



Report Cover Sheet

| | | |
|-----------------------|---|---------|
| Report to: | Trust Board | |
| Date of the Meeting: | 24 July 2019 | |
| Agenda Item: | P1/0152/19 | |
| Title: | Risk Management Annual Report 2018/19 | |
| Report prepared by: | Vicky Davies, Risk Management Facilitator | |
| Executive Lead: | Sheila Lloyd, Director of Nursing and Quality | |
| Status of the Report: | | Private |

| | |
|---------------------------------|--|
| Paper previously considered by: | Integrated Governance Committee Quality Committee |
| Date & Decision: | 8 July 2019: minor amendments made following feedback 17 July 2019: recommended for approval by Trust Board |

| | |
|---|---|
| Purpose of the Paper/Key Points for Discussion: | The report details the annual review of incidents, serious incidents, externally reported incidents, claims, risk register, inquests and safety alerts. The Executive summary highlights the key findings. |
|---|---|

| | | |
|------------------|------------------------|---|
| Action Required: | Discuss | |
| | Approve | x |
| | For Information/Noting | |

| | |
|---------------------|---|
| Next steps required | Trust Board is asked to review and approve the annual report. |
|---------------------|---|

The paper links to the following strategic priorities (please tick)

| | | | |
|---|---|---|---|
| Deliver outstanding care locally | x | Collaborative system leadership to deliver better patient care | x |
| Retain and develop outstanding staff | x | Be enterprising | x |
| Invest in research & innovation to deliver excellent patient care in the future | | Maintain excellent quality, operational and financial performance | x |

The paper relates to the following Board Assurance Framework (BAF) Risks

| BAF Risk | Please Tick |
|---|-------------|
| 1. If we do not optimise quality outcomes we will not be able to provide outstanding care | x |
| 2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments. | x |
| 3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home. | x |
| 4. If we do not have the right innovative workforce solutions including education and development, we will not have the right skills, in the right place, at the right time to deliver the outstanding care. | x |
| 5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce. | x |
| 6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness. | x |
| 7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future. | |
| 8. If we do not retain system-side leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside. | |
| 9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future. | x |
| 10. If we do not continually support, lead and prioritise improved quality, operational and financial performance, we will not provide safe, efficient and effective cancer services. | x |

Equality & Diversity Impact Assessment

| Are there concerns that the policy/service could have an adverse impact on: | YES | NO |
|---|-----|----|
| Age | | x |
| Disability | | x |
| Gender | | x |
| Race | | x |
| Sexual Orientation | | x |
| Gender Reassignment | | x |
| Religion/Belief | | x |
| Pregnancy and Maternity | | x |

If YES to one or more of the above please add further detail and identify if a full impact assessment is required.



**The Clatterbridge
Cancer Centre**
NHS Foundation Trust

**The Clatterbridge Cancer Centre NHS
Foundation Trust**

**RISK MANAGEMENT
ANNUAL REPORT 2018/19**

Author: Vicky Davies – Risk Management
Facilitator

Approved by: Integrated Governance Committee
Date: 6/6/19

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**THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION
TRUST**

RISK MANAGEMENT POLICY STATEMENT

The Trust is committed to a strategy, which minimises risks through a comprehensive system of internal controls whilst maximising potential for innovation and best practice. The Trust acknowledges that the contribution of its staff is fundamental to achieving this.

The Trust will support and help its employees in providing services that are safe for patients. This will require that all staff recognise that Risk Management is everyone's business.

1. Introduction

The annual report for Risk Management has been produced for the period of 1st April 2018 to 31st March 2019. The key purpose of the report is to assure the Trust Board of compliance against the key requirements of the Risk Management Strategy. The report outlines the activities that have taken place throughout the year to evidence that the management of risk is constantly reviewed, monitored, reported with appropriate risk escalation.

The management of risk is an essential tool in ensuring a safe environment for patients, staff and visitors and to ensure the stability and reputation of the organisation. This report sets out the Trust's approach to the management of risk and the implementation of a system that enables the assessment, management and monitoring of risk.

The Trust's key strategic risk management aims are:

- To protect service users, staff and others
- To create an environment that encourages and supports all staff to report risks so that learning and improvement can take place.
- To identify and assess risks (including near misses) that could cause harm, disrupt services, impact on health and safety or lead to loss or damage.
- To implement, monitor and evaluate risk control measures
- To encourage organisation and cross organisation wide learning
- To make the effective management of risk an integral part of everyday practice
- To comply with national standards, e.g. Quality Surveillance, ISO9001, Care Quality Commission, NICE etc.
- To provide high quality service and to strive for continuous improvements
- To have clearly defined responsibilities for risk management

The Trust endeavours to create an environment that encourages and supports all staff to report risks so that learning and improvement can take place.

Risk

Risk is an event or uncertainty that may have the potential to impair or affect the Trust's ability to meet its current or future objectives. Risk may be strategic or operational. Risk is also exposure to danger with the chance of loss or harm. Losses may occur in terms of finance or reputation. Risk is present in all elements of the organisation: - the four key risk areas are

- Clinical
- Corporate
- Financial
- Reputation

Executive Summary

- The trust continues to have a good reporting culture with high levels of patient incidents reported but low levels of harm. The Trust continues to be in the top 25% of reporters to NRLS (National Reporting and Learning System).
- There has been a slight increase in the number of incidents reported in 2018/19 compared to 2017/18.
- 92% of incidents resulted in no harm, 7% low harm, 1.3% moderate harm and 0.3% severe harm.
- 9 Serious Incident Learning Review Meetings were held and all reported externally to StEIS and CQC.
- No Never Events were reported.
- Reported chemotherapy errors per 1000 doses stayed the same with 1.31 reported in 2018/19 compared to 1.3 in 2017/18.
- Reported radiotherapy errors were 1.35 per 1000 fractions in 2018/19, compared to 1.07 in 2017/18.
- Reported inpatient Falls per 1000 admissions in 2018/19 were comparable with 2017/18. Pressure ulcers and VTE's increased in 2018/19.
- Six Letters of Claim (all clinical claims) were received in 2018/19, with an additional nine potential claims. Seven claims from 2018/19 or previous years were settled or closed in 2018/19.
- 5 deaths were investigated by a Coroner in 2018/19, however only 2 inquests were held which staff were required to attend. This compares to 6 the previous year with only 2 inquests which staff had to attend.
- All safety alerts received via CAS were acknowledged in 2018/19. Action was completed for all the alerts except for one which had ongoing actions but were within the timeframes for completion.
- There has been a reduction in the number of risks on the register but an increase in the number of corporate risks. There was change in the approval process for corporate risks in 2018/19 as approval was delegated to the General Managers/Heads of Departments, whereas previously all corporate risks had to be approved by an Executive Director. In 2017/18 there were 11 corporate risks on the register and the end of 2018/19 there were 45.

2. Risk Management Responsibility: Compliance Monitoring

The Risk Management Strategy sets out the risk management responsibilities of key individuals and committees. The key responsibilities have been monitored to assure the Trust Board of compliance against the key requirements of the Risk Management Strategy

- *The Chairman and Chief Executive support the concepts of risk management within the broader clinical and corporate governance agenda.*

The Chairman and Chief Executive have received regular quarterly reports at the Trust Board on the effective management of the top organisational risks.

Directors of the Trust Board participated in the development and monitoring of the Trust Corporate Board Assurance Framework.

- *The Director of Nursing and Quality has executive responsibility for risk management and is the designated Risk Manager.*

The Director of Nursing and Quality's approved deputy has chaired the Risk Management Committee and Health & Safety Committee during 2018/19.

- *The Director of Finance has responsibility for financial risk management.*

The Director of Finance has attended and supported the Trusts Audit Committee. He has reported finance performance and any related risk to the Board and managed the Trust's finance department who oversee financial performance within the Trust.

- *The Quality Committee, as a formal committee of the Board, has overarching responsibility for the Risk Management Agenda.*

The Committee received and reviewed the risks assigned to the committee.

- *The Risk Management Committee leads Risk Management in CCC.*

The Risk Management Committee reviews and directs the management of risk and risk escalation in the Trust. It has established monitoring processes to assure the Board that risks are being managed effectively and escalated appropriately

The committee met on three occasions in 2018/19, to review incidents, claims, inquests, safety alerts, complaints, risk register and to monitor all risk related action plans. Reports and updates have been received from the risk related committees to ensure an holistic and co-ordinated approach to Risk Management.

The frequency of meeting and the attendance at the meetings are monitored as part of the key performance indicators in Appendix 2.

- *The Board reviews and manages the top organisational strategic risks.*

The Board Committees have reviewed the corporate risk register.

- *Senior Managers have local responsibility for managing risk. Senior Managers contribute to the Trusts Risk Register and are responsible for ensuring risks are reviewed regularly.*

Directorate risk registers are reviewed as part of the monthly Quality and Safety data packs and managers escalate risks via the Triple A reports.

- *The Risk Management Facilitator is responsible for the management of the Risk Register and for the development of risk reports to the Board and Board Committees, Risk Management Committee, Health and Safety Committee and Directorate/Departmental risk reports. The Risk Management Facilitator is also responsible for updating and managing the risk management databases in Datix (incident, claims, and risk register) and the Patient Experience Manager is responsible for managing the complaints and PALS databases.*

Reports were produced for all the Risk Management, Health and Safety and Board Committee meetings. The ongoing management and development of all databases has continued, to ensure the availability of timely data to identify trends and support appropriate management and escalation of risk.

- *The Clinical Governance Support Team (CGST) provides a cohesive team to further support and develop the Quality agenda across the Trust and as such provides expert advice and support on all aspects of risk management.*

The team have led on a number of Trust wide programmes of work including ISO 9001:2008 accreditation, CQC review and document management, as well as the management of all serious incidents, complaints, PALS, claims and inquests.

3. The Risk Management Process

The management of risk is addressed through the following process:

3.1 Risk identification, control and review

This is the process of identifying what can happen or has happened and why. The Trust identifies and monitors risks through a number of mechanisms:

- Risk assessment
- Assurance Framework
- Incident Reporting
- Complaints and PALS
- Claims
- Safety Alerts
- Internal and External Reviews
- Audits

3.1.1 A Review of the Risk Assessment and Risk Register Process

The Trust is legally obliged to carry out risk assessments. Their main purpose is to identify hazards and to determine whether planned or existing controls are adequate. The intention is that risks should be controlled before harm can occur, i.e. it is pro-active risk management.

An annual environmental risk assessment audit is undertaken to ensure that Health and Safety risk assessments have been completed. This audit is reviewed by the Health and

Safety Committee for monitoring of any actions identified. This was completed and presented to the H&S Committee in June 19 and the outcomes reported in the H&S Annual Report..

