Health and Safety Annual Report

Presented by:	Tanya Claridge, Director of Governance & Corporate Affairs	**Author:**	Tanya Claridge, Director of Governance & Corporate Affairs
Previously considered by:	Health and Safety Committee		

Key points	**Purpose:**
1. The Health and Safety Annual report describes the progress made by the Trust during 2017/18 in relation to Health and Safety	To receive
2. The opportunity was taken during the preparation and analysis for this report to do a full review of areas of health and safety risk and compliance with regulation to ensure that objectives for 2018/19 and the subsequent work-plan were evidence based	To receive
3. The Board of Directors is asked to note the depth of enquiry that has been used to support the content of this report, and support the approach described to understanding risk and compliance in 2018/19	To receive

Executive Summary:

The purpose of this report is to provide the Trust Board of Directors with a 'pen portrait' of the progress made by the Trust in relation to Health and Safety during 2017/2018. It describes how resource has been used and continues to be used to help make Bradford Teaching Hospitals NHS Foundation Trust a safer place for both its staff and patients.

Nationally there have been many high profile incidents, for instance Alton Towers, Didcot, Bosley Mill and most recently Grenfell Towers, which have had a devastating and lasting impact on those involved and their families. They are powerful reasons why Health and Safety is so important. However, behind the incidents that attract national media coverage, there are many more health and safety incidents that have an impact on the lives of health care staff and their patients.

Whilst the Trust's performance in relation to Health and Safety is generally good, there are opportunities for change and improvement. During 2017/18 there were twelve incidents which were reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR). These represent a ratio of 229 reportable incidents per 100,000 employees, this compares with 384 per 100,000 employees (2016/17) for the acute sector.

The report provides summary information relating to principal activities associated with the management and promotion of Health and Safety issues. It also highlights the current key priorities for the Health and Safety team during this current financial year.

The report also provides a summary of a gap analysis undertaken in relation to key areas of national policy and Trust performance. This approach of identifying gaps and risks associated with any health and safety regulations benefits the Trust as it provides a clear picture of health and safety compliance. The results of the gap analysis have been used to develop a revised suite of key performance indicators that will be used during 2018/19 to support the optimisation of the work being undertaken in the Trust.

Financial implications:
No

Regulatory relevance:

Monitor:	Risk Assessment Framework
	Quality Governance Framework
	Code of Governance
	Choose an item.

Equality Impact / Implications:	Choose an item.
	Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes ☐ No ☒ If yes, what is the mitigation against this?

Strategic Objective: *Reference to Strategic Objective(s) this paper relates to*	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners

Bradford Teaching Hospitals
NHS Foundation Trust

Health and Safety Annual Report 2017-2018

Dr Tanya Claridge
Director of Governance and Corporate Affairs

Key contributions from:
Reginald Whitfield, Interim Non-Clinical Manager
Sarah Branigan, Datix Manager

June 2018

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Introduction

The Health and Safety risk profile across Bradford Teaching Hospitals NHS Foundation Trust ('the Trust') is developing exponentially across the Trust, with a defined governance structure, reporting to the Board of Directors through the business of the Health and Safety Committee.

The overall aim of this report is to assess the level of compliance with health and safety legislation and to identify areas which require further attention to improve compliance. This report therefore provides analysis of health and safety performance across the Trust for the year April 2017 to March 2018 by reviewing and assessing:

- The internal structure for the management of health and safety
- The arrangements in place to identify and remove/reduce significant risks.
- How the Trust is performing year on year (both internally and benchmarking with similar organisations)
- Compliance with relevant health and safety legislation
- Consultation with employees
- External stakeholders/influences (e.g. HSE, medical device alerts, best practice)

The report has been structured using the Health and Safety Executive[1] model of managing health and safety as described in HSG65. The four elements of this model are: Plan, Do, Check, Act.

[1] http://www.hse.gov.uk/pubns/priced/hsg65.pdf

Background

The basis of the United Kingdom's Health and Safety Law is the Health & Safety at Work Act (HASAWA) (1974). The Act sets out the general duties which employers have towards employees and members of the public, and employees have to themselves and to each other.

The Trust therefore has a legal duty to put in place suitable arrangements to manage for Health and Safety. As this can be viewed as a wide-ranging general requirement, the Health and Safety Executive encourages a common-sense and practical approach. It should be part of the everyday process of running an organisation and an integral part of workplace behaviours and attitudes. The keys to effectively managing for health and safety are:

- leadership and management (including appropriate business processes)
- a trained/skilled workforce
- an environment where people are trusted and involved

HSE advocates that all of these elements, underpinned by an understanding of the profile of risks the organisation creates or faces, are needed. This links back to wider risk management and can be pictured in Figure 1.

