presented at Clinical Governance meeting in July along with the latest third degree tear audit. It is likely that we will make a small change to the perineal repair proforma so that time of commencement of
suturing is clearly identified. It is also anticipated that this will be a required audit within the new CNST standards because of the high numbers of litigation in respect of perineal repair.

**Reporting by Staff groups**

The table below shows the breakdown in reporting by staff groups. Reporting continues to be dominated by midwifery staff, in the case of medical staff there has been an increase in the amount of reporting from 32 to 54 incidents. Managers (including Matrons) are now reporting incidents more frequently; the number of unknown form completers has also been reduced to an almost negligible amount. There are constant reminders through the Risk newsletter and now posters for the new electronic forms about reporting of incidents.

The table below shows a breakdown of reporting by medical staff groups. There is some improvement in reporting across all grades of medical staff, but there still needs to be further improvement, as there is still generally an assumption that the midwives will always complete the incident forms in the majority of cases. Medical staff are informed of incident reporting processes as part of their induction programme, and are given copies of the maternity trigger lists in order to support this process.
Classification of Incidents
As can be seen from the table the vast majority of incidents continue to fall into the ‘minor’ category. The number of incidents classified as moderate fell from 121 in 07/08 to 76 in 07/08. A number of the moderate cases will have been investigated and action plans implemented. There were 2 serious untoward incidents in 2007/08, which was the same as the previous year. Both cases were fully investigated and all relevant reports with required action plans escalated to the Strategic Health Authority. The Supervisors of Midwives also undertook a number of investigations into incidents, which involved midwives where there was practice issues raised.

Maternity Triggers
The two tables below show the specific triggers currently being reported in maternity. There has not been a significant increase in the number of actual incidents but in the reporting of those, which should trigger incident forms. For instance the seemingly large rise in delay to emergency caesarean section once a decision has been made is not because there is an increase in this but because there has been a concerted effort to identify these case where there is a delay of over 30 minutes. This is a CNST requirement, which should be audited as an ongoing project. Even with the increased monitoring by the Risk Lead and CNST clerk there is still considerable under reporting of some of the Triggers. This is expected to deteriorate initially with the introduction of electronic reporting, until all staff are routinely using the electronic form.
Appendix 7

Division of Clinical Support

Annual Risk Management Report 2007/08

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<td>113</td>
</tr>
</tbody>
</table>
1. **Introduction**

The Clinical Support Division aims to provide high quality, patient focused healthcare by seeking to ensure appropriate standards of professional competence, clinically effective treatments and safety in the provision of practice, which in turn will be shared across the organisation. The Division's continual strive to demonstrate and implement robust risk management arrangements throughout its services is designed to meet the Trust's aim “to embed risk management into the organisation, to the extent that it becomes ‘second nature’ to all staff.”

Evidence of the Division's pro-active approach to risk management is demonstrated through its participation at the various forums. At the Divisional Risk Lead meeting of February 08 the Division was asked to present to the group. For the meeting we chose to highlight issues surrounding inappropriate pathology requesting and how, despite constant pressure from Pathology highlighting this, there is still a major problem with this. The notes are included as follows:

**Divisional Risk Leads Meeting Wednesday 6 February 2008**

**Pathology Requests - Lessons Not Learned**

The information below is from the Pathology audit between Jan & May 06. In September 06 the results were published in the Trust Nursing & Midwifery Newsletter, Risk section. Details include:

- 24% completion errors (1,006 of 4,133 requests April 06)
- 70% of NHS number omission counted
- 251 duplicate phlebotomy requests (Jan to Apr 06)

This causes a number of issues:

- Patients are bled twice
- Results cannot be sent to patients – delays & re-tests needed
- Cost to the trust

Since then the following has been undertaken to get the message across:

- Pathology Service Manager has spoken with various staff groups e.g. Junior Drs during induction and in other meetings, divisional meetings, and GP forums.
- Raised issue with Clinical Governance Board
- Top Risk in pathology
- Taken now to Clinical Standards Executive
- PSM refers to issue in most correspondence
- Continued to publicise pathology user manual on intranet/extranet

The current figures show:
Blood Transfusion Errors (Cancelled Specimens October 2007)

<table>
<thead>
<tr>
<th>Department</th>
<th>HHGH No</th>
<th>HHGH %</th>
<th>WGH No</th>
<th>WGH %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>11</td>
<td>14%</td>
<td>36</td>
<td>18%</td>
</tr>
<tr>
<td>Antenatal Clinic</td>
<td>0</td>
<td>0%</td>
<td>20</td>
<td>10%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>3</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2</td>
<td>2%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>ENT</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>2</td>
<td>2%</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1</td>
<td>1%</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>6</td>
<td>7%</td>
<td>16</td>
<td>8%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>10</td>
<td>12%</td>
<td>11</td>
<td>6%</td>
</tr>
<tr>
<td>Haematology</td>
<td>11</td>
<td>14%</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Midwifery</td>
<td>7</td>
<td>9%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Obs &amp; Gynae</td>
<td>20</td>
<td>25%</td>
<td>70</td>
<td>36%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>6</td>
<td>7%</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>0</td>
<td>0%</td>
<td>13</td>
<td>7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>2</td>
<td>2%</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Urology</td>
<td>0</td>
<td>0%</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>81</strong></td>
<td><strong>100%</strong></td>
<td><strong>197</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Excludes General Practice

All these requests were for at least “group and save”. The patients would require re-bleeding causing additional distress to the patient and additional cost to the Trust.

- Each cancelled request takes at least 5 minutes to attend to and send out a report saying “cancelled test” and why.
- There will be a proportion of requests where pathology have to contact the ward to ask for a repeat because of the possibly for need of urgent turn around.
- Additional time is needed to do both the test itself on the new sample and all the clerical work associated.
- Additional cost of the test and consumables.