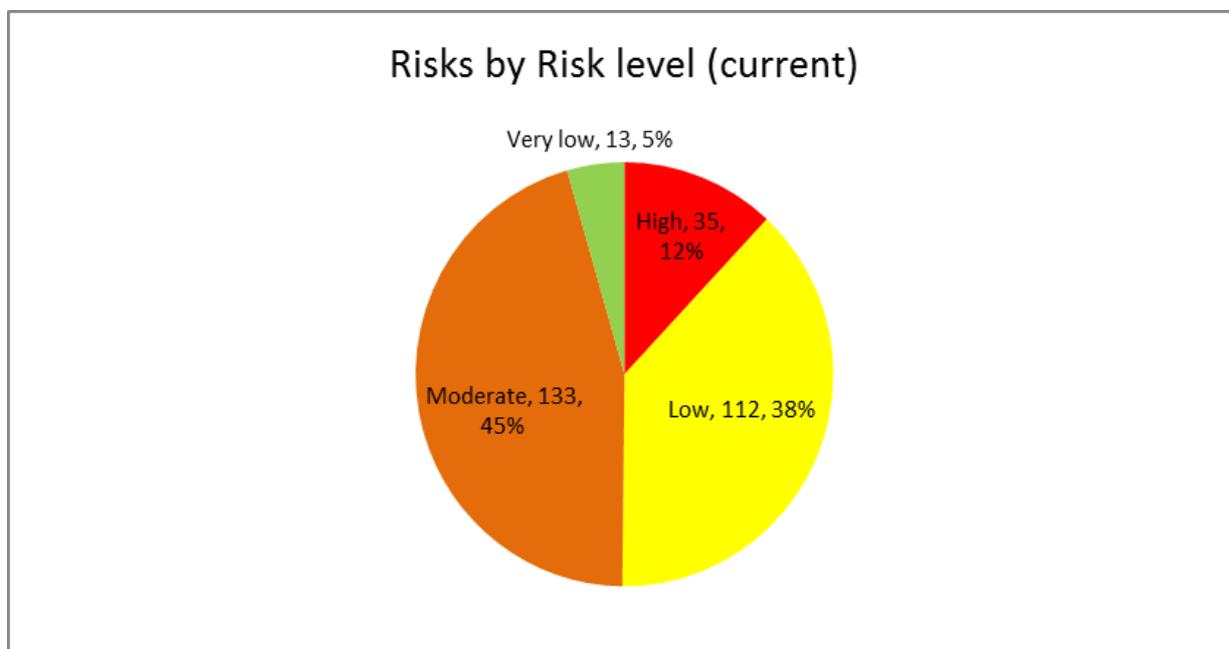
Risk Register Review

General and Departmental Managers are responsible for reviewing all of their risks and identifying and adding new risks to their registers in Datix. The system also enables them to produce their own reports, to enable improved management of risk in all departments and to recognise themes and trends for action.

A review of the Risk Register and monitoring of the risk register throughout 2018/19 was undertaken by the Risk Management Facilitator and reported to the Risk Management Committee, the Board Committees and via the monthly Directorate Quality and Safety data packs.

Departments were required to monitor their risk registers at least six monthly for all low risks, quarterly for moderate level risks and monthly for high risks.

At the end of 2018/19 there were 293 open risks on the register, with 35 high risks.



The table below shows the grading of the open risks on the register and compares them across the last 3 years

| Risk Grade | Number on Register end of 2016/17 | % | Number on Register end of 2017/18 | % | Number on Register end of 2018/19 | % |
|-----------------|-----------------------------------|-----|-----------------------------------|-----|-----------------------------------|-----|
| 1-3 (Very Low) | 42 | 7% | 46 | 9% | 13 | 4% |
| 4-8 (Low) | 343 | 61% | 315 | 60% | 112 | 38% |
| 9-12 (Moderate) | 165 | 29% | 153 | 29% | 133 | 45% |
| 15 (High) | 15 | 3% | 11 | 2% | 35 | 12% |
| Total | 565 | | 525 | | 293 | |

The table shows that there has been a decrease of risks on the register and this was due to a review that was undertaken in 2018/19 to refresh and update all risks on the register. The number of high risks increased during this time period. A change in the escalation process was introduced as previously all corporate risks had to be approved by an Executive Director but this was delegated to all General Managers and Heads of Department in 2018/19.

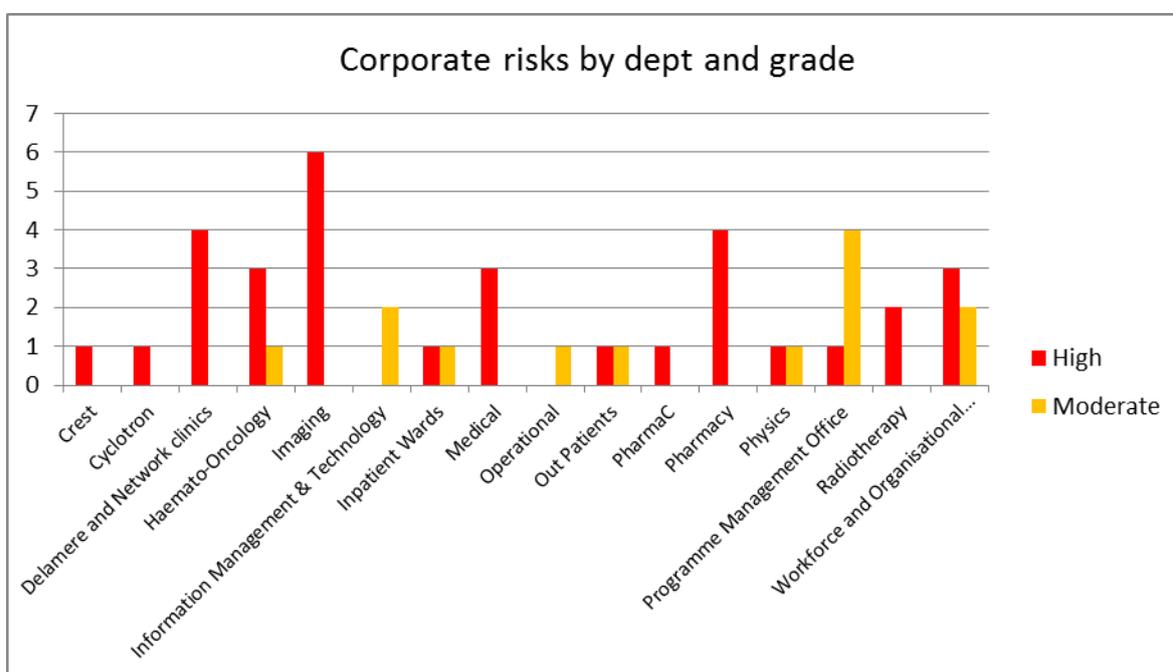
Source of Risks on the Register

A review of the Register showed that the risks were identified from a number of sources as detailed in the table below:

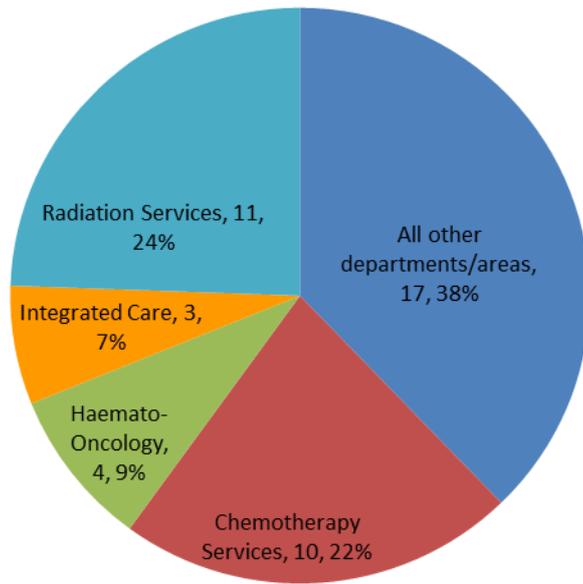
| Source of risk | Total 16/17 | % | Total 17/18 | % | Total 18/19 | % |
|-----------------|-------------|------|-------------|-----|-------------|-----|
| Risk Assessment | 449 | 80% | 400 | 76% | 146 | 53% |
| Incidents | 33 | 6% | 27 | 5% | 28 | 10% |
| Guidance/alerts | 13 | 2% | 14 | 3% | 8 | 3% |
| Audit | 5 | 1% | 13 | 2% | 8 | 3% |
| Complaints | 6 | 1% | 5 | 1% | 4 | 1% |
| Inspections | 4 | 0.7% | 7 | 1% | 7 | 2% |
| Other | 33 | 6% | 44 | 8% | 72 | 26% |

The table above shows that risks have been added to the risk register from a variety of sources. The majority have been identified from risk assessments but risks have also been identified from incidents, guidance etc

There were 45 risks in the corporate register at the end of 2018/19, 32 high risks and 13 moderate risks.



Corporate risks by Directorate



Risks (ALL) Over Due a Review by Current Grade

| Risk Grade | Overdue Review Date at 9/5/18 | Overdue Review Date at 5/6/18 | Overdue Review Date at 2/7/18 | Overdue Review Date at 6/9/18 | Overdue Review Date at 15/10/18 | Overdue Review Date at 6/11/18 | Overdue Review Date at 3/12/18 | Overdue Review Date at 7/1/19 | Overdue Review Date at 6/2/19 | Overdue Review Date at 4/3/19 |
|------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|---------------------------------|--------------------------------|--------------------------------|-------------------------------|-------------------------------|-------------------------------|
| 1-3 (Very Low) | 23 | 13 | 7 | 0 | 1 | 1 | 0 | 0 | 1 | 0 |
| 4-8 (Low) | 145 | 105 | 111 | 12 | 6 | 13 | 16 | 7 | 12 | 12 |
| 9-12 (Moderate) | 86 | 71 | 64 | 4 | 13 | 10 | 11 | 19 | 15 | 21 |
| 13-25 (High) | 9 | 7 | 10 | 0 | 2 | 4 | 9 | 2 | 6 | 5 |
| Total | 263 (53%) | 196 (41%) | 192 (42%) | 16 (4%) | 22 (5%) | 28 (7%) | 36 (10%) | 28 (9%) | 34 (12%) | 38 (13%) |

Directorates receive the above information in their monthly Quality Data Packs, in addition a weekly overdue risk review and action report is sent to the relevant managers. The data above includes PharmaC and The Private Clinic risks. The review of risk has improved over the year with less risks being overdue a review.

Risk Register Responsibility and Monitoring

Board Committees

The Board committees reviewed the corporate risks assigned to them at each meeting.

Directorates and Departments

Risks are reported in the monthly directorate Quality and Safety and a weekly overdue report is distributed to the managers.

3.1.2 Board Assurance framework

The Trust Board are committed to the maintenance of a robust Board Assurance Framework to identify key strategic risks that may prevent the organisation from achieving its corporate objectives. The Assurance Framework is used to map key risks and controls to objectives, identify gaps and determine action plans to close these gaps. Systematic processes are designed to highlight significant risks which may prevent organisation/directorate objectives being achieved. The Board redeveloped the assurance framework in 2018/19.

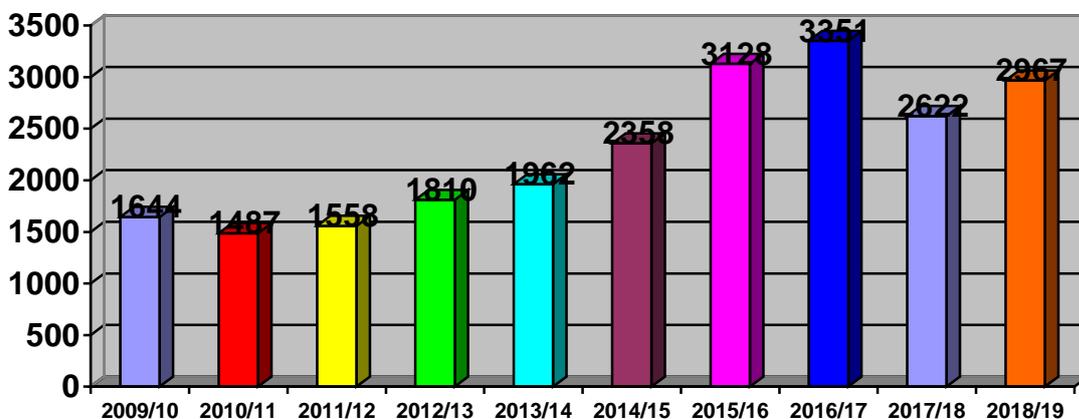
3.1.3 Incident Reporting

The reporting of incidents by staff is one of the most efficient and effective systems of identifying risk. It enables action to be taken and lessons to be learned with the aim of preventing recurrence. The Incident Reporting Policy sets out details of the systems in place, including the investigation, analysis and learning from incidents. Learning from incidents was shared across the Trust via the Team Brief and a quarterly lessons learned newsletter which was introduced in 2018/19.

All incidents have been monitored on a monthly basis and reviewed by the Risk Management Committee on a quarterly basis. Aggregated data was presented to the committee for review as part of the risk report. This involved qualitative and quantitative analysis of incidents, complaints, claims, inquests and safety alerts. Directorates review their incidents and an incident review report is produced as part of the monthly Quality and Safety data packs. In addition, patient harms were reviewed at the Harms Collaborative which met monthly to review falls, pressure ulcers and VTEs.

