Royal Devon and Exeter NHS
NHS Foundation Trust

GOVERNANCE ANNUAL REPORT 2006/07

1. Purpose

1.1 The purpose of this report is to update the Governance Committee and the Board regarding the activities undertaken in 2006-2007 to demonstrate that the Trust manages governance in an effective manner and to seek approval of plans for 2007/08. It does not cover areas of financial governance. This is dealt with via regular board reports and to Monitor, the independent regulator for Foundation Trusts.

2. Introduction

2.1 The overall responsibility for managing governance within the Trust rests with the chief executive. Operational responsibility for key components of the governance agenda is delegated to the medical director for clinical governance and the human resources director for health & safety.

3. Report Breakdown

3.1 The report is broken down into a number of distinct areas designed to cover the full range of both the corporate and clinical governance agenda. These areas are the governance framework (including clinical and corporate governance), risk management (including health & safety) and governance support unit (including clinical audit). Where sections overlap, this is indicated in the report. Appendices offer further information on each section.

4. Governance Framework

4.1 Governance Committee

4.1.1 The Trust manages its governance activities through the governance committee. This committee is a committee of the board of directors and met seven times during 2006-07. The committee covers both clinical and corporate governance activities across the Trust. The vice chairman of the Board chaired the committee for six months of the year. At this point, the chair of the committee was passed to other non-executive director and two other non-executive directors are also members. Representation is also drawn from the executive team and clinical specialities throughout the Trust.

4.1.2 Various specialist committees report their work to the governance committee. These committees all have agreed terms of reference and are chaired by senior members of staff.

4.2 The Assurance Framework and Risk Register

4.2.1 The assurance framework details the Trust's high-level objectives to ensure that there is adequate assurance at board level on its business processes. The governance committee is charged by the board to examine the process in detail.

4.2.2 Internal audit examined the assurance framework to ensure a positive sign off for the statement on internal control. The framework was considered fit for purpose. The framework covers all areas of Trust business, which include the healthcare standards, Monitor, service development strategy and new & existing targets. Any area where a gap is identified is transferred onto the Trust risk register.

4.2.3 The Trust has continued to develop the corporate risk register over the year. Both the board and governance committee undertake a quarterly review of the register, which highlights the changes made within that quarter. Internal audit also assess the validity of the register in assessing the overall statement on internal control.

4.3 Directorate Governance Groups

4.3.1 Directorate governance groups assist in embedding the governance and risk management framework into the organisation.

4.3.2 Directorate governance groups, chaired by the clinical director, cover all aspects of governance from a directorate perspective. An area of focus for 2006-07 was in the establishment of systems to record healthcare standards evidence.

4.4 Clinical Negligence Scheme for Trusts (CNST)

4.4.1 The Trust was not subject to an assessment in 2006-07. As CNST now assesses on a two year cycle, the next assessment will be in 2007-08.

5. The Healthcare standards and annual declaration

5.1 The Healthcare Commission is the statutory body responsible for performance managing the NHS on quality improvements for the benefit of patients. A major part of this activity is assuring compliance with the core national healthcare standards.

5.2 For the first time, two developmental standards were assessed in shadow form. These covered safety and clinical and cost effectiveness. The Trust assessed itself as achieving 'Fair' and 'Good' progress respectively against these standards.

5.3 Lead managers have been assigned to each of the standards with directors taking a lead on each of the domains.

5.4 The national standards, local strategy (NSLS) Committee, chaired by the operations director, oversees the implementation of action plans relating to the national standards. The NSLS committee reports to the governance committee.

5.5 During 2006-07, internal audit conducted an extensive review of evidence relating to each of the core healthcare standards. This enabled the Board to sign the annual declaration. Due to Commission rules, the Trust self assessed itself as meeting 42 of the 44 standards as action plans for two of the standards were completed in year.

5.6 The Trust underwent a random inspection by the Healthcare Commission in order to confirm that the stated compliance in a number of core and developmental standards was correct. Core standards C1a, C4c, C12, C14b & C24 as well as developmental standard D1 were assessed. The Healthcare Commission will notify the Trust of the outcome of its inspection in September 2007.

6. Risk Management (including health & safety)

6.1 Policy reviews

6.1.1 The cyclical task of reviewing and updating policies has continued throughout the year, as has the development of new policies that further enhance the safety of patients and staff.

6.2 Learning from Errors

6.2.1 The Trust continues to electronically send details of all patient incidents to the National Reporting and Learning System (NRLS) and is recognised as a good reporter. The NRLS is a central repository for all patient incidents that occur in the NHS and is administered by the National Patient Safety Agency. The National Patient Safety Agency analyses the information gathered by the NRLS and uses the data as a tool in developing national patient safety strategies.

6.2.2 There have been a number of root cause analyses (RCA) undertaken throughout 2006-07. Each has been reported to the Governance Committee and action plans are monitored via this committee.

6.3 Health & Safety Action Plan

6.3.1 The Trust developed a health and safety action plan for 2006-07, in liaison with staff side representatives in order to ensure continual improvement in health and safety. A further action plan was developed following an inspection from the Health & Safety Executive (see 6.10). An update of the combined plan progress can be seen in appendix 1.

6.4 Incident Reporting

6.4.1 The incident reporting and investigation policy and procedure encourages all members of staff to report incidents, including near misses within 48 hours. Incidents are then graded with regard to the "actual impact" and also the "future potential" risk to the Trust, should the incident recur.

6.4.2 A risk matrix for the total number of patient, staff and other incidents is shown in appendix 2 as well as run charts for the top five patient and staff incidents. The total number of incidents reported in 2006/07 was 6885; an increase of 8%, which further highlights a positive incident reporting culture.

6.5 Manual handling

6.5.1 All new starters to the Trust receive an overview presentation from the moving and handling advisor on spinal awareness issues. This holistic induction session is consolidated at ward/departmental level by "key trainers", who provide practical training commensurate with their work activity.

6.5.2 The manual handling advisor is responsible for training 'key trainers' who fulfil the role in addition to their normal duties.

6.5.3 When a new member of staff starts in their ward/department, the key trainer provides specific manual handling training appropriate to the role e.g. patients or inanimate loads.

6.5.4 Key trainers are responsible for providing the annual manual handling update training for staff within their ward or department.

6.5.5 From the 1st April 2006 - 31st March 2007 there have been 165 moving and handling incidents. Of these, 16 were reported to the Health and Safety Executive (HSE).

6.6 Environmental monitoring

6.6.1 The Control of Substances Hazardous to Health Regulations 2002 specifies the circumstances where hazardous substances are used and environmental monitoring is required.

6.6.2 The Trust purchased an environmental air monitor to measure potentially harmful substances in the workplace. No area sampled has shown over exposure to hazardous substances.

6.7 Violence and aggression

6.7.1 The Counter Fraud and Security Management Service (CFSMS) is a co-signatory to the concordat with the Health & Safety Executive (HSE) thus ensuring that violence and aggression remains high on the health and safety agenda.

6.7.2 Violence and aggression incidents are reported via the Trust incident reporting system. The security forum is the body charged with policy development in this area.

6.7.3 The CFSMS has required the Trust to have a nominated person responsible for security. As a result of this the Trust security manager is now fully accredited to give security advice.

