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Heuristics and Soft Systems of Health Care
Risk Management

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Volume 2
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Appendix 1

Glossary of Terms

Agent: The performer of actions such as people, professions, organisations etc.

Agents Perspective: Perceptions from the performer of actions (people, professions, organisations etc) point of view.

Acceptable Risk: '...a risk, perhaps in the region of 1 in a million of a seriously adverse occurrence, where the conduct of life is not affected provided that we are in fact satisfied that reasonable precautions are in place.' (Health and Safety Executive)

Action Learning Set: A group of people who over a period of time come together to help each other in the Action Learning process.

Acting Responsibly: Meeting one's obligations through rational action, taking into account the needs and context of the situation in which that person finds themselves.

Affordability Heuristic: A rule of thumb which states that if there is no budget for a risk control measure then nothing can be done to control that risk.

Anchoring Heuristics: A rule of thumb which states that once a perceived risk has estimated then the likelihood of the event does not change in spite of the evidence.

Assessed Risk: An estimation of risk made by an expert group.

Availability Heuristic: A rule of thumb which states that if an item is easily brought to mind then it must be important.

B-heuristic: Basic rules of thumb which can be summarised as single simple sentence.

BATNEEC Principle: Is the principle used by risk managers to determine the level of risk control expenditure and stands for: 'Best available technique not entailing excessive cost'.(Health and Safety Executive)
Check List Heuristic: A rule of thumb used by experts which states that a specific set of control measures must be used to effectively manage risks.

Claim: A demand for compensation for damages due to alleged negligence

Claims Management: The process of handling demands for compensation for damages due to alleged negligence.

Clinical Governance: 'a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.' (HSC1999/065).

Clinical Negligence: 'A breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgements made by members of those professions action in their professional capacity in the course of their employment, and which are admitted as negligent by the employer or are determined as such through the legal process' (Department of Health)

Commitment Heuristic: A rule of thumb which states that once a solution has started to be implemented it must be continued even if the feedback suggests that the solution is the wrong one or that there are better ones.

Confirmation Heuristic: A rule of thumb which states that valid information about a problem is that which confirms that the original solution is correct.

Controls Assurance: The process by which NHS organisations demonstrate that they are doing their “reasonable best” in managing themselves to achieve their objectives while at the same time controlling risks.

Consumer: The users of the products and services provided by an agents.

Consumer Perspective: Perceptions from the users point of view.

Corporate Governance: is the system by which an organisation provided with direction in order to ensure that it fulfils its function in an economic and efficient manner while at the same time ensuring there is effective management of risks it is facing.

Corporate Risk Management: Organisation wide management of risk.
Corporate Manager: The person with managerial authority and responsibility for a specific Trust wide function (Customer relations, capital development etc) or system (Contracting, risk management etc)

Crown Immunity: A state service free from the threat of prosecution.

Defensive Activity: Actions and procedures taken to protect the agent from criticism rather than for the benefit of the consumer.

Defensive Medicine: '...ordering of treatments, tests and procedures for the purpose of protecting the doctor from criticism rather than diagnosing or treating the patient...' (McQuade)

Dilution of responsibility: A feeling of reduced personal responsibility by being a member of a group.

Disaster Management: The process of dealing with a disaster in which attempts are made to mitigate the effects of the disaster and control additional risks occasioned by the disaster.

E-heuristic: Extended rules of thumb which can be summarised as related list of simple sentences.

External Risk Control Body: A formal organisation which has the remit to ensure that adequate risk control measures are being practised within another organisation.

External Audit: A body external to the Trust which provides independent services for examining and checking compliance with standards.

Financial Controls: The mechanisms by which an health care organisation controls all risks of a financial nature.

Groupthink: The effect on decision because of groups search for consensus which results in suppression of disagreement, incomplete analysis, excessive confidence, dilution of responsibility and risky sift.

Guessing: A process by which a solution is arrived at without assessing the nature of the problem.

Hazard: Something which has the potential to cause harm.
Heuristic: A simple rule of thumb which people use to help them come to a conclusion in a relatively quick and easy way, they provide answers as to what is going on and how to react to what is going on without the need to guess nor analyse the issues being faced.

Heuristic Decision Making: A process by which a set solution is applied to all problems which present with a particular set of common features.

Incidents: Events which resulted in harm or loss

Internal Audit: A body employed by the Trust which provides independent services for examining and checking compliance with standards.

Lead Clinician: The clinician with managerial authority and responsibility for a specific clinical functional area (division, directorate, department or ward) or specialty (diabetes, orthopaedics, etc) of the Trust.

Lead Manager: The person with managerial authority and responsibility for a specific functional area (division, directorate, department or ward) of the Trust.

Minimum Effort heuristic: A rule of thumb which states that the easiest way forward should be done before the more difficult way forward no matter what the risk priority.

Negligible Risk: 'Refers to a level of risk, usually presumed to be below 1 in a million per annum and perhaps much lower, of seriously adverse consequences occurring, where no thought is given to their likelihood in the conduct of normal life, though precaution (as against lightning) may have been taken as a prudential measure and will almost certainly be taken in case of peril.' (Health and Safety Executive)


Norms: The accepted behaviours of a specific group of people.

Near Miss: Events which if the circumstances had been right would have led to a serious incident. (Capstick)

NCEPOD: National Confidential Enquiry into Perioperative Deaths

Organisational Controls: The mechanisms by which an health care organisation all controls all risks with the exception of specifically clinical or financial.
**Operational Management:** Management of the day to day activity of the organisation so as to ensure it delivers the services and products required.

**Organisational Culture:** The ideas, norms, values and skills held by an organisation.

**Over-confidence Heuristic:** A rule of thumb which states that once a solution appears to be found there are no other solutions worth looking for.

**Perceived Risk:** An estimation of risk based on a non expert judgement.

**Personal Consequence Heuristic:** A rule of thumb which states that personal consequences of a risk take priority over all other priority criteria.

**Precautionary Principle:** '...where the analytical basis for assessment or risk is weak, the lack of full scientific certainty should not be used as a reason for postponing cost effective measures particularly where there are threats of serious or irreversible damage.' (Health and Safety Executive)

**Programmed Decision Making:** A clearly structured, repetitive, processes for assessing a problem and finding its solution.

**Programmed Learning:** A relatively permanent change in behaviour, knowledge, skills or attitude brought about by a clearly structured set of processes, with a clearly defined educational or training content and with specified levels of achievement.

**Prodromal Visibility:** The degree to which a particular risk gives early enough warning of the potential consequences so as to enable them to be mitigated at the last moment.

**Pure Risk:** The product of the likelihood of an event, together with its prodromal visibility and potential consequences which can only result in loss.

**Representative Heuristic:** A rule of thumb which states that if a problem belongs to a particular group then the same solution applies to all problems in that group.

**RIDDOR:** The health and safety regulations concerned with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

**Risk:** The product of the likelihood of an event, together with its prodromal visibility and potential consequences as perceived through the perspective of a particular consumer or agent.
Risk Analysis: The estimation of the product of the likelihood of an event, together with its prodromal visibility and potential consequences.

Risk Assessment: The identification of probable causes of a risk and what risk control measures should be taken.

Risk Control: Are the measures available for mitigating a particular risk and includes the options of actions pre and post a risk becoming an event, transferring the risk to others and retaining the risk.

Risk Management: The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects. (Australia/New Zealand Standard 4360:1999 Risk management.)

Risk Management Seed Heuristic: The rule of thumb which states that a set of key risk management principles should be used in determining what the appropriate risk control measure is.

Risky Shift: An increase or decrease in the amount of risk which will be taken when decisions are made in a group compared to those made as an individual.

Responsibly: Meeting one's obligations through rational action, taking into account the needs and context of the situation in which that person finds themselves.

Serious Incidents: Are events resulting in harm which are likely to lead to large claims for damages. (Capstick)

Speculative Risk: The product of the likelihood of an event, together with its prodromal visibility and potential consequences which could result in an overall gain or an overall loss.

Subjective Risk: '... the uncertainty of an event as seen or perceived by an individual. (Gordon)
**Subjective Probability Estimates**: The perceived likelihood of an event in which low risks are generally over-estimated and high risks are generally under-estimated.

**Tolerable Risk**: '...a range of risk that we do not regard as negligible or as something we might ignore, but rather as something we need to keep under review and reduce it still further if and as when we can.' (Health and Safety Executive)

**Trust**: A health care organisation given extensive rights to manage itself on behalf of the National Health Service

**Unacceptable Risk**: '... a risk which is beyond (above the region of tolerability and unless there are special reasons a risk regulator will demand control to bring the risk below this level, or will refuse the activity.' (Health and Safety Executive)

**Uncertainty**: Unpredictable.

**Untoward Incidents**: '... both unexpectedly poor outcomes and errors in the clinical process which do not lead to actual harm.' (Capstick)

**Vicarious Liability**: Legal responsibility for someone else's actions

**Value**: The criteria by which the worth of something is judged.
Appendix 2 - Health & Safety Enforcement Prosecutions in the Health Sector from 1988 to 1997

1. Sheffield Health Authority

Prosecuted on 24 February 1988 under Section 2(1) of HSWA for failing to provide a safe system of work for an employee handling hot fat in the hospital kitchen. Fined £500 plus costs.

2. South East Staffordshire Health Authority

Prosecuted on 7 June 1988 under Section 2(1) of HSWA for failing to maintain means of access to a place of work for a nurse crossing a courtyard at night. Fined £500 plus costs.

3. Walsall Health Authority

Prosecuted on 29 June 1988 under Section 21 of HSWA for failing to comply with the requirements of an improvement Notice relating to the safe disposal of Clinical Waste. Fined £450 plus costs.

4. Portsmouth and South East Hampshire Health Authority

Prosecuted on 20 September 1988 under Regulation 1 of the Electricity Regulations 1908 for failing to ensure that a piece of electrical equipment in the manufacturing pharmacy was so worked as to prevent danger. Fined £1200 plus costs. On the same day, the same Health Authority was prosecuted under Regulation 3 of RIDDOR 1985 for failing to report an electric shock accident within 7 days. Fined £200.

5. Airedale Health Authority

Prosecuted on 20 January 1989 under Section 2(1) of HSWA for failing to ensure that safety of employees who were overcome by diesel fumes whilst cleaning out a water tank. Fined £1200 plus costs.

6. Cambridge Health Authority

Prosecuted on 15 February 1989 under Regulation 3 of RIDDOR 1985 for failing to report major injury and 3 day accidents (11 cases). Fined £500 plus costs.
7. **North Staffordshire Health Authority**

Prosecuted on 21 February 1989 under Section 2(1) of HSWA for failing to maintain a pressure cooker resulting in injury to a technician in the out-patient department. Fined £500 plus costs.

8. **Bristol and Western Health Authority**

Prosecuted on 21 August 1989 under Section 2(1) of HSWA for failing to ensure the health of a nurse in the endoscopy unit working with glutaraldehyde. Fined £1000 plus costs.

9. **Barnett Health Authority**

Prosecuted on indictment on 6 October 1989 under Regulation 34(1) of the Gas Safety (Installation and Use) Regulations 1984 - 2 cases - and under Section 3(1) of HSWA for failure to maintain 2 gas fired central heating boilers, resulting in 2 fatal accidents. Fined £30,000 plus costs.

10. **Aylesbury Vale Health Authority**

Prosecuted on 1 February 1990 under Section 2(1) of HSWA for failing to protect nurses against the risk of Hepatitis B infection. Fined £1000 plus costs.

11. **Leeds Western Health Authority**

Prosecuted on 17 October 1990 under Regulation 3 of RIDDOR 1985 for failing to report the deaths of 2 patients who died after being given dishwater fluid believed to be lemon juice. Fined £100 on each case. Prosecuted also under Regulation 12 of COSHH re training of staff. Fined £800.

12. **Worthing Health Authority**

Prosecuted on 20 December 1990 under Section 3(3) of RIDDOR 1985 for failing to report 2 major accidents within 7 days. Fined £300 plus costs.

13. **South West Durham Health Authority**

Prosecuted on 25 February 1991 under Section 2(1) of HSWA for failing to ensure the safety of 2 engineers fitting smoke doors who were subsequently injured when a scaffolding tower collapsed. Fined £500 plus costs.

14. **Riverside Health Authority**

Appendix 2.2
Prosecuted on 4 March 1991 under Section 3(1) of HSWA for failure of the system in the hospital for segregation of clinical and domestic waste due to inadequate communication and monitoring resulting in refuse collection being contaminated with blood. Fined £750 plus costs.

15. P P Nann and M E Little BDS


16. Cornwall and Isles of Scilly Health Authority

Prosecuted on 5 August 1991 under Regulations 5(1) and 7 of the Ionising Radiations Regulations 1985 for failing to ensure that a patient was not exposed to ionising radiation in excess of the dose limit specified. Fined £3000.

17. Oxford Health Authority

Prosecuted on 8 August 1991 under regulation 3(1)(a) and (b) of RIDDOR 1985. A mentally handicapped patient was scalded whilst being bathed by a care assistant. Patient subsequently died 3 days later. The HSE discovered the incident through a press article, the accident was subsequently reported but too late for an investigation to take place. Fined £1000 plus costs.

18. Sandwell Health Authority

Prosecuted on 20 August 1991 under Regulation 10 of the Electricity at Work Regulations 1989. An electric plug had been wired incorrectly due to overloading, short circuited and caused burns to an employee, plus minor explosion and damage. Fined £250 plus costs.

19. Trafford Health Authority

Prosecuted on 4 September 1991 under Section 3(1) of HSWA. A female patient fell out of bed onto unprotected hot pipes receiving multiple site burns. Precautions had not been taken by the Health Authority to ensure patients were not exposed to risk from hot pipework. Fined £5000 plus costs.

20. Mr Vince Weeks

Prosecuted 27 November 1991 under Section 33(1) of HSWA. An Improvement Notice was issued in April 1990 requiring the setting up of preventative maintenance of a dental X-ray set. Notice was extended twice. Notice not complied with and
machine was only taken out of use after Prohibition Notice served June 1991. Fined £1000 plus costs.

21. **Mid Glamorgan Health Authority**

Prosecuted on 28 November 1991 under Regulations 5(1) of the Control of Asbestos at Work Regulations 1985. Two maintenance fitters were exposed to asbestos dust while removing steam pipes from the boiler room. Fined £3000 plus costs.

22. **South Birmingham Health Authority**

Prosecuted on 7 February 1992 under Section 3(1) of HSWA. Contractors working in a confined space were not controlled, they were not supervised to ensure that the tank was safe to enter, that they complied with safety instructions, and the tank was not isolated (locked off). Fined £1000 plus costs.

23. **Dr Bromley and Partners**


24. **Camberwell District Health Authority**

Prosecuted on 15 December under Section 14(1) of the Factories Act for unsafe machinery in the laundry. Fined £500 plus costs.

25. **North Staffordshire Health Authority**

Prosecuted on 30 April 1993 under Regulation 3(1)(a) of RIDDOR 1985 for failing to report a major accident. A patient stepped into a bath of hot water and was severely burned. Fined £2000 plus costs.

26. **Norwich Health Authority**

Prosecuted on 2 June 1993 under Section 3(1) of HSWA. DP was scalded whilst taking a bath. No physical safeguards or safe systems of work in situ. A fatal scalding accident occurred in another Health Authority earlier in the year. Fined £1200 plus costs.

27. **Public Health Laboratory Service**
Prosecuted on 8 August 1993 under Section 2(1) of HSWA and Regulations 8(1), 7(1) and 12(1) of COSHH Regulations 1988 for failing to take any action to prevent a potentially fatal infection. Fined £250 plus costs.

28. South Derbyshire Health Authority

Prosecuted on 22 November 1993 under Section 2(1) of HSWA for failing to ensure so far as was reasonably practicable the health and safety at work of nursing staff required to handle and move patients. Fined £12000 plus costs.

29. Airedale NHS Trust

Prosecuted on 8 December 1993 under Section 3(1) of HSWA. An 18 month old baby fell through inadequately protected barriers on a first floor landing, fracturing its skull and sustaining internal injuries. Poor management of risks were identified in 1988. Fined £3000 plus costs.

30. J F Broderick Ltd.

Prosecuted on 31 March 1994 under Section 3(1) of HSWA. DP fell from first floor window of nursing home. Window opening not restricted. Fined £10,000 plus costs.

31. Salford Community Healthcare

Prosecuted 8 April 1994 under Section 3(1) of HSWA. Client in care of Health Authority sustained 15% 2nd degree burns from hot bath. No thermostat mixer valves. Fined £12,500.

32. Loddon NHS Trust

Prosecuted on 6 June 1994 under Section 3(1) of HSWA. DP received burns after she fell between a hot radiator and locker. Trust unaware of guidance - no control measures implemented. Fined £1000 plus costs.

33. Basildon and Thurrock General Hospital

Prosecuted 5 July 1994 for two breaches under Regulation 3 of RIDDOR 1985 for the late reporting of two accidents to employees which resulted in absences from work of more than 3 consecutive days. Fined £1500 plus costs.

34. Parkside Health NHS Trust

Appendix 2.5
Prosecuted on 18 July 1994 under Section 3(1) of HSWA. An elderly in-patient was scalded and drowned whilst taking a bath. Thermostatic valve not fitted to water supply. Staffing levels inadequate. Fined £50,000 plus costs.

35. West Suffolk NHS Trust

Prosecuted on 28 October 1994 for two breaches under Regulation 3 of RIDDOR for late reporting of two accidents to employees, which resulted in absences from work of more than 3 consecutive days. Fined £3,500 plus costs.

36. North Staffs Hospital NHS Trust

Prosecuted on 18 December 1994 under Section 3(1) of HSWA. Little consideration was given to transport risks on site when psychiatric residents were picked up and offloaded on afternoon trips. This particular incident resulted in a fatality to a resident. Fined £1000 plus costs.

37. Copelands Tours (Stoke on Trent) Ltd.

Prosecuted on 18 December 1994 under Section 3(1) of HSWA. Little consideration was given to transport risks on site when psychiatric patients were picked up and offloaded on afternoon trips. This particular incident resulted in a fatality to a resident. Fined £1000 plus costs.

38. Frenchay Healthcare Trust

Prosecuted on 6 March 1995 under Section 3(1) of HSWA. An elderly male patient fell out of bed onto hot pipes and received full thickness burns. Reasonably practicable precautions were not taken by the Trust despite a previous similar accident. Fined £15,000 plus costs.

39. Greenacres Nursing Home

Prosecuted on 8 March 1995 under Manual Handling Regulations. Failure to comply with an Improvement Notice requiring a suitable and sufficient assessment of manual handling operations involving patient lifting to be carried out. Fined £1500 plus costs.

40. Lancaster House Nursing Home

Prosecuted under Section 3(1) of the Health & Safety at Work etc Act 1974. Spina Bifida patient sustained severe burns to his legs whilst taking an unsupervised shower at his home. The shower was not fitted with a thermostatic mixing valve allowing water temperature in excess of 70° at the shower head. Fined £3000 plus costs. Compensation of £1000 awarded to patient.

Appendix 2.6
41. **Dorset Community NHS Trust**

Prosecuted 21 August 1995 under section 3(1) of the Health & Safety at Work etc Act 1974. Profoundly physically and mentally handicapped left alone in bath - drowned. No instructions re safety of such patients in bath. Other care assistants also left alone. Fined £14,000 plus costs.

42. **City Hospitals Sunderland NHS Trust**

Prosecuted 19 February under Health & Safety at Work Act 1974 Section 3(1). A baby punctured its finger on a needle from an open ‘sharps box’ left on floor of a consultation room. Fined £15,000 plus £696 costs.

43. **South Glamorgan Health Authority**

Prosecuted on 18 February 1996. Hospital patient with Downs Syndrome ran a bath unsupervised. Scalded and subsequently died. Fined £3000 plus £836 costs.

44. **Downside Nursing Home**

Prosecuted on 14 June 1996 for failure to comply with an Improvement Notice requiring a manual handling assessment. Fined £3000 plus £1194 costs.

45. **Edenmore Nursing Home**

Prosecuted on 19/20 August under Health & Safety at Work Act 1974 Section 3(1). Elderly patient received full thickness burns to legs. Fined £6,000 each plus £5,000 costs.

46. **Bedford Hospital NHS Trust**

Prosecuted on 19/20 August under Health and Safety at Work Act 1974 Section 3(1) and Management of Health and Safety at Work Regulations 1992 Regulation 3. Patient died in fall of over 3m from a ground floor window with unrestricted opening. Fined MHSW Regs - £4,000 plus £3,000 costs.

47. **Surrey Heartlands NHS Trust**

Prosecuted in January 1997 under Health & Safety at Work Act Section 3(1) following fatal scalding accident to mentally ill patient. Fined £15,000 plus £6,000 costs.

Appendix 2.7
48. Premier Health NHS Trust

Prosecuted in January 1997 under Health and Safety at Work etc Act 1974 Section 3(1) following the drowning of a mental patient. Fined £7,500 plus £1147.80 costs.

49. Community Health Sheffield NHS Trust

Prosecuted in March 1997 under Health & Safety at Work etc Act 1974 following fatal drowning and scalding of an 85 year old patient. Fined £20,000.