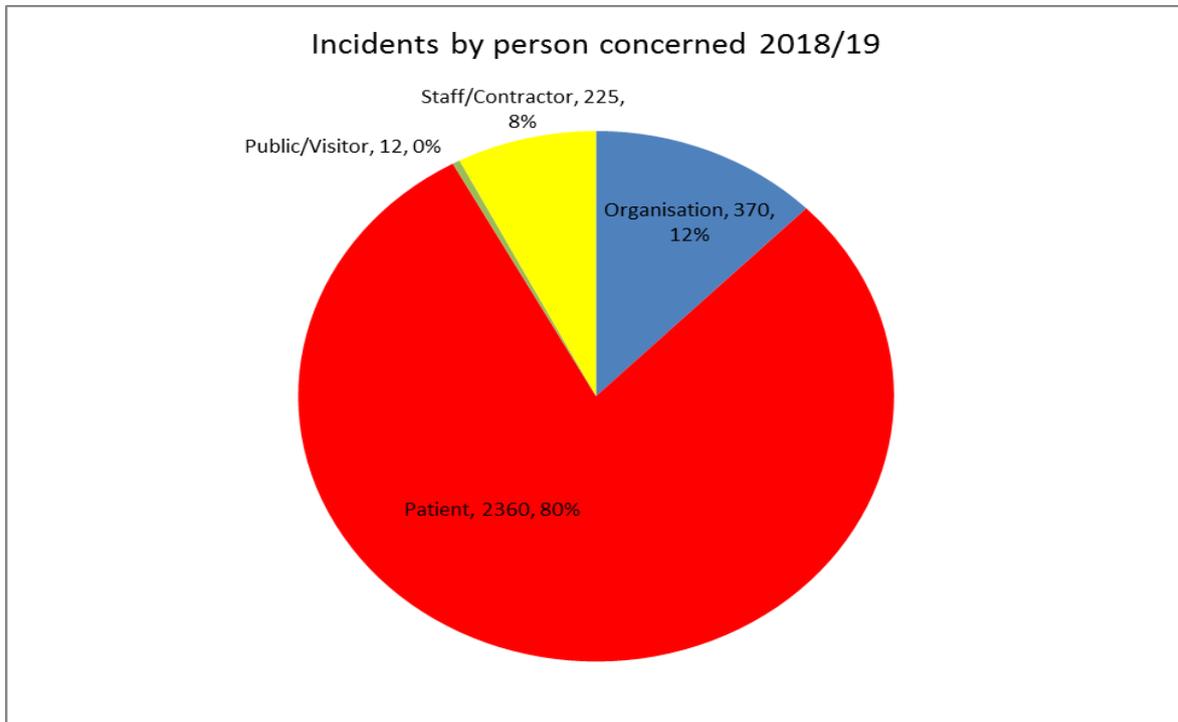
3066 incidents were reported from 1/4/18-31/3/19, however 99 incidents were rejected due to being duplicates or not incidents resulting in 2967 incidents; this was an increase compared to the previous year. The chart below shows the total number of incidents reported in previous years.

Incidents reported per year

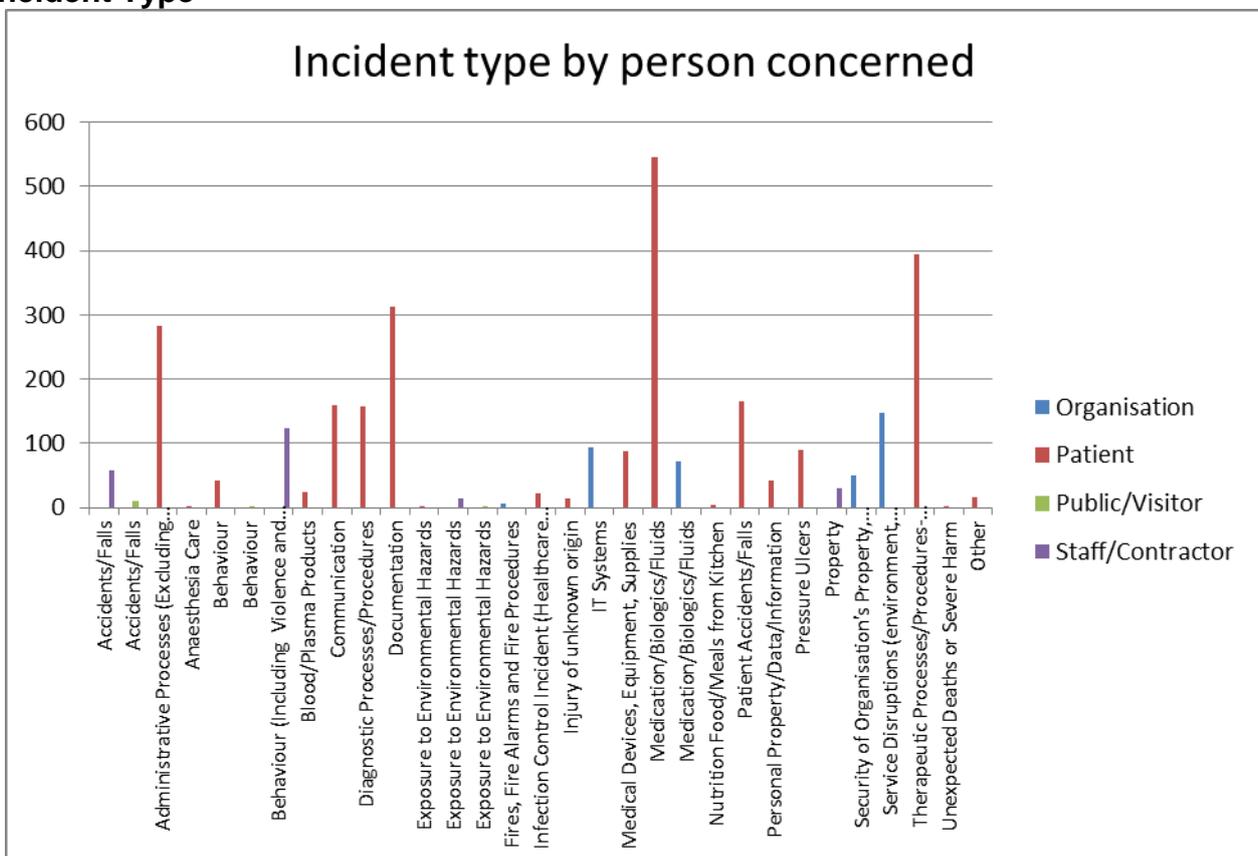


Person concerned

The majority of incidents were patient incidents (80%), with the remaining involving staff, visitors or the organisation



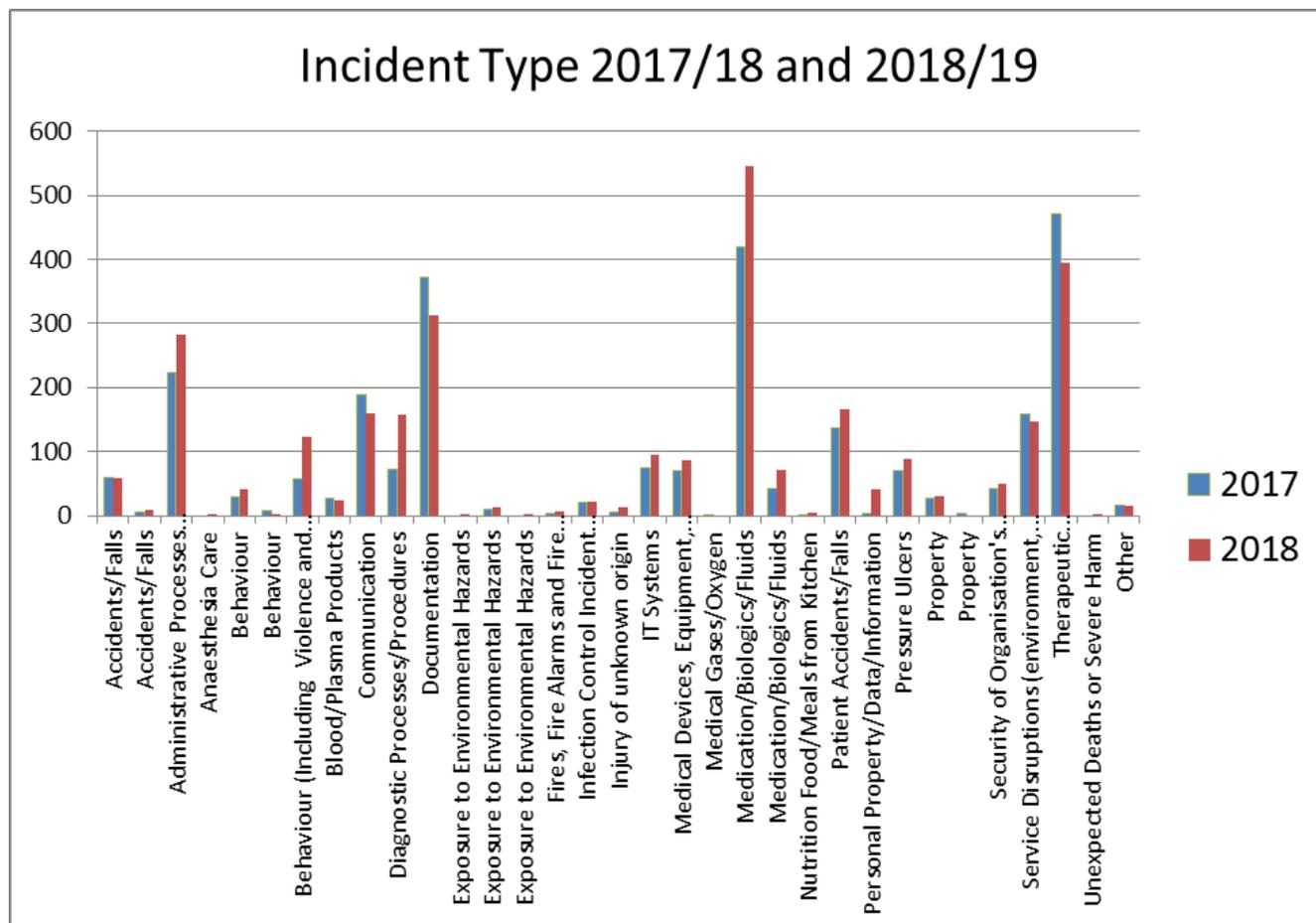
Incident Type



The majority of incidents reported were therapeutic process, medication, documentation and administrative process incidents.

Incident type 2017/18 and 2018/19

The table below compares the incident type in 2017/18 and 2018/19:



The chart above indicates that medication incidents, violence and aggression, diagnostic and administrative process incidents have increased in 2018/19 compared to the previous year.