Figure1: the Core elements of managing for health and safety

The Management of Health and Safety at Work Regulations (1999) require employers to put in place arrangements to control health and safety risks. As a minimum, the Trust should have the processes and procedures required to meet the legal requirements, including:

- a written health and safety policy
- assessments of the risks to employees, contractors, customers, partners, and any other people who could be affected by your activities – and record the significant findings in writing
- arrangements for the effective planning, organisation, control, monitoring and review of the preventive and protective measures that come from risk assessment
- access to competent health and safety advice

- providing employees with information about the risks in the workplace and how they are protected
- instruction and training for employees in how to deal with the risks
- ensuring there is adequate and appropriate supervision in place
- consulting with employees

HASAWA places the overall responsibility for Health and Safety with the Trust Board of Directors (as the employer). The Director of Governance and Corporate Affairs has delegated responsibility from the Chief Executive for the overall management of Health and Safety.

1. Plan

1.1 Health and Safety Governance

The Trust has a Health and Safety Committee which reports directly to the Board of Directors. It is chaired by the Director of Governance and Corporate Affairs. Staff side health and safety representatives are involved in all aspects of health and safety decision making, this includes membership on the Health and Safety Committee.

The business and governance of the Health and Safety Committee, is supported by an infrastructure of sub-groups representing and assuring key areas of legislation or regulation (including sharps Injuries, COSHH, ionising radiation, non- ionising radiation, medical devices, medical gas and waste). An organogram of this governance infrastructure is presented in Appendix 1.

The Compliance Risk Assurance Group (CRAG) also reports directly into the CHSC. CRAG is the overarching health and safety group for the Estates and Facilities Department (EFD). It is supported by a number of sub groups for; health & safety, fire safety, legionella, electrical safety, water safety, ventilation and violence & aggression.

In April 2018 the Estates and Facilities Health and Safety Group (E&F Group) was set up to provide a more integrated approach to health and safety management between the two previously separate departments. The group reports directly to (CRAG).

The EFD has a dedicated Risk Manager who is responsible for the health and safety of the department, supported by several subject matter experts covering:

- Fire
- Asbestos
- Legionella
- Manual handling
- COSHH
- Occupational Health

The EFD adopted the NHS Premises Assurance Model (PAM) on 1st April 2018. It is a self-assessment management tool that provides NHS organisations with a way of assessing how safely and efficiently they run their estate and facilities services.

The organisation commissioned a dangerous goods & healthcare waste audit from an external dangerous goods safety advisor, to assess the organisations compliance with the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011. The report was presented at the CHSC in 2017 along with an action plan developed to ensure the organisations compliance with the legislation. The monitoring of this action plan was originally overseen by a carriage of dangerous goods task and finish group, which reported into the health and safety committee. However, to ensure the risks associated with dangerous goods are managed effectively in the longer term, the task and finish group was converted to a sub group of the Health and Safety Committee in 2018.

Competent advice regarding H&S is provided by two Non-Clinical Risk Managers; both of whom are Chartered members of IOSH.

1.2 Policies and procedures

The Trust has an overarching Health and Safety Policy, which describes the maintenance of an effective health and safety management system that is proportionate to the risks face by the organisation. The Trust's policy sets the direction for effective health and safety management and is designed to ensure

communication of health and safety duties and benefits throughout the organisation. The policy is designed to meet legal requirements, prevent health and safety problems, and enable the Trust to respond quickly where difficulties arise or new risks are introduced. The Health and Safety Policy requires the Trust to set annual objectives designed to continually improve and refine the Trust's

- compliance with legislation
- approach to assessing risk
- engagement with staff and patients

The Trust's Health and Safety Policy is supported by a number of policies and procedures. The status of these policies is described in Appendix 2. There are a number of policies under review and this issue will be escalated during early 2018/19...

1.3 Roles and responsibilities

Roles and responsibilities regarding Health and Safety are clearly defined within the Trust's Health and Safety Policy. The Director of Governance and Corporate Affairs has delegated responsibility from the Chief Executive for the overall management of Health and Safety.

The day-to-day management of health and safety at a local level lies with Ward Sisters, Ward Managers and/or Heads of Department.

Non-Clinical Risk Managers:
There are two Non-Clinical Risk Managers employed by the Trust who act as the competent persons in providing health and safety advice

Fire Wardens:
Fire Wardens are nominated by the Ward/Department Manager. Their role is broadly twofold; fire prevention and responding to an incident. They also maintain the required fire safety log book.

First aid provision:
A first aid protocol/procedure has been written (pending ratification at the next Trust Health and Safety Committee meeting). This will identify which areas should complete a first aid needs assessment, and what type of first aid personal is needed.

Trade Union (TU) Safety Representatives
There are several Trade union (TU) Safety Representatives, who perform a valuable role in raising concerns on an ad-hoc basis and through their attendance at the Trust Health and Safety Committee.

The TU Reps' have also assisted the Non-Clinical Risk Manager in completing the workplace inspections.