50. The manor House Nursing Home Ltd.

Prosecuted on 8 April 1977 under Section 3 of the Health and Safety at Work Act 1974 following fatal scalding of a 77 year old dementia patient. Fined £12,000 plus £444 costs.
STRENGTHS - POLICY

1. The Trust has made clear, via the Statement of Intent signed by the Chief Executive, that it is committed to providing safe and healthy conditions for staff and others.

2. The Chief Executive clearly recognises his overall responsibility for health and safety standards within the Trust and takes a personal interest in achieving improvements.

3. The Trust has set out, in its Policy No. 2 "Arrangements and Responsibilities", some specific duties and procedures, such as the specific health and safety duties given to Heads of Departments.

4. The trust has set up several specialist groups who are able to guide policy and give advice on particular risks (e.g. Radiological Safety Committee, COSHH Group, Security Group, Manual Handling Steering Group etc.).

5. The Trust has set out, in its Risk Management Strategy and Implementation Plan, a series of strategic objectives, the achievement of which should significantly improve the management of all relevant risks.

6. The "Yellow Binder" system provides easy access to current approved Trust Wide policies related to health and safety.

7. The Executive Medical Director recognises and is keen to emphasise the integration of risk management into all aspects of management.

8. Some departments have drafted good "local" policies and procedures for managing risks within their remits (e.g. the draft Dermatology health and safety manual). These could form useful examples for other departments to build upon.

9. There appeared to be a good policy on immunisation for and awareness of blood-borne diseases in pathology.

10. Before HSE's audit the Clinical Radiology directorate had drawn up a "Staff guide to Health and Safety Policy and Documentation" in a user-friendly format.

11. Good policies had been drawn up in relation to radiation protection.

12. The Trust has very recently drawn up a detailed operational policy for the prevention of legionnaires disease.

13. The Sterile Services Units had local health and safety policies which described the expected "on the ground" precautions well (although roles and responsibilities
were not addressed in detail).

14. The Estates Dept has its own safety policy and, in draft, 4 topic-specific safety policy addendums (asbestos, pressure systems, drains and personal protective equipment).

15. All those policies which it is the responsibility of the health and safety adviser to produce are up to date.

16. All policies which the health and safety adviser is responsible for issuing are contained in the "Yellow binder".

17. The policy management group has to approve all Trust-wide health and safety related policies, having consulted the relevant departments and the health and safety committee on the contents, via a draft. Once approved, policies are signed by the Chief Executive.

18. Not all clinical directors have been set health and safety objectives.

19. The health and safety adviser has been consulted by some departments on the health and safety implications of proposed new equipment.

20. The health and safety adviser has had some involvement in the planning stage of the present phase of building.

21. The health and safety adviser has been given objectives and his progress towards achieving them is monitored regularly.

22. It is Trust policy that all senior managers have health and safety objectives.

23. Some directorates have departmental policies to put local detail onto Trust wide policies. For example, the gastroenterology ward has drawn up local policies to add detail, applicable to this area only, to the Trust's policies e.g. lifting, safe staffing levels, clinical waste. The Dermatology Directorate has formulated its own health and safety policy to supplement the main Trust's health and safety policy. Departmental policies should be approved by heads of department.

24. The pharmacy has drawn up a policy for the disposal of highly flammable liquids.

25. In the pharmacy there is a system for ensuring that drugs which are surplus to requirements are disposed of safely.

26. In the Day Surgery Unit there is a written policy on how to deal with a spillage of glutaraldehyde.

27. In the Surgical Specialities Group, written guidelines are being proposed in order
to assist departmental managers in fulfilling their health and safety responsibilities.

28. The recent 'self-assessment' exercise has resulted in the formulation of some health and safety action plans (e.g. in oral surgery, neurophysiology and administration in the Surgical Specialities group).

29. In Surgical Services, Directorate annual business plans sometimes include health and safety items (but only if they have been identified as capital expenditure).

30. Regarding manual handling, the Trust has had a 'minimal-lift' policy in place since January 1997 and is working towards a no-lift policy.

31. In the Accident and Emergency Unit, a policy is in place whereby new nursing staff are not allowed to work night-shifts without having first attended the Trust's 2 day violence and aggression.
STRENGTHS - ORGANISATION

1. There appeared to be a culture of openness in the Trust, with staff being encouraged to report any concerns about risks to management.

2. The trust has appointed a Risk Manager to oversee and advise on the management of clinical and non-clinical risks.

3. The Trust has established a Risk Management Team staffed by senior personnel from a wide range of interests, which is well placed to take a strategic view of risk management.

4. The Trust has drawn up a 2 year Risk Management Strategy, which aims to address risks covered by the Trust's duties under the Health and Safety at Work etc. Act 1974 as well as other risks.

5. The Trust has created a Health and Safety Committee with joint management and trades union representation, which provides a forum for discussion of current health and safety issues, although there appears to be no approved policy on Health and Safety Representatives and Committees as yet.

6. A policy document entitled "Risk Management System" was seen during the audit week (although it had not been referred to before), the content of which gives a good framework for managing risks.

7. Trust policy makes it clear that the health and safety department are able to provide a selection of checklists to facilitate risk assessments, and can readily provide assistance and advice.

8. Business/Directorate Managers have access to a wide range of in-house Health and Safety "competent persons".

9. It is recognised that, for the majority of risks, the most appropriate person to carry out risk assessment is a competent, responsible person within a particular department.

10. The Trust has held a series of Risk Management Workshops for managers which appear to have been well received by those who attended.

11. There is recognition in the Risk Management Strategy (objective 21) of the need for the Trust to properly integrate its risk management arrangements with the organisations it is clearly linked with (e.g. universities). The HSE team believe this requires further work.

12. The Trust Board receives an annual report from the risk management team, to inform decision making on risk management issues.

Appendix 3.4
13. The Trust has a Document Control System which, once fully developed, should clarify for staff the status of health and safety related documentation.

14. Section 6.1.4 of the Trust's Risk Management System (status of this document requires clarifying) requires directorate and department managers to have a health and safety plan with objectives (although few at present appear to have this).

15. The Trust rewards and gives credit to good practice in managing risks by several means, including quality awards and recognition in in-house magazines.

16. Some directorates and departments have well developed systems for managing risks (eg management of X-ray risks in radiology), which may be used as examples of possible approaches to controlling other risks in other directorates/departments.

17. The training of junior doctors on site now includes general advice on the identification of stress, its causation and coping mechanisms.

18. It was reported that working relationships between clinicians and management/support functions were very good within the Trust.

19. The analysis of capital requirements contained in departments' reports for the recent Risk Management Audit provides some degree of objectivity in prioritising competing demands.

20. The position of the health and safety adviser in the Trust facilitates easy communication with the most senior Trust managers and gives weight to the function, which will tend to raise the profile of health and safety management.

21. There were examples of the Trust co-operating with other Trusts in sharing health and safety related information (e.g. networking of staff, shared weather forecasting information for gritting etc.).

22. Many staff reported that the top-down communication methods within the Trust worked well.

23. The health and safety adviser used to meet the occupational hygiene team regularly and these meetings were felt to be beneficial.

24. A system exists for recording radiology staffs awareness of local rules on ionising radiations, and any amendments.

25. Job descriptions in some directorates (e.g. clinical radiology) described post holders' health and safety related duties reasonably well.

26. The culture of trust within the organisation and its openly expressed desire to achieve and maintain good health and safety standards encouraged staff to readily consult other individuals within the Trust (and outside) for advice on improving
standards.

27. Radiation Protection Supervisors are required to agree detailed health and safety duties (in the form of their letters of appointment).

28. Some of the local health and safety policies in the pathology department allocated clear responsibilities for health and safety to named individuals.

29. Much good work had been done in documenting health and safety policies and procedures in the pathology department, spurred on in part by the requirements of the Clinical Pathology Accreditation Scheme.

30. There were trades union safety representatives in the pathology departments, which should provide a good means of consultation on relevant risks.

31. There appeared to be comprehensive local rules for the various uses of ionising radiations within the Trust.

32. The analysis and documentation of procedures in Sterile Services for ISO 9002 (quality) purposes has proved valuable in helping identify health and safety issues which may have required attention.

33. Sterile Services had devised a simple, effective "competence matrix" for new starters, so that the training status of employees can easily be checked at a glance.

34. The cascade system of training for lifting and handling in Sterile Services was reported to work well.

35. Sterile Services had appointed a health and safety representative, who assists in the identification and control of risks, but this role required clarification.

36. The Pathology Directorate's Health and Safety Committee provides a suitable forum for discussion of risks in the Directorate.

37. Attempts to assess the condition of asbestos on the Hope site have been made in the past. This involved removal of most known asbestos.

38. Large contracts are only awarded to contractors resident on a list of contractors, the so-called North-West Consortium. Providing adequate assessments are made of contractors on this list, this should help achieve adequate levels of health and safety at such contracts.

39. The manual handling training arrangements in the wards (whereby local co-ordinators are trained by other more qualified staff, and then cascade their new knowledge to other staff), were broadly felt to work well in practice.

40. Department wide safety policies specific for hazards in the pathology
laboratories were said to be in development.

41. Documentation including risk assessments and COSHH assessments in Pathology were generally located near to where the relevant work was carried out. This ready access is to be encouraged.

42. Safety policies have been drafted at Departmental levels in Pathology.

43. The Trust's health and safety adviser is well placed to put any concerns directly to the Risk Management Group which meets monthly.

44. The post of health and safety adviser now forms part of the Risk Management Team, whose head attends Board meetings and has direct access to the Chief Executive.

45. An input by the health and safety adviser into the induction training of junior doctors had recently been negotiated (albeit with some difficulty) as they do not attend the half day induction session given to the rest of the staff.

46. The health and safety adviser can communicate directly with all Trust staff via the in-house magazine.

47. Many departments have a "safety representative".

48. There is an active health and safety committee.

49. Some clinical directors have set up effective systems for ensuring the health and safety of their medical staff.

50. Clinical directors are responsible for the management of risks affecting their medical staff.

51. In the Elderly Care Directorate, staff felt that the recent appointment of an 'Equipment Liaison Nurse' had led to improvements in the provision of necessary equipment to wards.

52. Junior doctors were said to hold a meeting with the Medical Director, Nursing Director, BMA representative and accommodation officer each month, which any doctors may attend. The forum was said to work well.

53. There is a 2 day course on violence run by the Trust, which many staff in Accident & Emergency have attended, which was said to be very useful.

54. New staff in Accident & Emergency attend the above 2 day course on violence before they go on night duty.

55. The knowledge of most junior doctors joining Accident and Emergency on how
to dispose of clinical waste was said to have recently improved markedly.

56. There are back-care co-ordinators in Accident and Emergency and cascade training has taken place.

57. The Directorate of Facilities has a budget for training and managers review training needs with individuals. Training records are kept.

58. Managers in the Directorate of Facilities have health and safety objectives which are measured six monthly.

59. Some risk assessments have been undertaken in the urology, pain management, oral surgery and ENT departments, using the guidance provided by the Trust’s health and safety adviser.

60. A comprehensive training scheme appears to exist for manual handling training co-ordinators.

61. Although a "mentoring" system exists, plans are being developed to introduce more systematic assessment of training needs in the Elderly Care Directorate; it is envisaged that competencies would include health and safety matters. However, it appears that these plans have not yet been implemented.

62. A risk management co-ordinator has been appointed in the Elderly Care Directorate.

63. The remit of the recent 'self assessment' exercise is to be extended to include activities relating to the work of medical clinicians.

64. In the Renal Unit, new junior clinical staff are given 2 weeks induction training during which some health and safety training (e.g. on blood sprays and cross-infection). It was noted that sharps injuries training was not included at induction.

65. Precautions to take in the event of some adverse incidents (e.g. blood spray) are written down and provided to junior doctors in the Renal Unit as part of their induction pack.

66. There are two trained manual handling co-ordinators in place in the Accident and Emergency department.

Appendix 3.8
STRENGTHS-CONTROL

1. The recent implementation of the Minimal Lift Policy appears to have led to a 50% reduction in manual and patient handling incidents.

2. The Trust has appointed a full time Manual Handling Trainer and Facilitator.

3. There have been recent efforts to increase junior doctors' knowledge of health and safety issues during their induction training.

4. The use of glutaraldehyde in radiology has been assessed, and less hazardous substitutes used where reasonably practicable. Air monitoring has been carried out for remaining operations to determine likely exposures and any controls necessary.

5. There appeared to be effective controls in place for Magnetic Resonance Imaging.

6. Possible risks of violence have been assessed as regards radiology staff (by joint management/trades union team) and actions identified by these assessments have been taken.

7. The removal of formaldehyde from sterilisation procedures in Sterile Services and its substitution with methods less harmful to health has reduced the risk of health problems.

8. There appeared to be reasonable procedures and policies for immunisation; stick injuries and occupational health screening in Sterile Services.

9. Sterile Services management were clearly committed to achieving and maintaining good health and safety standards and to continuous improvement.

10. There appeared to be a high level of awareness of manual handling risks and controls amongst those nursing staff we spoke to on medical wards, and it appeared that the cascade training worked well for manual handling.

11. We were informed that thermostatic mixing valves (which control the hot water temperature to a maximum of 43° C) have been fitted at all baths and showers within the Trust and that these are formally tested by the Trust's 'Competent Persons' at 6 monthly intervals, reducing the risk of scalds to patients.

12. The use of polypropylene sample tubes instead of glass in pathology reduces the risk of infection from contaminated sharps.

13. A survey of hot and cold water services considering the risk from Legionella has been completed. This identified tasks requiring disinfection and cleaning, which is carried out annually.

Appendix 3.9
14. There is a blanket site-wide policy of restricting window openings to 100mm (although evidence was found that some windows in some areas not accessed by patients do not meet this).

15. The decreasing use of radioisotopes in pathology, whilst largely the result of improved non-isotope methods, is beneficial from a radiation protection viewpoint.

16. The Trust has an Adverse Incident Reporting System which is now felt to be working well. It is believed that there is no significant under-reporting.

17. Occupational Health was felt by some staff to provide a good service to medical staff regarding health surveillance, information on infectious risks etc.

18. Junior doctors on call at night were said to have good access to advice from senior colleagues, which helped control stress in these individuals.

19. Staff interviewed in Accident & Emergency felt that they have good support from management within the department with regard to the stress caused by violence and that there is a good informal counselling system.

20. The Estates Department of the Directorate of Facilities had contingency plans for failures of critical pieces of plant, although this should rarely occur as the plant is subject to a planned preventive maintenance system.

21. 24-hour site security services are provided by contractors. There are a variety of cameras linked to a manned control room from where the controller can contact his staff via radio. The main car parks are manned.

22. The Estates Department, which manages the security contract, is aware that there is some feeling that the security staff, who are contractors, are likely to escalate a violent situation rather than diffuse it and that their training is inadequate to allow them to deal satisfactorily with such situations. The matter is being reviewed, particularly as the contract is due for renewal. The Estates Department liaised closely with Accident & Emergency to upgrade security precautions after a particularly nasty incident and, together with the liaison officer from the police, assisted with the risk assessment.

23. Staff on night shift can, on request, get an escort to their destination from the security staff.

24. Sharps boxes have been placed on the wall in the gastroenterology surgery.

25. Porters move laundry using trolleys and it is delivered in reasonably sized bundles. No instances of overfilling dirty laundry bags were noted on the gastroenterology ward.

26. There is a trained lifting co-ordinator on the gastroenterology ward, all the staff...
have been trained by her and there is an adequate supply of lifting equipment which is checked visually every month and has an annual external check.

27. There have been problems with ensuring that bank nurses have had suitable training for the gastroenterology ward, but the situation has improved markedly with the recent appointment of a co-ordinator.

28. Clinical waste is removed twice a day from the gastroenterology ward by contractors who wear gloves and who tie them up securely and mark them with the place of origin.

29. There is a Link Nurse for the control of infection on the gastroenterology ward. There are no hot surfaces in the gastroenterology ward onto which patients could fall and sustain burns.

30. The pharmacy has got written "recipes" for the drugs they make up themselves.

31. The GIP unit has completed a COSHH assessment of its use of glutaraldehyde, concluded it's use is required and ensured that all work is done in a fume cupboard containing a sink.

32. The Endoscopy Unit has a written policy on how to deal with a spillage of glutaraldehyde and have a spillage kit.

33. The Endoscopy Unit has completed a COSHH assessment of their use of glutaraldehyde, implemented the use of disposable equipment where possible (which has significantly decreased usage) and purchased 2 extracted automatic fill/discharge cabinets in which to disinfect those endoscopes which still require glutaraldehyde.

34. The cabinets used for cleaning endoscopes in the Endoscopy Unit are serviced regularly.

35. The Day Surgery Unit has completed a COSHH assessment of their use of glutaraldehyde. This has enabled them to reduce its use considerably by autoclaving and they have instituted a policy that wherever possible new equipment must be autoclavable. An extracted portable bath has been provided for those instruments which do need to be soaked in glutaraldehyde.

36. The risk assessment of the use of glutaraldehyde in the theatres has enabled them to reduce its usage significantly by increasing the amount of equipment which can be autoclaved. Most of the equipment which still needs to be cleaned in glutaraldehyde is done in an extracted tank.

37. A risk assessment of the use of glutaraldehyde in the theatres has been carried out.

38. As a result of the assessment of the use of glutaraldehyde in clinical biochemistry

Appendix 3.11
an order was about to be placed for a cleansing system which uses a less hazardous chemical. This will result in the department stopping the use of glutaraldehyde.

39. The Trust have identified the need to review the use of CIDEX (glutaraldehyde) for the disinfection of orthopaedic camera parts.

40. Trust policy requires that patient-centred manual handling assessments are conducted at ward level and this is being implemented in some wards.

41. A stress-counsellor has recently been appointed for use by employees, Trust-wide.
42. Some senior clinicians embrace health and safety management issues as part of their line management responsibilities.

43. Physical control measures such as alarm call systems, digital security locks and close circuit television are in place in the Accident and Emergency department.

44. Generic 'local rules' for the use of mobile x-ray sets were available in the Accident and Emergency department.

45. Patient-centred manual handling assessments are carried out for in-patients at the Ladywell site and the conclusions recorded in the patient's care plan.

46. A wide and appropriate range of lifting aids were available in (Ladywell) wards L4, L5 and L14.

47. The Elderly Care Directorate have drawn up guidelines for staff on the use of cot-sides.
STRENGTHS - MONITORING

1. The Adverse Incident Reporting system appears to be working well in capturing the information necessary to make valid judgements about the risks and controls.

2. Every department has been subjected to the first round of Risk Management "audits" by the Trust's health and safety adviser.

3. The validity of each department's "Self Assessment Checklist" is assessed by the health and safety adviser, who also provides feedback at this stage.

4. Results of the self assessment surveys were given to Heads of Department.

5. The bi-annual review for managers provides some mechanism for seeking information on directorates'/departments' past performance and future plans regarding risk management issues (although there is no specific requirement to address health and safety issues at these reviews).

6. Every department has completed a health and safety self assessment form in the last year. The health and safety adviser has followed these up and it is believed that central management now knows where the problems are and where capital expenditure is required.

7. Before the recent cleaning contract was awarded, some enquiries were made about the proposed contractor's health and safety performance with Trusts who already used the contractor.

8. The "performance agreements" for work carried out in-house provide a means of monitoring health and safety performance for these functions, provided that good indicators of health and safety performance can be selected.

9. Radiation Protection Supervisors are required to report annually to the Radiation Protection Committee on radiation protection issues within their remit.

10. Workplace inspections of the immunology department were carried out by the Senior Chief MLSO and the trades union health and safety representatives, using checklists.

11. Dose monitoring of radiology staff provides confirmation that staff radiation doses are low.

12. There appeared to be well documented, effective systems for the planned preventative maintenance of equipment in radiology.

14. The Health and Safety Adviser assesses Adverse Incident Reports (AIRs) daily and follows up any he thinks warrant special attention. AIRs and the report of any further investigation are copied to relevant people e.g. Occupational Health, Back Care Co-ordinator etc.

15. It is Trust policy that all departments carry out periodic inspections to ensure that health and safety precautions are being used.

16. The Lead Nurse in gastroenterological surgery checks monthly that staff are up to date on training and keeps computerised training records.

17. The Lead Nurse in gastroenterological surgery carries out six-monthly ward inspections to ensure compliance with health and safety procedures, using checklists. If she finds any omissions she carries out a risk assessment and attempts to implement any necessary precautions.

18. In the CIVA3 Unit in the pharmacy, levels of isopropyl alcohol (IPA) are sampled periodically using gas detector tubes to ensure levels are acceptable.

19. Health surveillance of those in GIP who use glutaraldehyde is about to begin.

20. Staff in the Endoscopy Unit who use glutaraldehyde are subject to annual health surveillance in the form of a questionnaire.

21. Staff in the Day Surgery Unit who use glutaraldehyde are subject to health surveillance.

22. A monitoring system for adverse incidents relating to manual handling is in operation. We were informed that, in comparative periods in 1996 and 1997, the system demonstrated that manual handling and patient handling adverse incidences had reduced by 50% and that those incidents still occurring are generally of a less serious nature.

23. A system is in place for monitoring the condition of manual handling/lifting aids and this includes servicing of equipment where appropriate.

24. Equipment shortages, in both patient and non-patient handling areas, have been identified and have been brought to the attention of the Trust Executive Board.

25. The recent risk management self-assessment exercise provided broad benchmark standards for Directorates/Departments to assess their health and safety performance against.