Audit of request forms for hospital patients booked in as unknown doctor 24/10/07 to 31/10/07 and published on the Electronic Reporting System were as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>HHGH</th>
<th>WGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>No consultant code on form</td>
<td>100% (29)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>No consultant name on form</td>
<td>65% (19)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>No consultant name or code</td>
<td>65% (19)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>No useful requester information</td>
<td>100% (29)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>Total forms</td>
<td>29</td>
<td>9</td>
</tr>
</tbody>
</table>

Where a consultant is written it is often illegible or there are more than one e.g.
Johnston where there are 3.

These figures are after efforts to identify the requesting doctor, which is time consuming for pathology and causes delay to the tests being run.

This has now become a major finance issue, as pathology is not paid for unallocated work.

As a result pathology have implemented the following:
- Have stopped publishing on the electronic reports service results, which do not contain a known consultant name.
- Connected pathology computer system to Trust Patients Master Index (PMI)

Conclusions - Messages
- Despite repeated attempts to get the message across the situation has not improved
- This causes additional pain and anxiety to the patient
- And increases costs to the Trust
- Pathology would like to take a ‘zero tolerance’ approach and not process any sample unless the minimum data set has been completed on the request form and sample.

This years Clinical Support Divisions Risk Report seeks to demonstrate the ongoing actions and progress made since the report of 2006/2007, in order to manage risk and to provide a safe and healthy environment for everyone patients and staff alike.

2. Risk Register Review

The imminent opening of the new Acute Admissions Unit (AAU) at WGH has raised a number of concerns for the Division, which have been entered onto the risk register. In reviewing the Top 5 Divisional risks these are all now associated with the AAU; the table below therefore shows the current top 10 risks within the Division which include other areas of significant concern to the daily functioning of the departments within the Division.

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Rating (initial)</th>
<th>Rating (current)</th>
<th>Opened</th>
</tr>
</thead>
<tbody>
<tr>
<td>1577</td>
<td>MRI WGH not available. Transfers of acute patients to the HHGH MRI from WGH require emergency care skills on site to support these patients during examinations in the event of deterioration. These will not be available when A&amp;E services transfer to WGH.</td>
<td>25</td>
<td>25</td>
<td>30-Jun-2008</td>
</tr>
<tr>
<td>1578</td>
<td>Pharmacy technical services unit not in place and fully operational when AAU opens</td>
<td>20</td>
<td>20</td>
<td>30-Jun-2008</td>
</tr>
</tbody>
</table>
The table above demonstrates there are significant issues affecting the Division surrounding the completion and opening of the new AAU. These are being proactively worked through via the appropriate meetings or work groups in order to ensure they are suitably resolved thereby helping the Trust in achieving a successful launch for the new unit.

If the risks were to be analysed by their current risk rating rather than the initial rating then numbers 9 and 10 above would be replaced by the two below.

**Risks 9 & 10 Current Rating (still open)**

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Rating (initial)</th>
<th>Rating (current)</th>
<th>Opened</th>
</tr>
</thead>
<tbody>
<tr>
<td>1310</td>
<td>Mammography Equipment at SACH (additional unit require to meet 18 week wait and to provide back up for existing machine)</td>
<td>16</td>
<td>20</td>
<td>20-Nov-2007</td>
</tr>
<tr>
<td>1312</td>
<td>Lack of MRI Facilities at WGH</td>
<td>9</td>
<td>20</td>
<td>22-Nov-2007</td>
</tr>
</tbody>
</table>

Although the AAU issues dominate the Divisions current risk register, it is interesting to note Pathology actually regard that the main risks remain temperature control particularly on the HHGH site however the problems at WGH, SACH and MVH remain significant both for samples and staff.

Their other main risk is the inability of users to complete request cards properly. This is despite significant efforts of pathology staff to raise this as an issue to all users both internally and externally. This was also the subject of the Divisions presentation to the
February 08 Divisional Risk Lead meeting where the title of the discussion was “Pathology Requesting – Lessons Not Learnt”.

The pathology computer system, which is now 18 years old, also requires replacement with support only available until 2010.

3. **SUI Review**

Between 1 April 07 and 31 March 08 there were no reported SUIs within the Division.

4. **Incident Information**

**Number of Incidents 2003/2004 to 2007/2008**

During 2007/08 a total of 640 incidents were reported on Datix. This represented a drop of 440 incidents or 41% over the previous year. This figure is explained primarily by a reduction of 339 incidents within Pharmacy. This was due to a Pharmacy audit of prescribing errors carried out in 06/07 which although attributable to Clinical Support for Datix purposes actually belong to the other divisions within the Trust.

![Clinical Support - Number of Incidents 03/04 to 07/08](image)

All comparison actual/percentage changes made in the following charts are from 06/07 to 07/08.

The table below shows the number of incidents by department. The significant change, the reduction in Pharmacy incidents, has already been explained above. The other major change is within the Pathology figure, this shows an increase of 69 incidents over the previous year however when combined with the other departments within the Pathology service the number of incidents reported is actually down by 5 on the previous year.
If the effects of the Pharmacy audit were to be removed the actual incidents over the past three years would be 651, 681 and 640, which would represent a drop of 5% on the 06/07 figure.