1.4 Objective setting

The Trust's Health and Safety Annual Report (2016/17) identified a suite of objectives for 2017/18. These are described and analysed in Appendix 3. For objectives where a review has resulted in the identification of outstanding actions, a recommendation is made. All recommendations made as a result of the reviews undertaken to support the content of this report are summarised in Appendix 7 of this report and have been used to develop the following objectives for 2018/19:

- To ensure that the Combined Risk Audit provides contemporaneous and consistent assurance that the Trust complies with the requirements of its Health and Safety Policy.
- To ensure that all risks associated with compliance with legislation are mitigated effectively and assured appropriately through the governance of the Health and Safety Committee

- To raise the profile of Health and Safety in the Trust through the use of a health and safety climate tool, awareness raising and increasing the profile of allied work-streams such as strengthening risk assessments and business continuity planning
- To ensure the wellness of staff with a particular focus on stress and support for staff involved in serious incidents through collaborative working with human resources and occupational health services
- To develop a suite of generic and work environment specific risk assessments
- To ensure the appropriate escalation of health and safety risk through divisional governance systems

1.5 Work-planning

In order to deliver the Trust's Health and Safety Objectives set for 2017/18 the Health and Safety Committee agreed and monitored a work-plan. The work plan and the associated progress with each action are described in Appendix 4. The work-plan for 2018/19 is described in Appendix 8. This work-plan is derived from the objectives for 2018/19 and the actions identified as a result of the analysis required for this report (Appendix 7).

1.6 Changes in legislation

The Health and Safety team and the governance structures associated with Health and Safety constantly horizon scan to ensure that policy and procedure is kept up to date.
The Ionising Radiation Regulations 2017 (IRR17) came into force January 2018 and replaced Regulation IRR99.

The main changes are:
- How to inform the HSE that the organisation is working with ionising radiation
- The dose limit for exposure to the lens of the eye - reduced from 150mSv to 20mSv in a year

The Trust is monitoring staff against the reduced eye dose and amending controls to ensure that the Trust meets its obligation in relation to this change to the regulations.

The Personal Protective Equipment (PPE) Regulations have also been updated during this reporting period, but these changes only apply to those who produce PPE, or who are in the supply change, therefore these changes do not apply to the Trust.

2. Do

2.1 Risk profiling

The Trust is committed to the principles of good governance and recognises the importance of effective risk management, as a fundamental element of its governance framework and system of internal control. To this end the Trust has in place a detailed Risk Management Strategy (RM51) which provides an overarching framework for the management of risk within the Trust.

Identified risks are assessed using a consistent risk scoring matrix from which an initial, residual and current risk score and rating is derived. Identified risks are added to the Trust's risk register via the Datix Risk Management system in line with the Trust's Risk Management Policy. This policy includes detailed guidance for staff on the identification, assessment, mitigation and monitoring of risk. The Trust manages risk at a strategic, organisational, divisional and service level. Strategic risks are risks that have the potential to impact significantly on the achievement of the Trust's strategic objectives. These are reflected in the Board Assurance Framework as 'principal risks'. Organisational risks are risks that apply to the organisation as a whole, cannot be managed at Divisional level or, are considered a risk to the delivery of the Trust's strategic objectives. These are reflected on the Corporate Risk Register. Service level risks (Divisional / Directorate / Ward) are risks that have been assessed as being active in relation to their likelihood and consequence, and following assessment it is considered can be appropriately managed and mitigated at Divisional, directorate or ward level.

During 2017/18 full site risk assessments were in place for

- Slips, trips and falls- external areas
- Fire
- Needle stick injuries

Where appropriate, risk assessments were completed for

- Manual handling;
- Lone Working;
- Stress;
- Display screen equipment;
- COSHH;
- New and expectant mothers;
- Violence & aggression;

There are a number of staff based, or working out of premises which are not own or controlled by the Trust. To ensure their safety, a monthly compliance report is completed by each landlord, and forwarded to Estates and Facilities Department; the report covers the following areas:

- fire safety
- water safety
- lifts and lifting equipment
- gas safety
- electricity

The reports are reviewed by the Estates and Facilities Department to ensure compliance with legislation, building regulations and Health technical memoranda (HTMs).