6.7.4 Front line staff are now required to attend a 1-day training course on violence and aggression. The Trust is on target to meet the requirement of all staff to attend this training by April 2008.

6.7.5 Detailed figures on violence and aggression are reported via the security forum.

6.8 Risk Management Training

6.8.1 Health and safety, including manual handling, is covered in the induction programme.

6.8.2 The Trust adopts a proactive approach to the management of risk and the foundations for this are risk officers who have completed the in-house three-day risk management training course.

6.8.3 The three-day package adopts a holistic approach to risk management and also incorporates the skills required to complete general risk, COSHH and display screen equipment assessments. Completion of the course qualifies staff to be risk officers who are integral for not only ensuring that risk assessments are completed but also help ensure that risk management issues are being communicated through the directorate structure.

6.8.4 There are now 192 risk officers who have completed the three day course.

6.8.5 Update training for risk officers who have completed the course two years ago has now been instigated. This is to ensure that risk officers are up to date in current legislation and practical issues surrounding risk management.

6.9 Health & Safety Committee

6.9.1 The Trust has a duty to consult with recognised safety representatives and the health and safety committee provides a forum for this to occur.

6.9.2 The committee meets on a quarterly basis and discusses health & safety issues, analyses staff incident data and ratifies health & safety policies. The director of human resources chairs the committee.

6.9.3 It is good practice that the committee has representation from staff side. To this end, 50% of the committee's membership is either trade union representation or appointed staff representatives.

6.10 Dealings with Health and Safety Executive (HSE)

6.10.1 The Trust is required to report certain incidents to the HSE under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. In 2006/07, the Trust reported 39 incidents out of a total of 6886. The risk management department carries out an investigation on all incidents that are reportable under RIDDOR.

6.10.2 In September 2006, the Trust underwent a rigorous 3-day inspection by the HSE. The inspection centred on a number of key topics. These were; moving and handling, sickness absence and return to work policies, slips, trips and falls, stress and violence and aggression.

6.10.3 Following the inspection, an action plan was developed, agreed by the board of directors which has now been amalgamated into the health & safety action plan for 2007-08.

6.10.4 Overall, the inspection was very positive and there were no areas identified where enforcement notices were required.

6.11 Safety Alert Broadcast System

6.11.1 The Safety Alert Broadcast System (SABS) is an electronic system developed by the Department of Health and is the primary method of distributing Medical Device Alerts (MDA) and Patient Safety Alerts to all NHS Trusts. Alerts are disseminated to SABS liaison officers in NHS Trusts. The liaison officer then ensures onward distribution of the alert and records the actions taken on SABS. This activity is undertaken in the risk management department. All alerts are also placed on the MHRA (Medicines and Healthcare Products Regulatory Agency) and NPSA (National Patient Safety Agency) websites. In 2006/07, there were 101 alerts issued, an increase of 23%.

6.11.2 In a reciprocal arrangement, Trusts are also required to notify the MHRA should they be alerted to any actual or potential product failures. The MHRA investigates the incident with the manufacturer and takes any appropriate action necessary and informs the Trust of the outcome. In the year 2006/07, 34 reports were made to the Agency which is in line with the previous year.

6.12 Departmental achievements

6.12.1 The following achievements by the department are worthy of note:

- The number of risk officers trained has increased by 25%
- Incident forms continue to rise and yet the total number of RIDDORs have dropped
- High number of reports of patient incidents to the National Patient Safety Agency's National Reporting & Learning System
- Improved information to both corporate and directorate departments
- Dedicated moving & handling training room
- Successful outcome from HSE inspection further highlighting the issue that health & safety is well managed
- Closer links with staff side representatives on the health & safety committee including resolution of the majority of staff concerns around health & safety

7.0 Governance Support Unit

7.1 Introduction

7.1.1 During the past year the role of the Governance Support Unit has continued to focus around national clinical audit and priorities, being driven by the healthcare standards and the Clinical Negligence Scheme for Trusts (CNST). The national picture for clinical audit focuses pre-dominantly on improvements in outcome for clinical care.

7.1.2 The Governance Support Unit continues to lead on audit activity throughout the Trust and is committed to the provision of a high quality service. It provides a pivotal role in the co-ordination of clinical audit activity across the Trust in order to prevent duplication of effort and to ensure a harmonised approach. All known audit activity is recorded on a departmental database from which quarterly reports on audit activity are disseminated to directorates via their directorate governance groups and the quarterly review process.

7.1.3 Strong links have been maintained within directorates between governance support facilitators and directorate audit leads.

7.2 Clinical Audit Committee

7.2.1 The Clinical Audit Committee met quarterly to co-ordinate, promote and oversee multi-disciplinary clinical audit activity throughout the Trust and provide strategic direction for the clinical audit programme. Audit Leads have been appointed within each directorate and attend clinical audit committee meetings to co-ordinate the directorate audit programme and provide evidence to confirm that change has been effective.

7.2.2 In 2007-08 the Clinical Audit Committee and Evidence Based Practice Group are to merge to form the Clinical Audit and Effectiveness Committee. This will further improve the reporting systems in these areas and provide extra assurance that the process is being delivered to standard.

7.3 National Confidential Enquiries and National Audit Projects

7.3.1 There are a number of national audits and confidential enquiries that are undertaken in the Trust. These audits and enquiries cover a wide range of services. Some are outcome based where others feed into national trend analysis. The Governance Support Unit leads on a number of audits / enquiries. Others are managed by specialty leads. All are reported to either the clinical audit committee or the Governance Committee. These are summarised below.

7.3.1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

7.3.1.1 The NCEPOD studies are detailed below:

Emergency Admissions Study
Coronial Autopsy Study
Sickle Cell Disease and Thalassaemia
Severely Injured Patient Study
Systemic Anticancer Therapy Pilot Study
Systemic Anticancer Therapy Main Study
Cardiac Arrest Procedures Pilot Study
Cardiac Arrest Procedures Main Study

7.3.1.2 The system for monitoring actions taken against the recommendations made on projects undertaken by the National Patient Enquiry into Patient Outcome and Death has been revised in line with the Healthcare Standards and has been introduced.

7.3.2 National audits

7.3.2.1 The following national audits have been completed in 2006-07:

National Audit of Sentinel Stroke
National Continence Audit
National Falls Audit

7.3.3 Confidential Enquiry into Maternal and Child Health (CEMACH)

7.3.3.1 Work continues in the Maternity Unit on this Confidential Enquiry. A six monthly report to the Governance Committee has highlighted good progress with the recommendations of this report and work continues.

7.3.4 Intensive Care National Audit and Research Centre (ICNARC)

7.3.4.1 Data continues to be submitted to ICNARC. Changes have been made in 2006 that will allow more accurate benchmarking against national performance; accurate data for supporting local activity such as mortality and morbidity meetings and provision of data for Paediatric Intensive Care Unit (PICU).

7.3.5 National Trauma Audit Research Network (NTARN)

7.3.5.1 Participation in the National Trauma Audit Research Network continues. Over 1,000 cases have now been submitted. Since January 2007 summary data including W statistics and various process measures have been made available in a de-anonymised manner to all participating hospitals. The TARN organisation has announced that within the next few months this information will be made available to the general public.