<table>
<thead>
<tr>
<th>Dept/Service</th>
<th>03/04</th>
<th>04/05</th>
<th>05/06</th>
<th>06/07</th>
<th>07/08</th>
<th>Change</th>
<th>Change %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biochemistry</td>
<td>9</td>
<td>16</td>
<td>18</td>
<td>16</td>
<td>15</td>
<td>-1</td>
<td>-6%</td>
<td>2%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>15</td>
<td>18</td>
<td>11</td>
<td>11</td>
<td>2</td>
<td>-9</td>
<td>-82%</td>
<td>0%</td>
</tr>
<tr>
<td>Chemical Pathology</td>
<td>6</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cytology</td>
<td>33</td>
<td>48</td>
<td>70</td>
<td>46</td>
<td>48</td>
<td>2</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>-5</td>
<td>-63%</td>
<td>0%</td>
</tr>
<tr>
<td>Haematology</td>
<td>24</td>
<td>20</td>
<td>15</td>
<td>18</td>
<td>12</td>
<td>-6</td>
<td>-33%</td>
<td>2%</td>
</tr>
<tr>
<td>Histopathology</td>
<td>78</td>
<td>19</td>
<td>23</td>
<td>33</td>
<td>30</td>
<td>-3</td>
<td>-9%</td>
<td>5%</td>
</tr>
<tr>
<td>Immunology</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Microbiology</td>
<td>8</td>
<td>7</td>
<td>57</td>
<td>72</td>
<td>21</td>
<td>-51</td>
<td>-71%</td>
<td>3%</td>
</tr>
<tr>
<td>Mortuary Services</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Nutrition &amp; Dietetics</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>10</td>
<td>-4</td>
<td>-29%</td>
<td>2%</td>
</tr>
<tr>
<td>Outpatients Nursing</td>
<td>8</td>
<td>50</td>
<td>125</td>
<td>109</td>
<td>102</td>
<td>-7</td>
<td>-6%</td>
<td>16%</td>
</tr>
<tr>
<td>Pathology</td>
<td>94</td>
<td>55</td>
<td>20</td>
<td>100</td>
<td>69</td>
<td>223%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>6</td>
<td>81</td>
<td>122</td>
<td>491</td>
<td>92</td>
<td>-399</td>
<td>-81%</td>
<td>14%</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>11</td>
<td>24</td>
<td>38</td>
<td>31</td>
<td>24</td>
<td>-7</td>
<td>-23%</td>
<td>4%</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>7</td>
<td>8</td>
<td>29</td>
<td>41</td>
<td>12</td>
<td>41%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>4</td>
<td>122</td>
<td>127</td>
<td>97</td>
<td>119</td>
<td>22</td>
<td>23%</td>
<td>19%</td>
</tr>
<tr>
<td>SALT</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>-1</td>
<td>-100%</td>
<td>0%</td>
</tr>
<tr>
<td>Surgical Appliances</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>40%</td>
<td>1%</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>14</td>
<td>10</td>
<td>-4</td>
<td>-29%</td>
<td>2%</td>
</tr>
<tr>
<td>Not Specified</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>51</td>
<td>0</td>
<td>-51</td>
<td>-100%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>313</td>
<td>508</td>
<td>651</td>
<td>1,080</td>
<td>640</td>
<td>-440</td>
<td>-41%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table below shows the number of incidents by Stage of Care. If the medication incidents reported during the Pharmacy audit were excluded the top incident would continue to be “Clinical Assessment (investigations, images and lab tests)”. For 07/08 there were 204 incidents of this type representing 32% of the Divisions total.
<table>
<thead>
<tr>
<th>Stage of Care</th>
<th>Year</th>
<th>Change</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>04/05</td>
<td>05/06</td>
<td>06/07</td>
</tr>
<tr>
<td>Communication Damage to Property</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Diagnosis, failed or delayed</td>
<td>0</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Financial loss</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Fire (Actual)</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Patient Information (records, documents, test results, scans)</td>
<td>15</td>
<td>48</td>
<td>58</td>
</tr>
<tr>
<td>Infection Control</td>
<td>6</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Infrastructure or resources (staffing, facilities, environment)</td>
<td>41</td>
<td>47</td>
<td>76</td>
</tr>
<tr>
<td>Internet Misuse and/or Abuse</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Medical device/equipment</td>
<td>3</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Medication</td>
<td>90</td>
<td>90</td>
<td>436</td>
</tr>
<tr>
<td>Motor Vehicle Crime</td>
<td>4</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Implementation of care or ongoing monitoring/review</td>
<td>0</td>
<td>7</td>
<td>32</td>
</tr>
<tr>
<td>Other - please specify in description</td>
<td>0</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Radiation</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Security</td>
<td>14</td>
<td>37</td>
<td>22</td>
</tr>
<tr>
<td>System Failure</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Theft/Loss</td>
<td>17</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Transfusion</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>8</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Unexpected Outcome</td>
<td>25</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>508</td>
<td>651</td>
<td>1,080</td>
</tr>
</tbody>
</table>

**Number of Incidents 1st April 07 – 31st March 08**

*Numbers of Incidents Throughout 2007/8*
The table illustrates the incidents per month, which range from 68 to 40 incidents.

**Number of Incidents by Stage of Care**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical assessment (investigations, images and lab tests)</td>
<td>204</td>
</tr>
<tr>
<td>Accident that may result in personal injury</td>
<td>127</td>
</tr>
<tr>
<td>Medication</td>
<td>73</td>
</tr>
<tr>
<td>Infrastructure or resources (staffing, facilities, environment)</td>
<td>60</td>
</tr>
<tr>
<td>Patient Information (records, documents, test results, scans)</td>
<td>32</td>
</tr>
<tr>
<td>Other - please specify in description</td>
<td>25</td>
</tr>
<tr>
<td>Abusive, violent, disruptive or self-harming behaviour</td>
<td>24</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>17</td>
</tr>
<tr>
<td>Security</td>
<td>17</td>
</tr>
<tr>
<td>Implementation of care or ongoing monitoring/review</td>
<td>15</td>
</tr>
<tr>
<td>Access, Appointment, Admission, Transfer, Discharge</td>
<td>15</td>
</tr>
<tr>
<td>Medical device/equipment</td>
<td>11</td>
</tr>
<tr>
<td>Consent, Confidentiality or Communication</td>
<td>8</td>
</tr>
<tr>
<td>Diagnosis, failed or delayed</td>
<td>6</td>
</tr>
<tr>
<td>Financial loss</td>
<td>2</td>
</tr>
</tbody>
</table>

Although the data in this table is presented above, this format may give a clearer picture of the number of incidents by Stage of Care.
Number of Incidents by Adverse Event

The graph of the Divisions Top 10 adverse events highlights incorrect patient identification, with 96 incidents, as the main adverse event. This is primarily within Pathology, although the event is not directly attributable to Pathology, and has been tackled with the other divisions within the Trust on a number of occasions most recently at the February 08 Risk Lead meeting.
The table above highlights the top 10 staff groups within the Division reporting incidents. The table shows that BMS staff within Pathology reported the most incidents. This correlates with Pathology logging the most incidents. Again though the incident is attributed to the Division ‘other Divisions originated the error’.