Trust performance against selected quality metrics

The table below shows the key quality metrics which are monitored on a monthly basis by the Board. Chemotherapy and Radiotherapy errors were reviewed at each Directorate meeting and falls were monitored at the Manual Handling/Falls Prevention Group. The Infection Control Committee monitors any infection control related incidents.

| | 2018/19 | 2017/18 |
|--|---------|---------|
| Attributable grade 2 or above pressure ulcers / 1000 bed days' | 1.34 | 0.92 |
| 'Never Events' that occur within the Trust | 0 | 0 |
| Chemotherapy errors (number of errors per 1,000 doses): | 1.3* | 1.3* |
| Radiotherapy treatment errors (number of errors per 1,000 fractions) | 1.35 | 1.07 |
| Inpatient Falls per 1,000 inpatient admissions | 15.2 | 15.07 |
| Number of patient incidents reported | 2360 | 2129 |
| Percentage of patient safety incidents that resulted in severe harm* or death. | 0 | 0.24% |

*excludes HO

Monitoring table for the commonest incidents reported:

| Incident Type | Apr 18 | May 18 | June 18 | July 18 | Aug18 | Sept 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 |
|---|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Therapeutic Processes | 37 | 33 | 20 | 25 | 36 | 42 | 35 | 36 | 33 | 32 | 43 | 23 |
| Medication (Extravasation) | 40 (3) | 43 (3) | 59 (2) | 73 (2) | 55 (3) | 32 (1) | 71 (4) | 61 (1) | 41 (0) | 47 (1) | 44 (3) | 53 (1) |
| Documentation | 30 | 21 | 28 | 26 | 32 | 25 | 28 | 22 | 23 | 22 | 25 | 25 |
| Communication | 14 | 16 | 16 | 9 | 11 | 16 | 15 | 8 | 11 | 6 | 17 | 19 |
| Fall -patient | 12 | 5 | 9 | 13 | 15 | 12 | 8 | 6 | 15 | 19 | 10 | 14 |
| Fall – staff/other | 3 | 2 | 3 | 2 | 1 | 1 | 1 | 4 | 1 | 1 | 3 | 2 |
| Administrative Processes (excluding documentation) | 8 | 25 | 35 | 30 | 28 | 16 | 23 | 20 | 21 | 21 | 33 | 21 |
| Equipment/Medical Devices | 2 | 2 | 3 | 3 | 5 | 3 | 17 | 7 | 10 | 19 | 9 | 7 |
| Needlestick/Sharp And inoculation | 0 | 0 | 1 | 3 | 0 | 0 | 1 | 1 | 1 | 2 | 1 | 0 |
| Manual Handling | 1 | 0 | 1 | 3 | 1 | 1 | 0 | 1 | 0 | 2 | 1 | 0 |
| Infection control | 2 | 3 | 6 | 1 | 1 | 2 | 3 | 3 | 3 | 2 | 7 | 2 |
| Information Governance | 10 | 12 | 10 | 15 | 17 | 13 | 16 | 17 | 12 | 12 | 10 | 9 |
| Diagnostic Processes | 2 | 2 | 14 | 25 | 11 | 5 | 10 | 13 | 16 | 21 | 10 | 22 |
| Service Disruptions (environment, infrastructure, human resources) | 9 | 17 | 7 | 10 | 12 | 10 | 5 | 7 | 12 | 21 | 18 | 19 |
| Blood/Plasma Products | 2 | 1 | 4 | 0 | 3 | 5 | 2 | 1 | 0 | 0 | 0 | 3 |
| IT | 11 | 10 | 8 | 6 | 5 | 6 | 12 | 11 | 9 | 2 | 4 | 8 |
| Safeguarding (incident highlighted a safeguarding concern) | 3 | 4 | 10 | 1 | 3 | 8 | 3 | 6 | 5 | 4 | 4 | 4 |

Incidents were monitored at the Risk Management Committee and H&S Committee at each meeting in 2018/19. Monthly reports were also produced at Directorate level via the Quality and Safety data packs to review and monitor incidents for trends and lessons learned. Lessons learned from incidents were included in the Lessons Learned Newsletter.

Reported by Department

The chart below shows that incidents have been reported by most staff groups in 2018/19, but mainly by Radiation Services and Integrated Care Directorates. The subsidiary companies also report incidents via Datix as they can involve Trust processes so they are included in the charts below:

Chart to show reported by Department

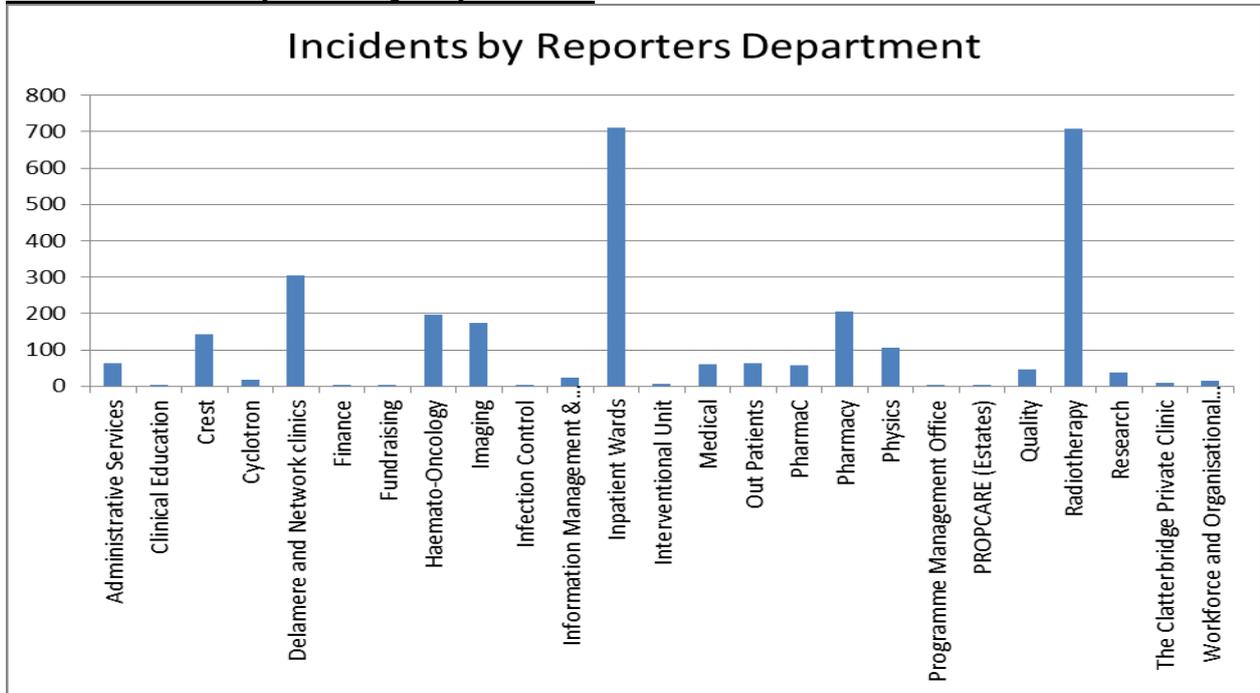
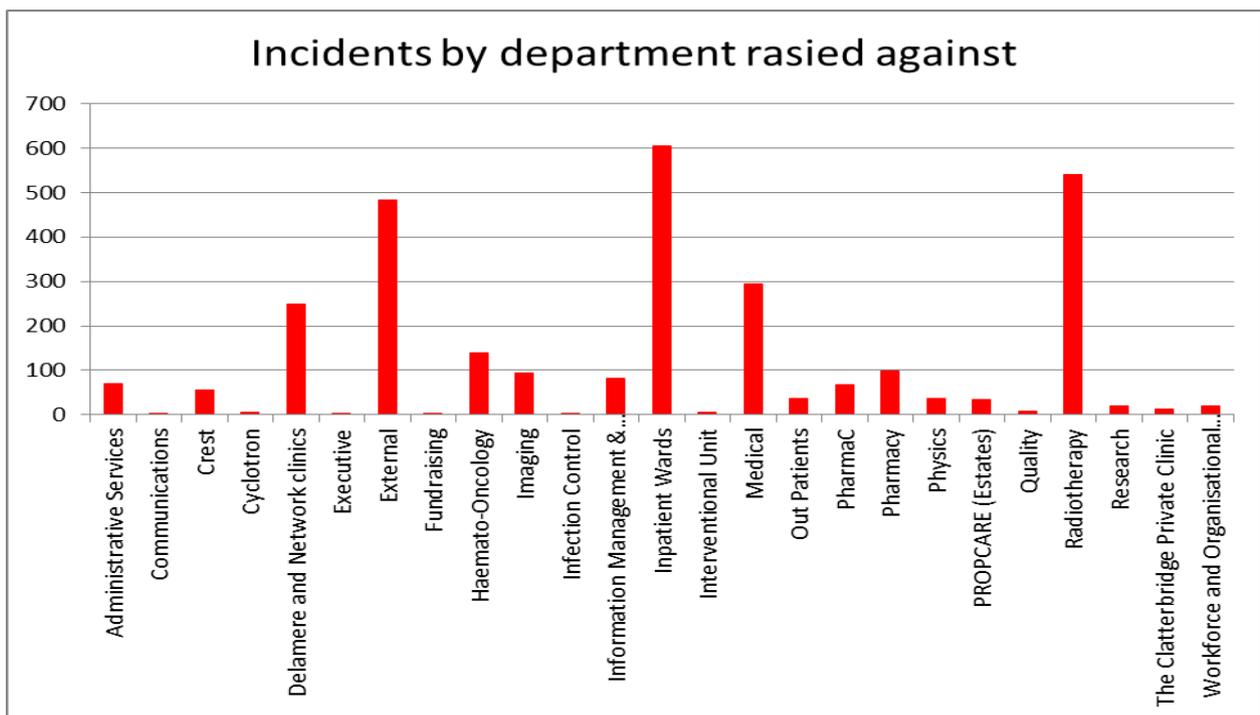


Chart to show the departments where the root cause was identified



The chart above shows that the majority of incidents were raised against Radiation Services and Integrated Care Directorates. A large number of incidents were raised against external organisations, e.g. transport incidents.

Externally Reported Incidents

All externally reported incidents are monitored at each Risk Management Committee meeting via the externally reported table. A summary of the last 3 years can be seen below:

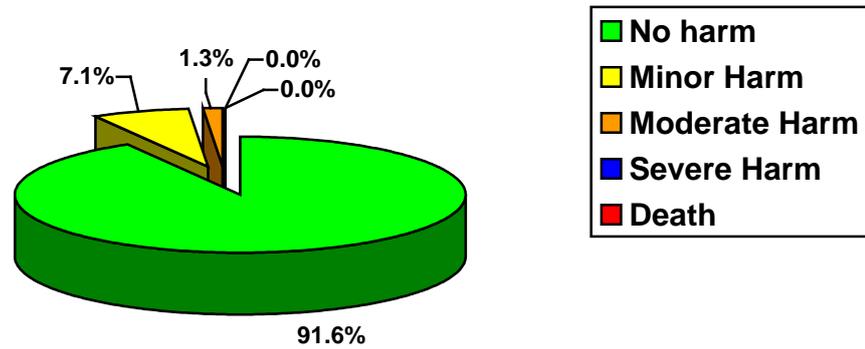
| External body | 2016/17 | 2017/18 | 2018/19 | Incidents reported in 2018/19 |
|------------------------------|----------------|----------------|----------------|--|
| HSE (RIDDOR) | 3 | 4 | 2 | ID4014 staff accident – over 7 days off work ID 5382 staff accident – over 7 days off work |
| HSE – other | | 1 | | |
| MHRA | | | | |
| CQC (IRMER) | 1 | 5 | 4 | ID3736 Orthovoltage under dose ID3695 Inadvertent exposure of foetus ID3872 Inappropriate use of sandbag ID5476 Incorrect CBCT protocol |
| STEIS | 8 | 9 | 9 | ID2968 Patient fall ID3338 Contrast ID 3555 Blinatumomab ID 3597 Treatment prior to medical review ID3772 Anticoagulation ID 4045 Oxycodone ID 4415 Triage: Cardiac Arrest ID 4384 Clinical Letters ID 4461 Haemato-oncology referrals |
| NRLS (incidents uploaded) | 2579 | 2145 | 2000 | All patient safety incidents |
| Information Commissioner | 1 | 0 | 1 | ID5364 Loss of staff folder |