7.3.5.2 Participation allows access to the national database and provides the ability for participating hospitals to generate customised reports to allow audit or research into any aspect of their care for which data is collected on the TARN database. Monthly clinical case reports are generated which are circulated to the audit leads for the key directorates involved with Trauma care. These reports highlight unexpected outcomes i.e. patients who have a low probability of survival but survive or vice versa. Quarterly themed issues are received from TARN and circulated by post to the audit leads. These reports focus on process measures relating to key topics and also review the most recent W statistic for each organisation.

7.3.5.3 Information received from TARN is reviewed together with cases of unexpected outcomes at the quarterly Multi Disciplinary Trauma Audit meetings. Any recommendations or important issues raised are reviewed at quarterly Trauma Team Steering Group meetings.

7.3.6 Myocardial Infarction National Audit Project (MINAP)

7.3.6.1 This is a mandatory on-going national audit project to monitor the standards for the management of acute coronary syndromes as stated in the National Service Framework for Coronary Heart Disease. MINAP data is analysed locally on a monthly

basis and also as and when required by clinicians and managers, to provide feedback on demographics and clinical management.

7.3.6.2 The next MINAP public report is due on 12th July 2007 and will include Call to Needle and Door to Needle times for thrombolysed patients, methods of reperfusion, the use of secondary prevention medications, and data completeness. Again this year there has been a requirement to participate in the annual Data Quality Study, and the report is due to be published in June.

7.3.6.3 In April 2007 the MINAP dataset was expanded and updated to reflect changes in clinical practice. The new dataset better reflects the increasing use of primary angioplasty as the first-line treatment for myocardial infarction and there is also more emphasis on the management of non ST elevation myocardial infarction and the management of diabetic patients with acute coronary syndromes.

7.3.6.4The second year of data collection for the National Infarct Angioplasty project is now nearing completion and a report is expected later in the year. Additional data collection and analysis for primary angioplasty activity is ongoing, as the service continues to develop.

7.4 National Service Frameworks (NSF's)

7.4.1 National Service Frameworks (NSFs) set national standards and define service models for a specified service or care group, put in place strategies to support implementation and establish performance milestones against which progress within an agreed timescale will be measured. Working parties have been set up to implement the recommendations of the following National Service Frameworks: Coronary Heart Disease, Diabetes, Older People, Renal Services, Children and Long Term Conditions. Audits have been undertaken as part of the NSF action plans.

7.5 Integrated Care Pathways (ICPs)

7.5.1 A new chair for the ICP Forum came into post in March 2007. A second internal ICP conference is planned for November 2007. The trials of the Generic Admissions ICP were successful and the document is planned to be rolled out in the whole of the medical directorate in April 2007. The Trust's learning and development service are involved with the staff training program.

7.5.2 An ICP project plan to implement the Generic documentation Trust wide is in place. Work is currently underway to adapt the medical version of the Generic Admissions ICP for use in surgery. It will incorporate pre, and post operative care, including pre-assessment documentation. It will use the Generic ICP as a base, ensuring that essential components and information are maintained.

7.5.3 An ICP policy has been approved. The policy will provide a formal process and guidance for the development of patient/condition specific ICP's. This will ensure future development of ICP's meet organisational priorities.

7.6 Multidisciplinary Audit

7.6.1 Multidisciplinary clinical audit meetings take place within specialties. Each team select audit projects to be undertaken and topics are audited using national standards. Audits using standards from guidance issued by the National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSFs) were incorporated within the clinical audit programme for 2006/07. NICE is responsible for

the provision of guidance for the NHS and patients on medicines, medical equipment and clinical procedures based on evidence of both clinical and cost effectiveness.

7.6.2 The membership of the clinical audit committee also reflects the Trust's recognition of the importance of multidisciplinary clinical audit.

7.7 User Involvement

7.7.1 The user involvement monitoring policy has been working effectively over the last year. There has been a marked increase in the number of surveys submitted for approval, demonstrating an increased awareness of the policy. The department's questionnaire design and advisory service for patient and staff satisfaction surveys has been well utilised within the last year.

7.7.2 The department continues to promote the importance of involving users in audit. Reports on user involvement activity are regularly reported to the patient and public involvement steering group and directorates through the quarterly review process and directorate governance groups.

7.8 Evidence Based Practice

7.8.1 The Evidence Based practice group, chaired by the Medical Director, has continued to meet during the year. However this group is soon to be subsumed within the Clinical Audit Committee as it was felt that this would be a more appropriate arena for discussion of NICE Guidance. The pathway for dissemination and feedback on activity around NICE Guidance implementation continues to work effectively. Audits of NICE guidance being implemented within the Trust are incorporated into directorate audit programmes.

7.9 Random Note Review

7.9.1 A six monthly programme of case note review, examining the quality of record keeping and consent was rolled out across the Trust to ensure compliance with standards set by the Clinical Negligence Scheme for Trusts and Royal Colleges. Directorates are being encouraged to facilitate the process within their areas. Reports on activity are included in the Trust's quarterly review reporting.

7.10.1 Informed Consent

7.10.1 The Governance Support Unit Manager continues to be the Trust lead for the development of procedure-specific consent forms. A Trust-wide audit of informed consent is currently being undertaken. Specialist Subject Lessons (SSLs) on informed consent continue to be provided to Peninsula Medical School students each term.

7.11 Research Governance

7.11.1 Links have been forged with the Research and Development Directorate and audits of research sites have been undertaken to ensure compliance with the Research Governance Framework.

7.12 Education and Training

7.12.1Training sessions on clinical audit have been provided to junior doctors and allied health professionals across the Trust. This has lead to a greater understanding of

clinical audit, raised the profile of the department and brought about an increase in the number of audit outcomes reported. Junior doctors are being requested to undertake meaningful audit projects as part of teams, which could lead to improvements in care. Audits of NICE guidance currently being implemented within the Trust have been given to junior doctors to audit as part of their training.

7.12.2 Highly successful workshops on clinical audit have been provided throughout the year to multidisciplinary groups of staff.

7.13 Department of Research Ethics and Medical Affairs

7.13.1 The department previously provided administrative support for the Drug and Therapeutics Committee, Medical Staff Committee and Clinical Ethics Reference Group. The support for the Drug & Therapeutics Committee has passed to the Governance Support Unit during 2006 and support for the other committees is also in the process of being passed over. It also provides extensive administrative support for the Devon & Torbay Research Ethics Committee, formerly North and East Devon Research Ethics Committee. This Committee is responsible for approving all research conducted within North, East and South Devon involving patients, staff and users of the NHS. The Committee is funded by the Central Office for Research Ethics Committees in London.

7.13.2 Devon & Torbay Research Ethics Committee

7.13.2.1The Research Ethics Service has undergone several changes and improvements during 2006 and a summary of the main events include:

- Merger in November 2006 of the North & East Devon Research Ethics Committee with South Devon Research Ethics Committee to form the Devon & Torbay Research Ethics Committee
- Flagged committees across the UK having expertise in reviewing specialised studies
- Building on Improvement: launch of the implementation plan of the Ad Hoc Advisory Group's recommendations
- COREC and NHS R&D Forum launch the integrated Site-Specific Information Form on 15 January 2007, avoiding the need for 2 separate forms to obtain both ethical and research governance approval

7.13.2.2 Merger of the two committees has resulted in a larger committee membership (now 18 members). The committee are no longer able to review Clinical Trials of Medicinal Products but are a flagged committee for having expertise in the area of Paediatrics. 2006/07 concludes a busy year, although the number of full projects reviewed has declined again for 2006/07, it is evident from a busier second half of the year that 2007/08 will see an increase in the level of reviews carried out. The committee reviewed 48 studies (a reduction of 11 from the previous year) over 10 meetings.