26. Every department has completed a health and safety self assessment form in the last year. The health and safety adviser has followed these up and it is believed that central management now knows where the problems are and where capital expenditure is required.
27. The extraction on the portable bath for cleaning instruments in glutaraldehyde is serviced regularly.
STRENGTHS - REVIEW

1. The Risk Management Group holds monthly meetings at which progress with risk management issues in general may be reviewed.

2. All adverse incidents which could have been avoided and reports which do not include 'action taken to prevent reoccurrence' are followed up by the Manual Handling Training Officer with the member of staff concerned, and a report sent to the Trust's Health and Safety Adviser.

3. As a result of reviewing procedures, the Trust-wide 'Moving and Handling' policy has recently been updated.

4. An annual report is produced for the Trust Executive Board by the Manual Handling Training Officer.

5. In the Facilities Directorate a quarterly report is made on the Adverse Incident Reports (AIRs) generated and, if necessary, policies are reviewed.

6. The quarterly meetings of the Radiation Protection Committee facilitate discussion and review of radiation safety issues and help ensure steady improvements in radiation safety generally, in accordance with best practice.

7. Local Rules for the use of ionising radiation are reviewed annually at the Radiation Protection Committee meetings, although this is not yet a written Trust requirement.

8. The microbiology department has assessed its own standards against the latest edition of the Advisory Committee on Dangerous Pathogens (ACDP)'s guidance on containment levels for biological agents, in order to identify any areas where further precautions may be necessary.

Appendix 3.16
Appendix 4 HEALTH & SAFETY EXECUTIVE AUDIT
(ACTION REQUIRED)

1. Clarify and assign roles & responsibilities for Health & Safety of:
   - Heads of Department/Directorate Managers & Clinicians,
   - Competent Persons,
   - Staff side Health & Safety Personnel,
   - Health & Safety Representatives,
   - Risk Managers

4. The Trust should clarify and make more explicit the duties of Heads of Departments in relation to health and safety.

5. The roles and responsibilities of all line managers and competent persons working within the Trust should be clarified and explicitly stated.

8. The Trust should examine ways in which the involvement of staff side health and safety representatives may be further encouraged, and if necessary formally approve a suitable policy on health and safety representatives and committees.

10. The Trust should clarify and make explicit the expected roles of all those groups of staff currently referred to as "health and safety reps/representatives".

13. The health and safety related responsibilities of clearly identified directorate and departmental managers should be made explicit. Section 6 of the Risk Management System would provide a useful starting point but requires clearer, unambiguous identification of "managers and senior clinicians".

15. The Trust should seriously consider drawing up a job description for the post of Risk Manager, to reduced the chance of misunderstandings about this role.

20. The Trust may consider providing examples of health and safety related objectives which could be incorporated into directorate and departmental plans (eg to ensure that individuals have been nominated for specified aspects of health and safety management by a specified date; to ensure those nominated individuals have received identified training by a specified date, to ensure risk assessments have been completed/reviewed by a specified date; to ensure staff competencies and training histories are documented etc).

23. The role of the Risk Managers for the Surgical and Medical Specialities Groups should be made explicit, any necessary training for these individuals.
should be identified and provided, and the Trust should give clear guidance on
the proportion of time these post holders should devote to Risk Manager
duties (and ensure this resource is provided).

26. The generic job description for directorate managers in Medical
Specialities should be reviewed to ensure it clearly sets out the Trust's
expectations of the post holder in contributing to health and safety
management.

36. The health and safety role of the wards' "health and safety representatives"
should be clarified, and distinguished from the expected role of the ward
sister.

41. The job descriptions of clinical directors should identify their
responsibilities for the health and safety of their staff, and they should where
possible be set measurable health and safety objectives.

47. The Trust should make clear whether Senior House Officers have
responsibility for the health and safety of their House Officers.

58. The health and safety management roles of clinical directors and
directorate (or business) managers should be made explicit in job descriptions
and relevant policy documents.

66. The Trust should consider ways of further strengthening the line-
management of junior doctors for non-clinical matters to ensure that they are
aware of, and understand the requirements of health and safety legislation, the
Trust's policies and any departmental policy.

2. **Improve monitoring of managers performance in relation to Health
   & Safety objectives set for them by the Trust**

1. It is recommended that the Trust should consider the benefits of requiring
all senior managers to have health and safety related objectives, based on the
Trust's long term plan. Managers' progress towards meeting health and safety
related objectives should be monitored regularly by their line managers

3. **Increase deployment of the Risk Management system especially at
   Directorate and Departmental Level**

43. The Trust should continue its efforts to encourage those areas which do
not have a safety representative to appoint one.

Appendix 4.2
45. The Trust should ensure that each Clinical Directorate has an effective system for informing its medical staff of who their line manager is, and that it is to their line manager that they should initially turn if they have any problems with health and safety.

46. Those Clinical Directors who have not set up effective systems for ensuring the health and safety of their medical staff should do so.

4. **Apply the policy on policy management and document control to all Health & Safety Related Policies.**

1. The Trust should clarify and make explicit who has responsibility for ensuring adequate health and safety policy coverage.

2. The Trust should review which health and safety related policies need to be present in the Trust-wide Yellow Binder, ensure these provide adequate coverage and are approved, and update the index to prevent confusion.

3. All Trust-wide policies which affect health and safety of staff or third parties should be contained in the yellow binder or, if certain policies are not contained in it, the binder should contain instructions on where to find the policies not in it (eg control of infection).

5. The Trust should ensure that all relevant health and safety policies have mechanisms for regular review built into them.

6. The Trust should draw up a single document listing all currently authorised Trust documentation which relates to health and safety/risk management so that managers/staff are easily able to check whether they are aware of the existence of/have copies of all relevant documentation.

16. The present efforts to apply the principles of the Trust's Document Control System to health and safety related documentation should continue so that all Trust-wide health and safety related documentation is subject to these controls.

5. All Trust health and safety policies and associated guidelines etc should include a review date and be reviewed in accordance with this.
5. **Improve completeness, coverage and distribution of all corporate and local health and safety policies and in particular:**

- Infection Control
- COSHH
- Planning of new/refurbished buildings
- Safe Bathing
- Violence and Aggression
- Safe Disposal of Sharps
- Display Screen Equipment
- Glutaraldehyde
- Review procedures for ionising radiation local rules
- Occupational Stress

12. It is strongly recommended that a list of Trust policies relevant to infection control is drawn up, so that staff may easily check what Trust guidance exists regarding particular infection control issues (policies related to infection control were forwarded on request to HSE by the health and safety adviser, but several were found to be out-of-date). Serious consideration should be given to implementing a "controlled document" system for control of infection documentation, if no such system yet exists.

13. The Trust should review whether the total coverage of infection control policies is adequate. Responsibility for producing new and reviewing existing policies should be given to nominated individuals, and a review mechanism incorporated which ensures that policies are reviewed not only when procedures or knowledge changes, but also at specified regular intervals (e.g., every year, every 3 years etc).

33. The Trust's infection control policy and supporting documentation should be reviewed to ensure that they take account of current organisations (e.g., the documents seen refer to Salford Health Authority) and, more importantly, recent advances in knowledge (e.g., Hepatitis C) and legal guidance (e.g., the most up to date guidance from ACDP).

15. It is recommended that Trust Health and Safety Policy 8 on COSHH is reviewed, giving particular consideration to who has responsibility for carrying out COSHH assessments locally; any procedures for checking the adequacy of local assessments (e.g., central checking of a random sample of assessments); a more accurate summary of the significance of occupational exposure limits (para 8.5), and, whether the Trust needs to give a more definite steer on the frequency of review of COSHH assessments.

16. The Trust should institute a policy on what involvement the Health and Safety Adviser should have in the planning of new/refurbished buildings.

Appendix 4.4
either with regard to the health and safety of its own staff and contractors during construction and/or to that of employees, patients etc who will use the completed building, and ensure that the policy is implemented.

21. The Trust should devise and implement a safe-bathing policy. The policy should address scalding risks, manual handling risks and drowning risks. Appropriate training should be provided to all staff who are required to bathe patients in order to ensure effective implementation of the policy.

23. The Trust should consider amending its violence and aggression policy (or issue supporting guidance to Directorates) to provide clarification of the various levels of the training available and which training may be suitable for different groups of employees.

20. The reporting of violent incidents within the Trust should be reviewed to decide whether verbal abuse or harassment is to be recorded and reported. It is recommended that the Trust provides supporting guidance to employees to clarify what types of incident require reporting. The Trust violence and aggression policy may need amending in the light of this review.

62. The Trust should ensure that all relevant employees practise the safe disposal of sharps, understand the Trust's policy on this issue and are aware of the application of the Control of Substances Hazardous to Health (COSHH) Regulations in this matter.

34. The Trust's Policy on display screen equipment should be reviewed, to include information on the course of action to be taken if DSE is suspected to be harming users' health.

59. The Trust should draw up suitably detailed glutaraldehyde spillage procedures. A written spillage policy was in place in DSU and theatres A, B, C and D, but this required more detail as to the type of personal protective equipment to use (namely: long sleeved nitrile rubber gloves (not latex 'double' gloves, as described at the time of the audit), an impermeable apron, chemical grade eye protection or face visor and a respirator which offers protection against toxic organic vapour).

6. The Trust should formally document the review procedures for ionising radiation local rules (e.g. frequency, who will review, agreement of Radiation Protection Adviser etc).

31. The Trust should clarify its procedures for agreement of local rules by the Radiation Protection Adviser and for documenting this agreement. The responsibility for, and frequency of, review should be clarified, as should the procedures for the RPA agreeing amendments and additions to local rules. All these agreements need clear documentation.
32. The Trust should clarify the identity of the radiation protection supervisor in the Gastro-Intestinal Unit (which remained uncertain at the time of our visit) and ensure the post holder carries out the necessary duties.

9. It is recommended that the Trust develops and properly implements its policy for the long term reduction of occupational stress, placing particular emphasis on the root causes. Although documents received after the audit refer to a Trust Stress Management policy, there was little evidence during the audit that staff were aware of any Trust policy on this issue.

10. The Trust should take prompt action to bring the above stress policy to the attention of staff and review the effectiveness of the system for bringing new policies to the attention of staff.

11. Estimates of the costs and business-effects of stress-related sickness absence and other consequences of occupational stress may be useful in gauging how important this health problem may be to the Trust, and in identifying any areas for priority consideration.

6. Job descriptions should be reviewed to determine whether they accurately reflect the work currently carried out by post-holders, so that possible stressors, such as excessive work-load or hours, may be identified. This should in turn, assist the identification of priority areas for action in relation to managing work-related stress.

6. Improve the monitoring by increased:

- Health surveillance of personnel exposed to glutaraldehyde,
- Clinical waste disposal

8. The Trust should clarify its policy for health surveillance of personnel exposed to glutaraldehyde, as the present arrangements appear rather ad hoc.

22. The Trust should ensure that the effectiveness of its clinical waste policy is monitored on a regular basis and that incidents/injuries relating to clinical waste are recorded and followed up.

24. The Trust should clarify its requirement for the reporting of 'near misses' under its adverse incident reporting system (the newly revised incident reporting policy may address this)

7. Directorates to establish procedures to ensure that (where appropriate), local, written health and safety policies and procedures are formulated and communicated to and understood by all relevant staff

Appendix 4.6
17. Directorates should ensure that (where appropriate), local, written health and safety policies and procedures are formulated and communicated to and understood by all relevant staff (a good example was Dermatology's Departmental health and safety manual).

19. Although Trust-wide policies on particular risks have been formulated, their usefulness may be enhanced by further adapting or customising them to meet Directorates' particular needs in order to make the policies more user-friendly to those dealing with the risks concerned.

22. Any existing "local" (ie. Directorate/Departmental health and safety policies, such as the Sterile Services health and safety policy) should be reviewed, to ensure that the roles and responsibilities of individuals in the management of health and safety are clearly explained (eg whose task it is to complete general risk assessments, COSHH assessments etc).

8. Increase the level of knowledge of staff of:

- The Trust's Risk Management System

7. The status of the policy document "Risk Management System" should be clarified, and if (as we understand from documentation received after the audit) it is official Trust policy, further efforts should be made to increase awareness of it amongst relevant staff and ensure it is implemented within an agreed timescale (current awareness of the document appears very low). A review mechanism should be incorporated.

9. Increase the focus on non-clinical risks in the next Risk Management Strategy and especially:

- Scope and frequency of the "regular" reports to the Board

8. Whilst it is appreciated that a good deal of the risks the Trust manages are of a "clinical" nature, it is felt that any future Risk Management Strategy should be examined before issue to ensure that the impact of risks of a more "non-clinical" nature is adequately considered in the strategy and clearly explained, and that relevant strategic objectives concerning "non clinical" risks are drawn up.

12. It is recommended that any future Risk Management Strategy should specify the scope and frequency of the "regular" reports to the Board (is the scope purely "clinical" issues or does this include "non-clinical" issues as

Appendix 4.7
25. Risk managers (and other relevant personnel) should be made aware of progress made in their areas of control against the Trust's Risk Management Strategy/Implementation plan.

14. Investigation of significant accidents and incidents should address any underlying causes and in this way, should be utilised to assess the effectiveness of the health and safety management arrangements in place within Directorates.

10. Health & Safety Advisor to take part in meeting related to:

- Occupational Health
- Project Planning
- Building and facility upgrades
- New equipment purchases

14. Although felt to be helpful, the meetings between the Health and Safety Adviser and the Occupational Health Team have not taken place for some time because of pressure of work. The Trust should consider the importance of these meetings and if they are needed, ensure they are held at appropriate intervals.

65. A mechanism should be devised to ensure that health and safety considerations are taken into account at the planning stage of any new project, and this should always include the involvement of relevant competent persons.

68. The Trust should ensure that its 'competent persons' are fully utilised and consulted during all building work or facility upgrades with regard to end usage.

69. Relevant competent persons should be more involved in the purchasing cycle of new equipment to ensure their health and safety implications are identified and eliminated wherever possible, before purchase.

11. Improve the level of risk assessments carried out across the Trust and especially in relation to:

- New equipment
- Infections
- Radiation
4. The Trust should make ongoing efforts to ensure that suitable and sufficient risk assessments are being undertaken and that appropriate review mechanisms are in place and operating. Risk assessments should, amongst other things, identify training needs and should include consideration of potential high hazard - low probability events.

7. The Trust should consider whether there is a need for the Health and Safety Adviser to become involved in assessing the risks of proposed new equipment and, if appropriate, devise a policy for this.

9. The Trust should make it a formal requirement that risk assessments be reviewed at regular intervals (for example annually) to ensure they remain valid.

28. Directorates and departments should clearly allocate the task of assessing risks to nominated individuals (in writing).

29. Some staff who conducted risk assessments were unaware of how the Trust expected them to deal with assessments of "miscellaneous" risks (ie where no risk-specific "risk assessment format" existed). There would be benefit in providing staff with guidance on this (ie an example of a format for recording assessments of general risks).

37. The Trust should assess possible infection and radiation risks to cleaners who clean the clinical biochemistry laboratories and document its expectations of cleaning staff. The Trust must ensure that contractors have adequate systems for training and supervising their cleaning staff, and should monitor the health and safety aspects of this work at suitable intervals. Cleaning issues should be addressed in local rules, which Trust laboratory staff should be familiar with.

38. The Trust should assess whether those individuals in departments whom policy 16 requires to undertake assessments of display screen equipment workstations yet have the necessary competence for this task and, if not, provide sufficient information/training to these individuals or re-allocate the task of workstation assessment to someone who does have the necessary competence.

Appendix 4.9
40. The Trust should ensure that risk assessments of particular activities include an overall conclusion as to whether any residual risks are acceptable.

57. The Trust should ensure that risk assessments within the elderly care directorate (and at Ladywell) have been undertaken to comply with Regulation 3 of the Management Of Health And Safety At Work Regulations 1992 and other associated legislation.

19. The Trust should ensure that the assessment of legionellosis risks from Trust activities addresses the possible risks from "deadlegs" in pipework. A review of infrequently or intermittently used taps should be undertaken.

21. The Trust should be able to demonstrate that glazing has been assessed by a competent person for compliance with Regulation 14 of the Workplace (Health, Safety and Welfare) Regulations 1992.

22. An assessment is required of the risks from water tank entry and cleaning. Assessment should include consideration of risks from legionella; oxygen depletion (which could be caused by rapid algal growth if the tank is left for a considerable time before entry); risks from drowning etc.

27. The Trust should assess the risks of violence in the haematology and transfusion areas. It is felt that the risks of violence could be reduced by better restriction of public access.

58. A suitable and sufficient COSHH assessment should be undertaken in relation to the use of glutaraldehyde in ENT(G1) and any identified preventative/protective control measures implemented.

61. The Trust should conduct a Trust-wide survey of the possible risks of burns to patients from prolonged contact with hot surfaces such as radiators and pipes. Preventative or protective measures should be implemented within reasonable timescales at those surfaces identified as posing a significant risk to patients.

16. The Trust should assess whether there is a need for health surveillance of staff exposed to formaldehyde during tissue handling. Suitable competent advice should be sought and acted upon.

20. When the pharmacy has moved to its new building, full air sampling of the levels of iso-propyl alcohol (IPA) should be carried to determine whether the ventilation is adequate to control exposure. Thereafter, regular e.g. monthly checks should be carried out using gas detector tubes.

21. The Trust should investigate the reason for health surveillance in the GIP unit not being available. This may have been due to a misunderstanding about
the rules as to when it is required. The Trust should ensure that all those concerned understand the situations in which health surveillance is required.


2. It is recommended that Directorates formulate an annual health and safety action plan to identify those measures they are to implement over the next year. Measures should include equipment purchase, work environment improvements, training of staff, undertaking of risk assessments and departmental inspections.

14. The Trust should clarify its expectations regarding plans for health and safety management at directorate and department levels, and then ensure its expectations are met.

54. The Trust should institute a system to ensure that disagreements on the nature of the health and safety precautions required in a particular situation (e.g., that in theatres about the sterilisation of camera parts and those in the GIP unit about health surveillance and carpet on the lab floor) are brought to the attention of senior management within a reasonable timescale and that an appropriate person is appointed to make the decision in a timely fashion.


3. The Trust should seriously consider setting objective performance standards for health and safety against which performance at Trust, Directorate and Department levels can be monitored.

19. It is felt that the Trust should consider whether it may be beneficial to specifically require directorates/departments to report on past and future health and safety issues at the biannual review sessions, in order to further increase awareness and consideration of this topic.

1. The Trust should continue its efforts to devise and implement suitable systems for monitoring progress against health and safety action plans and performance standards at Trust, Directorate and Department level. The Trust should require formal reporting back by heads of Directorates on health and safety matters against pre-set performance standards. In addition, a practical system of workplace inspections should be implemented at Directorate and Department levels, supported by guidance by relevant competent persons.
2. There would be benefit in calculating "ball park estimates" of typical costs of non-clinical incidents/accidents/ill health and providing this information to managers, since such costs are usually dramatically underestimated. Managers may then use these estimates to calculate likely costs of these events within their own departments. This should help the Trust to implement a strategy to reduce such incidents etc in a prioritised manner.

3. The Trust should develop a set of health and safety performance standards against which it could monitor the performance of its Directorates.

4. Proactive departmental / ward inspections should be undertaken at an appropriate managerial level as a means of monitoring compliance with health and safety legislation. The Trust should specify the frequency and quality of inspections and should require formal reporting back on inspections.

5. The Trust should consolidate and extend ward/departmental inspections throughout all Directorates. In doing so, the Trust should clarify its expectations about the content and frequency of ward/other workplace inspections and the actions to be taken following these inspections.

6. Heads of Directorates should be required to proactively monitor their Directorates' performance against benchmark standards on a regular basis. The Trust's health and safety risk management standard - as adopted in the recent Trust-wide risk management self-assessment exercise - could form the basis of this 'self-audit' approach.

17. The frequency of the inspections done by the Control of Infection Team, Occupational Health, the Back Care Co-ordinator and Health & Safety Adviser should be laid down by the Trust and steps taken to ensure they are carried out on time.

18. The Trust should make it clear to all Directors that requests for information / action from the health & safety team should be dealt with in the time specified and that, if this causes difficulties, the timescale should be re-negotiated by the relevant parties and then adhered to.

19. The health and safety performance of Clinical Directors should be regularly monitored.

1. The Trust should develop its system of 'self-audit' which would ensure proper review of the management arrangements for, and performance in, health and safety at department, directorate and Trust levels. The audits should allow the objective assessment of performance on health and safety against pre-determined targets and standards set by the Trust. Audit findings should be acted upon and progress reviewed.
2. A programme of audits should be drawn up and commenced having regard to the priority issues for the Trust. The scope of the audits should include assessment of management arrangements and adequacies of systems of work etc. Following audits, Directorate/Department action plans should be formulated to ensure that actions are set with target dates. It is recommended that Directorates/Departments set action plans in conjunction with the Health and Safety Department and any other relevant competent persons. In addition, it is recommended that, in the initial stages, the Health and Safety Department, in conjunction with line management, monitor whether progress against these targets is being made.

3. Competent persons, in conjunction with senior management, should review their approach to auditing, ensuring it is undertaken in a strategic manner as part of a rolling programme and that it addresses all elements of the health and safety management system.