During 2017/18 potential risk areas were identified, assessed and any significant risks which were not effectively mitigated at a local level were escalated through the risk escalation framework, which details the escalation procedure from workplace to the Health and Safety Committee. (This procedure can be

found in the “Risk Management Strategy”, policy ref: RM51). These risk areas are described in Appendix 5 and

- have been mapped to the appropriate legislation
- have been assessed in relation to the impact on compliance using the ratings descriptions found in table 1.
- recommendations have made to strengthen the existing mitigation

Table 1: Assessment of compliance with legislation based on risk profiling

RED	Non-compliant with regulations: Many gaps/areas of concern **MAJOR** level of risk due to non-compliance for Trust (no actions identified or plan in place to manage) and/or unsafe for patients/staff - Enforcement action almost certain
AMBER	Non-compliant with regulations: some gaps/areas of concern **MODERATE** level of risk due to non-compliance for Trust (actions identified, plan in place and on target to complete) And/or unsafe for patients/staff - Enforcement action likely/possible
YELLOW	Non-compliant with regulations minimum gaps/areas of concern. **MINOR/SIGNIFICANT** level of risk due to non-compliance for Trust (actions identified and plan in place and on target to complete). No risk to patients/staff– Enforcement action unlikely
GREEN	Fully compliant with regulations (i.e. Legislations, HTM’s, Guidance and no areas of concern. (actions complete and monitored for maintenance of compliance) No risk to patients/staff -No enforcement action expected

2.2 Organising for health and safety

Co-operation and Communication
The Non-Clinical Risk Manager has monthly meetings with the TU Convenor to discuss health and safety issues. In addition the workplace inspection programme, in collaboration with the TU Convenor is scheduled to restart in early 2018/19. The quorum for the Trust Health and Safety Committee includes two TU representatives.

Health and safety related policies/procedures are forwarded to the Trust Health and Safety Committee and disseminated to all members of the Committee for comment; this includes the TU Representatives.

The Trust communicates health and safety information through a variety of mediums, such as:

- screensavers (a recent example is information on RIDDOR incidents)
- posters (e.g. the HSE Health and safety Law poster)
- leaflets (a recent example is a leaflet produced about RIDDOR reporting)
- training sessions
- safety huddles
- learning matters publications

Competence: Providing competent advice to the Trust:
There are two Non Clinical Risk Managers in post (one interim, covering maternity leave) who act as the competent persons in providing health and safety advice/guidance to the Trust. They are both Chartered members of IOSH.
In addition there are subject matter experts in key areas:

- Fire
- Asbestos
- Legionella
- Manual handling
- COSHH
- Occupational Health

Competence: Ensuring staff competency:
A training needs analysis (TNA) is completed for all job roles; this determines the types of training the job holder should receive. It needs to be remembered that training alone does not equate to competency. To ensure the staff are competent in their role, more “on the job” checks are needed. This can take the form of coaching/monitoring/refresher training. A good example of this is the refresher training which is undertaken for manual handling. Rather than a training session, a competency assessment is carried out instead.

Recommendation: Add staff competency checks to the combined risk audit (AP18)

3. Check

The Trust uses both proactive and reactive methods to assure compliance with Health and Safety regulations. The Health and Safety Committee receives a summary of related key performance indicators at every meeting for review and challenge. The review conducted to support the completion of this annual report identified some opportunities for change and improvement in what is reviewed and used to assure that the Trust is making good progress in relation management for Health and Safety. The proposal for a revised suite of key performance indicators can be found in Appendix 9 of this report.

3.1 Proactive Monitoring

Proactive monitoring is a planned approach to understanding effectiveness of the infrastructure that supports health and safety performance. It includes:

- Training/induction
- Combined Risk Auditing
- Internal Audit
- Risk Assessments
- Workplace Assessments

The performance and outcome of each method are described below in the following sections:

- **Training attendance 2016/17 and 2017/18**

Table 2 shows the percentage compliance with a range of Health and Safety related training. Whilst compliance with all types of training requires further review, there is a significant concern in relation to the attendance at and delivery of moving hand handling training. The management of the risk associated with this is being assured through the Corporate Risk Register and the Integrated Governance and Risk Committee. Moving & Handling training has been revised to ensure that all staff who undertake high and medium risk moving and handing activities at work, will be provided with the relevant practical training within three weeks of commencing employment and receive refresher training every three years.

Figures for H&S and Low risk moving & handling training remains relatively unchanged, with the exception of strategic risk management training being 10% lower than last year. However with the introduction of the proposed H&S/Risk Management training the expectation is the compliance rates for risk based training will increase.

Table 2: percentage compliance with mandatory training type

Training type	2016/17 (%)	2017/18(%)
Fire safety (one or two yearly)	81	78
Moving & handling (Low risk three yearly)	81	85
H&S awareness (two yearly)	83	82
Moving & handling med/high risk (two yearly)	60	60
Strategic risk management (Two yearly)	73	65

- **Local inductions for new starters and visitors on site:**

Within the past year the Estates and Facilities Department have made significant improvements to its contractor induction process. Contractors are now required to watch a site specific induction video which comprehensively covers the Trust site and safety rules. To evidence that contractors have fully understood the information conveyed they are required to successfully pass a multiple choice question paper. On successful completion of the test, the contractor is subsequently issued with a contractor induction pass. However there does not appear to be a standard form or format for providing other new starters/visitors with a local induction, in relation to Health and Safety of their work environment.