7.13.2.3. There are still further changes and improvements planned as we go into Phase II of the implementation plans for 'Building on Improvement'. The Devon & Torbay Research Ethics Committee remain committed to provide a valuable and seamless service to the local research community and look forward to the challenges ahead.

8. Developments for 2007/08

8.1 Whilst much work has been has been completed in 2006-07, the Trust is committed to continually improving its services, year on year. To this end, a number of plans have been developed. These are detailed below.

8.2 Health & Safety action plan

8.2.1 The Trust has developed a health and safety action plan for 2007-08, in liaison with staff side representatives. This can be seen in appendix 3. The Health & Safety committee will monitor the action contained in this plan and the Board will receive six monthly updates.

8.3 Improvements in quality

8.3.1 Quality improvements continue throughout the organisation driven by various national and local initiatives. A main focus for this centres around the developmental standards developed by the Department of Health and managed by the Healthcare Commission (HC). In 2006-07, the HC monitored developmental progress across two themes, namely safety and clinical & cost effectiveness. For 2007-08, the HC have indicated that they will produce benchmarking information for Trusts to allow them to monitor how well they are improving in these areas. The HC have, as yet, not released this information.

8.3.2 In order to allow the Trust to move ahead an action plan has been developed for clinical & cost effectiveness which can be seen in appendix 4. A plan will also be developed concerning safety once the information has been received from the HC. In the meantime, the safety systems detailed in this report will continue.

8.4 Clinical Negligence Scheme for Trusts (CNST)

8.4.1 The Trust will be assessed against CNST standards in February 2008 for both acute and maternity services. The CNST strategy group, chaired by the Medical Director, will oversee the process to ensure that a successful outcome is reached in both assessments.

9.0 Recommendations

9.1 The Governance Committee is asked to receive this report, note the progress made to date and approve the health & safety action plan and the clinical & cost effectiveness plan for 2007-08.

Royal Devon and Exeter
NHS Foundation Trust

Health and Safety Action Plan 2006 - 07

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
1.	Trustwide	Introduce a complete ban on smoking, both inside and outside of the hospital for all staff and patients.	Create a complete smoke free environment.	Director of Nursing	Nov 2006	Completed
2.	Estates	Review the current Snow and Ice Policy and advise staff of any changes.	Will update current policy and raise staff awareness.	Head of Estates	Nov 2006	Completed

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
3.	Moving & Handling	Prepare a business case for the purchase of bariatric equipment.	If the business case is successful the Trust will then have a suitable and sufficient supply of bariatric equipment.	Moving and Handling Advisor	Sep 2006	Completed
4.	Risk Managm'nt	Initiate an H&S awareness raising campaign regarding slips and trips in the workplace through: • Investigation of all employees who slip or trip • Use of HSE posters • Presentations to staff • Assessment of roughness of floors in elderly care wards to assess if floor covering is appropriate	A reduction in employee slip and trips	Risk Manager	March 2007	Completed (see exception report)
5.	Estates	Conduct a risk assessment through the physical examination of every window that can be opened above ground level or ground level window where the ground outside the window falls significantly away. Ensure any opening restrictor devices already fitted to the above windows are operating correctly and fit restrictors to all other windows.	Remove the risk of people falling from first floor and above windows	Head of Estates	March 2007	Completed

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
6.	Risk Managm'nt	Update all risk management policies & procedures, which are scheduled for review and amend accordingly to reflect any legislative changes.	The Trust will be working with new policies, which reflect up to date legislation.	Risk Manager	March 2007	Completed
7.	Training	Promote the 3day-risk management in-house training course, across the Trust. This qualifies staff to be known as 'Risk Officers.'	Aim to have 160 - 190 Risk Officers across the Trust.	Risk Manager & Leaning and Development Service	Mar 2007	Completed
8.	Training	Promote the one-day refresher course, which will incorporate the previous incident investigation course, for Risk Officer's who have been qualified for 2 years.	Aim to run 3 refresher courses to update Risk Officer's on any risk management changes.	Risk Manager & Leaning and Development Service	Mar 2007	Completed
9.	Training	Conduct one further Root Cause Analysis (RCA) course.	Aim to have enough appropriately qualified staff capable of facilitating a RCA.	Risk Manager	Mar 2007	See exception report
10.	House keeping	All staff that are engaged permanently or temporarily in the deep cleaning of clinical areas, such as wards, must receive appropriate information, instruction, training (IITS) and supervision before commencement of the task. There must be a record kept of which members of staff have received the training.	Only appropriately trained staff will engage in deep cleaning duties.	Hotel Services Manager	Ongoing	Completed

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
11.	House keeping	The purchase of any machinery e.g. steam cleaners or chemicals, which are to be used for deep cleaning should be made in consultation with the Hotel Services Manager. The Hotel Services Manager should centrally store machinery used for deep cleaning and only issue them to appropriately trained staff.	The competent person regarding the cleaning throughout the Trust is responsible or the control of hazardous cleaning chemicals and machinery.	Hotel Services Manager	Ongoing	Completed
12.	Training	Front line staff are to have first allocation of conflict resolution training places. (This is a requirement of the Counter Fraud and Security Management Service (CFSMS)).	Those most at risk will be trained first in conflict resolution.	Learning and Development	Apr 2005	Completed
13.	Training	Complete and deliver "Conflict resolution training" programme for all other staff.	All Trust employees to have conflict resolution training.	Learning and Development	Apr 2008	Ongoing
14.	Training	Security awareness training and information to all new staff at corporate induction will continue.	All staff will receive security training.	Trust Security Manager D&C Police Partnership	Ongoing	Ongoing
15.	Security	There will be ongoing work throughout the year looking at the management and development of the following technical security measures: ❑ Access control ❑ CCTV ❑ Staff identity / access control I.D. badges.	Stricter access/egress control will be achieved, thus improving security.	Trust Security Manager	Ongoing	Ongoing

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
16.	**Security**	Continue to promote the "in-house" Security Service, including: ❑ Security Officer training and updates ❑ Implementation of statutes and directives ❑ Expansion of staffing levels ❑ Awareness of service by staff, visitors and public.	The newly formed in-house security service will assume a higher profile.	Trust Security Manager	Ongoing	Ongoing
17.	Estates Dept	Urban Environments Ltd will carry out a Legionella risk assessment review on all Trust properties. ❑ The findings of this assessment will be reported on. ❑ The report will be discussed. ❑ Recommendations implemented	The risk of Legionella continues to be assessed and controlled.	Estates Manager	Annually	Completed
18.	Estates Dept	Scheduled testing of portable electrical appliances continues.	Risk of electrocution and fire will be reduced.	Estates Manager	On going	Completed
19.	Estates Dept	The proactive regular inspection of the car parks and road surfaces to assess their condition continues all year round. Any identified problems will be rectified.	Road surfaces will have identified problems resolved.	Estates Manager	On going	Completed