7. Plans to introduce the 'Manual Handling Indicators Review' should be implemented.

8. The Trust should formally audit its manual handling policy to identify areas where further work may be required. Such an audit should involve the Trust's manual-handling trainer and other relevant competent persons.

11. Now that the AIR system appears to be working reasonably well, the Trust should analyse these reports regularly to, for example, identify trends/departments etc where further action may be required and determine whether precautions are resulting in a reduction in the number of incidents.

12. It is strongly recommended that the Trust should require directorates / departments to report back centrally on their health and safety performance, actions taken and plans in place for addressing outstanding or on ongoing health and safety requirements (eg annually).

13. A review mechanism should be established to enable each Directorate to assess its own health and safety performance level and to produce action plans for the work required. The action plans should clearly identify priorities, individual responsibilities for action and timescales for completion. A follow-up system should be implemented to ensure that actions identified are progressed.

4. The Trust should identify ways to benchmark its performance both internally (ie within the Trust) and externally (ie as compared to the performance of other similar Trusts).

Appendix 4.13
14. **Review Health and Safety arrangements related to contractors**

30. The Trust should review the procedure for the placing of contracts where there may be special risks (such as cleaning work in pathology areas) and ensure that adequately experienced Trust staff are involved in drawing up the specification for the work to be undertaken (e.g., pathology staff in the above example).

7. The procedures for vetting of contractors before contracts are awarded should be tightened up so that better information is obtained about the health and safety management arrangements of contractors before contracts are awarded.

26. The arrangements for monitoring of contractors' health and safety performance whilst on site should be reviewed and formalised, to ensure that contracts are monitored by a competent, nominated Trust member of staff.

28. The Trust should review and where necessary, consolidate and extend its programme for monitoring the performance of all contracted services on site. The review should ensure that random monitoring of actual systems of work and site conditions is undertaken by relevant (and appropriately trained) Trust employees and that the type and frequency of monitoring is sufficient to ensure that contractors meet previously agreed health and safety standards.

15. **Increase Health and Safety Training especially in relation to:**

- Duties of health and safety representatives
- Managers and Clinical Directors roles and responsibilities
- NEBOSH Diploma status or equivalent for Health and Safety Advisor
- New staff
- Manual Handling
- Pan Hospital Risks
- Fire
- Violence and Aggression
- Risk Management
- Glutaraldehyde
- Clinical Waste Disposal including sharps.

2. Once the role of the departmental "health and safety representatives" has been clarified, their training needs in order to perform their duties should be analysed and any necessary training provided within a reasonable, agreed timescale.
11. The Trust should analyse the training needs of all managers, and others in relation to their health and safety roles and draw up a prioritised programme for delivering any outstanding training needs.

17. It is strongly recommended that the incoming health and safety adviser obtains NEBOSH Diploma status or equivalent, in order to develop the necessary breadth and depth of knowledge to act as competent adviser to the Trust.

18. The Trust should review its arrangements for complying with Regulation 6 of the Management of Health and Safety at Work Regulations 1992 (competent advice on health and safety issues) for the period between the former health and safety adviser's departure and his replacement gaining NEBOSH diploma (or equivalent) status.

21. Many consultants and other senior clinicians were reported to be reluctant to attend the recent risk management workshops due to the pressures of clinical work. The Trust should explore how these groups of staff may be best equipped with the knowledge necessary to fulfil their statutory duties as managers in relation to health and safety.

24. The Trust should develop procedures to ensure that senior managers new to the Trust receive any necessary training in health and safety management as soon as possible, since these new staff will not have had the opportunity of attending past Trust training sessions.

25. The Trust should review whether the current staff induction procedures, where all staff receive identical health and safety briefing, are best suited to the differing needs of eg a senior manager and a porter.

27. Health and safety related training must be clearly targeted. Where the Trust has identified that a particular group or individual needs particular training to enable the Trust to meet its legal obligations, it is recommended that the training be made compulsory. The vast majority of staff should understand this compulsion if the reason is properly explained.

34. It is understood that there have been some difficulties in ensuring permanent night staff receive appropriate training in lifting and handling, but the Trust has already identified these and now has arrangements. The Trust should ensure it has identified all those night staff requiring this training and ensure they receive it.

35. The Trust may wish to consider whether the "cascade" training system (as used at present for eg manual handling) could be adopted for some other risks and, if so, formalise this.

42. The Trust should ensure that the induction training for junior doctors does not omit anything which is relevant from the general health and safety
induction course given to other new staff.

48. The Trust should ensure that all junior doctors are given adequate training in pan-hospital risks and in the risks specific to the Directorate in which they are working. This should include time for thorough reading of relevant policies and checking that their contents have been understood. The Trust should also ensure that each Clinical Directorate has an adequate system for disseminating health and safety information and that staff have understood it.

49. The Trust should review the question of whether junior doctors need to attend a fire lecture annually and, if it decides not, should ensure there are adequate other means of instructing them about their role in the event of a fire.

50. The Trust should ensure that all staff who work in Accident and Emergency have contact with the public and who have not attended the two day training course on how to deal with violence do so in the next few months. Thereafter, arrangements should be made for new staff to attend such training as soon as possible.

51. The Trust should review the training given to the contract security staff who work in Accident and Emergency to ensure that it is sufficient to allow them to diffuse situations where possible and, if required to do so, safely eject people.

53. The Trust should ensure that, whether the security staff are provided by contractors or are their own employees, the standards of training required to deal with all the levels of violence with which they are expected to deal are laid down and met.

55. Directorate business managers should ensure that within each department, there is a sufficient number of trained manual handling co-ordinators. It is felt that at least one trained manual-handling co-ordinator should be in place in every relevant ward/department. It is recommended that the Trust aims to train a minimum of two such co-ordinators to allow for staff departures, absences etc. Directorates / departments should ensure that sufficient time is made available for manual handling co-ordinators to train colleagues (including those on night shift) in their work areas, in accordance with the requirements of the Trust's manual handling policy. Appropriate training records should be kept to assist managers in pro-actively identifying training needs of staff.

56. The health and safety training needs of key nursing staff should be identified and a subsequent programme of targeted training devised and implemented.

59. It is recommended that directorates / departments consult with relevant
health and safety 'competent persons' (eg infection control team, Trust health and safety adviser) to formulate comprehensive, customised health and safety induction training programmes for new starters in their directorates / departments..

60. It is not clear whether all members of the Trust risk management team have received training in risk management as indicated in the Trust's risk management strategy; the Trust should establish the current status and provide any outstanding training where necessary.

61. The Trust should identify which employees require training in dealing with violence and aggression, and to what level. Priority attention should be given to those employees identified (via risk assessment) as being most at risk, and appropriate levels of targeted training should be provided within specified timescales. Training should be targeted to include for example, 'breakaway' and 'control and restraint' as appropriate. In particular, it is recommended that in the accident and emergency department, appropriate annual refresher training should be provided for existing staff. In addition, it is recommended that all staff new to the accident and emergency department are provided with appropriate violence and aggression training within their first 3 months regardless of whether they are working day or night shifts.

63. The Trust should ensure that all staff at risk of exposure to glutaraldehyde are informed of the health risks involved and are trained in safe methods of its control. Only staff who have completed such an education and training programme should be allowed to work with glutaraldehyde.

8. It is recommended that the Trust examine whether there may be benefit in the more widespread use of a "competence matrix" for documenting the competencies and training history of staff, to enable managers and staff to easily identify any training needs.

28. Clinical Directors are responsible for the management of risks affecting their medical staff but it is understood that none (or few) have attended the Risk Management Workshop designed for Senior Managers. This should be rectified promptly and an effective system introduced to ensure that Clinical Directors attend the course within a reasonable timescale.

35. There are still some junior doctors who join Accident and Emergency, and other departments, who do not have an adequate knowledge of how to dispose of clinical waste. The Trust should ensure that the induction course, which we understand now does include training in this subject, includes testing/assessment of the doctors' understanding of the subject and their ability to put it into practice.

37. The Trust should assess the effectiveness of the new system for allocating bank nurses and ensuring they are adequately trained.

Appendix 4.17
56. The Trust should ensure that all staff who are required to handle or move clinical waste are thoroughly trained in the risks involved and the precautions that need to be taken. The level of training for an individual member of staff will depend on their involvement with clinical waste. Staff need to be aware of all the elements of the clinical waste policy that are relevant to them.

27. Those responsible for investigating incidents should receive training in identifying the root causes of incidents, so that any causative weakness in the management system may be identified and corrected.

52. Senior doctors should be reminded of the need to safely dispose of clinical waste they create.

18. The Trust must continue its efforts to educate all clinical staff about the vital need for proper disposal of sharps, to reduce the risk of needlestick injuries and any subsequent infections.

16. **Specific departmental corrective actions required**

   a) **Facilities Directorate**

39. Estates should ensure that the replacement computer system for planned preventative maintenance is brought on-line before problems in getting up-to-date lists of necessary work can create a health and safety risk.

1. Concerns continue to be expressed by staff about the working temperatures and level of ventilation in phase I buildings. The Trust should continue to seek to resolve these concerns.

3. The Trust should identify any remaining situations where a Permit-to-Work or similar formalised controls are needed to adequately ensure the safety of Trust and other maintenance staff, and draw up safe systems of work for these tasks (situations to consider may include work on drains from pathology facilities and on those handling radioactive wastes).

17. It is understood that the incinerator operators North West Energy respond to boiler alarm calls, whilst the boiler attendant is at the Ladywell site. Estates should confirm the formal procedure for handover and ensure that NW Energy staff are adequately trained at responding to alarms.

20. The Trust review its policy on restricted window openings for preventing falls, to ensure that precautions are commensurate with likely
risks. The Trust should draw up a planned preventative maintenance scheme for window restrictors, and simple records should be kept.

23. A powered hydraulic access platform used frequently on site has slots for optional outriggers. The supplier has advised that, given the generally level ground at the hospital, the outriggers are not needed. Given the high hazard, the exact conditions when outriggers are required should be established in writing from the supplier.

24. At the gas pressure boosters for the steam boilers, the Trust should confirm that there is a low pressure detector on the incoming gas supply. It is also thought that the Trust should instal a gas detection alarm, the alarm being set as low as practicable (eg 10% of Lower Explosible Limit is suggested).

25. The Trust should ensure that suitable planned preventative maintenance checks are undertaken on all ladders. Simple records should be kept of these checks.

26. The Trust should investigate the reasons for staff seen clambering on top of clinical waste bins and take action to prevent this practice.

29. The Trust should establish whether the fans and associated electrical equipment in fume cupboards where flammable liquids are used may provide a source of ignition of flammable vapours (this could not be confirmed during our inspections).

57. The Trust should consider installing "satellite" stores for clinical waste to prevent the waste accumulating in unsuitable places such as corridors.

62. Where practicable, lidded bins should be used for the temporary storage of clinical waste in public areas.

63. Good housekeeping should be maintained in designated storage areas. Arrangements should be made for any surplus equipment to be removed promptly from wards. Alternatively, equipment should be stored in a safe location. In general, sluice rooms and bathrooms should not be used as storage rooms.

9. The Trust must ensure that potentially high risk work such as cleaning in pathology areas is adequately monitored (in terms of health and safety) by appropriate Trust personnel. In the case of the above example this will involve monitoring at night when cleaners are working.

10. For potentially high risk work such as cleaning in pathology areas, the Trust should set up procedures to ensure that contractor personnel have received adequate training and instruction on the specific risks involved.
before undertaking this work, and to ensure that the contractor provides adequate supervision to ensure safety.

b) Pathology Directorate

9. Centrifuge buckets in the clinical biochemistry department are currently cleaned using a glutaraldehyde method, involving a significant risk to health. The Trust's plan for switching to a safer, glutaraldehyde free method should be implemented as a matter of priority.

10. The potential health and safety problems in the old mortuary facility have been recognised for some time. The plan for the provision of new facilities which the Trust has drawn up should be implemented as soon as is reasonably practicable.

11. Concerns were expressed by staff in pathology about hot working temperatures and inadequate ventilation in certain laboratories. These concerns should be investigated.

12. The Trust must implement the recommendations contained in the report by BioSafe Safety Services to rectify the existing problems in the containment level 3 laboratory, regarding sealability for fumigation and the ventilation system. It was understood that the required work was to be completed by 31 March 1998, and no slippage in this date should be considered.

13. The Trust should assess the possible contamination risks associated with the use of absorbent seat coverings in pathology areas and, if necessary, replace such upholstery with impervious materials which readily show contamination and may be easily decontaminated.

14. The risk assessment for possible violence/aggression in pathology should be reviewed in light of concerns expressed by staff about easy public access from heart care.

12. The Trust should review the procedures used for thorough examination and testing of its microbiological safety cabinets (especially in the Containment level 3 laboratory), and seriously consider whether Operator Protection Factor tests should be carried out at regular intervals to determine whether control is adequate.

13. It was not clear when the contamination monitors used in unsealed radiation source areas were last calibrated (in immunology and clinical biochemistry). The expected frequency of calibration should be determined.
with the aid of the radiation protection adviser and manufacturer. A check of Trust procedures should be made, to ensure that calibration checks are being performed at appropriate intervals.

14. Trust should ensure that appropriate monitoring of formaldehyde levels in histopathology has been carried out, and any necessary action taken to protect health.

15. The local exhaust ventilation systems associated with the histopathology specimen handling benches should be thoroughly examined and tested by a competent person in accordance with the Control of Substances Hazardous to Health Regulations 1994 (COSHH).

c) Emergency Medicine

31. There is a significant risk to staff in Accident and Emergency who have to lift patients onto trolleys and/or who have to administer resuscitation while standing on a horizontal strut of the trolley. This is because the height of the trolley is fixed and is too high. We understand that a business case for ensuring that all trolleys are adjustable in height is being put forward. However, this matter should now be dealt with as a matter of priority and in the meantime measures need to be taken to reduce the risks as far as is reasonably practicable (particularly with regard to the need to stand on the strut). At least here it will probably be necessary to provide a platform on which to stand.

32. There is some feeling that the reduced level of staffing in Accident and Emergency at night, when violent occurrences are more prevalent, puts night staff at risk, particularly as it is not always possible to close the minor treatment area. In addition, some night staff feel vulnerable in the minor treatment assessment room and by the toilets. The Trust should investigate these matters and, if necessary, take remedial action.

33. There is some feeling among the staff in Accident and Emergency that there is insufficient visible support from or concern shown by senior management outside the Department. This is said to increase the feeling of stress and the Trust may wish to consider whether they can address this in their policy on management of stress (it was suggested by some staff that the Trust should send a warning letter to people who have been abusive).

53. The Trust should assess the apparent ventilation problem in the Accident
and Emergency department's resuscitation room and then identify and implement suitable corrective measures.

54. The Trust should review the adequacy of its provision of moving and handling aids in the Accident and Emergency department with a view to providing the necessary control measures to ensure their compliance with the Manual Handling Operations Regulations 1992.

10. The Trust should urgently review the manual handling situation in the Accident and Emergency department, where only 1 out of 23 trolleys is of the "rise and fall" type, with a view to providing suitable equipment in those areas where unacceptably high risks to health or safety of staff have been identified.

d. Gastroenterology Directorate

36. The sharps boxes on the gastroenterology ward should be repositioned at such a height that children who are not old enough to realise the danger cannot reach in.

39. Clinical waste awaiting collection from the end of the gastroenterology wards should be segregated.

e) Pharmacy

40. It is understood that in the new pharmacy, dispensers will not have to stretch quite so far to reach some of the products on the ready-use shelves as they did in the old premises, but that the need for reaching has not been removed and so there may be some risks of musculoskeletal disorders. The Trust should assess these risks promptly and ensure that any additional precautions are implemented.

41. The "recipes" for the drugs the pharmacy makes up do not contain spillage procedures: this should be rectified.

42. The Trust should reconsider the type of container used for drugs surplus to requirements. If it decides to continue the use of bins these should be clearly labelled as to their contents.

43. In the CIVAS Unit in the pharmacy, highly flammable liquids should be stored in a half hour fire resisting container.

Appendix 4.22
f) GIP Corrective Action

44. The examinations required by Regulation 9 of COSHH do not appear to have been completed for the fume cupboard used in GIP for work with glutaraldehyde: this should be rectified.

45. The carpet on the floor of the lab in GIP where glutaraldehyde is used should be removed and replaced with impervious material allowing easy cleaning of any spillage.

46. The Trust should review the procedure for emptying the right hand tray of glutaraldehyde in the fume cupboard in GIP, to reduce the risk of spillage caused by the position of the taps.

47. The type of mask being used in GIP to provide respiratory protection, mainly in the case of spillage, against glutaraldehyde has a "use by" date and is disposable, although not necessarily after one wearing. The unit did not appear to be aware of this. The same type of mask was being used in most of the other areas using glutaraldehyde which we visited, with similar problems. The Trust should ensure that these masks remain in their original packing until needed, that these masks are not out of date and that, if the masks are to be used more than once, staff are given adequate instruction on how to decide when to dispose of them.

48. The build up of fumes of glutaraldehyde in the room in GIP housing the fume cupboard should be prevented e.g. by putting a cover over the gap in the front of the cupboard at night.

49. The ventilation in the room in GIP where glutaraldehyde is used appears to be poor and should be reviewed.

g. Endoscopy Unit

50. In the Endoscopy Unit the mask in the spillage kit for glutaraldehyde was out-of-date. There should be a procedure for ensuring it remains in-date.

51. The cabinets for cleaning endoscopes in the Endoscopy Unit do not appear to have been subject to the annual examination required by Regulation 9 of COSHH: this should be rectified.
h) Theatres

52. In theatres 5, 6 and 7 open tanks of glutaraldehyde are still used to clean some of the camera equipment used in arthroscopy. This is unacceptable especially as it would seem that there is more than one solution to this problem already known. One of the available solutions should have been implemented some time ago. We were assured that the matter would be dealt with as a matter of urgency.

i) Radiology Directorate

55. The Trust should ensure that the Trust's generic local rules for the use of mobile x-ray sets are in fact applicable to all work areas where mobile sets may be used (eg Ladywell) or whether the generic local rules need to be 'customised' for certain work areas or in certain circumstances.

5. Concerns were expressed by some radiology staff about the resources available for investment in equipment for the long term patient dose reduction strategy. The Trust should continue its bench marking exercises in order to ensure doses remain as low as is reasonably practicable, with equipment being replaced where necessary for health and safety reasons.

4. The Trust should review the existing procedures for checking that staff who direct exposures to ionising radiations have adequate knowledge of the Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988 (POPUMET). It is recommended that lists of all personnel who have been checked in this way are made available to clinical radiology staff.

j) University Departments

11. The Trust should satisfy itself of the adequacy of the local rules and procedures adopted by Manchester University in relation to their use of unsealed radioactive sources in shared buildings, and ensure that adequate liaison procedures exist between the two bodies.
k) Radioisotopes Department

6. In the non-imaging radioisotopes department, care should be taken to ensure that items of personal clothing (coats etc) are not stored in areas where unsealed radiation sources are handled and then worn around other parts of the hospital (to reduce the spread of any contamination). The relevant RPA should advise on this.

7. In the non-imaging radioisotopes department, the means of transporting waste which could present a risk of infection and a (probably low level) radiation risk should be reviewed. The present sack barrow lined with absorbent chip-board would be better replaced with a trolley which would contain any spillage and is lined with impervious material.

I) All Departments/Directorates

15. The Trust should review its compliance for first aid measures in accordance with the Health and Safety (First Aid) Regulations 1981, and document its arrangements for compliance.

16. The Trust should ensure that all workstations with display screen equipment (DSE) are assessed in accordance with the Display Screen Equipment Regulations 1992, and that appropriate action is taken to reduce, as far as reasonably practicable, any associated risks.

30. The Trust should ensure that all staff on call at night know that they can gain entry to the main hospital via Entrance 3 (with the appropriate door code) and that they can be escorted to their destination by a member of the security staff (some relevant staff were unaware of this).

38. Directorates and departments should ensure that storage areas are large enough to allow safe access, storage and removal of the contents and that those whose contents present a risk are locked.

60. The Trust should ensure that it has adequate monitoring safeguards in place for patients who may be prone to "wandering". Assessments of patients should include consideration of this issue and where patients may be at risk. This assessment, together with the appropriate control strategies, should be documented, brought to the attention of all relevant staff and implemented.

23. Directorates should set up a system of routinely checking hot water discharge temperatures at baths used for patients, as a means of monitoring the continued effectiveness of the thermostatic mixing valves used in

Appendix 4.25
helping prevent scalds.

9. The Trust should review its equipment shortages with respect to moving and handling equipment and draw up a prioritised, Trust-wide action plan, based on a risk assessment approach, with the aim of providing those resources essential for ensuring its compliance with the Manual Handling Operations Regulations 1992.