Recommendation: develop a local induction procedure which can provide the assurances necessary, complemented with a recording process to measure compliance. (AP20)

- **Combined Risk Audits**

The next bi-annual Combined Risk Audit is scheduled to be completed by the third quarter of 2018/19. The audit is sent out to all wards and areas (including the Estates and Facilities Department) and is completed by ward managers, who send the completed audits back to the Risk Department. The results of these audits are reported to the Trust Health and Safety Committee.

- **Internal audit**

Audit Yorkshire undertakes regular audits of the Trusts health and safety systems and an internal audit was conducted by Audit Yorkshire in March 2017. The objective of this audit was to gain assurance that there are appropriate processes in place at the Trust to ensure that it is meeting its statutory duties for Health and Safety.

This audit produced six recommendations, five of which have been completed. The recommendations and the associated progress can be found in Appendix 6. The one remaining one involved RIDDOR reporting. A number of changes have already been made to the Datix system to enable RIDDOR reporting to be made easier, and to ensure compliance. Further changes are planned which will require those completing the forms to use the generic risk management email address to ensure accurate monitoring.

- **Risk assessments**

The Trust's Risk Management Strategy requires a formal risk assessment to be completed when a hazard is identified. The Trust has implemented a two phase approach to health and safety risk assessments:

  - Phase one: Generic risk assessments are being undertaken for tasks which are common across the organisation (e.g. slips and trips, manual handling, stress). These are held centrally and made available to all areas. In some instances these generic assessments will be sufficient, but in other areas they may need to be adapted to reflect local conditions.
  - Phase two: Additional risk assessments will also be identified and completed, which will be area-specific (e.g. clinical, admin, communal).

These assessments are being added to the combined risk audit which will be used to measure the level of compliance and provide levels of assurance.

There is a structure in place which enables unresolved risk assessment to be escalated onto a particular level of risk register (Sub-Committee/Divisional/Corporate), depending on the risk score. In addition, copies of all completed risk assessments are sent Risk Department and added onto a database (the risk assessment repository).

- **Workplace inspections**

Workplace inspections in collaboration with the TU Convenor were limited during 2017/18, and the programme of inspections will be strengthened during 2018/19.

- **Health and Safety Climate Survey**

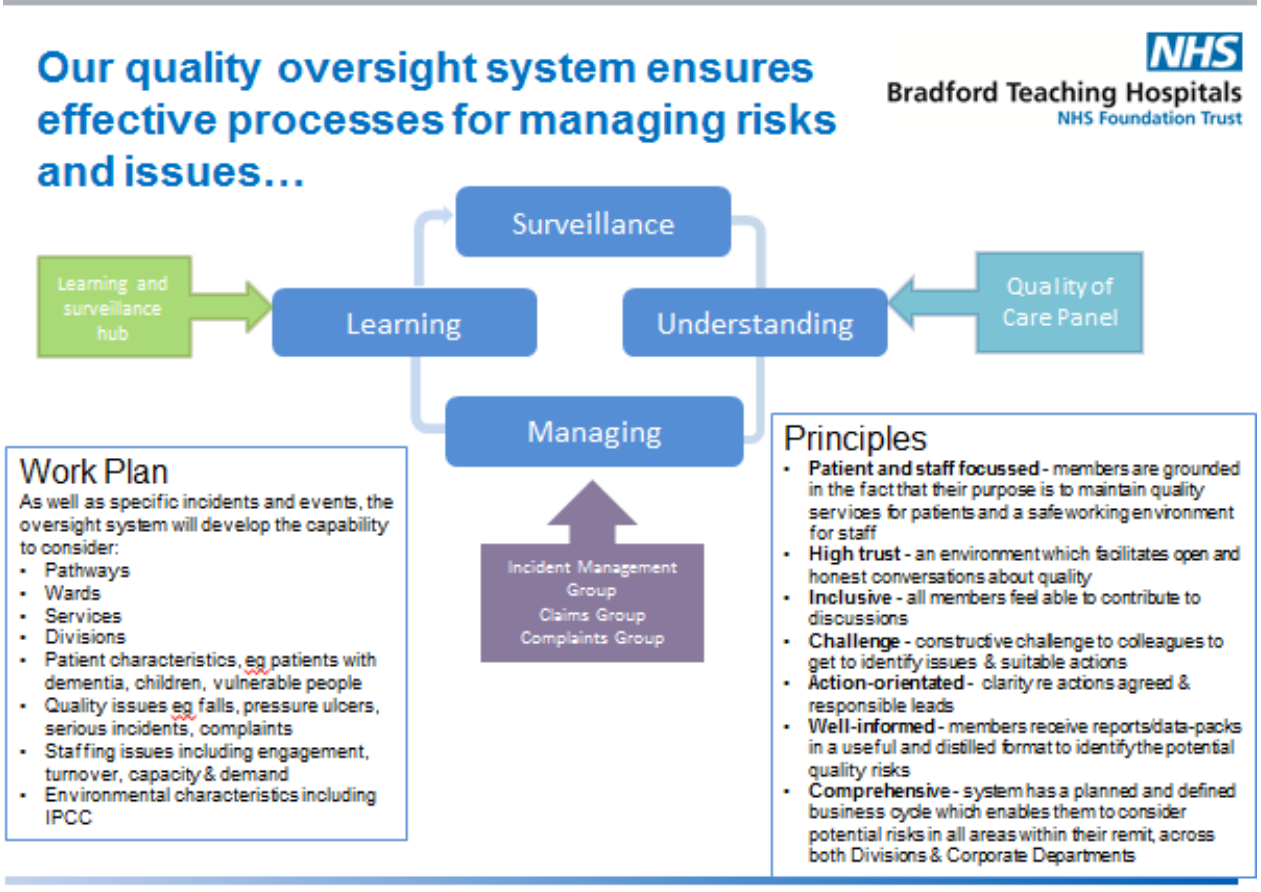
The prevailing health and safety culture within an organisation, i.e. the way it approaches and manages health and safety issues, is a major influence on the health and safety-related behaviour of people at work. The HSE advocate that developing a positive health and safety culture is important if high standards of health and safety are to be achieved and maintained. The Trust has never used cultural or climate assessment tools in relation to Health and Safety. The Trust engaged with some external providers during 2017/18 to enable a programme of surveys and work to contextualise the outcomes with other health and safety data to be delivered.