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
20.	Catering Dept	To ensure that all staff who are engaged in the handling of food are trained commensurate with their work activity.	Compliance with Food Safety and Hygiene regulations	Head Chef and Catering Manager	Ongoing	Ongoing
21.	COSHH	Complete a Capital bid application for the purchase of an environmental air monitor.	Will allow the Trust comply with its statutory requirement to monitor chemicals hazardous to health	Risk Manager	August 2006	Completed
22.	Estates	Conduct a Trustwide risk assessment to identify areas where persons might fall from a height e.g. flat roofs and implement control measures accordingly.	Reduce the possibility of anyone falling from a height	Head of Estates	March 2006	See exception report

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
23	Estates	Ensure the close supervision of the contractors carrying out the demolition of the old incinerator chimneystack, with particular attention paid to dust suppression and noise pollution.	A safe controlled removal of the stack with no nuisance complaints.	Head of Estates	Oct 2006	Completed
24.	Facilities	Conduct a workplace noise assessment within the laundry.	To ensure that the latest 'action levels' laid down in the Noise at Work Regulations are not being breached.	Risk Manager	March 2007	Completed
25.	Trust wide	Pandemic Flu will pose health risks for staff caring for sick patients and will put severe strain on services and therefore a Trust wide Action Plan is being developed to control an outbreak.	A reduction in the likelihood of infection and serious ill health in staff.	Director of Operations	Sep 06	Completed

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
26.	Trust wide	Extend the enquiry about health, health and safety and wellbeing at appraisal, to include doctors.	This will fulfil HSE's requirement for health surveillance for such things as latex and stress.	Consultant Occupational Physician	March 07	See exception report
27.	Risk M'gement	Identify and convert a room to provide a risk management/moving and handling (M&H) training facility. The room should be fitted out with a hospital bed, hoist and any other M&H equipment required to demonstrate and practice M&H techniques.	Provide a facility which can be utilized by Directorate M&H Key trainers.	Risk Manager	Oct 06	Completed
28.	Human Resources	Ratify Management of Sickness Absence and Return to Work Policy. Implement above policy and develop training awareness sessions for managers.	Closer monitoring of sickness trends will assist in early identification of potential problems, thus allowing timely and expedient implementation of remedial measures.	Head of Human Resources	Dec 06	Completed

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Progress
29.	Estates Dept	Conduct a Trust wide risk assessment of roads, pavements and anywhere where pedestrians and vehicles have the potential to come into contact with one another e.g. road between PEOC and ED Make appropriate recommendations as necessary.	Identification & remedial action taken as necessary where there is a risk of vehicles & pedestrians coming into contact.	Estates Manager	Oct 06	Completed
30.	Infection Control	The feasibility of introducing safer needle systems will be investigated.	If the introduction is feasible and goes ahead then there should be a reduction in inoculation injuries.	Occupational Health Manager/ Deputy Director of Infection Control.	Mar 07	See exception report

Health and Safety Action Plan 2006/07
Exception Report

The following points of the H&S Action Plan 2006/07 remain partially complete:

4 In preparation for the HSE inspection of September 2006 the risk management database was interrogated. Analysis of staff slip, trips and falls identified that this was not an identified need. However, a Slips, Trips and Falls policy was introduced, which formalised good current practices.

9 As a result of the very small number of RCA's conducted each year, there is no identified need to train additional RCA facilitators as staff may lose their existing skills through if not used regularly.

22 An assessment has been carried out for Heavitree but Wonford remains incomplete – target date January 2008.

26 The questionnaires are currently being trialled and will be reported back to the H&S committee in December 2007.

30 The review is complete and is now being considered under the Trust's commitment to standardisation.

APPENDIX 2

Incident Reporting

Risk Matrix – Incidents 01/04/06 - 31/03/07

Actual Impact - Patient incidents

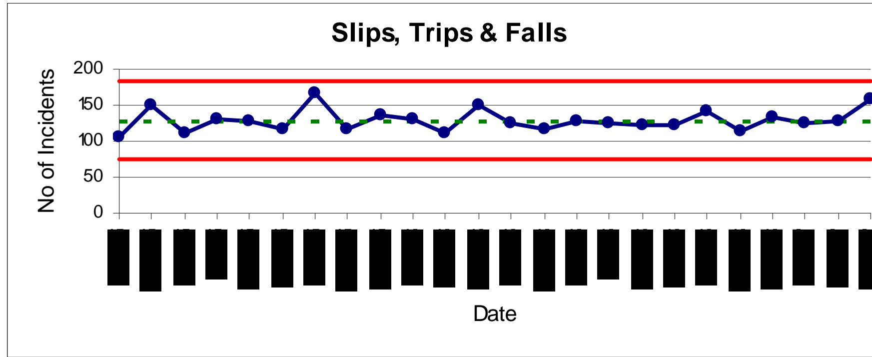
None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
3607	1279	53	0	0

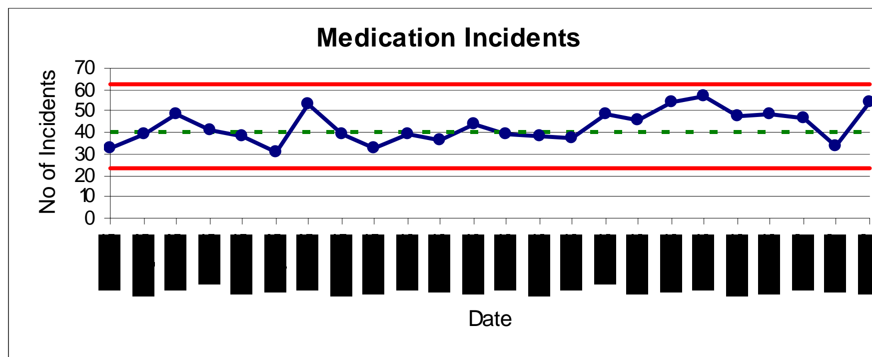
Future potential impact to the organisation

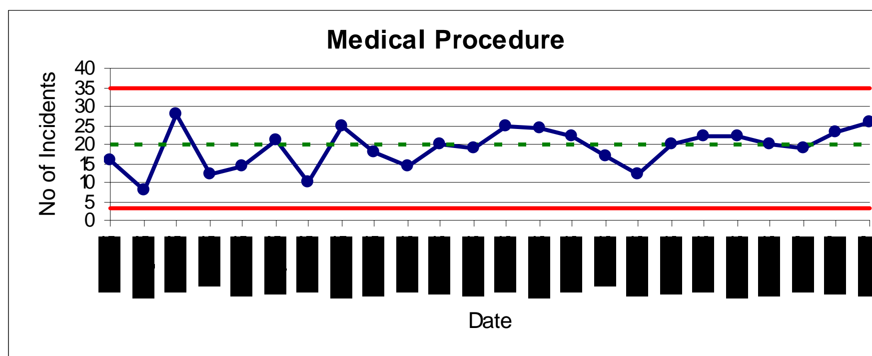
Patient Incidents 2006 - 07

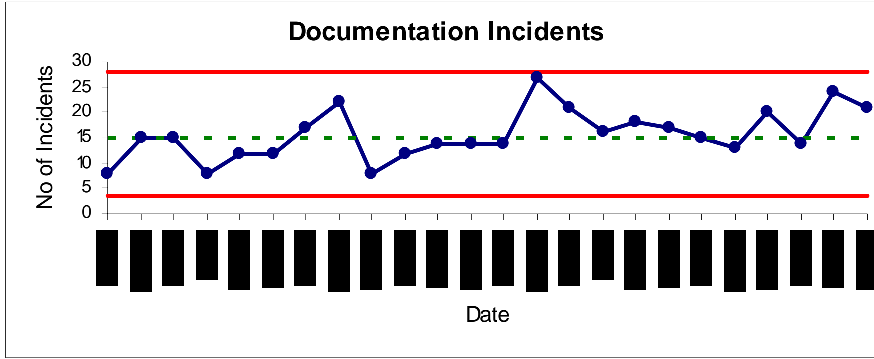
LIKELIHOOD of hazard being realised	**CONSEQUENCE**				
	None (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	83	79	43	6	1
Unlikely (2)	478	622	144	3	3
Possible (3)	1039	991	116	0	1
Likely (4)	703	60	4	0	0
Almost Certain (5)	561	2	0	0	0