67. The Trust should explore mechanisms by which examples of good health and safety practice, already adopted in a part of the Trust, may be speedily and effectively communicated to other relevant parts of the Trust.
Appendix 5 Main requirements of Clinical Governance
1999/2000

<table>
<thead>
<tr>
<th>Main Components of Clinical Governance</th>
<th>Trust</th>
<th>HA</th>
<th>PCG</th>
<th>PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clear lines of responsibility and accountability for the overall quality of clinical care through:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The NHS Trust Chief Executive carries the ultimate responsibility for assuring the quality of services provided by the Trust</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• A designated senior clinician responsible for ensuring that systems for clinical governance are in place and monitoring their continued effectiveness</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Formal arrangements for NHS Trust, PCG and PCT Boards to discharge their responsibilities for clinical quality through a clinical governance committee</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Regular reports to NHS Boards on the quality of clinical care given the same importance as monthly financial reports</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• An annual report on clinical governance</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2. A comprehensive programme of quality improvement activities which includes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full participation by all hospital doctors in audit programmes, including speciality and sub-speciality national audit programmes endorsed by the Commission for Health Improvement</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Full participation in the current four National Confidential Inquiries</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Evidence-based practice is supported and applied routinely in everyday practice</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Ensuring the clinical standards of National Service Frameworks and NICE recommendations are implemented</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Workforce planning and development (i.e., recruitment and retention of appropriately trained workforce) is fully integrated within the NHS organisation’s service planning</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Continuing Professional Development: programmes aimed at meeting the development needs of individual health professionals and the service needs of the organisation are in place and supported locally</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

continued.......

Appendix 5.1
### Main Components of Clinical Governance

<table>
<thead>
<tr>
<th>Trust</th>
<th>HA</th>
<th>PCG</th>
<th>PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appropriate safeguards to govern access to and storage of confidential patient information as recommended in the Caldicott Report on the Review of Patient-Identifiable Information</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Processes for assuring the quality of clinical care are in place and integrated with the quality programme for the organisation as a whole</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Participation in well-designed, relevant R&amp;D activity is encouraged and supported as something which can contribute to the development of an &quot;evaluation culture&quot;</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

### 3. Clear policies aimed at managing risks:

<table>
<thead>
<tr>
<th>Trust</th>
<th>HA</th>
<th>PCG</th>
<th>PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Controls assurance which promote self-assessment to identify and manage risks</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Clinical risk systematically assessed with programmes in place to reduce risk</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

### 4. Procedures for all professional groups to identify and remedy poor performance, for example:

<table>
<thead>
<tr>
<th>Trust</th>
<th>HA</th>
<th>PCG</th>
<th>PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Critical incident reporting ensures that adverse events are identified, openly investigated, lessons are learned and promptly applied</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Complaints procedures, accessible to patients and their families and fair to staff. Lessons are learned and recurrence of similar problems avoided</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Professional performance procedures which take effect at an early stage before patients are harmed and which help the individual to improve their performance - whenever possible - are in place and understood by all staff</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>• Staff supported in their duty to report any concerns about colleagues’ professional conduct and performance with clear statements from the Board on what is expected of all staff. Clear procedures for reporting concerns so that early action can be taken to remedy the situation</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

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Appendix 5.2
<table>
<thead>
<tr>
<th>Clinical Governance Reports – 1999/2000</th>
<th>Relevant To</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An explanation of the leadership, accountability, and working arrangements for implementing clinical governance</td>
<td>ALL NHS organisations</td>
</tr>
<tr>
<td>• Work to ensure that clinical decision making is increasingly evidence based. This should include local action as well as progress on implementation of National Service Framework (NSFs) and NICE guidelines</td>
<td>ALL NHS organisations</td>
</tr>
<tr>
<td>• Progress on integrated planning for quality including information establishing explicit links to HIMPs and where appropriate, National Service Frameworks</td>
<td>ALL NHS organisations</td>
</tr>
<tr>
<td>• Progress on continuing professional development and lifelong learning and on designing the ways in which staff development, educational, and workforce solutions are being used to support clinical governance</td>
<td>ALL NHS organisations</td>
</tr>
<tr>
<td>• Participation in and impact of multi-disciplinary clinical audit programmes – including national speciality and sub-speciality audits – and national confidential enquiries</td>
<td>ALL NHS organisations</td>
</tr>
<tr>
<td>• The identification of particular services in which there are identified shortfalls in quality and of deficits in other clinical governance support mechanisms (e.g., risk management, clinical audit)</td>
<td>ALL NHS organisations</td>
</tr>
<tr>
<td>• Evidence of active working with patients, users, carers, and the public</td>
<td>ALL NHS organisations</td>
</tr>
<tr>
<td>• An account of the mechanisms that have been established to ensure that lessons are being learned from complaints, adverse incidents, and enquiries into services.</td>
<td>ALL NHS organisations</td>
</tr>
</tbody>
</table>

Appendix 5.3
Policy Statement

Controls assurance within Salford Royal Hospitals NHS Trust is achieved through an interdependent tripartite division of responsibilities for the management of all risk in which:

☐ All staff will act responsibly:

Risk management will form part of the daily duties of all staff. They will be able to identify and assess risks, take local economic action to reduce those risks to an acceptable levels and inform appropriate lead clinicians and managers of unacceptable risks outside of their local ability to control.

☐ Lead clinicians and managers will manage risks responsibly:

Lead clinicians and managers will assess their management of risk using the Trust’s EFQM self-assessment framework and agree actions, as part of their business planning process, to minimize risks within their own areas of responsibility. They will ensure that agreed risk control measures are carried out and will ensure that all staff within their area of control understand and carry out their individual responsibility for the management of risk.

☐ Corporate management will ensure that standards of responsible risk management are applied at all levels within the Trust.

Corporate management will apply controls assurance mechanisms to assure the Trust Board that risks are being managed adequately. The Corporate Risk Management Team will coordinate these controls assurance mechanism and through its specialist risk management teams will provide advice to lead clinicians and managers on effective risk control mechanisms, establish standards of responsible management practice and audit compliance with those standards.
RISK MANAGEMENT PROCEDURE SUMMARY

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Action</th>
<th>Frequency</th>
<th>Form</th>
<th>Controls Assurance Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Staff</td>
<td>Protect self and others from risks</td>
<td>Continuous</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                | Report hazards/incidents and near misses to responsible manager/clinician and to the Trust | Continuous| Hazard/Incident Report form | Internal audit
|                | Ensure attendance at mandatory training                                 | Annually  | Personal Development Plan  | Internal audit
|                |                                                                        |           |                           | External audit                 |

Appendix 6.2
<table>
<thead>
<tr>
<th>Directorate/departmental Managers (all areas)</th>
<th>Local risk assessment</th>
<th>Annually &amp; when changes in practice have been introduced</th>
<th>Risk Assessment Form available from appropriate specialist risk management team</th>
<th>Internal audit External audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritise risk identified</td>
<td>Annually &amp; when changes in practice have been introduced</td>
<td>Risk Prioritisation Index</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Local risk control plans based on risk assessment</td>
<td>Monthly review</td>
<td>Risk Management Action Plans</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Local written policies and procedures for key risk areas which communicated and understood by all staff</td>
<td>Reviewed annually</td>
<td>Trust policy and procedure format</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Report to Risk Management Team serious risks which are outside of the Directorate/Department's ability to controls</td>
<td>Annually &amp; when changes in practice have been introduced</td>
<td>Risk Management Highlight Report</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Clinical Areas (additional to Directorate/Departmental requirements)</td>
<td>Have a local policy and procedure for reporting clinical hazards/incidents and near misses to Clinical Director.</td>
<td>Review annually</td>
<td>Trust policy and procedure format</td>
<td>Internal audit External audit</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Take part in Clinical Audit</td>
<td>Monthly</td>
<td>Audit record</td>
<td>Internal audit External audit</td>
</tr>
<tr>
<td>Trust Policy: 94TD(G)6</td>
<td>RISK MANAGEMENT SYSTEM</td>
<td>Authorization Date: 4/7/00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>above)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prioritise clinical risk identified</td>
<td>Annually &amp; when changes in practice have been introduced</td>
<td>Risk Prioritisation Index</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Local written clinical protocols and guidelines for key risk areas which communicated and understood by all staff.</td>
<td>Reviewed annually</td>
<td>Care pathways or protocols/ guidance notes</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Report to Risk Management Team serious clinical risks which are outside of the Directorate/Department's ability to control</td>
<td>Annually &amp; when changes in practice have been introduced</td>
<td>Clinical Risk Management Highlight Report</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Provide patients with written information on risks and benefits of common elective treatments and procedures</td>
<td>Reviewed annually</td>
<td>Information leaflet</td>
<td>Internal audit External audit</td>
<td></td>
</tr>
<tr>
<td>Comply with Clinical Negligence Scheme Risk Management Standards</td>
<td>Reviewed annually</td>
<td>Standards Checklists available from Risk Manager.</td>
<td>EFQM Self-assessment. Internal audit External audit</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 6.5
<table>
<thead>
<tr>
<th>Specialist Risk Management Teams</th>
<th>Provide advice on assessment and management of risks.</th>
<th>Continuous</th>
<th>Audit record</th>
<th>Internal audit</th>
<th>External audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review policies and procedures to ensure that they are in line with good practice guidelines</td>
<td>Annually</td>
<td>Audit record</td>
<td>Internal audit</td>
<td>External audit</td>
<td></td>
</tr>
<tr>
<td>Audit compliance with policies and procedures</td>
<td>Annually</td>
<td>Audit record</td>
<td>Internal audit</td>
<td>External audit</td>
<td></td>
</tr>
<tr>
<td>Carryout risk assessment</td>
<td>Annually &amp; when changes in practice have been introduced</td>
<td>Risk Prioritisation Index</td>
<td>Internal audit</td>
<td>External audit</td>
<td></td>
</tr>
<tr>
<td>Report to Risk Management Team serious risks which are not being controlled adequately</td>
<td>Annually &amp; when changes in practice have been introduced</td>
<td>Clinical Risk Management Highlight Report</td>
<td>Internal audit</td>
<td>External audit</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust Risk Management Team</th>
<th>Coordinates all risk management activities of the Trust and assesses their effectiveness</th>
<th>Continuous</th>
<th>Corporate EFQM Self-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritises the risk portfolio of the Trust</td>
<td>Monthly</td>
<td>Risk Prioritisation Index</td>
<td>Internal audit</td>
</tr>
<tr>
<td>Report to the Trust Board serious risks which are not being controlled adequately</td>
<td>6 monthly</td>
<td>Trust Board Risk Management Highlight Report</td>
<td>Internal audit</td>
</tr>
</tbody>
</table>

Appendix 6.6
<table>
<thead>
<tr>
<th>Trust Policy: 94TD(G)6</th>
<th>RISK MANAGEMENT SYSTEM</th>
<th>Authorization Date: 4/7/00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develops for Trust Board approval the Trusts Risk Management Strategy and Policies.</td>
<td>Every three years and reviewed annually.</td>
<td>Policy and procedure formats</td>
</tr>
<tr>
<td>Report to the Trust Board serious risks which are not being controlled adequately</td>
<td>Annually &amp; when changes in practice have been introduced</td>
<td>Clinical Risk Management Highlight Report</td>
</tr>
<tr>
<td>Monitors actions that actions required by the Trust Board and Management Board are carried out by the Trusts responsible officers</td>
<td>Monthly</td>
<td>Risk Management Action Plan &amp; when changes in practice have been introduced</td>
</tr>
</tbody>
</table>

Appendix 6.7
<table>
<thead>
<tr>
<th>Trust Board</th>
<th>Signs off Controls Assurance Statement that risks are being adequately managed.</th>
<th>Annually</th>
<th>Controls Assurance Statement</th>
<th>External audit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Determines budgets to be applied to control the overall risk portfolio of the Trust</td>
<td>Monthly</td>
<td>Risk Prioritisation Index</td>
<td>Internal audit</td>
</tr>
<tr>
<td></td>
<td>Ensure that risk control measures agreed are carried out by its officers'</td>
<td>6 monthly</td>
<td>Trust Board Risk Management Highlight Report</td>
<td>Internal audit</td>
</tr>
<tr>
<td></td>
<td>Reports to Regional Office serious risks which are outside of the Trust's ability to control</td>
<td>Annually</td>
<td></td>
<td>External audit</td>
</tr>
</tbody>
</table>

Appendix 6.8
1.0 Salford Royal Hospitals NHS Risk Management System

1.1 The risk management system consists of processes and structures which help to identify risks, then ranks them in order of importance, evaluates the options for control of these risks and then ensures that agreed action is taken. Finally it evaluates how effectively the agreed control measures have been.

1.2 The risk management system is supported by the following key elements of the management structure:

   1.2.1 Trust Board and Chief Executive
   1.2.2 Risk Management Team
   1.2.3 Claims Management Team
   1.2.4 Specialist Risk Management Groups
   1.2.5 Directorate & Departmental Managers and Clinicians
<table>
<thead>
<tr>
<th>Trust Board</th>
<th>Corporate Risk Management Team</th>
<th>Complaints, Claims and Litigation Group</th>
<th>Specialist Risk Management Teams</th>
<th>Clinical Directorate and Departmental Management Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREES STRATEGIC PRIORITIES</td>
<td>RISK MANAGEMENT REPORT</td>
<td>COORDINATE RISK ANALYSIS &amp; AGREES PRIORITIES FOR ACTION &amp; COORDINATES ACTION</td>
<td>COMPLAINTS/CLAIMS &amp; LITIGATION ANALYSIS REPORTS</td>
<td>IDENTIFY LOCAL RISKS</td>
</tr>
<tr>
<td>PRIORITIES FOR ACTION LIST</td>
<td></td>
<td>DAMAGE LIMITATION &amp; CRITICAL LESSONS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ADVICE &amp; POLICY DEVELOPMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ACTION PLAN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IMPLEMENT CORRECTIVE ACTIONS</td>
</tr>
</tbody>
</table>

Appendix 6.10
2.0 Trust Board and Risk Management Steering Group

2.1 The overall responsibility for risk management lies with the Chief Executive and the Trust Board which co-ordinates its responsibilities through its Risk Management Steering Group which is a formal sub-committee of the Trust Board.

2.2 The members of the Trust Board Risk Management Steering Group are:

2.2.1 Chief Executive
2.2.2 Non-Executive Director
2.2.3 Director of Finance
2.2.4 Executive Medical Director
2.2.5 Risk Manager

2.3 This group receives assessments of how well significant risks are being controlled across the Trust as a whole and is able to help prioritize action sensitive to the balance of overall clinical, organisational and financial needs and circumstances faced by the Trust as a whole. They can bring resources to resolve unacceptably high risks faced by the Trust and can directly monitor how well risks are being managed on the Trust Board's behalf by its lead clinicians and operational manager.

2.4 The Trust Board receives once every six months a report on the status of the Trust's risk control measures together with recommendation for action which needs to be taken by the Board to ensure acceptable risk control measures are in place. The report uses the Risk Management Trust Board Highlight Report Form Appendix 1

2.5 Because within Salford Royal Hospitals clinical, organisational and financial risk management are integrated, the Board level responsibility for Controls Assurance is taken by the Chief Executive with Board level responsibility for clinical governance taken by the Executive Medical Director and Board level responsibility for financial controls being with the Director of Finance.

2.6 The key responsibilities of the Board and Chief Executive are to ensure:

2.6.1 There is a strategy for risk management and that the strategy is implemented.
2.6.2 Compliance with the requirements of legislation and other regulations.
2.6.3 Achievement of standards set for health and safety, clinical, organisational and financial controls.
2.7 Achievement of these responsibilities are assessed and reviewed under the following section of the EFQM Excellence Model:

<table>
<thead>
<tr>
<th>Approach</th>
<th>Deployment % Implemented</th>
<th>Measured effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Management Policy and Strategy</td>
<td>Percentage compliance with all: a) Risk Management Standards b) CNST Standards: Level 1 Level 2 Level 3 c) Health &amp; Safety Standards d) Standing Financial Instructions</td>
<td></td>
</tr>
</tbody>
</table>

3.0 The Risk Management Team

3.1 The Risks Management Team coordinates the identification of risks and any agreed action taken to deal with and reduce such risks across the Trust. It also develops the risk management system in line with the Trust’s strategy and the changing environment in which the Trust operates. The membership of the team is made up of core members and specialist members.

3.2 Core members attend all meetings and provide continuity and coordination between the whole portfolio of risks being managed by the Trust. Core Membership of the Risk Management Team is:

3.2.1 Risk Manager
3.2.2 Executive Medical Director
3.2.3 Management Accountant
3.2.4 General Manager - Surgical Services
3.2.5 General Manager - Medical Services
3.2.6 General Manager - Diagnostic and Therapeutic Services
3.2.7 General Manager - Facilities
3.2.8 University/Research & Development Liaison
3.2.9 Human Resources Manager
3.2.10 Training and Development Manager
3.2.11 Corporate Affairs Manager - Policies and Procedures
3.2.12 Trust Solicitors
3.2.13 Internal Audit
3.2.14 Professional Nursing Lead
3.2.15 Health & Safety

3.3 Specialist members provide expertise in a particular field of risk management and provide expert advice to the team on the best way to manage those particular areas of risk. Every six months each specialist team provides a risk management highlight report on risk within their specialism, using Specialist Risk Management Highlight Report form (Appendix 2) The specialists include the chairs of specialist risk management groups and people with particular areas of expertise.

3.3.1 Clinical Governance

3.3.1.2 Senior Midwife - Obstetrics and
3.3.1.3 Emergency Resuscitation Officer
3.3.1.4 Infection Control Officer
3.3.1.5 Clinical Director of A&E Major Incident Planning
3.3.1.6 Medical Equipment Committee Chair
3.3.1.7 Senior Pharmacist - Drugs and Medicinal Products
3.3.1.8 Blood Transfusion Committee

3.3.2 Organisational Controls

3.3.2.1 Health and Safety Adviser
3.3.2.2 Fire and Security Issues Adviser
3.3.2.3 Radiation Protection Adviser
3.3.2.4 Assistant General Manager Facilities - Building, Plant, Installed Services, Non-Medical Equipment
3.3.2.5 Catering Manager - Catering and Food Hygiene
3.3.2.6 Manual Handling Officer
3.3.2.7 Complaints Manager
3.3.2.8 Information Technology and Records Management
3.3.2.9 Senior Manager - Capital Projects

3.3.3 Financial Controls
3.3.1 Internal Auditor

3.4 Role of the Risk Management Team is to manage the risk management system on behalf of the Chief Executive in order to:

3.4.1 Coordinates all risk management activities of the Trust.

3.4.2 Ensures that standards for risk management and control and related legislation and regulations are brought to the attention of the responsible clinician/manager and through its specialist risk management audits compliance with these standards.

3.4.3 Standardises the Risk Priority Index using the Risk Priority Index form (Appendix 3) set by Specialist Risk Management Teams.

3.4.4 Assesses the whole risk portfolio of the Trust and recommends risk control priorities to the Trust Board and Management.

3.4.5 Evaluates risk control measures available to control agreed risk priorities and recommends the action to be taken by the Trust Board and Management Board.

3.4.6 Bring to the attention of the Chief Executive and responsible manager/clinician inadequately controlled risks identified via the risk management system.

3.4.7 Assures the Trust Board that risk control mechanisms are effective.

3.4.8 Ensure coordination between systems of insurance and claims management’s, complaints handling, litigation, hazard, occurrence and adverse incident reporting and managerial/clinical decision making.

3.4.9 Recommends key performance indicators related to risk management and controls assurance which should form part of the EFQM Self-assessment and review process. For the Risk Management the corporate indicator is:

Appendix 6.14
Key Performance Results – Key Performance Indicators (EFQM 9b)
(Key operational results which make it likely that key outcomes are achieved)

<table>
<thead>
<tr>
<th>Results</th>
<th>Trends</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of claims (number) against the Trust for clinical negligence.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Society Results – Performance Indicators (EFQM 8b)
(Internal measured used to give an indication of the perception of society of the organisation)

<table>
<thead>
<tr>
<th>Results</th>
<th>Trends</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Risk Priority Index of top ten risks facing the Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value of claims (number) against the Trust for Public Liability.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

People Results – Performance Indicators (EFQM 7b)
(Internal measured used to give an indication of the perception of people of the organisation)

<table>
<thead>
<tr>
<th>Results</th>
<th>Trends</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of claims (number) against the Trust for Employers Liability</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.0 Criteria for Reference to the Risk Management Team

4.1 Risks should be managed by the ward, department or directorate in which the risk arises. However, some risks cannot be effectively managed within a specific clinicians or managers span of control. In such cases those risks should be reported to the risk management team. The following risks should be reported to the Risk Management Team:

4.1.1 Any significant risk which cannot be managed within the Directorates own resources or budgets.

4.1.2 Any significant risks which cross more than one of the General Manager's/Executive Directors spans of control.

Appendix 6.15
4.1.3 Any risks control decisions to retain risks which could result in a breach of legislation, associated regulations or risk management standards.

4.1.4 Any risk control decision which may result in the transfer of that risk to another's clinical or management areas of responsibility.

4.1.5 Any significant risks whose control requires cooperation which cannot be gained from others at the operational level.

5.0 Claims and Litigation Management

5.1 Claims and litigation management is represented on the Risk Management Team by the Corporate Affairs Manager.

5.2 The Corporate Affairs Manager reports to the Executive Medical Director on claims and litigation management issues and specifically:

5.2.1. Develops and maintains a policy on handling of clinical negligence, personal injury and insurance claims against the Trust.

5.2.2. Ensures that procedures comply with standards set by NHS Litigation Authority.

5.2.3 Determines when legal advice, related to claims against the Trust should be sought.

5.2.4 Agrees settlements up to a specified figure determined by the Trust Board.

5.2.5 Reviews claims after closure and ensures, through the Risk Management Team, that preventative actions are taken and general lessons are learned and disseminated.