Incidents resulting in harm

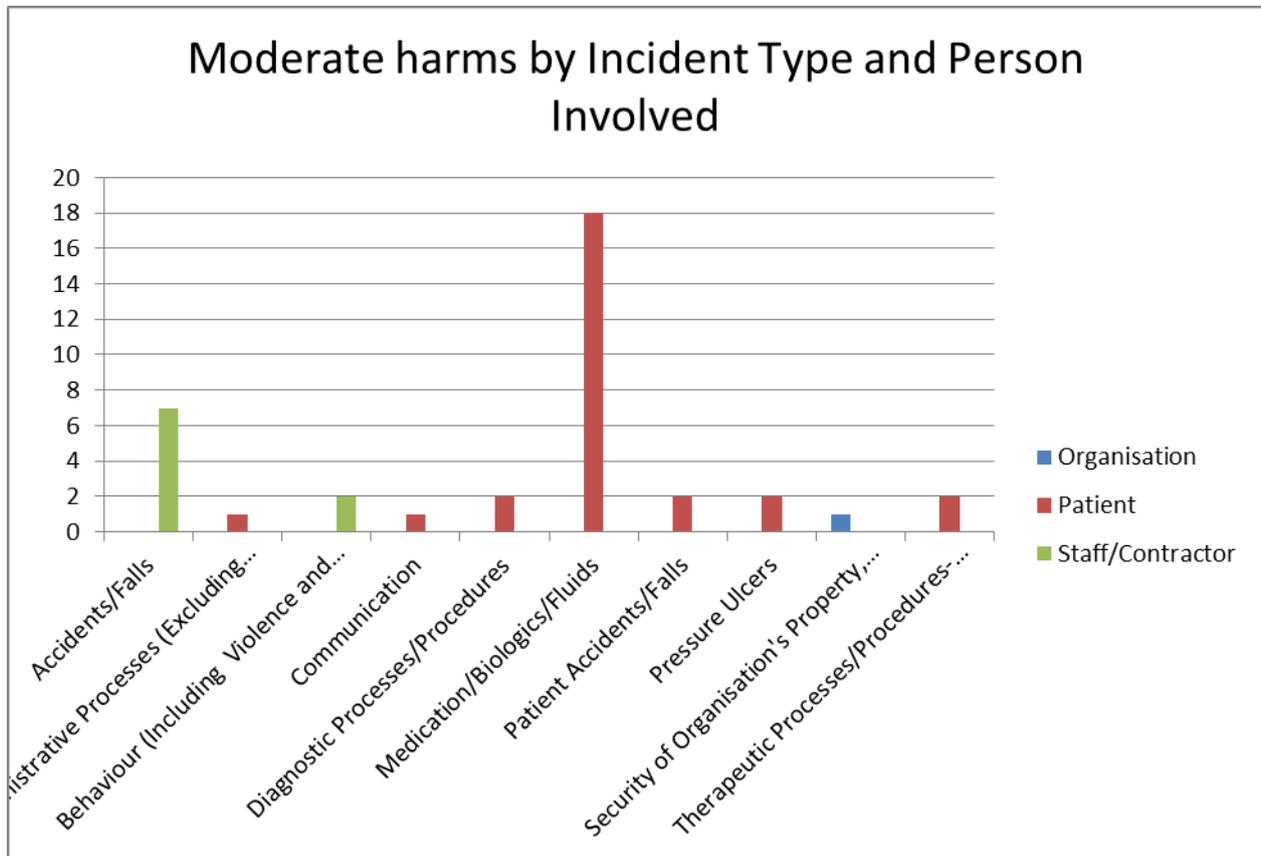
Levels of Harm

Of the 2967 incidents reported 8% resulted in harm; 7% resulted in low harm and 1% resulted in moderate harm. A visitor incident resulted in severe harm when she bent down to pick up something she had dropped on the floor and her hip dislocated.

Pie Chart to show levels of harm for all incidents



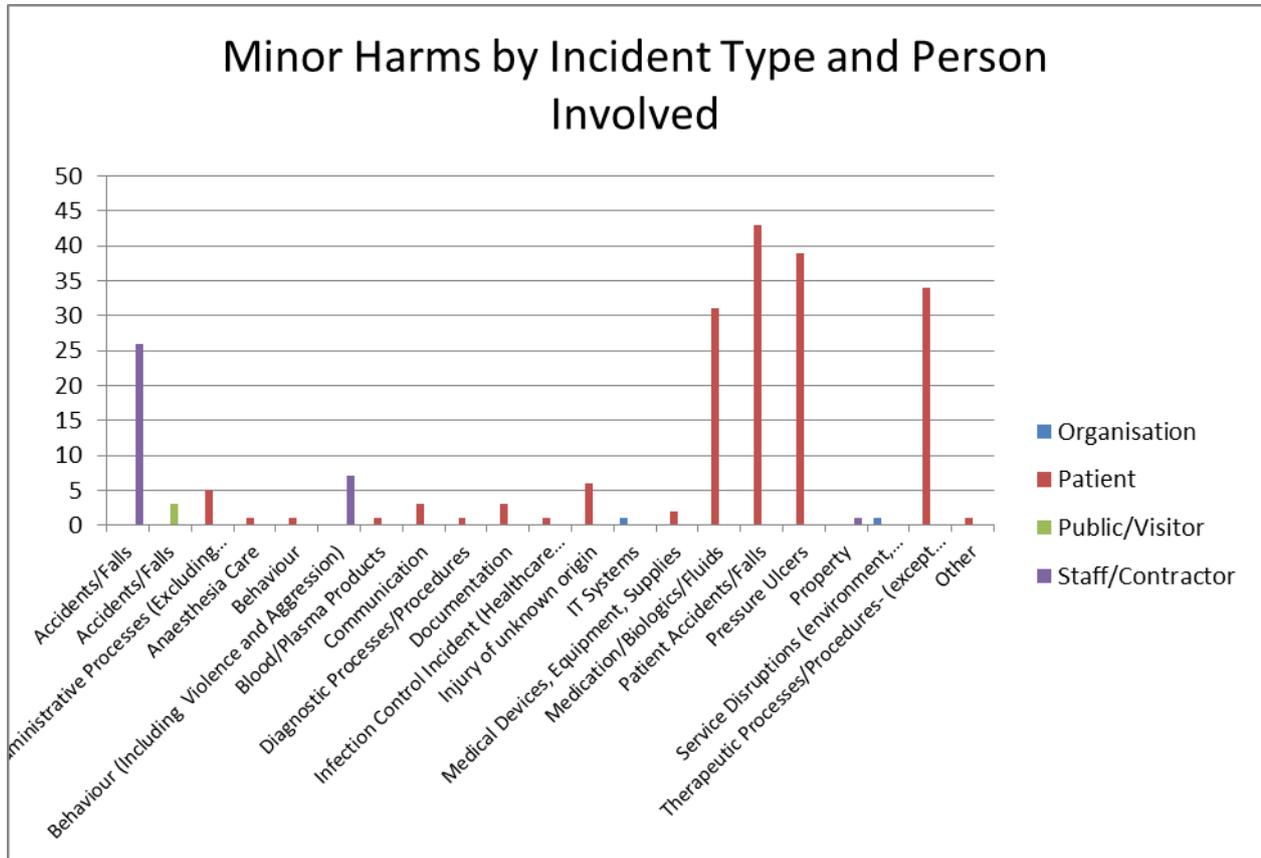
Moderate harm by person involved and incident type



The majority of the moderate harms were patient harms as a result of medication incidents, patient falls and pressure ulcers.

Low Harm by person involved and incident type

The chart below shows that the majority of low harm incidents involved patient medication, therapeutic, pressure ulcers and falls incidents.



Falls:

Chart to show ALL falls per quarter over the last three years

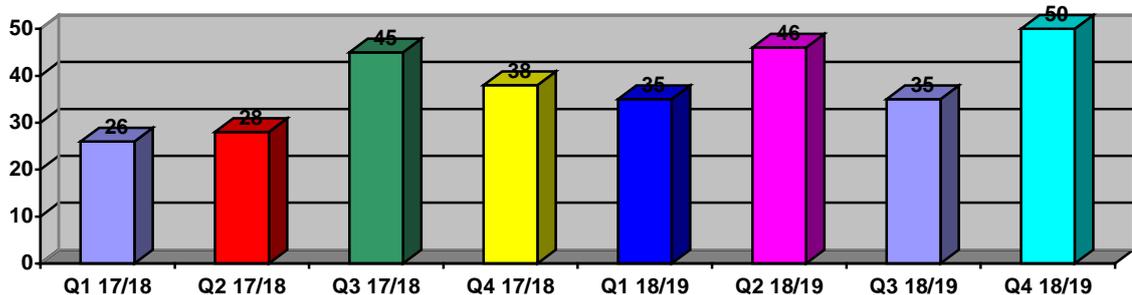
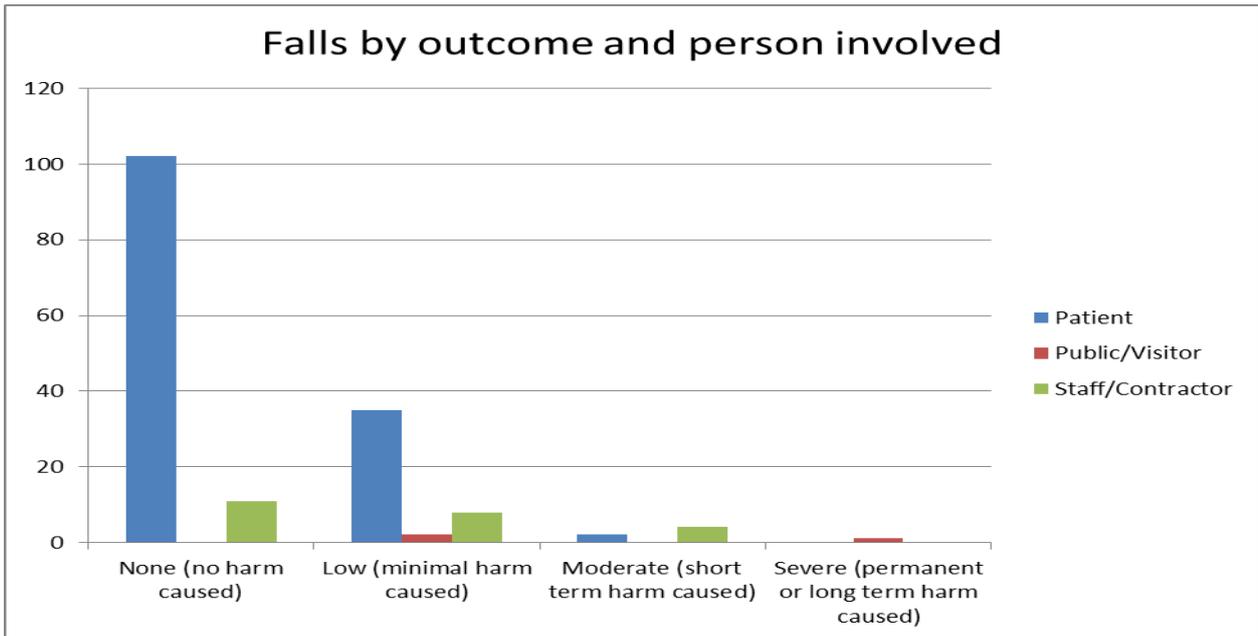


Chart to show the outcome of falls by person in 2018-2019:



113 (68%) of the falls did not result in any harm, 45 (27%) resulted in minor/low harm and 6 (4%) resulted in moderate harm and 1 (0.6%) visitor fall resulted severe harm

Inpatient Falls

The majority (44%) of inpatient falls occurred on Mersey ward, with 26% occurring on Conway Ward, 25% in Haemato-oncology wards and 1% on Sulby Ward. This is as expected given the types of patients cared for on these wards. The remaining 3% fell whilst off the wards, e.g. in imaging or radiotherapy.