Trustwide Top 5 Patient Incidents Apr 2005 to Mar 2007
Statistical Process Control Charts








Documentation Incidents
No of Incidents
30
25
20
15
10
5
0
Date

Actual Impact - Employee incidents

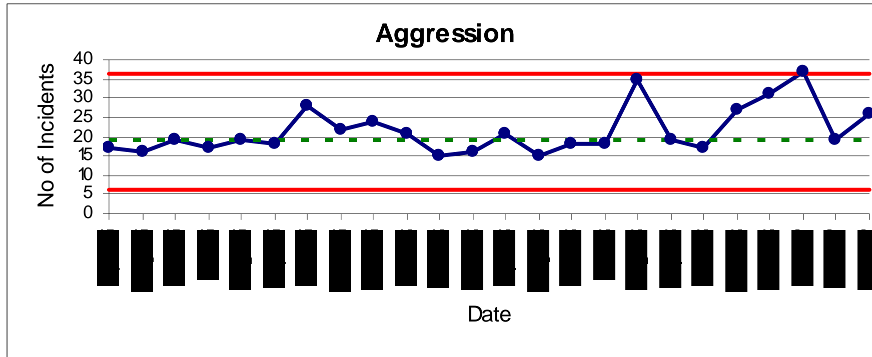
None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
898	904	36	0	0

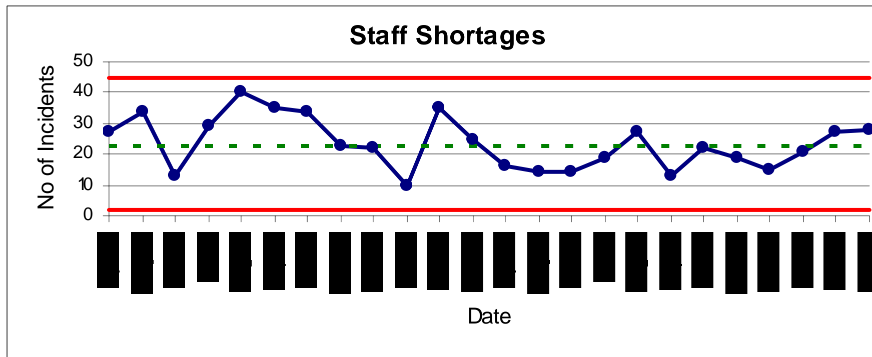
Future potential impact to the organisation

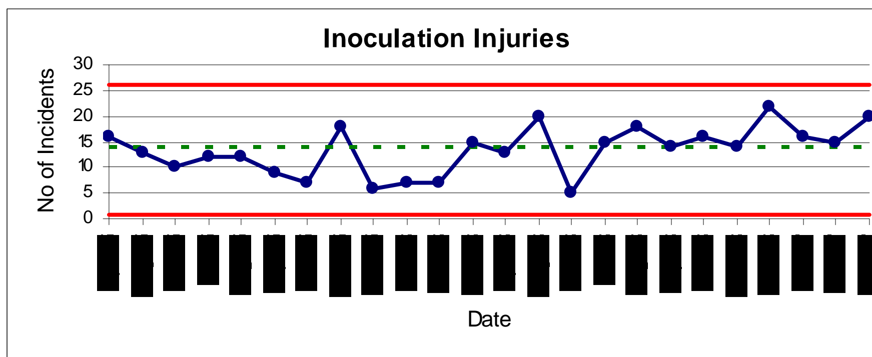
Employee Incidents 2006 - 07

LIKELIHOOD of hazard being realised	**CONSEQUENCE**				
	None (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	33	30	14	1	0
Unlikely (2)	335	227	16	0	0
Possible (3)	616	383	17	0	0
Likely (4)	119	37	9	0	0
Almost Certain (5)	0	1	0	0	0

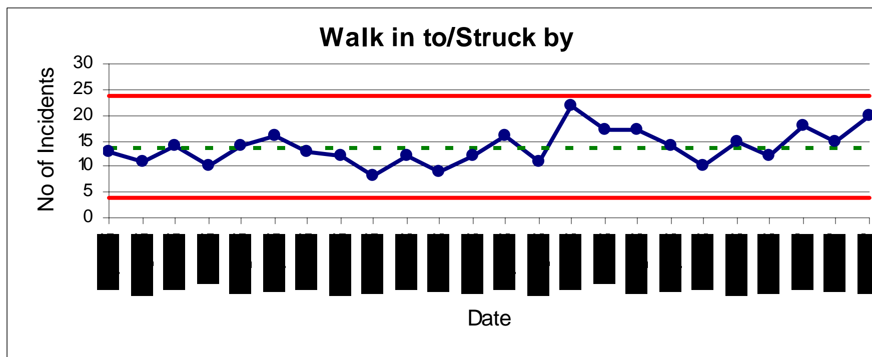
Trustwide Top 5 Employee Incidents Apr 2005 to Mar 2007
Statistical Process Control Charts

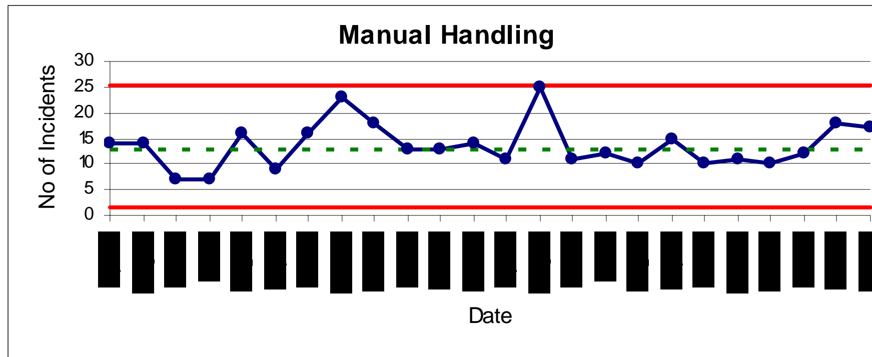






Inoculation Injuries - 20% near misses





Actual Impact - Visitor/others incidents

None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
38	68	2	0	0

Future potential impact to the organisation

Visitor/others Incidents 2006 - 07

LIKELIHOOD of hazard being realised	CONSEQUENCE				
	None (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	4	5	0	0	0
Unlikely (2)	27	18	1	0	0
Possible (3)	29	17	0	0	0
Likely (4)	5	2	0	0	0
Almost Certain (5)	1	0	0	0	0