Of all the incidents reported by the Division 75% of these contained the title of the reporter.
Number of Incidents by Time of Day

The graph and table above highlight the top 10 locations within the Division and the time of day. Once again Pathology have logged the most incidents however this is down to missing information, duplicate requests or requests for inappropriate testing.

As expected the majority of the incidents occurred during normal working hours with only a few out of hours incidents in Pharmacy and A&E Xray.

75% of incidents within the top 10 locations had the time logged.
The number of incidents reported within the Division was highest on a Monday. Though this could be due to catch up from the weekend. The next highest day is Thursday though this is not significantly higher than other weekdays.
The figures above demonstrate that 16% of incidents occurred to patients between 41 and 50 years old. However only 42% of incidents within the top 10 locations included the age of the patient.
55% of incidents within the top 10 locations occurred to female patients. However only 16% of incidents falling within this group had recorded the patient’s gender.
Number of Incidents by ‘Other’ stage of Care

The table above highlights the frequency which ‘Other’ codes were used within the top 5 care stages. The highest being Accidents that may result in personal injury.

5. **NICE Review**

The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

- NICE compliance comes under Clinical Effectiveness
- New NICE guidance is issued around the 23rd of each month and is sent to the relevant clinicians
- Clinicians are asked for percentage of compliance and to give reasons for non-compliance
- Records are held in Clinical Governance of WHHT compliance
- Clinical audit against NICE guidance is formally requested in some of the newer guidance.

The Division remains pro-active in complying with any guidance issued.
6. **SABS Review**

The Division has nominated SABS Leads, see table below. They must ensure arrangements are in place for the dissemination, action, and review of alerts within their area. In addition, under the new SABS policy, all staff with responsibility for managing alerts must be appropriately resourced and provided with support and guidance in relation to the management of alerts though the Division await guidance on how the support will be made available and where any additional funding to carry out these duties will be found.

Within the SABS policy the SABS lead responsibilities include:
- Maintaining a robust system for distribution of alerts to appropriate departments.
- Maintaining records confirming distribution.
- Maintaining records of actions taken within departments.
- Providing confirmation of actions taken to SABS Liaison Officer.
- Providing guidance to departments with regard to alerts and medical device adverse event reporting.
- Providing the SABS Liaison Officer with confirmation of completed actions by the timely completion of alert response forms.

In line with SABS policy as the Division does not have a risk lead the Clinical Governance Department will ensure that the alerts are distributed appropriately with the divisional manager and head of nursing informed if the alert requires action to be taken.

If a SABS lead is unavailable then the Nominated Point of Contact (NPOC) should be contacted. The Divisions NPOC’s are given in the table below.

Within the SABS policy the NPOC’s responsibilities include:
- Ensuring actions are taken within area of responsibility to enable compliance with the alert.
- Providing documented evidence of actions taken to NSL.
- Ensuring dissemination of information within alerts to relevant personnel within the department using appropriate methods of communication.
- Providing a timely response to the NSL for each alert received in the department.
- Maintaining complete records of alerts, allowing for easy reference.
- To support any review process performed to assess compliance with the SABS policy / process.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Nominated SABS Lead (NSL)</th>
<th>Nominated Point of Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>Elaine Donald</td>
<td>Val McIndoe</td>
</tr>
<tr>
<td>Pathology</td>
<td>Gerard Felix</td>
<td>NA</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Martin Keble</td>
<td>NA</td>
</tr>
<tr>
<td>Radiology</td>
<td>Sue Daniels</td>
<td>NA</td>
</tr>
<tr>
<td>Surgical Appliances</td>
<td>Luke Bonci</td>
<td>NA</td>
</tr>
</tbody>
</table>
7. **Divisional & Departmental Risk Management Arrangements**

The Clinical Support Division remains the only Division without an appointed lead for risk or clinical governance however in recognising the importance of the risk and governance agendas the following processes remain in place:

- Rotation of Divisional Service Managers to Risk Lead meetings
- Service Managers to take responsibility for individual areas of service.
- Monthly figures produced by Risk Department
- Datix system updated by risk Management team on behalf of Division.
- RIDDOR reportable incidents entered by appropriate Service Manager

Departmental team meetings and the Clinical Support Divisional meeting always include risk and clinical governance as agenda items. The Division has been asked to submit its divisional agendas and minutes, which are then logged as proof of Trust compliance with the appropriate standards. The larger service departments of Pathology, Pharmacy and Radiology each run their own Clinical Governance committee and Service Boards. Cross-departmental meetings, such as the medicines governance meetings attended by both Pharmacy and Pathology, are encouraged.

By attending a wide variety of meetings with other service areas from within the Trust, the Division can assess the impact of any proposals to its service and be able to advise as to how best to meet the needs of these services. It also enables the Division to be able to discuss risk and governance at senior levels formulating plans and cascading the relevant information quickly.

The Division remains committed to updating the Risk Register. This document provides an understanding of risk and the impacts of these within our Division.

The Division is proactively working towards the implementation of electronic incident reporting with staff training arranged and in some instances undertaken.

It has long been recognised that the complaint process has close links with clinical governance and risk management and from 1st April 2007 all complaints have been entered onto Datix. By maintaining its 100% record of prompt complaints compliance the Division is quickly able to identify potential risks and trends and to tackle these eliminating the risk and reducing the likelihood of future complaint.