5.2.6 Maintains records and a database relating to claims and their outcomes.

5.2.7 Provides regular reports to the Risk Management Team on the number and aggregate value of claims, their progress and eventual outcome. For major claims this should be made within 3 months of notification, with updates every 3 months.

Appendix 6.16
on those in which proceedings have been served or in which settlement is expected within the next 12 months.

5.2.8 Ensures that the checklist in Annex C of EL(96)11 is complied with for all settlements likely to be between £1,000 and the Trust’s delegated upper settlement limit.

5.2.9 Notifies the NHS Litigation Authority of claims which have unusual and new features which if not correctly handled might set an unfortunate precedent for other NHS litigation or, which appear to represent a test case for potential class action.

5.3 If litigation for alleged negligence or failure to comply with statutory requirements is considered to be a possibility, this must be reported in writing to the Chief Executive. A register of potential litigation will be kept by the Corporate Affairs Manager.

5.4 Legal advice can be commissioned by the Corporate Affairs Manager or any Executive Director. In addition the Human Resources Manager and the Capital Development Director can commission legal advice within their area of responsibility.

5.5 The point of contact for solicitors and clients involved in litigation within the Trust will be the Corporate Affairs Manager who will:

5.5.1 Provide support for staff involved

5.5.2 Coordinate agreed action

5.5.3 Provide an analysis of the key learning points for the organization

5.5.4 Keep the Risk Manager informed of progress, issues and recommended action to avoid future incidents.

5.6 The Claim Manager can agree out of court settlements up to £20,000. The Chief Executive can agree out of court settlements between £20,001-£50,000. Out of court settlements above £50,001 requires Trust Board approval. All such payments must conform to Standing Financial Instructions.

5.7 All incidents related to Employer and Public Liability, Clinical Negligence and other potential losses must be reported to the Corporate Affairs Manager.
5.8 The Corporate Affairs Manager can, following an investigation of a complaint made by the public which involves a loss, make recommendations for settlement of:

Up to £99.99 Corporate Affairs Manager
£100 - £499 General Manager
£500 - £999 Exec Director
£1,000 - £10,000 Chief Exec of Director of Finance
Over £10,000 Trust Board.

All such payments must conform to Standing Financial Instructions.

5.9 The Corporate Affairs Manager will provide a six monthly report on themes and trends in financial losses to the Risk Management Team.

6.0 Specialist Risk Management Teams

6.1 Specialist Risk Management Teams comprise a membership of experts within a predefined field of risk management. The role of these teams is to ensure that:

6.1.1 A strategy and policies related to the management of predefined area of risks across the Trust are developed and maintained.

6.1.2 Formal risk assessments related to that area of risk is carried out across the Trust and prioritized using the Risk Priority Index (Appendix 3)

6.1.3 Advice on the management of specific risks is available to staff across the Trust.

6.1.4 Appropriate training is available to staff in the prevention and management of specified risks.

6.1.5 A set of key indicators related to the risk area is developed and maintained.

6.1.6 That auditing of compliance with policies on the management of the risk is carried out.

6.2 The following is a list of specialist risk management teams:

Appendix 6.18
6.2.1 Clinical Governance

6.2.1.1 Obstetrics and Gynaecology
6.2.1.2 Emergency Resuscitation
6.2.1.3 Infection Control
6.2.1.4 Major Incident Planning
6.2.1.5 Medical Equipment and Devices
6.2.1.6 Drugs and Medicinal Products

6.2.2 Organisational Controls

6.2.2.1 Health and Safety
6.2.2.2 COSSH
6.2.2.3 Fire and Security Issues Adviser
6.2.2.4 Radiation Protection
6.2.2.5 Building, Plant, Installed Services, Non-Medical Equipment
6.2.2.6 Catering and Food Hygiene
6.2.2.7 Manual Handling
6.2.2.8 Occupational Health
6.2.2.9 Complaints Management
6.2.2.10 Capital Projects

6.2.3 Financial Controls

6.2.3.1 Internal Audit

7.0 Directorates and Department Management Teams (All Areas)

7.1 All staff have a responsibility for the management of risks but managers and senior clinicians have specific responsibilities to:

7.1.1 Have a local written policy and procedures on the management of risks within that area and to ensure they are communicated and understood by staff.

7.1.2 Have plans to deal with non-routine, new work and serious risks such as fires, spillage, exposure to ionizing radiation, pathogens and genetically modified organisms.

Appendix 6.19
7.1.3 Have allocated responsibility for health and safety to specific people.

7.1.4 Have a health and safety plan with objectives which are specific, measurable, achievable, realistic and with target dates for completion.

7.1.5 Ensure that all employees are competent and have the necessary physical and mental abilities and facilities to do their job and that they have access to competent health and safety advice.

7.1.6 Assess the health and safety risks to staff and others and identify preventative and protective measures required by health and safety law.

7.1.7 Establish priorities using the Risk Prioritization Index (Appendix 3) for the management of identified risks within the resources available to deal with them.

7.1.8 Report serious risks which are beyond their ability to control to the Trust's Risk Management Team.

7.1.9 Ensure training and instruction on all aspects of health and safety appropriate to that area of work is provided on recruitment, and at periodic intervals following recruitment and whenever staff are exposed to a new or increased risk due to changes in responsibility, the environment or the introduction of changes in technology.

7.1.10 Consult with the health and safety adviser and specialist risk management teams to ensure that risks are being managed appropriately.

7.1.11 Have a recording system for injuries, ill health and other incidents with assessment of associated costs so as to be able to audit performance in the management of risks and compliance with health and safety regulations.

7.1.12 Ensure all staff attend mandatory training and maintain a record of that training.
7.2 Each department/directorate should include the following in their local EFQM Self-assessment:

<table>
<thead>
<tr>
<th>Policy and Strategy – based on present and future needs and expectations of stakeholders (EFQM 2a)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approach</strong></td>
</tr>
<tr>
<td>Local Risk Management Policy</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People – Knowledge and competencies identified, developed and sustained (EFQM 3b)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approach</strong></td>
</tr>
<tr>
<td>Mandatory Training</td>
</tr>
</tbody>
</table>

8.0 Directorates and Department Management Teams (Additional Requirement for Clinical Areas)

8.1 Clinical areas directly involved in the treatment of patients will need to comply with the standards set under the Clinical Negligence Scheme for Trusts and specifically will need to:

8.1.1 Have a policy and procedures for the reporting of clinical incidents and specific clinical occurrences.

8.1.2 Ensure that the policy is part of the induction training of all clinical staff.

8.1.3 Ensure all clinical staff attend a specific induction training appropriate to the specialty in which they work.

8.1.4 Carry out detailed investigations of all serious clinical incidents and take action to prevent recurrence as far as reasonably possible.

8.1.5 Provide patients with information on risks and benefits of common elective treatments.
8.1.6 Ensure consent forms comply with NHS Management Executive Guidelines for design and use.

8.1.7 Ensure consent for elective procedures is obtained by a doctor capable of performing the procedure.

8.1.8 Take part in regular clinical audit and develop methods for improving clinical practice.

8.1.9 Ensures entries in medical records follow best practice in the recording of information and are signed and dated correctly.

8.2 Each clinical department/directorate should include the following in their local EFQM Self-assessment:

<table>
<thead>
<tr>
<th>Approach</th>
<th>Deployment % Implemented</th>
<th>Measured effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Clinical Risk Management Policy</td>
<td></td>
<td>Percentage compliance with all:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) CNST Standards:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1</td>
</tr>
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<td></td>
<td>Level 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 3</td>
</tr>
</tbody>
</table>

9.0 Individual Staff Personal Responsibilities

9.1 Individual staff are personally required to make the management of risk part of their daily duties and to act responsibly by:

9.1.1 Taking action to protect themselves and others from risks.

9.1.2 Bringing to the attention of others the nature of the risks which they are taking in order to ensure that they are acting with informed consent.

9.1.3 Co-operating with others in the management of risks
9.1.4 Timely and comprehensive of hazard/incidents and accident reporting using the Hazard/Incident Reporting form (Appendix 4).

10.0 Hazard/Incidents and Accident Reporting.

10.1 All staff but especially managers and clinicians have a responsibility for reporting any observed risks to the manager/clinician responsible for the area in which the risk exists.

10.2 Incidents should be reported on an Hazard/Incident Reporting form (Appendix 4) as soon as possible following the incident or identification of the hazard. If the incident/hazard occurs elsewhere than in a department (ie hospital corridor, car park etc.) then the report should be completed by the nearest department or by the department to whom the incident/hazard was first reported.

10.3 The person completing the report should take time to examine the scene whilst contributing conditions still exist. Names and addresses of witnesses should be taken as well as a brief statement.

10.4 In case of serious incidents the scene should be preserved and equipment maintained until further examination by senior staff, or the police, have completed any necessary enquiries. If possible photographs should be taken of the relevant area.

10.5 The person completing the form should specify the immediate action taken to safeguard others and prevent recurrence.

10.6 The Hazard/Incident form should be completed as fully as possible and sent immediately to:

10.6.1 White copy to Health & Safety Advisor who will inform the necessary statutory bodies (eg Health and Safety Executive).

10.6.2 Pink copy to the Head of Department who will review that the corrective action taken has been effective.

10.6.3 Yellow copy is retained as the ward/departmental record for 10 years

Appendix 6.23
11.0 24 Hour Hot Line Reporting System

11.1 Serious incidents and hazards which cannot be managed locally should be reported using the Hazard/Incident Hot Line during normal working hours Bleep 3092 and at other times through the switchboard.

11.2 During normal working hours this will be staffed by the Health and Safety Manager. At all other times the call will be transferred to the Trust’s duty site coordinator.

11.3 The designated manager on receiving a Hot Line call will:

11.3.1 Check with the caller that it is a serious incident/hazard and that priority calls, if applicable, have already been made to:

Cardiac Arrest 2999
Fire 2999
Security 5555

11.3.2 Check that other appropriate immediate action has been taken.

11.3.3 Ensure that the adverse incident form has been completed and agree further corrective action with the person reporting the hazard/incident.

11.3.4 Bring to the attention of the appropriate manager responsible for the management of that risk.

11.4 The responsible manager will then take appropriate action, or delegate that action to the appropriate departmental head/manager/clinician, to minimize the hazard and reduce any further chance of the incident recurring.

11.5 The department head/manager/clinician responsible for the corrective action will report back to the Trust’s Risk Manager on what initial action has been taken within 24 hours. For serious incidents this initial action may involve the establishment of an inquiry team to investigate the incident. The Trust’s Risk Manager will agree any further central reporting on progress that may be required.

Appendix 6.24
11.6 If the incident/hazard relates to the malfunctioning of medical equipment or device then this should be preserved and not used until examined and released as safe by the Medical Physics department.

11.7 If the incident is reportable under RIDDOR to the Health and Safety Executive (HSE) this should be done by the Health and Safety Manager by telephoning 0161 952 8200 stating 'RIDDOR REPORT' and specifying 'National Health Service'. The HSE ask for brief details of incident. Staff incidents which become reportable because it resulted in an absence of more than 3 days need not be reported by telephone. However, all RIDDOR reportable incidents should be reported using F2508 which must be sent within 10 days to the HSE at:

H.M. Principal Inspector of Factories,
Health and Safety Executive
Quay House
Quay Street
Manchester
M3 3JB

11.8 The following should be informed by phone if serious incidents/hazards occur which involve:

11.8.1 Incidents which potentially have adverse effects or publicity on the Trust.
Chief Executive Office (5186)

11.8.2 RIDDOR incidents
Health and Safety Adviser (5677)

11.8.3 Malfunctioning of medical equipment or devices
Medical Equipment Maintenance Manager (4870)

11.8.4 Fire
Fire Officer (Ext 4230 or Bleep 5213)

11.8.5 Security including assaults and violence

Appendix 6.25
General Manager Facilities (5190)

11.8.6 Radiation
Radiation Protection Advisor (4878)

11.8.7 Food and food hygiene
Catering Manager (4440)

11.8.8 Drugs and medicinal products
Chief Pharmaceutical Officer (5219)

11.8.9 Infections
Control of Infection Officer (5034)

11.8.10 Buildings, plant and non-medical equipment.
Estates manager (4504)

11.8.11 Potentially involving litigation or claims.
Corporate Affairs Manager (4551)

11.9 A number of officers have special responsibility for reporting of adverse incidents and defective products and these should be notified according to procedures laid down in Health & Safety Policy No 2.

12.0 Confidential Clinical Occurrence Reporting:

12.1 The following clinical occurrence should be reported via a locally agreed confidential Clinical Occurrence Reporting system to the Clinical Director:

12.1.1 A significant error in diagnosis which in retrospect could have been avoided.

12.1.2 Incorrect interpretation of X-rays or other diagnostic images.

12.1.3 Unplanned return to surgery due to complications.

Appendix 6.26
12.1.4 Variation from prescribed medication/I.V. therapy causing or potentially causing ill effects/truma.

12.1.5 Variation from standard prescription of medical/I.V. therapy which led to ill effects.

12.1.6 Foreign body inadvertently left in situ

12.1.7 Equipment failure/misuse causing or potentially causing injury.

12.1.8 Tests/treatments carried out on the wrong patient or body part.

12.1.9 Hospital acquired infection

12.1.10 Other clinical incidents not pre-specified.

12.1.11 Specialty pre-specified clinical incidents.

12.2 The Clinical Director and team will analyze the data in search of 'Hot Spots' and common clinical practice errors. A review of this analysis will be carried out by a Directorate Clinical Management Team and appropriate corrective action agreed and implemented.

12.3 Local clinical risk assessments together with corrective actions implemented should be reported to the Executive Medical Director using the Clinical Risk Highlight Report form (Appendix 5) in order for Trust wide issues and recommended action to be considered as part of the Trust's overall risk portfolio.

13.0 Dealing with the media in a crisis

13.1 The detailed policy is given in the Corporate Communications Strategy Appendix 2 Media Relations in a Crisis.

14.0 Serious Incident Review

14.1 Some clinical and non clinical incidents will be of such a serious nature that an independent review of the incident and its management will be need to be carried out on behalf of the Chief Executive.
14.2 The following types of incidents are likely to initiate a Serious Incident Review:

14.2.1 Serious injury or harm to a member of staff, patient or other person could have occurred and systems to prevent such occurrence either do not exist or failed to function properly.

14.2.2 Breaches of duty of care or potentially negligent treatment or activity.

14.2.3 The Trust is likely to receive serious public criticism.

14.2.4 The event revealed a serious breach of the Trust's legal obligations.

14.2.5 The financial consequences could result in the Trust's inability to meet its financial obligations.

14.2.6 However, the final decision as to what constitutes a need for a Serious Incident Review will be that of the Chief Executive.

14.3 Serious Incident Reviews are carried out on behalf of the Chief Executive by a designated senior manager with the overall process coordinated by the Trust's Risk Manager. The aims of the review is to provide:

14.3.1 A detailed understanding of the factors leading to the serious incident,

14.3.2 An assessment of likelihood of the event occurring again,

14.3.3 An appraisal of the ways in which such incidents can be prevented in future,

14.3.4 A set of recommendation for Management Board action.

14.4 Within the Trust a number of key groups may identify the need for a Serious Incident Review at an early stage. Therefore, the following groups can make a request the Chief Executive for a Serious Incident Review:

Appendix 6.28
14.4.1 Trust Board,
14.4.2 Management Board,
14.4.3 Clinical Governance Committee
14.4.4 Audit Committee
14.4.5 Risk Management Team,
14.4.6 Executive Directors,
14.4.7 Clinical Directors
14.4.8 General Managers.

14.5 All requests for a Serious Incident Review should be via the Trust’s Risk Manager who will discuss all requests for Serious Incident Reviews with the Chief Executive. The Chief Executive will make the final decision whether or not a Serious Incident Review is warranted. Information gathered as the result of a Serious Incident Review may be made available to other organizations lawfully entitled to request information.

14.6 The scope of the Serious Incident Review and timetable will be agreed between the Risk Manager and the person with lead responsibility for the review. The methodology used in the review will be as determined by the review leader however they will ensure, as far as possible, that:

14.6.1 All those involved in the incident are given an opportunity to explain how the incident occurred and how it might be avoided in the future.

14.6.2 Formal risk analysis techniques, such as Risk Prioritisation Index, Failure Mode and Effect Analysis, Fault Tree Analysis etc, are used to determine the causes and degree of risk present.

14.6.3 An option appraisal is carried out on potential methods by which the risks could be controlled.

14.6.4 A set of recommended actions are developed out of the best options available.

14.7 Once the review is completed a Serious Incident Review Report will be presented to the Chief Executive for consideration. The report will comply with the Serious Incident Report Guidelines available from the Trust’s Risk Manager:

Appendix 6.29
14.8 Actions agreed by the Chief Executive will then be implemented by a designated manager and monitored via the Trust’s Risk Management System using the Risk Management Action Plan form (Appendix 6).

15.0 Learning from experience

15.1 The Risk Management Team will analyze failures in risk management. Lessons learned will be shared with appropriate staff.

15.2 Any organizational training needs identified will be reported to the Human Resources Director for action.

16.0 Independent Verification and Monitoring of Controls Assurance

16.1 Internal audit, supported as necessary by in-house specialist expertise in fields such as estates, facilities, health and safety, risk management and infection control, and by 'external' expertise from organisations such as the NHS Litigation Authority and NHS Estates, will be responsible for the verification of organisational controls assurance statements. It is envisaged that the Audit Commission will play a role in externally reviewing the arrangements in place for controls assurance and this will be explored during 2000/2001.

17.0 Conclusion

17.1 Risk management is a systematic approach to taking care of the welfare of staff, patients, visitors and the organization. It is the common thread through which the responsibilities of the Trust Board for Corporate Governance is assured through system for Clinical Governance, Organisational and Financial controls.
<table>
<thead>
<tr>
<th>Issue Status:</th>
<th>Risk Priority Index</th>
<th>Risk Summary</th>
<th>Controls Established</th>
<th>Area of Concern for the Trust Board</th>
<th>Recommended action to achieve satisfactory risk control</th>
<th>Chief Executive</th>
<th>Executive Responsible</th>
<th>Trust Board Report Back Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checked:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Salford Royal Hospitals NHS Trust**

**RISK MANAGEMENT TRUST BOARD HIGHLIGHT REPORT**

**Authorization Date: 4/7/00**
<table>
<thead>
<tr>
<th>Risk Priority Index</th>
<th>Risk Summary</th>
<th>Controls Established</th>
<th>Area of Concern for the Risk Management Team</th>
<th>Recommended action to achieve satisfactory risk control</th>
<th>Responsible Officer</th>
<th>Report Back Date</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Risk Prioritization Index</td>
<td>Risk Assessment Team:</td>
<td>Date:</td>
<td>Responsibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of Risk:</td>
<td>Control Measures Agreed</td>
<td>Target Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Criteria</td>
<td>Judgement Criteria</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>(A) Most Seriousness</td>
<td>Estimate based on research literature/litigation or adverse incidents recorded in the Trust</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Consequence</td>
<td>Estimate based on subjective judgement of expert panel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(B) Likelihood of most</td>
<td>Estimate based on research literature/litigation or adverse incidents recorded in the Trust</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Serious Consequence</td>
<td>Estimate based on subjective judgement of expert panel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(C) Ability to avoid</td>
<td>Estimate based on research literature/litigation or incidents recorded in the Trust</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>serious consequences by</td>
<td>Estimate based on subjective judgement of expert panel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>controlling incident</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>just prior to a critical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>event</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(E) Risk Score Possible</td>
<td>Estimate based on research literature/litigation or adverse incidents recorded in the Trust</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Maximum Loss = (A)x(B)x(C)</td>
<td>Estimate based on subjective judgement of expert panel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(F) Seriousness of most</td>
<td>Estimate based on research literature/litigation or adverse incidents recorded in the Trust</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>frequent consequence</td>
<td>Estimate based on subjective judgement of expert panel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(G) Likelihood of most</td>
<td>Estimate based on research literature/litigation or adverse incidents recorded in the Trust</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>frequent consequence</td>
<td>Estimate based on subjective judgement of expert panel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Trust Policy: 94TD(G)6</td>
<td>RISK MANAGEMENT SYSTEM</td>
<td>Authorization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(H) Ability to avoid most frequent consequences by controlling incident just prior to a critical event</td>
<td>Estimate based on research literature/litigation or incidents recorded in the Trust</td>
<td>Date: 4/7/00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Estimate based on subjective judgement of expert panel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(I) Risk Score Most Probable Loss = (F)x(G)x(H) =</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Score = ((E+1)/2000)x100 =</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions:**

Risk scores are made up of three key variables (1) Seriousness of the potential loss to the Trust, (2) the frequency which such a loss could be experienced by the Trust and (3) how likely it is that the loss could be prevented by action taken to control critical events just prior to the loss occurring. In addition to these variables the score needs to take account of the quality of the data which is being used to make such judgements. Where possible there should be supporting evidence for the judgement, for example, case law, incident reports in the Trust or held by the Clinical Negligence Scheme or Health and Safety Executive, research literature. Judgements based on this type of data is scored using the top line for each criteria. Where such data does not exist an expert panel can make the estimation but are restricted to using one of the three non shaded scores on the second line for each criteria.