Recommendation: undertake a health and safety climate survey on an annual basis and use the results as part of the KPI's for health and safety. This should include the number of completed surveys and the "scores" from them. This can then be used to view progress on a year by year basis, and could identify particular areas of concern (AP19)

3.2 Reactive Monitoring

The Trust monitors health and safety performance in a reactive way by ensuring that precursor incidents are identified, analysed and contextualised through its Quality Oversight System (See Figure 1). Precursor incidents can be identified through incident reporting, personal injury claims, complaints, staff and patient feedback, risk assessments, failures of business continuity plans etc. The Quality Oversight System enables the categorisation of precursor incidents, the agreement in relation to the level of investigation required and the identification of any learning.

Figure 1: Quality Oversight System



Health and safety incidents 2017/18

The Trust monitors all health and safety incidents with specific reference to the top five occurring incidents. The Foundation Trust has encouraged managers and their staff to report incidents throughout 2017-2018. The Data categories used to generate this report have been reviewed and updated to enable more accurate reporting of H&S related incidents. It is expected that with the continued promotion for managers to report incidents, these figures may increase in the following year. Table 3 provides as summary of the top five incidents by frequency for 2017-2018 and is compared to the previous reporting year.

Table 3: The top five Health and Safety Reported Incidents

Incident category	2016/2017	2017/2018	Trend
Verbal abuse	149	157	↑
Threatening behaviour	161	165	↑
Physical assault	124	132	↑
Contamination incidents	79	102	↑
Staff fall, slip or trip on same level	57	55	↓

Incidents coded as 'cut with a sharp object 'were also reviewed as there was a clear increase between the number reported during 2016/17 and during 2017/18. Over half of these incidents are actually needlestick injuries which have been incorrectly reported .These should have been reported as a "contamination" incident. The categories have been discussed with the Occupational Health Manager who has agreed to changes to the system which will enable more accurate reporting. However this means that we do not fully understand the totality of needlestick injuries due to the coding errors. Although it is clear with a rise in contamination incidents and also cut with sharp object incidents, the incident profile in relation to needlestick injuries is not insignificant.

There were 55 incidents of staff slips, trips on the same level. Of these, 14 involved staff slipping on wet floors, there were no incidents reported involving patients slipping on wet floors.

The Board of Directors will receive papers during 2018/19 from the Head of Security describing proactive measures in relation to the measures being taken to prevent incidents relating to violence and aggression.

Twelve incidents met the criteria for being reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and are discussed in detail in the section below.

RIDDOR reportable Incidents 2017/18

Twelve incidents were identified as meeting the criteria for reporting under RIDDOR during 2017/18. These are described in Table 4. Twelve RIDDOR reportable incidents at BTHFT represent a ratio of 229 reportable incidents per 100,000 employees, this compares with 384 per 100,000 employees (2016/17) for the acute sector.