In June 2008 the Division completed its review of risk leads, health and safety representatives and staff able to offer first aid. The lists are attached below:

**Outpatients**

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPD HHGH</td>
<td>Sr. Val McIndoe</td>
<td>Sr. Val McIndoe</td>
<td>Elaine</td>
</tr>
<tr>
<td></td>
<td>HCA Carol Gregory</td>
<td></td>
<td>Donald</td>
</tr>
<tr>
<td># Clinic HHGH</td>
<td>SHCA Howe</td>
<td>Sr. Sue Osborn</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SHCA Thomson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPD SACH</td>
<td>SHCA Margaret Hedges</td>
<td>SN Jenny Dunndon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SHCA Rachel Pearce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPD WGH</td>
<td>Sr. Patsy Powenski</td>
<td>Sr. Patsy Powenski</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sr. Katerina Morris</td>
<td></td>
<td></td>
</tr>
<tr>
<td># Clinic WGH</td>
<td>SN Jacquie Lockett</td>
<td>Paul Woodward</td>
<td></td>
</tr>
</tbody>
</table>

**Pathology**

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEQAS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematology</td>
<td>Kim Martin (WGH)</td>
<td>Sushila Sakthitharan (WGH)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elanor Leonard (HHGH)</td>
<td>Elanor Leonard (HHGH)</td>
<td></td>
</tr>
<tr>
<td>Histopathology</td>
<td>MVH Via MIU</td>
<td>Jenny Coffee (HHGH)</td>
<td></td>
</tr>
<tr>
<td>Mortuary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microbiology</td>
<td>Amin Belal (WGH) (await Trust training)</td>
<td>Philip Spiers (WGH)</td>
<td>Gill Adlington-Graham (WGH)</td>
</tr>
<tr>
<td></td>
<td>Josiane Vuddamalay (WGH) (lapsed)</td>
<td>Bill Champion (HHGH)</td>
<td>Jules Peart (HHGH)</td>
</tr>
<tr>
<td></td>
<td>Claire Hallett (WGH) (await Trust training)</td>
<td></td>
<td>Gerard Felix</td>
</tr>
<tr>
<td></td>
<td>Jules Pert (HHGH) (await Trust training)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Pathology</td>
<td>Mary Duddy (WGH)</td>
<td>Mike Brady (HHGH)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mike Brady (HHGH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cytology / Phlebotomy</td>
<td>Jessica Fernandes (WGH) Fully CPR trained</td>
<td>Jan Stammers (WGH)</td>
<td>Nadene Short (HHGH &amp; SACH)</td>
</tr>
</tbody>
</table>

**Pharmacy**

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHGH</td>
<td>Siobhan Kelly</td>
<td>Shamim Jivraj</td>
<td>Martin Keble</td>
</tr>
<tr>
<td>SACH</td>
<td>TBC-exploring training</td>
<td>Shamim Jivraj Linda Hobbs</td>
<td></td>
</tr>
<tr>
<td>WGH</td>
<td>Judith Wilson (training needs update)</td>
<td>Sue Schechter</td>
<td></td>
</tr>
</tbody>
</table>
First aid training requirements are currently under review.

**PPAS**

There are no H&S or first aid staff within this area.

### Radiology

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHGH</td>
<td>Lois Potter, Pam Higgins</td>
<td>Sue Daniels</td>
<td>Sue Daniels</td>
</tr>
<tr>
<td>SACH</td>
<td>Beverley Walters, Lorraine Beck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WGH</td>
<td>Barbara Gavin, Denise Taylor, Debbie Adams</td>
<td>Louise Devereux</td>
<td></td>
</tr>
</tbody>
</table>

### Surgical Appliances

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHGH</td>
<td>Via Outpatients</td>
<td>Via Outpatients</td>
<td>Luke Bonci</td>
</tr>
<tr>
<td>SACH</td>
<td>Via Outpatients</td>
<td>Via Outpatients</td>
<td></td>
</tr>
<tr>
<td>WGH</td>
<td>Via Outpatients</td>
<td>Via Outpatients</td>
<td></td>
</tr>
</tbody>
</table>

### Therapies

Although therapy services fall within the Clinical Support division health and safety arrangements are slightly more complicated due to a number of the staff being employed by the PCT and not West Hertfordshire Hospitals NHS Trust.

All PCT employed staff follow both their PCT risk management process as well as having active involvement with the internal Trust processes.

### Nutrition and Dietetics

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHHT</td>
<td>Lynne Graham 3 days per week – otherwise visit A&amp;E</td>
<td>Lynne Graham</td>
<td>Smita Ganatra</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Fire Warden</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sally Spenceley</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Natalie Whitehead – on return from maternity leave</td>
<td></td>
</tr>
</tbody>
</table>

### Occupational Therapy

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
</table>
Physiotherapy

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHGH</td>
<td>Janet Boast</td>
<td>Ann-Marie O'Reilly</td>
<td></td>
</tr>
<tr>
<td>SACH</td>
<td>Debbie Paradise</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>WGH</td>
<td>Staff use A&amp;E</td>
<td>Tina Calvano</td>
<td></td>
</tr>
</tbody>
</table>

Speech and Language Therapy

<table>
<thead>
<tr>
<th>Department</th>
<th>First Aid</th>
<th>Health &amp; Safety</th>
<th>Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHGH</td>
<td>Staff use A&amp;E</td>
<td>Andrea Milton</td>
<td></td>
</tr>
<tr>
<td>SACH</td>
<td>Use Maple Unit or MIU</td>
<td>Carol Stokes</td>
<td></td>
</tr>
<tr>
<td>WGH</td>
<td>Use Janet Boast Physio</td>
<td>Anne Torrance</td>
<td></td>
</tr>
</tbody>
</table>

8. Conclusion

The Clinical Support Division continues to take a proactive approach to risk management. During 2007/08 the Division
- Completed all department risk assessments on time
- Were asked to submit Divisional minutes and agendas which include risk, governance, H&S and complaints management as specific items for review and discussion for the Trust to include as evidence of compliance to standards.
- Routinely attend all risk meetings and in February 08 presented to the group.