Inpatient Falls on Ward per month

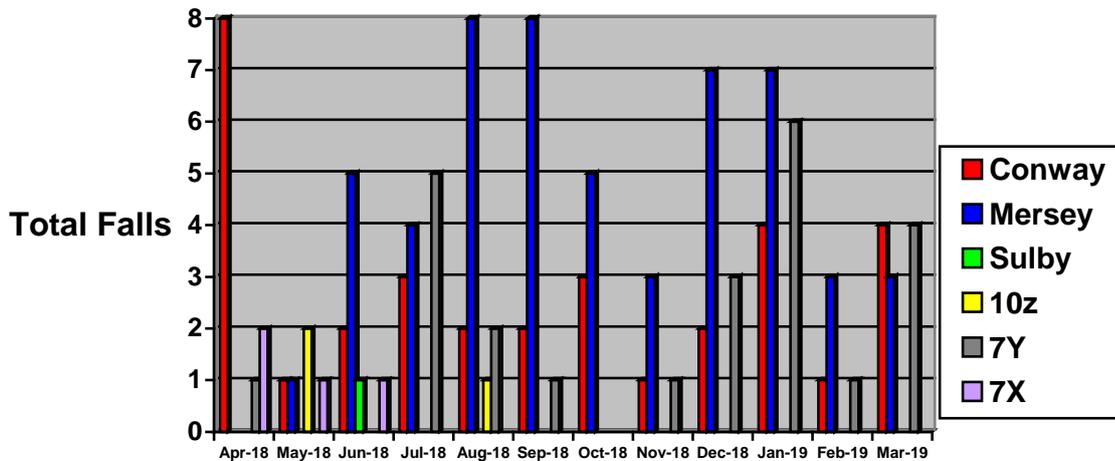
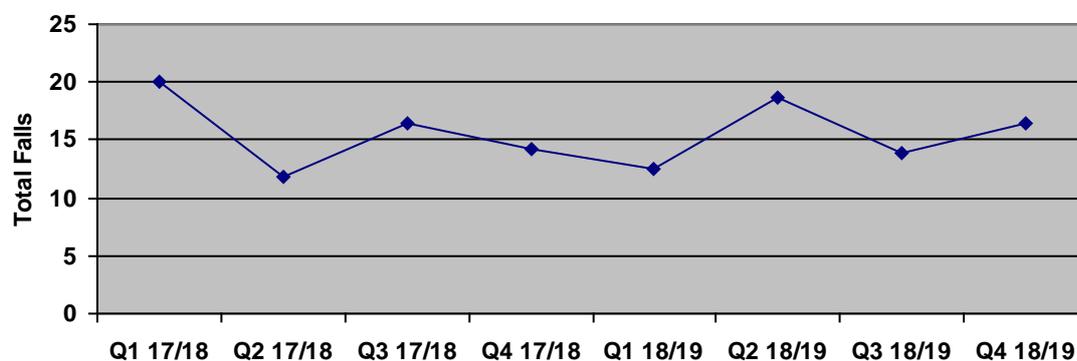


Chart to show total inpatient falls per 1000 inpatient admissions per quarter



How falls are monitored:

- All falls are reported using the Trust's incident reporting system.
- All inpatients have a falls risk assessment completed on admission and then updated as required
- If a patient is assessed as being 'at risk' of a fall then a falls care plan is implemented
- A falls summary RCA (Root Cause Analysis) is completed for all inpatient falls.
- Falls are monitored at various committees including Moving & Handling/Falls Prevention Group which meets quarterly and at the monthly Harms Collaborative meetings.
- An annual falls audit is completed

What we have done to try to prevent falls:

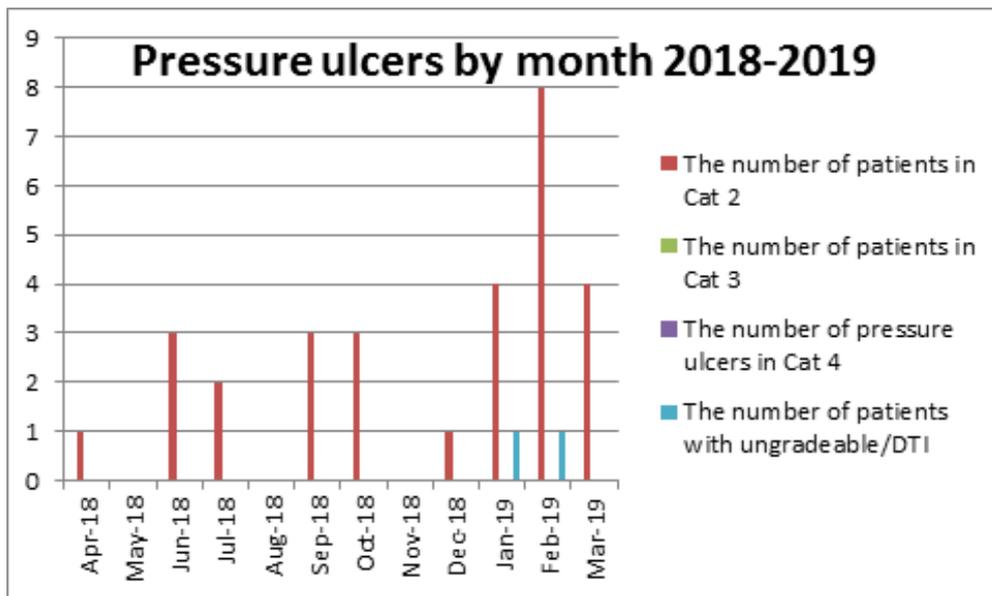
- Safety Huddles relaunched using an update form
- Magnet system on noticeboard to highlight 'at risk' patients so staff can easily identify those patients at risk of falls.
- Non-slip socks continue to be available on inpatient wards.
- Trend of patients falling going to/from toilet:
 - Intentional Rounding charts – pro active toileting
 - Introduction of 'Call don't fall' signs for toilets/bathrooms
- Green wrist bands (separate from the white ID wristband) for at risk patients introduced as a visual alert for when patients are off the ward.
- A pilot to trial sensor pads was completed and following this funding was agreed for 4 monitors on each of the Conway and Mersey wards, extra training in April 19 to have Ramblegard champions on Conway and Mersey.
- Medication reviews with emphasis on fall prevention launched in October 2017, included in audit plan to monitor the compliance with new interventions.
- 12 point checklist to educate patients in falls prevention from Royal College of Physicians included inpatient handbook
- 2 glideaway beds purchased to allow relatives to stay overnight which is especially helpful if patients are confused or disorientated which is a falls risk.

- Mobility aids are labelled by physiotherapy team following assessment to give a clear visual aid to communicate if the patient can mobilise independently or if they require assistance from 1 or 2 staff
- Lying and standing BP launched and field built on Meditech to allow electronic recording.

What we plan to do to try to prevent falls:

- Funding for reminiscence therapy software has been agreed and purchased, currently recruiting inpatient volunteers.
- Trialling of non-slip pad planned for 2019/20.
- CCC have joined the Cheshire and Merseyside falls steering group to work collaboratively with other trusts in the region.
- Work started to meet the new falls CQUIN for 2019/20 launched April 19.
- Propcare have been awarded a grant to enable work to begin to change energy saving lights to LED, allowing bathrooms and toilets to be better lit at night.

Pressure sores:



In the period from 1st April 2018 to 31st March 2019 there were **31**, CCC attributable, Grade2 and above, pressure sores identified, compared to 20 in 2018/19. Please note that in line with guidance a pressure ulcer is now deemed to be attributable if it was not identified on the initial skin assessment at time of admission, previously criteria was if identified post 72 hours of admission.

All 31 incidents were subject to a detailed root cause analysis and discussed at the monthly Harms review panel meetings. Timelines, presented by the ward staff involved in the care of the individual patient, act as a useful education tool for learning and setting improvement objectives.

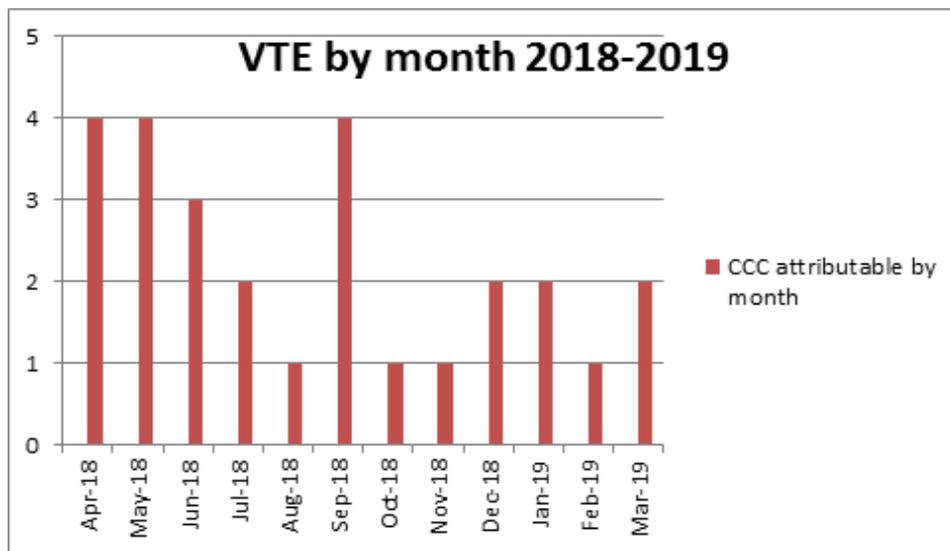
Each case is assessed and classified as lapse/no lapse in care. Of the 31 classed as CCC attributable one was deemed to be due to a lapse in care. The lapses identified:

Pt was admitted to CCC from RLH where catheter had been placed, good documentation re skin care and noted history of moisture lesions and pressure ulcers. Noted occasional non-compliance re pressure care also patient required assistance transferring. Device related harm as the pressure ulcer was as a result of the catheter securelock being too tight. Following identification of pressure ulcer appropriate care and checks resulted in good ulcer management and healed during the period of admission.

No trends identified across the pressure sores identified, however, the following actions have implemented:

- Interim measures for TVN cover in place. Quality Improvement Manager continues to attend the North West Regional Pressure Ulcer Steering group allowing us to link with local partners in assessing a single resource and pooling of information to learn and improve not just as a Trust but on a regional basis
- CCC representation at the North West Tissues Viability information exchange group
- React2Red – imbedded into Intentional rounding charts.
- April 2018 – following trial period WUTH agreed to continue to provide medical photography service to CCC
- May 2018 – with approval of safeguarding consultant, addition of safeguarding flowchart to pressure ulcer policy to reflect the new guidance
- May 2018 – list of alternative terms devised and circulated to staff to avoid using ‘intact’ and encourage better description of skin integrity.
- June 2018 - NHSI guidance for revised definition and measuring pressure ulcer, all guidance met apart from lack of TVN service, interim measurements in place.
- July 2018 – CCC joined the #pjparalysis campaign to encourage patient to get dressed in their own clothes and keep moving
- Increased training on wards regarding incontinence product and treatments
- Collaborative work with Christie TVN
- Stop the Pressure day- November 2018
 - Wear a red dot campaign launched on inpatient wards
 - Clatterbridge radio played a pressure ulcer prevention message for patients everyday throughout the week (developed by The Royal Marsden)
 - Clatterbridge logo mirrors provided to all inpatient staff to review difficult to view areas, e.g. heels

VTE



During 2018/19 **70** VTEs were identified; of which **27** were classed as CCC attributable, either occurring during an in-patient stay or the patient had had a previous in-patient stay within 90 days, as per NICE guideline definition. This compares to 89 during 2017/18, of which 20 were classed as CCC attributable.

In order to identify VTE's that have not been reported through Datix, the CGM-Patient Safety receives daily and monthly data for VTE care plans from the Clinical Effectiveness Team. The Quality Improvement Manager assesses whether the VTE is attributable to the Trust and checks the nursing care to establish whether a lapse in care has been identified. For patients identified as CCC attributable the timeline and RCA are presented at the monthly Harms Collaborative. In addition they receive Consultant review at either CCC or HO to determine if there has been a lapse in care.