Table 4 RIDDOR incidents 2018

Incident	Actions
Specified injuries	
porter fractured wrists whilst pushing/pulling large waste bins	The porter was trained in the moving of beds, wheelchair and trolley, including push and pulling of items **Action:** The porter was advised that he must always confirm with his supervisor if he is not certain on whether he should be carrying out a procedure.
porter fractured wrists whilst pushing/pulling large waste bins	A wheel was defective on this bin was probably due to wear and tear. **Action:** all defective bins taken out of service New SOP being written Changes to waste collection has resulted in reduced manual handling of bins
Staff member slipped on black ice in BRI car park, fracturing lower leg	Gritting record confirms foot path were gritted on morning of incident, but roadways gritted same day but post incident.
Dangerous occurrence	
During hip surgery clean wire grazed glove and scratched skin underneath before then being entered into the patient. The patient is hep C antibody +	**Action:** The sharps injury protocol was followed

Incident	Actions
Specified injuries	
Dr taking blood from a patient, patient flinched and needle stick injury result	**Action:** All appropriate action was completed at the time and the Dr involved went to see Occupational Health
Over 7 day injury	
Staff member strained knee pushing ETC cart	**Action:** manual handling risk assessment completed and advice given to staff on push/pull techniques. Cart manufacturers asked why new carts are fitted which four free wheels rather than with two fixed wheels
Staff member injured back & leg pain whilst pulling baskets of frozen food from freezer	Report refers to faulty, or frozen blue wheels as the cause of the incident. **Action**: new wheels on order Wheels inspected by risk management –deemed safe to use. New procedure – staff to seek assistance when blue wheels are found to be frozen
Staff member burnt hand taking food out of regen oven. Gloves not being worn	Film lifted during re-heating, causing gap whereby hot liquid squirted onto her hand. Although oven gloves & gauntlets available, report suggests not being worn **Action:** risk assessment to be revised Refresher training for staff
Staff member slipped in labour ward kitchen and tripped over wet floor sign	Unknown if the floor was wet. **Recommendations:** If floor was wet, consider placing wet floor sign at eye level on outside of kitchen door.
Patient falls	
In- patient fell fracture NOF RCA completed	Patient 5 days post –op. advised not to leave the ward on his own. Patient walked off ward using Zimmer frame. Found on floor (going to get a hot drink). Falls assessment not required (<65) Patient non concordance ambulating off ward area to main entrance to smoke **Action:** falls assessment completed
In-patient fell fractured clavicle No record of RCA on Datix	Patient found on floor, had been sat in wheelchair with lap belt in- situ. Patient undid her lap-belt and attempted to stand. **Action:** Falls alarm has been applied to bed and chair. Patient moved to main ward to be more visible
Patient tripped & fell injured shoulder unwitnessed. RCA completed	Falls assessment in place. The fall took place in an area where some bubbling of the lino had been reported to NHS Property services. After the fall there was evidence that the join in the lino was lifted **Action:** NHS PS came that day to tape the floor with hazard tape. They will fix the lino on 4.9.17. (incident date 18.8.17)

There was a number of administration process failures associated with the management of RIDDOR in the Trust as evidenced during the review of the RIDDOR incidents reported during 20/17/18. These administration failures include:

- 11 RIDDOR reportable incidents have the Datix section “actions taken to prevent recurrence” completed.
- 2 of the 3 patient falls incidents have a root cause analysis uploaded onto Datix.

- A RIDDOR assessment pro-forma should be completed by the manager for each RIDDOR reportable incident. This is to identify the key points and actions needed to prevent a re-occurrence. Only one RIDDOR incident had a pro forma attached to the Datix report.
- 4 incidents were reported to the HSE within the required timescales.
- 7 of the incidents reported had a copy of the RIDDOR report form attached to the Datix report.

It is essential to ensure that all incidents which are reportable under RIDDOR are firstly identified, and secondly reported to the HSE on time. In addition copies of the RIDDOR report from the HSE should be attached to the Datix report. Changes have already been made to the RIDDOR reporting process to address these issues.

Recommendations:
Amend Datix to auto email the reviewer with this guidance;

- Report this incident to the HSE within 10 days of it occurring, via this link ** (enter Risk.Management@bthft.nhs.uk on the first page of the RIDDOR report form)
- Complete this form "RIDDOR assessment pro forma" via this link, and attach to Datix
- Update Datix when recommended actions are implemented and embedded within the work area

** (this will result in all RIDDOR acknowledgements coming back to the Risk Department. This will enable the department to monitor and attach a copy of the form to the Datix report)

Include the "WR" number in the RIDDOR report. This will cross-reference the RIDDOR report to the incident.

Incident investigation

All reported incidents should be investigated by the manager and assessed as to whether additional control measures are needed to prevent any re-occurrence. The Trust has a policy which describes its approach to incident investigation, which is compliant with national guidance. The depth of investigation should be proportionate to the severity or potential severity of the situation. The trust uses four types of investigation methodology.

Where a low or no harm incident that does not meet the threshold for a declaration of a serious incident has occurred a local investigation is undertaken to review the circumstances relating to incident and identify any learning.