By adopting this approach and through continual review and monitoring of its practices in respect of risk management the Division seeks to provide safer and improved patient care, the provision of which is at the heart of everything it does.
Appendix 8

Estates, Facilities, Clinical Engineering and Fire Department

Annual Risk Management Report 2007/08

Author
Jacky Jones*

Authors Job Title
Facilities Manager

Division
Estates, Facilities & Clinical Engineering

Manager Responsible for Review
Paul Mosley

Manager Job Title
Acting Director of Estates & Facilities

E-mail Address of Manager
p.mosley@whht.nhs.uk

*the report was undertaken with the help of additional leads within the division
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<td>131</td>
</tr>
<tr>
<td>8.</td>
<td>Conclusion</td>
<td>131</td>
</tr>
</tbody>
</table>
1. **Introduction**

The division does not have an overall risk lead and the Managers of each specific department listed below take on this role:

- Estates - Richard Simon
- Facilities - Jacky Jones
- Fire - Roy Oliver
- Clinical Engineering - Sami Belhaj/Hassan Aghourime

2. **Incident Reporting**

During 2007-08 the division have continued to make progress with capturing incidents onto Datix and managing them through to a successful conclusion where possible.

The following incident tables capture those incidents that occurred from 1st April 07 – 31st March 08 for Estates, Facilities and Clinical Engineering.

**Number of Incidents from 1st April 07 – 31st March 08**

![Incident Reporting Graph]

From the table it is evident that there is a considerable amount of fluctuation in the reporting of Estates, Facilities and Clinical Engineering Incidents. 317 incidents were reported.
From the above table it is evident that the majority of incidents concerned Transport (32%). The majority of these transport incident occurred in A&E (Adult) Inpatients 47 (45% of the total) and related to transport between HHGH and WGH and to nursing/homes.

The Rapid Assessment Unit recorded the second highest transport problems with 14 (13% of the total). The majority of these incidents were due to transport delay and transport failing to turn up.
The highest reported incident by Stage of Care was infrastructure with 108 (34% of the total. 34 of these incidents were categorised as ‘other’, 30 were categorised as failure/delay in collection which relates to Portering, 15 were categorised as unsafe clinical environment and 13 were categorised as unsafe environment (personal safety, light, temp, noise, air).
Number of Incidents by Adverse Event

The table above confirms the problems/incidents with transport as the highest reported incidents concerns ambulance failing to turn up or being late (20% of the total)
The majority of the incidents concerning Estates, Facilities and Clinical Engineering are reported by ward staff.

72% of incidents had the job title of the reporter stated.
The majority of the incidents that have concerned Estates, Facilities and Clinical Engineering have occurred during the day (if we are to assume that the time stated on the incident form was the time of the incident and not the time the form was completed).

87% of the incidents had the time stated.
Number of Incidents by Day of the Week

Incidents by Day of the Week (Top 10 Locations)
The reports in the other divisions have included incidents by patient age and gender.

In this report the age of the patient does not have an effect on the incident in relation to this division and has been excluded. The same could be said for incidents by gender, however it is interesting to note that all car park related incidents have been reported by female staff.

Only 49% of incidents had the gender stated.
Number of Incidents using the category of 'other'

Frequency Which 'Other' Codes are Used Within the Top 5 Care Stages

- Infrastructure or resources (staffing, facilities, environment) - 33
- Other - 15
- Access, Appointment, Admission, Transfer, Discharge - 9
- Accident that may result in personal injury - 5
- Security - 1

3. Directorate Risk Register Review ~ Top 5

The Division regularly reviews the risks scoring 15 and above and reviews and update the actions, at quarterly Environmental Risk Meetings, and consequently proactively address and minimises the elements of Risks within the Directorate.

The Risk register for the Division is predominantly made up of the following:

- **Estates Risk Notifications**, which highlight Estates related risks, however, there are risks from
- **Facilities**, relating to security, car parking, catering, clinical and domestic waste and portering.
- **Fire**, adequate alarm systems and building/department risk evaluation and finally
- **Clinical Engineering**, maintenance and management of medical devices and equipment library.
The top 5 risks within the Division are currently:

<table>
<thead>
<tr>
<th>Risk ID Number</th>
<th>Title</th>
<th>Description</th>
<th>Controls In Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>1657</td>
<td>WGH ~ PMOK ITU electrical supply</td>
<td>Risk of danger to patients in CED &amp; CCD (ITU) by providing electricity supply from temporary hired generators.</td>
<td>Temporary transformers and LV switch gear installed</td>
</tr>
<tr>
<td>475</td>
<td>Fire risk in Accommodation at Willow House WGH</td>
<td>The fire precautions within Willow House fall well below the required national standards. The prime faults are: 1/ no fire resisting doors on bedrooms or store cupboards 2/ inadequate fire alarm system 3/ no emergency lighting 4/ the wrong door furniture (which is padlocked) to the emergency exit doors 5/ no fire protection to the external staircases from the kitchens</td>
<td>All existing fire doors signed 'fire door keep shut'. All storage removed from corridors/staircase enclosure. Review under Interim Measures. The 2nd and 3rd floors are now unoccupied and there are only 10 staff on level 1.</td>
</tr>
<tr>
<td>1650</td>
<td>WGH - Boilerhouse Yard</td>
<td>Risk: To Boilers and operatives. Both pumps (blow down and R.O) in deep pits in yard have stopped. They are being run from 1 control panel this is not safe and does not comply to good practise.</td>
<td>Immediate Steps: To attend on site to pump no. 1, windings found down to earth, remove pump and return to works for a strip and its repair. The current set up with 2 individual pumps running from 1 control panel is not a safe practise and requires updating. The set up is not serviceable in its current condition and requires all of the old cables and junction boxes removed and a new clearer dedicated system installed into each of the foul &amp; boiler condense chambers. The recommended action is: that the existing control panel is removed and replaced with 2 dedicated single pump control panels, which will be clearly marked to the corresponding chamber. That 3 new floats are installed into each chamber and connected back to the dedicated SWA cables are installed from the control panels to the junction boxes. The new control floats &amp; pump cables are terminated into the junction boxes. The system is commissioned and reinstated back into service</td>
</tr>
<tr>
<td>1643</td>
<td>HHGH - Main block X-Ray</td>
<td>Pump and associated flow switch failure on MRI scanner cooling circuit.</td>
<td>Operate system on manual/bypass circuit. Replace defective parts asap</td>
</tr>
</tbody>
</table>