**Score guide for seriousness of loss criteria**

<table>
<thead>
<tr>
<th>score</th>
<th>score</th>
<th>score</th>
<th>score</th>
<th>score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No loss</td>
<td>3 £10,000 - £25,000</td>
<td>6 £100,000 - £250,000 or professional body recommendation</td>
<td>9 £750,000 - £1,000,000 or serious criminal offence</td>
</tr>
<tr>
<td>1</td>
<td>£1 - £5,000</td>
<td>4 £25,000 - £50,000</td>
<td>7 £250,000 - £500,000 or enforcing agency recommendation</td>
<td>10 More than £1 million or imprisonable criminal offence</td>
</tr>
<tr>
<td>2</td>
<td>£5,000 - £10,000</td>
<td>5 £50,000 - £100,000</td>
<td>8 £500,000 - £750,000 or criminal offence</td>
<td></td>
</tr>
</tbody>
</table>
### Score guide for likelihood of loss criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>Likelihood of Loss</th>
<th>Score</th>
<th>Frequency</th>
<th>Score</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>once in more than 20 years</td>
<td>3</td>
<td>once every 5 years</td>
<td>6</td>
<td>once every 6 months</td>
</tr>
<tr>
<td>1</td>
<td>once every 20 years</td>
<td>4</td>
<td>once every 2 years</td>
<td>7</td>
<td>once every quarter</td>
</tr>
<tr>
<td>2</td>
<td>once every 10 years</td>
<td>5</td>
<td>once every year</td>
<td>8</td>
<td>once every month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td>once every week</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td>daily or more often</td>
</tr>
</tbody>
</table>

### Score guide for avoidability of loss by action taken to control critical events just prior to the loss occurring.

<table>
<thead>
<tr>
<th>Score</th>
<th>Avoidability</th>
<th>Score</th>
<th>Avoidability</th>
<th>Score</th>
<th>Avoidability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Always avoidable</td>
<td>3</td>
<td>70% avoidable</td>
<td>6</td>
<td>40% avoidable</td>
</tr>
<tr>
<td>1</td>
<td>90% avoidable</td>
<td>4</td>
<td>60% avoidable</td>
<td>7</td>
<td>30% avoidable</td>
</tr>
<tr>
<td>2</td>
<td>80% avoidable</td>
<td>5</td>
<td>50% avoidable</td>
<td>8</td>
<td>20% avoidable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td>10% avoidable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td>Not avoidable</td>
</tr>
</tbody>
</table>

In order to ensure that this risk is included in the Trust's total portfolio of risks a copy of the completed risk score should be sent to the Trust's Risk Manager, Trust Executive, 10th Floor, Worthington House, Hope Hospital Salford M6 8WH or email hstahr@hope.srht..nwest, nhs.uk

Copies are available on the Trust's Intranet
<table>
<thead>
<tr>
<th>1. Details of person involved in Incident</th>
<th>2. Category</th>
<th>3. Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name:</td>
<td>□ In-Patient □ Out-patient</td>
<td>Full Name:</td>
</tr>
<tr>
<td>Home Address:</td>
<td>□ Volunteer □ Contractor (resident)</td>
<td>Contact Address:</td>
</tr>
<tr>
<td>Post Code:</td>
<td>□ Visitor □ Contractor (visiting)</td>
<td></td>
</tr>
<tr>
<td>Tel:</td>
<td>Purpose of visit</td>
<td></td>
</tr>
<tr>
<td>Male/ Female* Date Of Birth:</td>
<td>□ Staff Post:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward/ dept.*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Location of Incident</th>
<th>5. Details of Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>□ Striking object</td>
</tr>
<tr>
<td>Time:</td>
<td>□ Struck by object</td>
</tr>
<tr>
<td>Exact location:</td>
<td>□ Exposure to harmful substance</td>
</tr>
<tr>
<td>Ward/ dept*:</td>
<td>□ Needlestick/ sharp object</td>
</tr>
<tr>
<td>Directorate:</td>
<td>□ Manual handling</td>
</tr>
</tbody>
</table>

Appendix 6.36
## RISK MANAGEMENT SYSTEM

### Details of Injury

<table>
<thead>
<tr>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruise</td>
</tr>
<tr>
<td>Swelling</td>
</tr>
<tr>
<td>Loss of consciousness</td>
</tr>
<tr>
<td>Sprain/ strain</td>
</tr>
<tr>
<td>Internal injury</td>
</tr>
<tr>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>

| Laceration |
| Abrasion |
| Skin puncture |
| Burn/ scald |
| Fracture/ dislocation |

| Part of body (please specify) |

### Details of treatment

<table>
<thead>
<tr>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>First aid</td>
</tr>
<tr>
<td>A&amp;E</td>
</tr>
<tr>
<td>Occupational health</td>
</tr>
<tr>
<td>Admitted to hospital</td>
</tr>
<tr>
<td>Advised to see own GP</td>
</tr>
<tr>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>

| Seen by Doctor |

### Absence

<table>
<thead>
<tr>
<th>None</th>
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</thead>
<tbody>
<tr>
<td>Likely to be less than 3 days</td>
</tr>
<tr>
<td>Likely to be more than 3 days</td>
</tr>
<tr>
<td>Not yet known</td>
</tr>
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</table>

| Hours expected to work |
| Hours actually worked |

### Details of occurrence

### Action taken to prevent recurrence:

---

Appendix 6.37
<table>
<thead>
<tr>
<th>Processed</th>
<th>Legal external</th>
<th>Internal investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received by:</td>
<td>Phone HSE: yes/no*</td>
<td>Copy to:</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
<td>1.</td>
</tr>
<tr>
<td>Entered by:</td>
<td>Form F2508: yes/no*</td>
<td>2.</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
<td>3.</td>
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</table>

Appendix 6.38
<table>
<thead>
<tr>
<th>Risk Priority Index</th>
<th>Risk Summary</th>
<th>Controls Established</th>
<th>Area of Concern for the Risk Management Team</th>
<th>Recommended action to achieve satisfactory risk control</th>
<th>Responsible Officer</th>
<th>Report Back Date</th>
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Appendix 6.39
<table>
<thead>
<tr>
<th>Risk Priority Index</th>
<th>Risk Summary</th>
<th>Action agreed (date)/ Target completion date/ Responsible Officer</th>
<th>Check Date</th>
<th>Progress/Comments</th>
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</thead>
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Trust Policy: 94TD(G)6
RISK MANAGEMENT SYSTEM
Authorization Date: 4/7/00

Insert Clinical/Organisational/Financial
Page 1 of 1

Appendix 6.40
Risk Management and Controls Assurance

1.0 Introduction

1.1 The United Kingdom National Health Service is one of the largest and most complex organisations in the world. It employs about one million people and deals with about 14 million patient attendances in its accidents and emergency departments, 34 million in its outpatient departments and 8.6 million in its in-patients acute hospital facilities. Twenty four hours a day the service is dealing with vulnerable people. Concerned relatives and friends swell the numbers of people flowing through its doors. Healthcare activities require staff with high levels of skills because of the complexity of the procedures involved in treating and caring for people. In support of these activities there is sophisticated equipment and a large, complex physical infrastructure. Such a large scale complex activity has large risks associated with it.

2.0 Cost of Failure to Manage Risks Effectively in the NHS

2.1 There are over 5000 new claims for compensation against the NHS for clinical negligence each year resulting in about £200,000,000 per year paid out in compensation. In addition, legal fees can add another 20% to these costs.

2.2 The National Audit Office has estimated that there are over 1,000,000 injury accidents within the health service per year with an immediate cost of around £12,000,000. A further £54,000,000 is paid out to NHS staff because of early retirement due to occupational ill health.

2.3 The Audit Commission reports that detected fraud rose from £1.4 million in 1996/97 to £2.6 million in 1997/98. However, this is only the small proportion of detected fraud the real level of fraud is likely to be much higher. The biggest area of fraud is thought to be prescription fraud which is estimated to be in the region of £150 million per year.

2.4 These financial losses hide the pain and suffering of thousands of people directly affected by these losses as well as the anxiety and extra work created for clinicians and managers who have to manage the consequences of these failures of risk management. In addition, officers of the Trust are open to fines and imprisonment for breaches of the Health & Safety at Work Act and other related legislation.
3.0 Corporate Governance

3.1 Corporate governance is the system through which an organisation is directed and controlled in order to ensure that its activities are economically, efficiently and effectively managed and that the risks it is facing are properly assessed and controlled.

3.2 The importance of effective corporate governance was highlighted when in the early 1990's a series of serious failings in financial control, in a number of major private sector companies led to the establishment of the Cadbury Committee. The Cadbury Code (1992) identified three fundamental requirements of good corporate governance:

3.2.1 Internal financial controls
3.2.2 Effective and efficient operations
3.2.3 Compliance with applicable laws and regulations

4.0 Controls Assurance

4.1 The Greenbury and Hampel Committees developed the 'Cadbury Code' further and consolidated their findings into one 'Combined Code of Principles of Good Governance' published by the London Stock Exchange. The key requirement of these principles is that "...the board should maintain a sound system of internal control to safeguard shareholders' investment and the company's assets" and that "the directors should, at least annually, conduct a review of the effectiveness of the group's system of internal control and should report to the shareholders that they have done so.

4.2 Controls assurance review should cover all controls, including financial, operational, compliance and risk management controls. The Turnbull Committee (1999) makes reviewing the effectiveness of internal control the responsibility of the board having regard to any information provided by the audit committee, or any other board committees.

4.3 The essential features of an effective board is that there is a balance of power between executive and non-executive directors; effective systems of monitoring and controlling the activities of the organisation, effective systems for managing risk and uncertainty and accurate information and statements on the financial status of the organisation verified through independent audit. Company directors on the Board of private companies are responsible for corporate governance and they achieve this through setting a company strategy, implementation of this strategy through effective leadership and ensuring that management carries out their delegated duties in line with the requirements of the Board. The shareholders appoint the board and receive reports from the board that they are controlling their company.

Appendix 6.42
appropriate. In addition the shareholders appoint auditors to verify that appropriate controls are in place and are effective.

4.4 Though the concept and key principles of controls assurance were developed to deal with specific failures in control within the private sector, the NHS has agreed that these good practice guidelines apply equally to the NHS. The NHS has therefore, embraced the principles of good governance. For the National Health Service, corporate governance is achieved in a similar way to that of the private sector with Parliament acting as the shareholder and the chief executive of the NHS Executive having overall responsibility for ensuring that the NHS keeps proper accounts and is prudent, economic, effective and efficient in the use of NHS resources. The NHS chief executive is supported in this role as accountable officer by local accountable officers, the chief executives of Trusts and Health Authorities.

4.5 Clearly, an effective controls assurance system will save resources for use in providing direct patient care but the most important reason for an effective controls assurance is a moral one. The NHS is there to provide a public service which prevent unnecessary ill health, suffering and wasted resources which are the result of poor clinical and non-clinical practices.

5.0 The New NHS: modern, dependable

5.1 The government’s White Paper ‘The New NHS: modern, dependable sets out a ten year vision for ensuring that the focus of all activity within the NHS is on the delivery of continually improving treatment and care for patients. This vision will be achieved by building on the historic NHS principles of access based on need alone and not on ability to pay, or the area in which the patient lives. Quality will be assured through a new statutory duty for quality which will compliment the duty for effective financial management. Three key and interrelated mechanisms: Clinical Governance, Organisational Controls and Financial Controls, will provide the means of achieving good corporate governance of the NHS.

5.0 Clinical Governance

5.1 Healthcare professionals have always been and will continue to be responsible for ensuring high standards of clinical practice and the management of clinical risks associated with that practice. However, chief executives now have a statutory responsibilities for ensuring that all healthcare professionals achieve the quality of clinical treatment and care which is expected of them. The key mechanism by which chief executives
Clinical governance is defined as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (HSC(99)065).

A senior health professional at board level must be appointed as the person responsible for ensuring proper processes which ensure high quality care and these will include:

5.3.1 Clinical risk assessment and management.
5.3.2 Evidence based practice.
5.3.3 Involvement of all clinicians in clinical audit and continuing professional development.
5.3.4 Using high quality data to monitor clinical care.

6.0 Organisational Controls

6.1 Clinical excellence cannot flourish unless the environment in which that treatment and care is provided is also excellent. The boundary between clinical and organisational controls is blurred. For example, some aspects of medical device management, radiation protection and infection control clearly fall under the direct responsibility of individual clinicians, while others aspects are the responsibility of the organisation as a whole. However, there are many other aspects of care of patients, staff and visitors which are not directly clinical but which if not managed well will affect their wellbeing. These areas include:

6.1.1 Health & Safety
6.1.2 Manual Handling
6.1.3 Fire and Security
6.1.4 Catering and Food Hygiene
6.1.5 Building, Plant, Installed Services and non-medical equipment

6.2 Many of the organisational control requirements are imposed by civil and criminal law on individuals and organisations. Failure to comply can result in fines and/or imprisonment.

6.3 Organisations must be able to show that they have done their "reasonable best" to manage themselves so as to protect patients, staff, the public and other stakeholders against risks covered by their activities.
6.4 The basic requirements of organisational controls is that there is evidence of regular risk assessments being carried out. That risks identified are prioritised and that reasonable steps have been taken to effectively control them.

7.0 **Financial Controls**

7.1 For financial matters chief executives must sign a statement in the annual accounts outlining their responsibility as accountable officers and that they assure that the accounts have been properly prepared under principles and rules directed by the Secretary of State with the approval of the Treasury. They must also sign a statement of assurance that the systems of internal control as laid down in NHS Executive circulars and should address issues of risk management.

7.2 Standing orders describe how business is conducted, including board membership and voting rights, delegated powers, rules on declaration of interest such as directorships and conflicts of interest, rules on tendering and contracting. These fulfil the dual role of protecting the Trust and Health Authority and the staff from possible accusations that they have not acted properly.

7.3 Standing financial instructions identify the financial responsibility of everyone working for the health authority and includes financial management and audit, negotiation of contracts, non-pay expenditure, information technology and data protection and payments to independent contractors.

8.0 **A Model for Corporate Governance in the NHS**

8.1 Clinical Governance focuses on ensuring appropriate standards of clinical treatment and care are delivered. Organisational controls focus on ensuring that the total environment of care supports and enhances clinical care while at the same time is safe for staff, patients and visitors. Financial controls focus on ensuring that healthcare resources are used appropriately to provide the services required by the NHS.
8.2 Clinical governance, organisational controls and financial controls, when integrated and effectively carried out, fulfil the requirements of effective Corporate Governance of the NHS required by Parliament (fig 1).

9.0 Risk Management

9.1 The 'common thread' running within each elements of the Corporate Governance framework is risk management. Risk management is defined as "the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects" (Australia/New Zealand Standard 4360:1999 Risk management). The Australian Model of risk management (fig 2), outlined below, contains the key elements of a good risk management system. This together with a national NHS risk management standards and assessment criteria will be used to assess the degree of compliance of all NHS organisations with the requirements of NHS Controls Assurance.

Appendix 6.46
9.2 The effectiveness with which risks are managed within the Trust is assessed as a key component of the European Foundation for Quality Management (EFQM) Excellence Model so as to ensure that risk management is fully integrated into all aspects of the Trust's activities.
Appendix 7

ACTION LEARNING SET

Present: Hazel, Henry, and Gerald
Date: December 1998

Hazel The purpose today is for us to look back and reflect on how we feel that the action learning model has been appropriate to our own research.

Whether it has helped us to develop further or how it has influenced our research. If we go back to the beginning of the set in its early development and perhaps if we do some historical development as we perceive it and see if we’ve got similar perceptions of what was happening. At the start there were originally 5 members. I think that is an appropriate place to start.

Gerald I think sharing what our initial perceptions were will be useful. My feelings were an element of philosophy as well as an element of activity and that differentiates Action Learning and Action Learning PhD from conventional PhD so that even if nothing else, that before I walked into the Set, I had different expectations and one of these expectations was that Action Learning was an easier route to getting a PhD and it was quite ambiguous as it turned out to be, but there was a lot more freedom so there was a lot less academic constraints. People weren’t saying ‘you must do this or you must do that.’ It was actually quite difficult, quite painful at times, but it was difficult and I wondered if anybody else felt that they had expectations going down the Action Learning route as against going down the conventional PhD route.

Henry Really, right from the beginning I confused Action Learning with Action Research and I assume Action Research to be the heart of my research because it had to be done in the field of practical use immediately and so I saw the Action Learning element as being a support group, a group that could reflect aspects of Action Research on it and get the support of colleagues that that process whereas a conventional PhD route meant that I would have acted in isolation of anyone other than the Supervisor and so my attraction was working with a group of people who could support me through Action
Research. That is how I saw it at the time.

Gerald

Was it difficult to convert in your mind from Action Research to Action Learning?

Henry

It took quite a long time to do that and in fact it really developed as I developed the methodology and tried to understand the Action Learning element of my work. One of the things I learnt was that Action Learning itself was a way of gaining knowledge, about how the different elements of research came together as a whole.

Gerald

How does that experience fit in with your experience Hazel?

Hazel

I was looking for something completely different because I think it’s fair to say Henry was driven by the research primarily. The tasks that you had to complete (Henry agreed) and I think it was at a particular point in my life where because I’d experienced Action Learning and found that to be such a powerful personal development that I wanted to continue, so I almost thought that this PhD was a continuation of what I had done at Masters’ level. (In terms of my own personal development,) and the research came somewhere in there and I’ve had to adjust considerably and had to become much more task-focused as the time has gone on. Because that was really just an almost very flippant approach to what I was doing at this level and I think that it was just a reflection of the stage I had got. So, when I joined the Set originally, I was at a loss because I assumed that we would be all at a similar level in terms of Action (in our understanding of Action Learning and in our experience) and that we would then continue with the Action Learning being the uppermost focus of everyone, and when we came together we had such very different backgrounds and experiences and expectations. I don’t think that we shared those I think we stumbled across them accidentally from time to time when we perhaps found a lack of shared understanding about what we were discussing and it was almost a blockage to some extent as far as my understanding initially. I think somewhere in between your stance and my stance might have made something a bit more appropriate.

Gerald

I found, like you I came from an Action Learning background. I can actually detask myself because I’ve been running a MDA Programme which is a very task orientated degree and so I had to get out of the model of this traditional, academic, rigorous, conventional, scholarly conservative activity. I found that as a group we were all expecting

Appendix 7.2
something different in terms of how much we were going to have to do with each other, and so my background in Action Learning meant you shared everything with your Action Learning Set where as I think other people's background said 'No, we're not too sure that Action Learning Sets do, but one thing we're sure about is we don't want to share that, and my feeling was that in the early days it was almost a Tutorial as against an Action Learning Set that weren't being facilitated because we were making demands on the Academic present to tutor us and so there was a bit of resistance. Some people said ‘Oh that's really good let me make lots of notes, and some of us were saying 'No, this is not what we really want.”

Henry

I think that reflects the two extreme positions of perhaps me and Hazel that if you come into an Action Learning Set and expect to achieve a task then in a sense you are looking for people to help you to choose the task and if there is someone in the room who can ask the right questions from the right direction or challenge your views in such a way that you find new things to do then it’s quite different than if you are coming into the Set to develop an individual, and it really was only about half way through the three year period that I realised that Action Learning was about personal development not simply achieving the task and that took quite a while. I think the problem for a lot of people in the Set, some people were looking for the learning element and other people were looking for an achievable task and because we were looking in entirely different areas it appeared there was something wrong with the Set in a sense that it wasn’t taking us through where we expected to go because in fact we were in different directions not purely because of our initial expectations of the Set or of the approach.

Gerald

I totally agree with that. I wonder though how much the three of us left in the Set have exploited the freedom. Speaking personally I exploited because I approached this saying I wanted to do some unconventional research so it did not sit comfortably with a conventional research background not having a director of study telling me what to do. I found that the Action Learning Set, when it worked was tremendously powerful. I could bring questions in and say what do you think of this? and when it worked it worked very well and I went out with a great deal of clarity and I felt good about what had gone on. It didn’t always work of course, but I was conscious of the fact that as I think for myself and I suspect for you two as well you would have found it far more difficult to do the research you wanted to do if you had gone down the conventional route, if you’d gone and got an expert on x or y to supervise you.

Appendix 7.3
Hazel  I don’t think it would have been possible for me to explore the areas that I’ve explored following a conventional route. One thing I didn’t want were doors closing. So I found that the freedom offered of this approach has been extremely beneficial. Now as the day of judgement approaches I’m a little bit worried that that freedom might have been not necessarily so advantageous but that’s probably just the stage that I’m at.

Gerald. That’s one of the prices of action learning in as much as at no point have we had somebody in authority take us by that hand and say, in a parental way, ‘That’s good enough’ or ‘That’s not good enough’ or we should do it this way or that way, which has led us all on occasions to being quite vulnerable.

Hazel Yes, I would agree.

Henry I feel because of the treatment, because of different approaches, and different ways of exploring, that in fact we get a broader, more realistic picture of the situation and that’s even more clear in terms of the person involved. I think, on reflection, going back or doing it the traditional way would have meant a) would have poorer b) that it would have been simpler but the result in the task of research, the quality of research, it probably wouldn’t be practical in reality. c) I think I’ve developed an understanding of what knowledge is, and what research is. That really is the key advantage. The difficulty is that without that structure we feel more vulnerable about succeeding.

