Northampton General Hospital
NHS Trust

Request under Freedom of Information Act 2000

Request Ref: NGFOI 19/20: 008

Thank you for your request for information received at Northampton General Hospital NHS Trust (NGH) on 02/04/2019.

I am pleased to be able to provide you with the following information:

Please provide details of clinical service incidents caused by estates and infrastructure failure at your hospital trust in 2018/19.

A "clinical service incident" is defined as follows: Number of incidents caused by estates and infrastructure failure which caused clinical services to be delayed, cancelled or otherwise interfered with owing to problems or failures related to the estates and infrastructure failure. Exclude failures relating to non-estates causes e.g. nursing availability, but include where external incidents which estates and infrastructures should have mitigated e.g. utility power failures where the Trusts backup power system failed to offset. An incident is considered to be a delay of at least 30 minutes to clinical services affecting at least 5 patients or equivalent. Both inpatient and outpatient service incidents should be included.

Such incidents will include, but are not limited to: • Power and/or heating failures including overheating • Fires and false alarms (where caused by equipment faults or malfunction, deliberate/malicious causes should be excluded) • Water and/or sewage supply • Food production and/or delivery • Pest control

For each incident, please provide a summary of the incident and the impact on services. Please provide details of the problem and in what way clinical services were affected, including the number of patients affected, the service and how long the service was delayed/if it was cancelled.

The information below has been taken from the Trust Datix Incident reporting system which has varying amounts of information supplied to each event.

It has not been possible to fully determine the number of patients involved and the duration of the delay in all incidents. I can confirm on behalf of the Trust and in accordance with S.1 (1) of the Freedom of Information Act 2000 (FOIA) that we do not collate the information you have requested in a centralised system.

Description	Action taken
Air temperatures in theatres 3 and 4 began to rise significantly at 12.30pm reaching a high of approximately 36 degrees centigrade in theatres and anaesthetic rooms. Surgical procedures were delayed due to high temp.	Estates were called when temp continued to rise out of normal limits. Patient's surgery was delayed due to the high temps. When temps came down, and remained at acceptable limits, surgery recommenced at approximately 14.30.
Leaks occurred in the pharmacy over hang and above and onto the pharmacy robot, robot had to be shut down for most of the day, causing delays to medicine dispensing activity.	Asbestos has been removed under licence to expose defective pipework. A significant volume/ cost of medicines has been destroyed following this leak. Leak over robot area repaired, after accessing pipework from above to rectify problems. Robot and surrounding area has been cleaned, medicine damage to be assessed and valued. Damage to robot to be assessed and valued/ repaired
Failure of site water softening plant. This plant feeds softened water to the SSD Reverse Osmosis water plant for subsequent production of water used in the Thermal Disinfection stage of the SSD Automated Washer Disinfectors. Unable to process any surgical equipment through washers. This had a knock on effect to Theatre Lists planned for next day as SSD could not process any equipment at this time.	All Theatres advised by telephone by MCD.E-mail sent out to all Theatre Managers.
Endoscopy unit decontamination room, number of Wassenburg washers being out action due to high micro bacteria results and a further two out of action due to being unable to thermal the machines. There was a back log of 17 scopes to reprocess before being used on each patient. The remaining Wassenburg machines that are in working order repeatedly kept alarming to say that the water temperature is not high enough in order to wash the scopes. Due to this it has meant that from mid day that the decontamination room has closed as there is no scopes or machines ready to use. As a result the patient lists have been cancelled.	Manager has been informed throughout and as a result all afternoon lists have been cancelled. Effecting both endoscopy, urology and main theatres all of which have cancelled patients.

Description	Action taken
Water turned over to emergency tank, water not hot enough to thermal the machines so cannot clean any scopes	Estates informed, patients cancelled
Water was found to be leaking from service Hatch and Light fitting in Lab 1. After moving list to Pacing lab (Lab 2). Leak was found from service hatch in Lab 2 also.	Both labs out of action so patient had to be cancelled. All remaining outpatients from the day list cancelled.
2222-fire alarm – Gynae 73-01-017.	The room was an electrical cupboard next to head and neck and there was a very strong battery smell coming from behind it. The fire brigade were called. As the electrical door was opened, the strong smell spread and the area was cordoned off. Head and Neck Ward was evacuated. Fire brigade kept members of the public, patients and staff away from the area until safe to return. .
Water leaking from pipes in dirty utility room, overflowing into sinks in the dirty utility room, anaesthetic room 1 and anaesthetic room 2 and scrub sink in between theatre 1 and 2.	Reported to estates to attend the incident. Delayed start of operating list in theatre 1 and 2. Sealed off contaminated area, prioritised patients with the consultant operating in theatres 1 and 2 as operating time had been reduced. some patients were cancelled, the other patients were operated on in Manfield theatre and the day surgery unit..
Theatre ventilation in DSU 1 and heating has not been working awaiting external part. Temperatures in theatre dropped to 16.3, and as a result list had to be cancelled for patient safety reasons. Decision to cancel lists taken at 15.30..	Plan going forward is to discuss with the surgeon and re date the patient as soon as possible. Waiting list will contact the patient with another date.
During a laparoscopic hernia repair a water leak was spotted coming from the ceiling the team was informed and the case was completed. Due to the unidentified nature of this leak the list was stopped at this point.	The list was stopped and estates informed.
Water supply lost several times.2x Electricity cuts throughout the night. Resulting in patients being cancelled, patients rescheduled.	Matron and directorate manager aware. Estates aware. All patients given new appointments.

Total power failure throughout whole of hospital. Two women in labour affected by this. **Site wide loss of electrical supply. Generators came on and power returned to site with the exception of old part of site (excluding Cripps and Out Patients) and A&E, Theatres and Reception Area. Areas had power returned in stages.**	**Drs present on labour ward. Triage phone contacted surrounding hospitals to check availability of beds due to the unit being closed.** **On call Estates Team was contacted.**
Laminar flow failure in Manfield theatre 1,affecting list.	**Reported, patients delayed.**