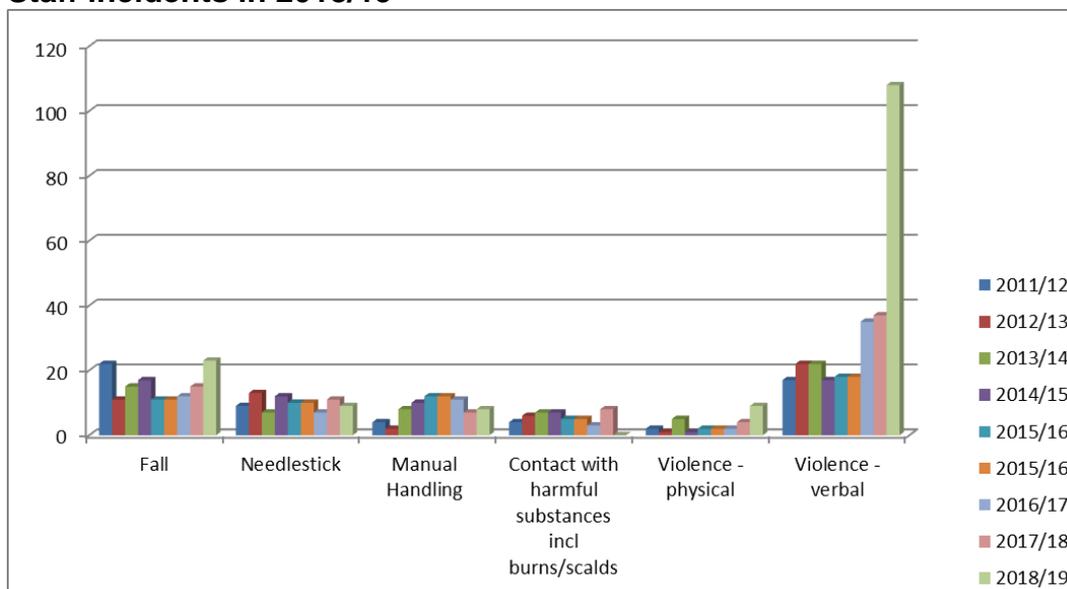
In Datix any CCC attributable VTE is classed as "harm". Where there is no lapse in care it is identified as a low harm, where lapse is identified e.g. prophylaxis not given or failure to carry out assessment this will be classed as moderate harm. 13 of the 27 related to PICC/Portacath device related VTE's, VTE development is a recognised potential side effect. Monthly audits are carried out to ensure compliance to completion of VTE assessment on admission and to assess whether prescribed prophylaxis has been given and reported for inclusion in the Integrated Performance Report. Work that has been undertaken in the past year includes:

- VTE assessment added to 'planned admission proforma' and a standalone assessment developed
- Missed VTE assessments added to daily reports from CET
- Agreement that Advance Nurse Practitioners could pick up theatre patients who arrive on ward before doctor handover
- Physician Associates included in completing VTE risk assessments

- Medical staff given training to enable them to place new patients on MEDITECH to complete assessments
- Flowchart developed and placed in all doctors areas to clarify process to risk assessments
- TV screens showing live assessment compliance placed in doctors rooms
- Exclusion criteria agreed in collaboration with the commissioners
- Anti-embolic ward based training undertaken
- VTE is a standing agenda on the Deteriorating patient group

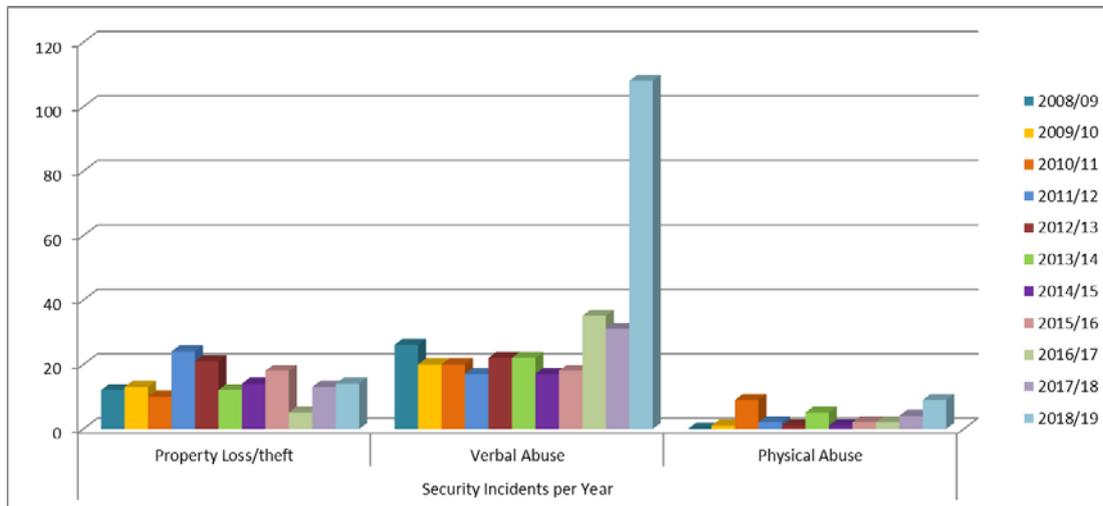
Health and Safety Incidents

Staff incidents in 2018/19



The chart above shows the staff incidents in 2018/2019. The number of needlestick injuries sustained has decreased slightly after the previous year's increase. Again, most of the incidents could have been avoided with a number attributed to human error. All needlestick injuries reported have a root-cause analysis completed to identify any issues and if process has been followed. All injuries are monitored through the Health and Safety Committee. Both verbal and physical violence against staff has increased in 2018/19. The increase in verbal violence dramatically so with some of the incidents reported attributed to the patients clinical condition or repeat offenders identified.

Security Incidents



The chart above shows an increase in security incidents last year compared to previous years. There is a large increase in verbal abuse and increase slightly in physical assaults without any particular trends. However some of the incidents do include serial offenders. The possible rise could also be due to more staff reporting incidents as reinforced by security and conflict resolution training. Property Loss & Thefts has increased due to a number of thefts involving staff possessions.

The following areas were identified as high risk and extra CCTV swipe access has been installed.

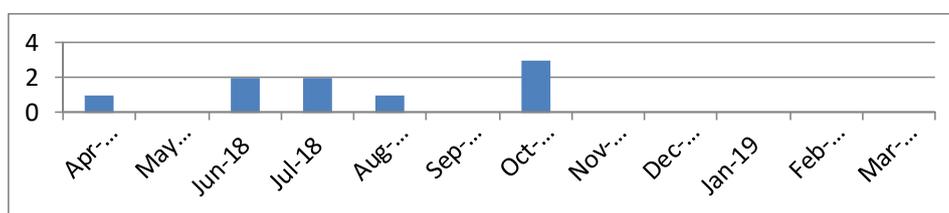
- Cash handling departments
- Server rooms
- Switch gear rooms
- Areas that store drugs.

Panic buttons have also been installed in areas that handle money and are public facing and the main reception desk. The Trust continues to work hard to reduce the risk of security incidents by a combination of preventative measures, increased training, investigation and raising awareness of the role of the LSMS.

Please see H&S Annual Report for further details.

Serious Incident Learning Meetings

Serious Incidents by month



9 serious incidents were reported in 2018/19 and serious incident learning meetings were held. A root cause analysis was undertaken for all the incidents below and a serious incident review meeting was held with key staff in attendance to review the incident. Action plans were produced for all of the incidents, which have been monitored at each Risk Management Committee meeting until completed. All incidents were reported externally to StEIS and to CQC.

| Incident ID | Incident Date | Incident Type | Harm | Duty of Candour | Final report to commissioner in 60 days | Action Plan complete Y/N |
|-------------|---------------|--|--|-----------------|---|--------------------------|
| ID 2968 | 17/04/2018 | Patient fall on ward | Moderate | Yes | Yes | Yes |
| ID3338 | 6/6/2018 | Contrast reaction - Radiotherapy | Patient died but no harm as a result of incident | Yes | No | Yes |
| ID3555 | 27/6/18 | Medication – Blinatumomab infusion rate | Low | Yes | No | Yes |
| ID3597 | 03/07/2018 | Medication-chemotherapy prior to review | None | Yes | No | Yes |
| ID3772 | 22/07/2018 | Medication-Chemotherapy treatment given without LMWH | None | Yes | Yes | Yes |
| ID4045 | 26/08/2018 | Medication-Oxycodone | Moderate | Yes | Yes | Yes |
| ID 4384 | 3/10/18 | Clinical Letters | None | Yes | No | Yes |
| ID 4415 | 7/10/18 | Triage: Cardiac Arrest | Patient died but no harm as a result of incident | Yes | Yes | Yes |
| ID 4461 | 16/4/18 | Haemato-oncology referrals | To be confirmed | Yes | Ongoing | Investigation ongoing |

3.1.4 Claims

All claims, both clinical and non clinical, were reported and monitored at each Risk Management Committee and to the Board via the Quality Committee.

New Claims/Potential Claims

Six new clinical negligence claims have been received and ten new potential clinical claims were received in 2018/19, this compares with six new claims (2 clinical and 4 non-clinical) and seven potential claims received in 2017/18. Five claims from previous years were closed in 2018/19 as indicated in the tables below:

New Claims 2018/19

Of the six new claims received, four are ongoing and two have been closed with no costs.

| ID | Type | Description | Current Stage |
|----|---------------------------------------|--|---|
| 40 | Clinical Negligence Scheme for Trusts | Alleged failure to measure the tumour before starting chemotherapy, failure to change chemotherapy in light of disease progression, failure to initiate radiotherapy, delay in restarting treatment after surgery and incorrect treatment post op. | Letter of Response – all allegations denied. |
| 33 | Clinical Negligence Scheme for Trusts | Named as 5th Defendant - allegations relate to failure to consider presenting symptoms, delay in referring for treatment for metastatic treatment. | Closed as claim is not related to care given by NHS |
| 4 | Clinical Negligence Scheme for Trusts | Alleged failure to give HRT following the completion of treatment resulting in osteoporosis | Letter of Claim |
| 29 | Clinical Negligence Scheme for Trusts | Extravasation | Particulars of Claim |
| 27 | Clinical Negligence Scheme for Trusts | Treatment given when contraindicated due to abnormal liver function - serious incident ID 2224 | Letter of claim |
| 28 | Clinical Negligence Scheme for Trusts | Alleged delay in assessment, failure to provide treatment and/or investigate possible treatment options, resulting in the claimant being unable to have curative surgery. | Closed – claim discontinued against Trust. |

Closed claims in 2018/19

| ID | Type | Description | Costs |
|----|---------------------------------------|---|---|
| 33 | Clinical Negligence Scheme for Trusts | Named as 5th Defendant - allegations relate to failure to consider presenting symptoms, delay in referring for treatment for metastatic treatment. | Closed as claim is not related to care given by NHS |
| 28 | Clinical Negligence Scheme for Trusts | Alleged delay in assessment, failure to provide treatment and/or investigate possible treatment options, resulting in the claimant being unable to have curative surgery. | Closed – claim discontinued against Trust. |

| | | | |
|----|---------------------------------------|---|--|
| 11 | Liabilities to Third Parties Scheme | Alleged slip/trip/fall injury | Closed with no costs as claim repudiated |
| 9 | Clinical Negligence Scheme for Trusts | Alleged negligent delay in diagnosis | Closed with no costs as allegations did not relate to the care provided by the Trust |
| 19 | Clinical Negligence Scheme for Trusts | Alleged failure to provide treatment and follow up care | Closed as claim repudiated. Defence costs only - £1,085 |
| 14 | Liabilities to Third Parties Scheme | Alleged slip/trip/fall injury | Closed with no costs as claim repudiated |
| 7 | Liabilities to Third Parties Scheme | Alleged manual handling injury | Closed with no costs as claim repudiated |

Ongoing claims from previous years

| ID | Year | Type | Description | Last stage |
|----|------|---------------------------------------|---|----------------------|
| 21 | 2017 | Clinical Negligence Scheme for Trusts | Alleged negligent mismanagement of cancer treatment including failure to identify/diagnose/treat. | Letter of Claim |
| 10 | 2017 | Clinical Negligence Scheme for Trusts | Alleged mis-diagnosis of brain metastases resulting in unnecessary radiotherapy to the brain | Letter of response |
| 12 | 2017 | Liabilities to Third Parties Scheme | Needlestick | Letter of Claim |
| 23 | 2017 | Liabilities to Third Parties Scheme | Alleged manual handling injury | Letter of response |
| 18 | 2017 | Clinical Negligence Scheme for Trusts | Allegations - negligently performed treatment which caused nerve damage. | Letter of Claim |
| 8 | 2017 | Liabilities to Third Parties Scheme | Alleged manual handling injury | Particulars of Claim |
| 24 | 2016 | Liabilities to Third Parties Scheme | Alleged slip/trip/fall injury | Letter of response |

3.1.5 Inquests

The Coroner requested reports following the deaths of five patients in 2018/19, as detailed in the table below. Staff were required to attend and give evidence for two of the Inquests. One investigation remains open and no date has been set for an inquest to date.