Gerald If it makes it high risk it also makes it more fun, so you get more high’s and more low’s. What I’ve thought more and more is as the process has gone on is that what I’m interested in researching into has driven the way I’ve researched it, and I have a sneaky feeling if we’d gone down the more conventional route we would have said ‘This is the conventional way that academics research this level. We would tailor and modify our research to fit into the methodology’ Because very often a PhD is seen as a qualification to say you’re a researcher and the thing that we all have in common is we want to address issues and so I can’t plan exactly the right way to do it, in the methodology books, so I bring it to the Action Learning Set and say this, this and this everybody say no to this or yes to that, so suddenly we’ve got the core of the research driving the way we’re researching it. Which I think is immensely powerful and having gone through two years of muddled PhD where I’ve been driven, very much more conventionally. “Go away and read those 10 books and then I’ll test you,” where it was a radical thing for John Morris to say ‘Don’t read

Appendix 7.4
yet just think, just find out, don’t read at the moment. And that is just reinforcing what your saying, that personal learning and the task go very much hand in hand. I suppose the other thing that might be worth mentioning is the concern we’ve got that when we submit this piece of work is it too ‘touchy-feeling,’ because all of use have this feeling that PhD should be x or y and our PhD’s are going to be a & b

Henry

A small part of my research will be touchy-feely’ but because of the nature of the research there will be plenty of non’-touchy feeling bits as well to get the data. There are elements for the conventional type of research but refined, if you want, or elaborated on, with the touchy-feeling bits I’ve tried to combine the two together rather than be one or the other. I’ve to find where it’s appropriate to get the hard data, facts as they appear that are there, but there’s all the rest of it as well. I don’t maintain special objectivity for everything, as I would have done. I would have produced a piece of research that would have claimed to be objective and I would have claimed to maintain some sort of disembodied precedence, but I don’t, I recognize that my subjective influence on what is clearly the objective truth but I haven’t excluded objective measures, I’ve just been honest about it. Where I think many researchers, conventionally, would not have been honest about it. Where as I think in conventional research you would have claimed, almost by default, what they are saying is an objective reality.

Hazel

I found that as the research developed that my research has been more rigorous than probably it would have been, had it gone down a conventional route, because I felt it necessary to justify what I was doing. Perhaps because of the fear that it may be not conform to what I had in mind. So, I found that I thought much deeper about what I was doing than I would have done otherwise. Because I think if I had a prescription, a Proforma that I was just going to follow, I would never have even considered any other option. Or even the most powerful thing I think about the Set is that, the ability of somebody just to ask a very simple question so simple, so basic, that I’d never even considered it. That is the most challenging part of following research in this way.

Gerald

If any of us had to talk to somebody who was thinking about doing a PhD and they said ‘Well you’ve gone down this route, what would you pick up as being the key elements of the type of research you’d done that was very significant, and influential in what you’d done. What would we sell if we were trying to sell this centre.

Appendix 7.5
Hazel I think I'd say that the depth of research, the quality of research that I've been able to carry out.

Henry I think it's significantly higher, than conventional PhD's it's the quality of support I've been offered by the set, and the challenges enable you to go beyond the boundaries of conventional routes.

Gerald I agree with both of you. I'd add on to it that what it's allowed me to do, and feel a little more legitimate about it, has been to find out things which are not necessarily measurable, not necessarily provable and not necessarily replicable, and that to me was what academic research should do. Measure and prove what we say is so, and replicate it. Now, as social scientists, we know that's not reality but nevertheless in the back of our minds because we've gone through the system we all know that was something we should be able to do. The set has said, 'if there's something that's not measurable, talk about it, learn about it, but if you can't measure it, it's still valid; If you can't prove it, it's still valid. And that's been tremendous. It's left me feeling very insecure because I now look back and say, 'I've done all this research, and it's been a lot of years, I can't prove it, measure it. I can't say x is better than y. I can just say I did x, and that's what happened. That's a very significant thing to me. But you need a certain academic maturity I guess. It's quite uncomfortable at times but we've all seen it in each other that I ought to perhaps revert back to classical research methodology, just in case, because it's safer.

Henry From my experience, I no longer feel that the classical way of doing things is rigorous, is reliable, is really replicable, because I think that the things we're dealing with can't be dealt with in that way. It's a myth that's been created within academia that there's such a thing as absolutely, rigorous, valid proof for anything and I think that having had this experience that I've lost any belief in that even though I was searching for it at the beginning. I think there's degrees of understanding which further our knowledge. There are lessons to be learned and I'm not sure that there's anything we can record as truth in its absolute sense.

Hazel No it's security to be able to see our world so simply, isn't it? But I think what we've done is to look at the complexity of the reality. Once we started to look at the various facets and then start to think about our personal perceptions influencing these it then became very difficult to try to analyse what was happening with any clarity, certainty, consistency and coherence. So, if you're not careful, you
can get stalled and I think this is where the set is so valuable because it stops us getting lost in those labyrinths of reflection.

Gerald

I’ve been trying to find an analogy in my own mind, and there’s always a danger with analogies that you’ll take them too far. What I’ve come up with is that we’re all drivers and we’ve all got Instruction Manuals for our cars which tell us to check this or that, once per week, month, etc. Put this dipstick in, which is very much the positivist thing to do, to measure the height of the oil. If you’re going on a long journey, instinctively from our knowledge and our learning over the years we know that we’d check the oil and we know even if there’s enough oil, measurably, it may not be good quality. So it seems to me that we went from being positivists when we were first learning to drive, when we were changing gear we thought about changing gear. Now we don’t, which doesn’t make us poorer drivers, we are now using instinct and that seems to me to be something of an analogy between what classical academia says and (use the dipstick and put measurements on) as against what we’re doing. We’re saying, ‘Right, we’ve got a long journey ahead of us, we need to put the oil here, or empty the ashtray there’. To me that was the analogy I had to come up with so I could understand what was going on.

Hazel

I saw myself as a helicopter. The helicopter going down, touching base from time to time, and then I could look down to see what was happening, so that kind of free movement. Whereas, if you’re in a traditional programme you’d be constantly in that helicopter and never touching base at all so you seize up’.

Henry

I must admit I found the set didn’t actually do what I expected with the research and that once I understood a lot more about action learning and that the set was meant to be a group of people in adversity learning together. I expected the set to help, challenge and provide some sort of verification of the learning that was taking place in the research I was doing. That didn’t work out because the place that I managed to find that was with the other people I was working with the other “set”, who were actually doing the risk management with the trust, and that was where the learning, the verification, the development of new ideas, and so on, actually took place, and that was that I was expecting the set to do, but that didn’t work. But what the set did was to give me more of the Meta analysis of the overall approach that I was doing. In effect there were two sets of sets. There was a set of sets at work dealing with various aspects of risk management, comrades in adversity trying to get the trust to develop a way of managing this and we learned together what risk management was. We learnt what worked, and the standard nature of the reality,
what we could do, and couldn't do, and set up conceptual models of
that, and so on. But what they couldn't do was to check that the
learning, the approach, the philosophical basis, was right. And that’s
what I found the set was useful for.

Hazel

I like the idea of the meta analysis. I think that’s a super concept.

Gerald

I agree. I think that Hazel and I did that with each other. At one time I
think that we were perhaps a learning pair as opposed to a learning set.
At one time you were using your other resources heavily, the other
two were fairly isolated and I’m thinking about the conversion from
MPhil!PhD. Suddenly there was ‘them’ and ‘us’ and a lot of hostility
around. You and I, Hazel, we were talking, were bouncing ideas off
each other a lot. And all of us, because we’re adults because we have a
network, and that network includes people we trust, we all dip into our
own networks as well. I suppose if we’ve answered the question of
how we sell it, what would be the ‘down-side’, what would we say. I
wish we’d done this, or perhaps it hasn’t achieved that.’

Hazel

But before we go on to that, may I just ask, because we’ve all talked
about personal development, and one thing we haven’t mentioned is
“personal development” because presumably this is something we’d
want to sell on. Do you feel you have achieved personal development,
as opposed to intellectual development? Something that’s transferable
to all aspects of your life.

Henry

I find it difficult to separate intellectual and personal development. I
don’t think the two can be separated, so I have to combine the two.
I’m not sure, in a 3 year process, has changed me in a way that I’m
more.... I’ve got a better understanding of the nature of the reality of
which I’m developing: I’m developing skills and competence in that.
I’m not sure of how it has changed me as a person, as a human being,
and I’m not sure that I would have expected it to have done very much
of that because I don’t think I’ve changed because my reality has not
changed in any way. I’m still married, I’ve still got the same sorts of
problems, the same level of confidence, same sorts of ambitions, same
sorts of comfort with myself I didn’t come thinking I was not coping
in some areas, or tensions, some aspect of my [personality has
changed so that I’m better off in that sense. If you combine that with
my ability to think around things, which is still part of me, I think I’m
better able to think about things and I’m more sensitive about other
people. I think I couldn’t say it’s just this set, because of the rest of the
sets I’ve been working with at work. But being in a situation where

Appendix 7.8
I've had to drive things through and deal with crises, and so on, that ability to reflect that I am more sensitive. I have noticed I think much more carefully.

Hazel

I don't know whether it's the point I'm at with writing up because I'm still trying to come to terms with what things actually mean. I'm questioning now what I thought was reality and absolute truth, that it isn't as easy to understand the world in which we operate, it is so complex. If you remember, my research is examining the nature of the relationship between the change manager and the change project. In terms of what I think I understand about organisational development, I have now an entirely different perspective of what organisational life is all about, and how we seek to influence it, and so on. What has been impressed upon me is how little I actually know, and how little I'm capable of I don't know whether that's personal development, or personal regression. It's a reflection of my writing at the moment, which is very introverted.

Gerald

It's very difficult for me because two significant things have happened which have nothing to do with this process. I don't know how much those 2 significant events have impacted upon me, or how much is the learning. Becoming a parent and becoming disabled have been 2 significant factors. Now I am different to what I was 3 years ago because I don't feel such a need to provide evidence for the research that I'm doing on the way we ought to behave, and an alternative way of behaving in groups. I suppose 3 years ago I would have been saying, 'I'm teaching about Belbin, but I'm not convinced it's the best way, but everyone else is convinced about this so I feel quite defensive, it's like bringing a ham to a Barmitzva, not too sure.' Now I feel, I've done a lot of research on this dance card business, and if people want to go down the Belbin route, 'fine', or D/C, 'fine', but I've now done enough research, I've had enough feedback to say, 'It does work on certain occasions.' If you want to use it, that's fine with me. I think I'm much more mellow than I was 3 years ago. I would never research this subject under a conventional environment, that's why I'm so pro-the Revans Centre. I would have done a conventional PhD. It's a much easier route. It's far easier to be told what to do and have some measurement. I'm now 5/8 of the way through, finished', where really and truly, we don't know where we are, it's not incremental, so what, it doesn't really matter, we feel that we're moving along, so what, we're getting towards an end where we feel it's right, as opposed to know it's right, so what? I've had significant changes and I've enjoyed it.

Appendix 7.9
Hazel  So, how would we sell ‘personal development’? Would we actually sell 'personal development’?

Henry  I wouldn’t. I think it’s probably over sold, that some people come to Action Learning for personal development per se. I came into it as a means of helping me, with personal development a part of that. It was more than about personal development - about developing new vision, new skills, new ways of working. Some people say Action Learning has made them a better person. I must admit that I did psychiatry many years ago, so I’ve done all my personal development, had all my deep insights many years ago. I’ve got very good insights into what I’m like. I’ve got the badge! As part of a package, that’s fine but it shouldn’t be over-sold.

Gerald  Could I just re-frame that? I think your point about the development being a part of your education is a valid one. But it seems to me that my personal development over the 3 years is that I would use this approach to learning about lots of other subjects. Now if I want to try and understand and learn about a subject, I won’t necessarily say the only way to do it is to go to a book. The only way to do it is to go to an author who is recognised as being an expert as being “right. I don’t think of it as being therapy, or feel a more whole human being, or anything like that, I think the Action Learning element of it has said you can apply this idea of living and sharing and discussing with other people who are interested, and not just to look at risk analysis or O/D, it may be quite a useful way of understanding the world in a whole range of things. Now I think that’s what Action Learning is about - not about making great friendships, or bonding. I think there was some resistance from our colleagues earlier, because they did not understand what Action Learning was about. It was like another methodology for research. Action Learning doesn’t need to be labelled. It is an efficient way of operating. that is development whether professional, intellectual, academic, I don’t know....

Hazel  I’m glad you both mentioned “therapy” because I think that was one issue connected with our other two colleagues who may have been using the research for personal therapy perhaps, and that governed their interaction within the set. It’s quite interesting that, although Action Learning is sometimes perceived by some as being therapeutic, our two colleagues were not receiving therapy from our set. Indeed, I did not feel, they were able to ‘engage’ with us.

Appendix 7.10
Henry

I’m not sure about that, I didn’t get a sense that they wanted therapy. To me, they wanted a lot of guidance and direction of professional research, and support. I don’t feel we managed to do that for them. It was quite a shock when they didn’t progress with us through the interim's. We hadn’t really explored their work alongside our own at that stage. I don’t think we had formed a group that felt comfortable with supporting each other. In hindsight, if we had been a more together set, they may not have failed their interim's.

Gerald

I think I’d like to put a counter argument. Looking back, when we came to the interim’s (about 24 months into the process) I did not know what the other two were doing. Now, is that my failing because I did not know what they were doing or theirs? It seemed to me, one of them did not want support from the group. In fact, she said: “I don’t want support from this group. I can get support from my family.” It was only after that the groups dynamics changed. There were three of us, not five. We were all pleased to get rid of the “aggro” / the “baggage” so we could do our work. There was never a feeling of shared interest, even at an academic level.

Henry

I agree with that. there wasn’t any clarity of the work. But somehow that was what the group should be about. I was happily doing my work. And I must admit, when someone was a bit vague, I didn’t really know what sort of questions to ask to make it clear. But I think if the group had been ‘right’, if there is such a thing, we should have been able to say, ‘What are you trying to get at here?’ But the group hadn’t “gelled” at that stage. I wouldn’t have felt comfortable. I would have felt I was attacking, insensitive. I didn’t feel that at that stage it would not have been taken as being helpful. and I think that was part of that problem.

Hazel

What about the size of the group for this purpose? Is a 3 better than a 5 irrespective of membership? I think we’ve achieved a lot more in a smaller group

Gerald

In some ways, it’s more difficult not to participate in a smaller group. far fewer hiding places. But the point you made, Henry, about the group at the interim’s is significant because I don’t think we were a group. One of the definitions of a group is “psychologically aware of
each other” which we weren’t. Another is, if you believe you’re a group, you’re a group. We didn’t. We were paired, or a triad and a couple of isolates. Yes, I felt I was a member of this Action Learning set but it was only a title, it didn’t have any real meaning. I wasn’t psychologically aware of L, for example, I didn’t know what she was doing, I didn’t feel I had any input into what she was doing, or that she wanted me to have any. By the time we got to 3, we were much more focused on the task, because groups don’t work well when the task is vague. By that time, we had all invested a lot of time, and became prepared to trade with each other. The question should be whether the group should have been formed in a different manner. Whether someone should have said, ‘This is a bit about groups. We’re going to get to know each other first before we start.’ We never did.

Hazel Would you not expect anyone doing research at the “Revans Centre” to have read around Revans and Action Learning before they came? Perhaps, also, then a facilitator capable of influencing group dynamics and help the group to mature, might have been appropriate, but in terms of Action Learning I would have thought that they would have undertaken pre-reading.

Henry I think it’s always worth repeating what the basic principles are. It doesn’t matter about your level of understanding, there’s always more to learn. Even if you read around it. All will bring to the group different things, it is important group to come to agree an agenda. I think that was missing.

Gerald But Henry, don’t you think some people don’t want to be in a group, which is quite reasonable. Some people want to be told what to do. Some people want to go down a positivist route or have a much more positivist attitude towards life. But if you come into an Action Learning set you should at least be prepared to work in a group. So it was a bit surprising when, 18 months into the thing, when 1 of our colleagues said ‘I’ve never read anything by Revans.’ It’s such a big emotional commitment, it’s so expensive in terms of time away from your family, just to sit at a keyboard. I think someone would say, ‘I want to know what this is before I do it.’ Yet 18 months, and 1 colleague still didn’t know what it was.

Henry Sometimes people think that they want something, but when they get into it, it isn’t. The sooner that that is made clear, the better for the
Perhaps, then, we should have started with some input, perhaps about Revans’s work, to enable the group to get to a, say, plateau of shared understanding from which it could have moved forward.

A shared agreement.

I recall one set meeting when I suggested that we share our understanding of how our Action Learning set might work, and from that draw up some “rules”, what we wanted from the set, and were prepared to give to it.

It was an attempt to gain some shared understanding, agreement. At that stage, I was told “No, we don’t want to do that.”

In the early days, I think because we all felt so uncomfortable, we tried to establish some ground rules, for example, we would all have 20 minutes. That didn’t happen. I think we did not “gel” because, one of the reasons, we didn’t have a common aim. I think in the first year, the group didn’t have a common aim. I don’t think we were comrades. I don’t think we saw any similarities in our adversity. We didn’t see any advantage in helping somebody else. We didn’t see how that could benefit us.

How did that effect our research? Did it, in fact, affect what we were doing?

I didn’t think we did not wish to help each other. I thought that helping others helped me to clarify my position, to move on with my research. I never got that sense that we were not trying to do that. I got a sense of a clumsiness in doing that.
Gerald: I strangely agree with you. But your argument supports what I originally said. That colleague did not see any added value in sharing what she was doing.

Hazel: I didn’t think she had anything to share.

Henry: I agree. My problem was I did not know how to raise that without intimidating her. I couldn’t challenge her. Perhaps we were too sensitive to be of any help.

Hazel: I agree with that. I did not want to ask the challenging question because I knew it would cause her stress. So I didn’t.

Henry: It hasn’t affected it in that sense. It did not affect it because the meta analysis has been going on all the way through. The pace of the research has been dictated by the field.

Gerald: I can’t answer that because I don’t know. It’s like saying, ‘How much has it affected you being white and not black?’. I just don’t know. I’m sure it has affected. I think all of us spent quite a lot of time trying to get the group “named”. We seemed to get jammed in the “storming” stage. At certain points I did shut myself off and get down to work. I think at points it was easier just to sit down at the keyboard, do some research, or open a book, than to talk to somebody.
Appendix 8

Topics covered in the programmed learning element of the research provided by the Institute of Risk Management Associateship Examinations

Within the topic Business Organisation and Finance the nature of risk and risk management was placed in the context of the business environment and how it created risk. Business topics such as the cycle of production, supply and demand, market conditions and macroeconomics were explored in relation to how these generated risks and how businesses tried to manage these risks.

In addition to the business economic factors related to risk the topic included an understanding of the English legal system, rules of contract, insurance and legal remedies available to businesses and the public.

Finally, the social and political factors influence on risk and risk management were introduced along with an introduction as to how risks could be classified and measured. Utility theory was introduced as a way of trying to explain attitudes to risk and risks on organisations.

Within the topic of Risk Analysis the use of statistical analytical methods was extensively covered as was the cost of carrying out the process of risk analysis.

Risk identification techniques and programmes such as:

- Physical inspections
- Check lists
• Organisation charts
• Flowcharts
• HAZOP's (Hazard and operability studies)
• Fault tree analysis
• Hazard Indices and consequence analysis

Statistical methods for measuring and evaluating the level of risk was also extensively explored and covered topics such as:

• Probability theory
• Probability by using A Priori and Relative Frequency techniques
• Probability trees and effects of different combinations of probabilities
• Balance of risk and benefits
• Sampling and data analysis and presentation techniques.

The debate about the relative value of scientific versus subjective judgements of acceptable risk and the role of the effects of preconceived ideas on the perception of risk raised serious questions about the limitations of statistical techniques. Also explored was the role of attitudes, perception, moral values, legal requirements and group dynamics on risk decision making and risk taking behaviours.

Following Risk Analysis the topic Risk Control introduced the differences between risks and hazards and introduced specific risk control techniques for the following risks:

• Fire
• Subsidence and earthquakes

Appendix 8.2
- Burglary
- Public liability
- Motor and mobile plant
- Engineering
- Contractors and temporary erections
- Fidelity guarantee
- Worker injury
- Marine

The role of insurance within the risk control toolkit of the risk manager was also extensively explored and covered areas from an insurance perspective on:

- Loss Forecasting
- Time Value of Money
- Unfair Contracts Terms Act
- Forms of contractual transferral
- Forms of risk financing transfer
- Management of non-insurance contractual transfer.
- Methods, incentives and conditions for self insurance
- Organising and managing the self-insurance funds including determining retention levels and financing the fund.
- Determining levels of deductibles
- Types of captives, preconditions for their formation, benefits and problems associated with them.
- Managing a captive

Appendix 8.3
• Risk transfer and financing
• Types of insurance
• Analysis and evaluation of insurance cover
• Use of brokers
• Special situation of multinational organisations

Under the topic of Corporate Risk Management the techniques of risk analysis and control were brought together and focussed on the nature and role of risk management within organisations and how the function fitted into and related to other organisational roles and responsibilities. Included in this topic was included risk management decision making probabilistic and non-probabilistic methods, contingency, business recovery planning and disaster management.