Risk Management Department
Date of report: August 08
Open and Closed Risks (April 07 – March 08)

Open Risks (By Department)

- **C Eng**: 6 open risks, Risk Score 9
- **Fire**: 15 open risks, Risk Score 16
- **Estates**: 2 open risks, Risk Score 5
- **Facilities**: 2 open risks, Risk Score 6

<table>
<thead>
<tr>
<th>Department</th>
<th>Open Risks</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Eng</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Fire</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Estates</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

Legend:
- Number of open Risk
- Risk Score
4. **Risk Management – Estates**

4.1 Capital Schemes
The Estates Department carries out a number of capital schemes for both West Herts Hospitals Trust and the Herts Partnership Trust.

Capital Schemes encompass a number of risks which take different forms as you progress through the life of the project being undertaken:

- **At the design** stage the Professional Team must consider risks to the project and are required to assess these thoroughly from each of their professional standpoints.
- **During construction** there are obvious risks to consider, including those directly affecting the scheme itself. As well as personal risks to the contractor working in hazardous conditions and those, which could affect staff, visitors and patients. There are also financial risks of delay, identification of additional works not previously included or enforced change of contractors, for example.
- **Post construction** there are still risks to consider ~ have there been errors in construction, which need to be rectified, and are not entirely the fault of the contractor (e.g. design omissions).

4.2 Maintenance
The current financial situation is a substantial risk given the condition of the Trust’s Estate and the need to keep crucial services running in order to not compromises the clinical services. A large proportion of the current risks are due to the aging condition of the buildings and the controls poor response to fluctuations in the weather conditions.

In order to reduce the risk to the clinical and associated services and minimize the impact on access to services, a change from reactive maintenance to that of planned preventative maintenance is being made along with improved use of the estates management software. The principle being that a regular inspection routine on critical plant is more likely to detect a problem before its failure causes additional expense and loss of service. Due to resource constraints this can only be achieved by affecting the reactive maintenance response times.

**Electrical Infrastructure**
The HSE report identified the need for an Authorising Engineer (electrical) and this has been addressed by the appointment of an appropriate consultant. Authorised Persons (AP) have been trained for each site and a small revenue allocation enabled Estates to start addressing the equipment needs of compliance along with the security issues of the site plantrooms. There is still a shortfall in appropriately trained electrical staff and the necessary additional staff to carry out the necessary maintenance and to backfill the APs in execution of their role. Given these resources, the concerns raised by HSE could be actioned as a matter of priority.

The 5-year electrical installation test program is also overdue although a small start has been made on this with the commissioning of testing in PmoK at Watford.
Business cases to cover these areas are being resubmitted.

**Water Infrastructure**
A historic lack of investment and base information has resulted in the situation of insufficient drawings and information as to where the service supplies run, the areas they serve and the condition of the system. It is clear that there is an excess usage of water at WGH. Ad hoc surveys have been carried out which have located the source of some of the leaks but there is still an issue with the state of the pipe work and usage of water, which may still be due to leakage rather than consumption. A contract with ADSM via PASA contract has been enacted to improve this situation.

**Piped Medical Gas**
The onset of design work around DaHF has demonstrated that we do not have adequate current drawings of the Medical Gas Pipeline Systems on the three sites. A survey and risk assessment of each site is necessary to identify any areas of weakness. This has been funded for WGH and SACH and is ongoing.

**Emergency Electrical Generation Capacity**
Increase in the Electrical consumption has resulted in the Emergency Electrical Generators at all 3 sites being at or beyond their design capability. WGH have had to rent an additional back up generator to keep up with demand. Only 1/3 of the site would be able to function if the power failed since the other 2/3 of the site are on non-essential circuits not protected by generator cover. This was confirmed during an exercise in conjunction with the 5 yearly maintenance of the sites HV electrical system. A proposal to replace the generators along with associated reinforcement of the cabling essential for supporting DaHF has been submitted with an estimated cost of £1.3M. There are similar problems at HHGH and SACH. Business cases have been submitted for the works at WGH and SACH as these represent the highest risks to DaHF.

**Temperature Control**
The heat generation for the hospital estates is via gas and oil fired boilers with the exception of WGH where oil is their primary source of energy for the heating and hot water, therefore, failure of any part of the fuel oil system at Watford could be critical. The majority of the Trusts estate is in excess of 20 years old and does not reflect acceptable practice in terms of energy efficiency. Many complaints received are that the wards are too hot in summer and too cold in winter. Our electrical peak loads are during the summer when the cooling loads exist and combined with the fragility of the electrical infrastructure gives rise for some concern.

**Staffing Levels**
The levels of staffing particularly in the electrical discipline are too low to maintain the Estates in a safe condition. The Electrical Infrastructure business case and that related to staffing for the AAU will be resubmitted in 2008. The loss of the Estates Services contract for the community trusts have put substantial strain on staffing as the shared service nature of the provision meant that a number of key staff were identified as at risk.
5. **Risk Management in Facilities**

Facilities Management (FM) performs a corporate role, helping the organisation deliver its services to patients and staff in the following services. Reports are produced for the Trust Health & Safety Committee.

**Security**

A specification for the provision of security services has been in place now since November of 2004, and the presence of the security officers help maintain the safety of staff, visitors and patients alike whilst on the premises.

- Security hours have been increased at SACH from 9pm to 11pm to ensure the safety of all staff working late on site.
- Staff are trained in control and restraint in situations when required, they must take guidance from a Senior member of Trust staff in these situations
  - CCTV across all sites is currently being investigated and we await quotes
  - We now have in place a Local Security Management Specialist (LSMS) that we share with Bedford Hospital.