Risk Matrix – Definition of likelihood

LIKELIHOOD	DESCRIPTION
ALMOST CERTAIN	Will undoubtedly occur on a regular basis (daily)
LIKELY	Will probably occur (weekly)
POSSIBLE	May occur (monthly)
UNLIKELY	Do not expect it to happen but it is possible (once per year)
RARE	Cannot believe that this will ever happen (< once per year)

Risk Matrix – Definitions for consequence of incident (actual or potential)

DESCRIPTION	ACTUAL OR POTENTIAL IMPACT	NUMBER OF PERSONS AFFECTED	ACTUAL OR POTENTIAL IMPACT ON THE ORGANISATION
CATASTROPHIC	Death	Many (>50) e.g. cervical screening concerns, vaccination error etc.	• International adverse publicity, loss of confidence in the organisation • Extended service closure • Litigation >£1million
MAJOR	Major permanent harm	16-50	• National adverse publicity/major loss of confidence in the service • Temporary service closure • Litigation >£500,000 • Increased length of stay >15 days
MODERATE	Semi-permanent harm (up to 1 year)	3-15	• Local adverse publicity/moderate loss of confidence • Litigation £50k-£500k • Increased length of stay 8-15 days
MINOR	Non-permanent harm (up to 1 month)	1-2	• Litigation <£50k • Increased length of stay 1-7 days
NONE	No obvious harm	N/A	• Minimal impact, no service disruption

APPENDIX 3

Health and Safety Action Plan 2007 - 08

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
1	Moving & Handling	Review the current system for moving and handling of linen to the wards. Identify and implement improvements that will reduce the risks associated with this operation.	A safe system of work will be introduced which will reduce the potential for moving and handling injuries.	Portering Manager & Moving and Handling Advisor	April 07
2.	Moving & Handling	Review the current storage of storing chemicals in boxes under the shelving in the Breast Care Unit. Identify and implement a system for the management of the load which negates the need for stooping and lifting.	A safer system of the storing boxes containing chemicals will be introduced that will reduce the risk of moving and handling injuries	Mammography Department Manager & Moving and Handling Advisor	April 07

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
3.	Moving & Handling	Complete a task inventory of all non-patient moving and handling operations where the load exceeds 15 kg. Ensure a risk assessment has been carried out each of the tasks identified on the inventory and implement appropriate control measures as identified. .	Each directorate will have identified non-patient moving and handling operations and will implemented control measures.	Directorate Managers & Moving and Handling Advisor	June 07
4.	Moving & Handling	Review and monitor the quality of manual handling training being delivered at a local level at regular intervals. This to be achieved by:- • Reviewing Trainers Portfolios annually • Observe trainers delivering training at least once per year. • Ensure all trainers attend an annual update	Standard of Manual Handling Training delivered is of a suitable standard	Moving and Handling Advisor	Ongoing
5.	Moving & Handling	Establish a system so as to ensure all that all moving and handling key trainers are kept up to date with any changes in procedures / techniques etc. via newsletter or email.	A demonstrable system to ensure all key trainers are up-to-date with changes/policies we will be established.	Moving and Handling Advisor	April 2007
6.	Moving & Handling	Review the current numbers of Manual Handling Trainers within the Trust and ensure there are adequate numbers available in order to deliver local training and supervise manual handling practice within their workplace.	The requisite number of manual handling trainers will have been trained for all departments.	Moving and Handling Advisor	Sep 2007

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
7.	Moving & Handling	Identify discrepancies in moving and handling risk assessment forms being used and in ensure that all departments are using the same assessment form.	A Trust wide standard will be achieved	Moving and Handling Advisor	April 07
8.	Moving & Handling	Identify common manual handling tasks e.g. removing a patient with a bath and develop generic assessments that recommend safe handling practice in these situations.	Consistency will be achieved through staff following generic assessments	Moving and Handling Advisor	June 07
9.	Moving & Handling	Review the Moving and Handling policy and ensure that the following points are made explicit: • that induction training is general and therefore local training needs to be comprehensive • that non-clinical handling risks are just as important as clinical	Robustness of the policy will be improved.	Moving and handling Advisor	April 07
10.	Moving & Handling	A twice yearly meeting chaired by the Moving and Handling Advisor will be established to discuss work related upper limb disorders. The following departments, Sonography, Echocardiography and Maternity should be represented.	Common issues can be resolved.	Moving and Handling Advisor	April 07

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
11.	Display Screen Equipment	Ensure DSE assessments are carried out in the Echocardiography rooms.	Compliance with the DSE regulations.	Cardiology Services Manager	April 07
12.	Key Performance Indicators	The number of staff in date for moving and handling training should be reintroduced as a key performance indicator in the quarterly review template.	Improvement in the quality of data in the quarterly review template.	Risk Manager	June 07
13.	Risk Assessment	The quality of risk assessments, including whether identified remedial measures have been actioned, will be monitored as part of the Health and Safety Technician's and Moving and Handling Advisor's inspection programme.	Will provide an overview of whether identified control measures are being implemented	Risk Manager	Ongoing
14.	Out of hours response to violence and aggression incidents (Out of hours = when security not available)	• Review current policy and procedure on out of hours response to incidents. • Reassess risk of out of hours response to incidents and consider its priority on Facilities & Trust risk register. • Review staff training and guidance on security awareness and appropriate response to out of hours incidents.	The Trust will have assessed and considered it's "out of hours response" to violence and aggression incidents and will have a robust plan for managing such incidents.	Trust Security Manager	Sept 07

No.	Area.	Action to be taken	Outcome	Lead responsibility	Delivery date
15.	Control and restraint	• Review current policy and procedure on control and restraint. • Seek confirmation of statutory minimum staffing levels for control and restraint of persons in an acute hospital environment. • Undertake a training needs analysis exercise in conjunction with a cost benefits analysis exercise for training all front line staff in assisting with and/or practicing control and restraint. • Review all incidents of control and restraint. • Investigate using restraint devices.	The Trust will have assessed and considered its management of control and restraint.	Trust Security Manager	Sept 07
16.	Violence and aggression risk assessment for staff training needs.	• Review current compliance with V&A policy. • Consider security specific training updates for risk officers. • Agree a definition for “front line staff”. • Agree Trust lead for risk assessments. • Consider the need for “breakaway technique” training for some staff.	The Trust will be able to evidence that risk assessments for staff training needs, including non-clinical staff where appropriate, have been undertaken and are acted on.	Trust Security Manager Risk Manager	Sept 07
17.	Lone worker policy monitoring.	• A pilot reporting and monitoring scheme for community midwives is due to commence in January 07.	The Trust will consider the results of the pilot scheme with the intention of rolling out the scheme to all lone workers.	Trust Security Manager/ Head of Midwifery/ General Services Manager	April 07