| Inquest Number | Coroner | Staff requested to attend | Conclusion |
|----------------|---------|---------------------------|------------|
| | | | |

| | | | |
|---------|------------------|-----|---|
| 2018/04 | Liverpool/Wirral | No | Cause of death = natural. 1.a Cardiac arrhythmia 1.b Hypercalcaemia 1.c Non-Hodgkins lymphoma |
| 2018/05 | Liverpool/Wirral | Yes | Ia Anaphylactic Shock, 1b Hypersensitivity to intravenous contrast medium, II Ischaemic heart disease, coronary artery atherosclerosis. The coroner concluded Misadventure |
| 2019/01 | Cheshire | Yes | Ia Cardiorespiratory arrest, 1b Moderate Ketoacidosis and multi-drug effect including moderate citalopram excess, II Treatment for hypopharyngeal cancer. Narrative conclusion given: The patient died from the effects of necessary prescribed drugs and treatment |
| 2019/02 | Liverpool/Wirral | No | 1a) Malignant Mesothelioma. The Coroner concluded Industrial Disease |
| 2019/03 | Cheshire | | No inquest set to date |

3.1.7 Safety Alerts

There were 110 alerts issued by the Central Alerting System over the period 1st April 18 - 31st March 2019.

| Originator | Total | % |
|--|--------------|----------|
| MHRA Medical Devices Alerts | 48 | 43% |
| NHS Improvement – Estates and Facilities | 23 | 21% |
| MHRA Drug Alerts | 19 | 17% |
| NHS Improvement | 9 | 8% |
| CMO Messaging | 5 | 4% |
| MHRA Dear Doctor Letter | 3 | 3% |
| DHSC Supply Disruption | 3 | 3% |

All alerts were acknowledged and assessed to determine whether action was required.

| Response Status | Total | % |
|------------------------|--------------|----------|
| Action Completed | 16 | 15% |
| Action Not Required | 65 | 60% |
| Action ongoing | 2 | 2% |
| No Response Required | 27 | 24% |

For the 18 (17%) alerts that action was required, action was completed within the required timeframe for 16 of them and 2 have ongoing actions but are within the deadline. These alerts can be seen in Appendix 3.

All alerts were monitored at the Risk Management Committee and reported to Health and Safety Committee.

3.1.8 Internal and External reviews/reports

Other risks are identified from internal and external audit reports and other reviews ISO9001-BSI assessments, audits etc. The Quality and Risk Management Standards were incorporated into the Trust wide annual plan in 2018/19.

MIAA completed a risk management review in 2018/19 and moderate assurance was given. An action plan to address the recommendations has been produced and continues to be monitored until completion.

Please see Clinical Governance Annual Report 2018/19 for details of:

- Compliance with ISO9001 Quality Management Standard
- Registration against Care Quality Commission Regulations and Fundamental Standards
- NICE Compliance
- Clinical Audit

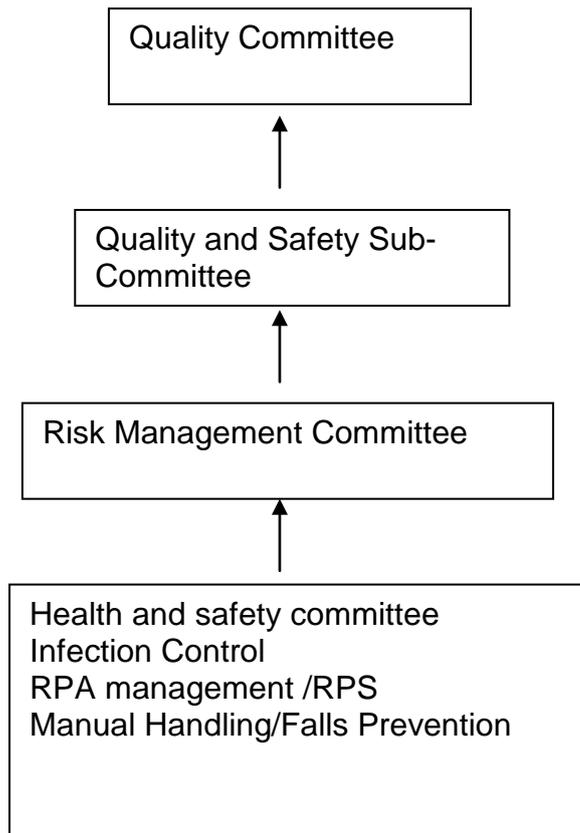
4. Recommendations/actions identified from annual review

| Action | Responsibility | Target Date | Progress |
|---|--|--------------------|-------------------------|
| 1. Report to be reviewed by Integrated Governance Committee | Risk Management Facilitator | July 19 | Completed 6/6/19 |
| 2.Action plan from MIAA audit to be completed | Risk Management Facilitator | August 19 | On track for completion |
| 3.New Risk Management Committee Terms of Reference to be agreed | Associate Director of Corporate Governance | July 19 | Completed 4/7/19 |

APPENDIX 1

Risk Management Organisational Structure 2018/19

The structure below is what was in place in 2018/19, a new structure will be in place for 2019/20



Appendix 2 – Risk Management Key Performance Indicators

| INDICATOR | 2016/17 | 2017/18 | 2018/19 |
|--|--|---|--|
| Number of incidents reported | 3351 | 2720 (180 rejected due to being duplicates/not incidents) | 3066 (99 rejected due to being duplicates/not incidents) |
| Top five incident type reported | Procedure = 748 Documentation = 553 Staffing = 420 Communication=256 Equipment = 266 | *change in coding in 2017 with introduction of Datix Therapeutic processes=470 Medication=448 Documentation= 371 Admin processes=221 Communication=189 | Therapeutic processes=395 Medication= 613 Documentation= 313 Admin processes= 284 Communication= 159 |
| Number of serious incidents Panels | 10 Serious incident panels | 7 Serious Incident panels | 9 Serious incident learning meetings |
| Number of 'harm' incidents | Minor harm= 204 Moderate harm= 10 | Low=207 Moderate=30 Severe=2 Death=1 | Low=211 Moderate=38 Severe=1 |
| Number of claims received | 8 Clinical (2 Letters of Claim, 6 potential) 5 Non Clinical Letters of Claim | 9 Clinical (2 Letter of Claim and 7 potential) 4 Non Clinical Letters of Claim | 6 Clinical Letters of Claim |
| Claims status – settled, discontinued, open | <ul style="list-style-type: none"> • 7 Letters of Claim • 6 Potential • 3 claims settled/closed from previous year | <ul style="list-style-type: none"> • 7 Open Claims • 7 Potential • 2 Closed • 1 settled and 1 closed from previous year | <ul style="list-style-type: none"> • 11 open claims • 9 potential claims • 7 closed |
| Number of Inquests | 0 (2 Investigations) | 2 (in addition reports were requested for a further 4 investigations) | 2 (in addition reports were requested for a further 3 investigations) |
| Number of complaints | 21 | 26 | 17 |
| Percentage of CAS alerts actioned within required timeframe. | 140 alerts received 100% acknowledged 28 required action, action completed except for one which is ongoing within deadline. | 128 alerts received 100% acknowledged 17 required action, action completed except for two which are ongoing within deadline. | 110 alerts received 100% acknowledged 18 required action, action completed for 16 alerts, 2 ongoing within deadline |
| Attendance at risk management committee | 5 meetings held: Director of Nursing=100% Non Executive= 100% Director of Finance= 0 HR Business Partner= 40% Medical Lead =100% Risk Management Facilitator =100% Health & Safety Advisor =60% H&S Advisor/LSMS = 60% Clinical Governance Manager-Radiotherapy =80% Clinical Governance Manager – Medicine Safety = 60% Clinical Governance Manager-Regulation =20% Secretary=60% | 4 meetings held: Director of Nursing= 100% Non Executive= 25% Director of Finance= 25% HR Business Partner= 75% Medical Lead =75% Risk Management Facilitator =100% Health & Safety Advisor =100% H&S Advisor/LSMS = 75% Clinical Governance Manager-Radiotherapy =75% Clinical Governance Manager – Medicine Safety = 50% Clinical Governance Manager-Regulation =25% Secretary=100% | 3 meetings held Director of Nursing= 0 Associate Director of Quality = 100% Non Executive= 100% Director of Finance= 0 HR Business Partner=100 % Medical Lead =100% Risk Management Facilitator =100% Health & Safety Advisor =100% H&S Advisor/LSMS =100 % Clinical Governance Manager-Radiotherapy =33% Clinical Governance Manager – Medicine Safety =67 % Clinical Governance Manager-Regulation =33% Secretary=67% |

Appendix 3– Safety Alerts

| Reference | Alert Title | Originated By | Issue Date | Response | Deadline |
|---------------------|--|--|------------|--------------------------|-----------|
| EFA/2019/003 | Anti-ligature type curtain rail systems: Risks from incorrect installation or modification | NHS Improvement Estates and Facilities | 11-Mar-19 | Action Required: Ongoing | 11-Sep-19 |
| MDA/2019/013 | All T34 ambulatory syringe pumps need a sponge pad fitted to the battery compartment to prevent batt ... | MHRA Medical Device Alerts | 04-Mar-19 | Action Completed | 28-May-19 |
| EFA/2019/002 | Ingestion of Cleaning Chemicals | NHS Improvement Estates and Facilities | 28-Feb-19 | Action Completed | 07-Jun-19 |
| MDA/2019/004 | Arjo Minstrel passive floor lift (portable hoist) risk of spreader bar detachment from lifts witho ... | MHRA Medical Device Alerts | 30-Jan-19 | Action Completed | 29-Jul-19 |
| EFA/2019/001 | Portable fans in health and social care facilities: risk of cross infection | NHS Improvement Estates and Facilities | 11-Jan-19 | Action Completed | 02-Apr-19 |
| NHS/PSA/W/2018/009 | Risk of harm from inappropriate placement of pulse oximeter probes | NHS Improvement | 18-Dec-18 | Action Required: Ongoing | 18-Jun-19 |
| EFA/2018/007 | Fire risk from personal rechargeable electronic devices. | NHS Improvement Estates and Facilities | 05-Dec-18 | Action Completed | 05-Jun-19 |
| MDA/2018/035 | All T34 ambulatory syringe pumps update concerning battery information | MHRA Medical Device Alerts | 14-Nov-18 | Action Completed | 08-Jan-19 |
| EFA/2018/006 | Vernacare Vortex macerator: potential to contamination mains water supply. | NHS Improvement Estates and Facilities | 22-Oct-18 | Action Completed | 29-Mar-19 |
| EFA/2018/005 | Assessment of ligature points | NHS Improvement Estates and Facilities | 19-Sep-18 | Action Completed | 19-Mar-19 |
| EFA/2018/004 | Integrated Plumbing System (IPS) Panels - risk of accidental detachment | NHS Improvement Estates and Facilities | 22-Aug-18 | Action Completed | 21-Nov-18 |
| NHS/PSA/RE/2018/006 | Resources to support the safe and timely management of hyperkalaemia (high level of potassium in the ... | NHS Improvement | 08-Aug-18 | Action Completed | 08-May-19 |
| MDA/2018/027 | Breast implants, all types, makes and models – Continue to report suspected cases of Breast Implant ... | MHRA Medical Device Alerts | 26-Jul-18 | Action Completed | 06-Sep-18 |
| NHS/PSA/RE/2018/004 | Resources to support safer modification of food and drink | NHS Improvement | 27-Jun-18 | Action Completed | 01-Apr-19 |
| EFN/2018/17 | High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - Schneider Electric - RN2c - R ... | NHS Improvement Estates and Facilities | 06-Jun-18 | Action Completed | 04-Jul-18 |
| NHSI/2018/001 (U) | UPDATE - Reporting of Defects and Failures and disseminating Estates and Facilities Alerts | NHS Improvement Estates and Facilities | 30-May-18 | Action Completed | 04-Jul-18 |

| | | | | | |
|---------------------|--|--|-----------|------------------|-----------|
| NHS/PSA/RE/2018/003 | Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) | NHS Improvement | 25-Apr-18 | Action Completed | 21-Jun-18 |
| EFN/2018/11 | High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Schneider Electric - RN2c - Ring ... | NHS Improvement Estates and Facilities | 04-Apr-18 | Action Completed | 02-May-18 |