**Staff Residential Accommodation**

Due to site reconfiguration the site accommodation at HHGH will cease from March 09 when the AAU at WGH opens and the Doctors will move to the Watford site where currently a considerable amount of money is being spent on upgrading the existing accommodation.

**Catering**

A major project continues to resolve problems associated with the lack of gas to the WGH kitchen. Medirest have provided an excellent service throughout these troubled times, however with the end in site we are planning to resume a normal service which will again include freshly prepared ‘home’ cooked meals where required and porridge and soup prepared in the main kitchens and transferred to the wards.

**Car Parking**

This continues to remain a contentious issue, as there are not enough car parking spaces to accommodate all staff on each site.

- Parking permits have been issued in accordance with the Trusts agreed criteria.
- Facilities continue to monitor the space allocation every week from information supplied by CP Plus on space counts, which are taken twice a day.
- Park and ride option continues to be made available connecting all sites.

**Portering**

There exists a 15 minute response time to all Portering issues bleeped directly through to them. The Trust and Medirest continue to explore ways in which to improve the portering service.

**Clinical Waste Contract**

All of the yellow bins have now been fitted with secure locks.
Feedback from the Contract Monitoring Management indicates that increased awareness is having a positive effect in the Trust, with examples being:

- Clinical Waste rarely seen outside of the appropriate receptacle
- Collections of scrap metal waste from the site
- Large increase in numbers of waste bins labelled according to clinical or domestic waste
- Systems in place to dispose of batteries, refrigerators, freezers and mercury
- Aluminium recycling scheme about to be launched, in conjunction with Medirest, although Medirest are phasing out the purchase of drinks in aluminium in favour of plastic bottles.

**Sani Bins**

The bins are changed monthly at which time they change colour from a pale blue to white.

6. **Risk Management in Fire**

The Fire Safety Department has two members of staff, one based at Watford and the other at Hemel Hempstead General hospital, although the Department covers all 3 WHHT sites. This past year has seen a substantial improvement in making the Trust a safer environment for staff, patients and visitors.

New fire safety legislation came into force on 1st October 2006, which puts the onus to comply on the ‘responsible’ person. This ‘risk’ based legislation has put a greater strain on resources within the Department due to the fact that ‘competent’ persons can only do fire risk assessments. Subsequently, deficiencies in the fire safety infrastructure in the Trust building stock are being identified by fire risk assessments.

There are 16-recorded risks on the Trust DATIX system, a reduction of 6 from last year’s report, ranging from a score of 25 to 8. Some of the highest scoring risks will soon be removed as they relate to fire related risks in the staff accommodation at Watford. These premises have had a substantial amount of Capital funding spent over the last year to improve the safety and wellbeing of the residence.

Members of the Fire Safety Department also address minor issues i.e. replacement of signage etc, as and when identified during the ongoing risk assessment process.

Some of the Fire safety Department achievements are:-

- Fire risk assessments of over 200 departments / wards are ongoing across the Trust on a rolling programme throughout the year.
- Fire Marshall, fire extinguisher and specialist fire training on all sites ongoing.

The Hertfordshire Fire & Rescue Service is expected to visit and inspect the Trust later this year under the new Fire Safety legislation.
7. SABS Review

The majority of the SABS alerts received by the Division have been closed however the follow alerts still remain to be fully implemented. Action plans are in place.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Deadline - Action</th>
<th>Deadline - Completion</th>
<th>Subject</th>
<th>Device: Risk/ Problem</th>
<th>Acknowledged as</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>DH 2007 04</td>
<td>30-Apr-07</td>
<td>30-Nov-07</td>
<td>Liquid fuels with sulphur content</td>
<td>Comply with new legislation that oil gas has only 0.1% sulphur content</td>
<td>Assessing Relevance of Alert</td>
<td>Unknown. Reply received by Richard Simon on 12/06/08: Note out to sites regarding storage of high sulphur gas oil. This relates only to old stock as oil is consumed in generator running or as back up to gas on boilers at HHGH and SACH.</td>
</tr>
<tr>
<td>DH (2007) 06</td>
<td>24-Jun-07</td>
<td>28-Sep-07</td>
<td>Electrical Extension lead</td>
<td>Develop faults and domestic appliances are not for use in medical areas</td>
<td>Action is necessary: ongoing</td>
<td>Sent to GM on the 12.06.07. Sent to GM on the 12.06.07. Reply received by Richard Simon on 12/06/08: Clinical areas where such leads are required have been identified and a scheme is in production to install additional fixed socket outlets to obviate t</td>
</tr>
<tr>
<td>DH 2007 09</td>
<td>13-Nov-07</td>
<td>05-Feb-08</td>
<td>Window restrictors</td>
<td>Pts have fallen from the windows of upper floors</td>
<td>Action is necessary: not yet started</td>
<td>Reply received by Richard Simon on 12/06/08: A review is to be carried out to ensure all windows comply with HTM 55. A business case is to be submitted to the Director of Estates and Facilities for appropriate funding. There is a related issue identified</td>
</tr>
<tr>
<td>DH 2008 01</td>
<td>14-Jan-08</td>
<td>31-Jan-08</td>
<td>Reporting of Defects and Failures and Disseminating Estates and Facilities Alerts</td>
<td>Requirement to have a reporting system in place for estates and facilities</td>
<td>Action Completed and Matter Resolved</td>
<td>Sent to Gordon Males. Reply received on 12/06/08: Action: Document to be circulated to all Estates Managers for information / action as necessary. Lead Estates person to be identified by June 30th 2008 By Richard Simon.</td>
</tr>
</tbody>
</table>

8. Conclusion

Risk Management continues to play a large role in the decision making process within the Directorate Facilities Function. This is particularly important as resources become scarcer and the need to be able to evaluate the competing demand for investment.

Our common aim is to bring about demonstrable improvement in the quality of the Trust’s patient care through a more co-ordinated, systematic and focused risk management strategy,
ensuring all staff understands risk and how to manage it.