No.	Area.	Action to be taken	Outcome	Lead responsibility	Delivery date
18.	ED alarm buttons.	• Review the requirement for consultation room alarms. • Remove or repair non-functioning or obsolete alarm buttons. • Review staff awareness and training needs for consultation room alarms.	Effective alarm call system where required in the ED.	Trust Security Manager Assistant Directorate Manager for Critical Care	April 07
19.	Linen distribution	Implement the recommendations of the post HSE linen distribution meetings, namely: • Identify a suitable enclosed trolley that can be used to store linen on the wards • Identify a suitable mechanical aid which can be used to move the above trolleys around the Trust • Complete a CAP 1 form for the purchase of the above two items • Purchase the trolley and mechanical aid for the Trust	Cross infection and moving and handling risks associated with linen distribution will have been reduced.	Head of Commercial Services	June 07
20.	Floor covering	Oversee the purchase/supply and fitting of the new floor covering to the main corridors.	The movement of trolleys around the hospital will be easier due to the reduced resistance offered by the floor covering.	Head of the Estates	June 07

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
21.	Sickness Absence	To develop and implement a system for collecting and collating sickness absence information in order to determine how much sickness absence is work related, where it is occurring and what the causes are.	A system will be developed and implemented.	Head of HR	June 07
22.	Work related stress management	A Stress Management Group will be created to consider matters relating to work related stress in the workplace.	Group members will be identified and routine meetings set up to take forward the 'stress' agenda.	Head of HR	April 07
23.	Training	Complete and deliver "Conflict resolution training" programme for all other staff.	All Trust employees to have conflict resolution training.	Learning and Development	Apr 2008
24.	Estates	Conduct a Trustwide risk assessment to identify areas where persons might fall from a height e.g. flat roofs and implement control measures accordingly.	Reduce the possibility of anyone falling from a height	Head of Estates	Jan 2008
25.	Trust wide	Extend the enquiry about health, health and safety and wellbeing at appraisal, to include doctors.	This will fulfil HSE's requirement for health surveillance for such things as latex and stress.	Consultant Occupational Physician	April 07

APPENDIX 4

CLINICAL & COST EFFECTIVENESS
ACTION PLAN 2007-08

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
1.	NSF for CHD (DoH 2002)	Action Plan/Position Statement to be received from Cardiology Services Manager	Evidence that the Trust is meeting the standards for developing services (and is implementing action plans to meet the requirements of any relevant subsequent guidance) of the NSF for CHD.	Cardiology Services Manager	Sept 07
2.	NSF for Older People: Standard 5 – Stroke (DoH, 2001)	None – all criteria met	Evidence that the Trust is meeting the standards for developing services (and is implementing action plans to meet the requirements of any relevant subsequent guidance) of Standard 5 of NSF for Older People	Directorate Manager – Medical Directorate	June 2007
3.	National Clinical Guidelines for Stroke (RCP, 2004)	Full participation in National Sentinel Stroke Audit for Stroke 2006. Action Plan to be developed and taken forward.	Evidence that the Trust is meeting the standards for developing services (and is implementing action plans to meet the requirements of any relevant subsequent guidance) of National Clinical Guidelines for Stroke	Clinical Services Manager – Stroke Unit	Dec 2007
4.	NHS Cancer Plan (DoH 2000)	Being implemented across all areas. National Cancer Peer Review and Action Plan in place.	Action Plan Implemented	Cancer Services Manager	June 2007

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
5.	Guidance on Commissioning Cancer Services: Improving outcomes in gynaecological cancers (DoH 1999)	Implementing across Network. RD&E is a Gynae Centre. Peer Reviewed in 2006.	Action Plan Implemented	Cancer Services Manager	June 2007
6.	Guidance on Commissioning Cancer Services: Improving outcomes in lung cancer (DoH 1998)	Implementing. Peer reviewed in 2006.	Action Plan Implemented	Cancer Services Manager	June 2007
7.	Guidance on Commissioning Cancer Services: Improving outcomes in gastrointestinal cancers (DoH 2001)	RDE is a centre for this with Plymouth taking specialist pancreatic work etc. Still some Network discussion re. Implementation. Peer reviewed in 2006.	Action Plan Implemented	Cancer Services Manager	Dec 2007
8.	Children and Young People with Cancer (NICE 2005)	Participating in Network-wide data collection and review of services against the guidance.	Action Plan Implemented	Cancer Services Manager	June 2007
9.	Sarcoma (NICE 2006)	Working with Network on Implementation Plan currently. To be finalised.	Action Plan Implemented	Cancer Services Manager	Dec 2007
10.	Skin Tumours including Melanoma (NICE 2006)	Working with Network on Implementation Plan currently. To be finalised.	Action Plan Implemented	Cancer Services Manager	Dec 2007

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
11.	Referral for Suspected Cancer (NICE 2005)	Referral guidelines in place across our catchment and Network. Also to be implemented via Choose and Book.	Action Plan Implemented	Cancer Services Manager	Dec 2007
12.	Atrial Fibrillation (NICE 2006)	Meeting criteria.	Steps towards Initial implementation	Clinical Services Manager (Cardiology and Stroke Unit)	June 2007
13.	Colorectal Cancer (NICE 2004)	NICE additional standards to be peer reviewed 2008. Implementation in progress.	Action Plan implemented	Cancer Services Manager	June 2007
14.	Familial Breast Cancer (NICE 2004)	Implemented.	Action Plan Implemented	Cancer Services Manager	June 2007
15.	Haemato-oncology (NICE 2003)	Implementing. Peer reviewed in 2006.	Action Plan Implemented	Cancer Services Manager	June 2007
16.	Head and Neck (NICE 2004)	Currently implementing across Network. Not finalised yet. Data collection and service reviews in progress.	Action Plan Implemented	Cancer Services Manager	Dec 2007
17.	Lung Cancer (NICE 2005)	Agreed to implement CT in advance of first Out-patient appointment.	Action Plan Implemented	Cancer Services Manager	June 2007

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
18.	Hypertension (NICE 2004)	Guidance primarily directed at Primary Care but should be reviewed for management in our clinics. For review by cardiologists.	Action Plan Implemented	Clinical Services Manager Cardiology and Stroke Unit	Dec 2007
19.	Breast Cancer (NICE 2002)	Implemented and Peer Reviewed in 2006.	Trust meeting recommendations	Cancer Services Manager	June 2007
20.	Urological Cancer (NICE 2002)	Implemented and RDE is a Centre. Peer Reviewed in 2006. Some service changes not yet completed across Network (e.g. Transfer of work from Torbay to RDE). Planned to happen during 2007.	Trust meeting recommendations	Cancer Services Manager	Dec 2007
21.	Post Myocardial Infarction (NICE 2001)	Guidance implemented.	Trust meeting recommendations	Cancer Services Manager	June 2007
22.	Supportive and Palliative Care (NICE 2004)	Guidance implemented. Peer Reviewed in 2006.	Trust meeting recommendations	Cancer Services Manager	June 2007
23.	NSF for Renal Services (DH 2004)	Action Plan being implemented.	Evidence that the Trust is meeting the standards for developing services (and is implementing action plans to meet the requirements of any relevant subsequent guidance) of the NSF for Renal Services.	Renal Services Manager	December 2007

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
24.	NSF for Diabetes (DH 2004)	Action Plan being implemented.	Evidence that the Trust is meeting the standards for developing services (and is implementing action plans to meet the requirements of any relevant subsequent guidance) of the NSF for Diabetes Services.	Diabetes Services Manager	December 2007