Where there is moderate harm and the incident does not meet the criteria for the declaration of a serious incident a Level One: concise internal investigation is undertaken locally by a manager. Serious incidents are investigated either with a Level two: comprehensive internal investigation which is undertaken by the Risk Management team or a Level three: independent investigation which is undertaken by an externally appointed person (all of these are root cause analysis investigations).

All RIDDOR reportable incidents should be investigated using the RIDDOR assessment pro forma form. This is not being done at present. This is an essential part of the process to demonstrate remedial actions have been identified and implemented.

Patient falls are investigated where harm has occurred to the patient. The Quality Committee receives separate reports in relation to patient's falls.

Personal injury claims

Table 5 provides as summary of personal injury claims have been submitted to the Trust, and relate to incidents which have occurred during this reporting period.

Table 5: Type of claim and actions taken during 2017/18

Type of claim and numbers	Examples	Actions
Sharps injuries (5)	A porter was closing lid on waste bin when he received a sharps injury from a needle protruding from an orange bag. On opening the bag he noticed that it was attached to a syringe.	Needle in a soft waste bag, rather than sharps bin. Collection wheelie bin overfull. Porter tried to shut overfull bin thus causing bag to squeeze out side and needle to catch arm. SOP in place doesn't cover what to do if bin overfull.
Manual handling (3)	Whilst pushing a cart of notes through an open door it closed striking the porters finger.	An assessment was carried out It was timed as to how long was necessary for doors to remain open to safely transfer a bed through a set of double doors and maintain the security of the ward. Estates set all wards to this timescale
Violence and aggression (2)	A patient hit a porter on the side of his head with an aerosol can causing injury to the porter's head.	Reminded the porter to be aware of their surroundings and always carry out a dynamic risk assessment in order to be aware of other patients on the ward at all times. Also advised porter where possible not to stand with his back to a patient when waiting for a patient to get out of bed.
Slips, trips, falls (1)	staff member slipped on wet floor, sustaining a fracture to her finger	Unknown spillage on the floor. The staff member was asked what she slipped on and she didn't know what it was

4. Act

4.1 Action taken in response to the top five reported health and safety incidents 2017/18

Verbal abuse and threatening behaviour

Last year the Executive Management Team considered a paper submitted by the LSMS requesting clinical leadership to review training and review the measures required to improve the prevention and management of those patients who display clinically related challenging behaviour leading to physical assault. This work is now being led by an Associate Medical Director and the Divisional Head of Nursing, Medicine and Integrated Care and remains on-going. Despite a significant amount of work to reduce violence and aggression (V&A) inappropriate/threatening behaviour, and verbal abuse towards staff this behaviour remains an issue in all areas of BTHFT and may indicate that staff are not identifying inappropriate behaviour at the earliest opportunity to prevent escalation to more serious aggression.

The security management team visit V&A high reporting wards on a Friday afternoon. This is to engage with staff and support them in reviewing and addressing inappropriate and often challenging patient behaviour. Sisters/Nurses in charge are encouraged to discuss specific patients and their behaviours so that appropriate management plans can be put in place. The patient is made aware of the consequences of not complying with these plans. The team use this opportunity to provide general security and crime prevention awareness as well using taking this opportunity for improved engagement with the clinical teams. This measure has significantly reduced the number of times the Security team are contacted over the weekend period as appropriate plans are in place.

A key measure to protect NHS staff and those who deliver NHS services from violence is Conflict Resolution Training (CRT) which is mandatory for all frontline staff. CRT provides staff with important de-escalation, communication and calming skills to help them prevent and manage violent situations.

The Education and Training department continue to deliver Conflict Resolution Training (CRT) in line with NHS Protect guidelines (refresher training is provided 3 yearly). At the end of March 2018, 79.78% of BTHFT staff were up to date with their training.

Whilst the BTHFT Education Department delivers the national syllabus for CRT, there is a gap for staff to receive ‘Breakaway training’ and Physical Intervention Theory training in line with the Trust Physical Intervention Policy.

A significant number of incidents relate to clinically related challenging behaviour, staff currently do not receive ‘clinically related challenging behaviour awareness training’. NHS Protect has provided guidance on the prevention and management of clinically related challenging behaviour and provides organisations with a model for training in this area.

Physical Assault

Whilst there is a slight increase in the overall numbers of assaults reported within the reporting period, the number of assaults ‘involving medical factors’ i.e. clinically related (where the perpetrator did not know what they were doing, or did not know what they were doing was wrong due to medical illness, mental ill health, severe learning disability or treatment administered) remains significantly high. This demonstrates that our current prevention and management strategies are having a limited effect in reducing these types of assaults and the importance of the work being done review training and

reviewing the measures required to improve the prevention and management of those patients who display clinically related challenging behaviour leading to physical assault.

Where assaults occurred not involving medical factors i.e. intentional assault, the Security Management Team supported the Police in prosecuting offenders. Of the eleven intentional assaults three offenders received criminal sanctions and three received administrative sanctions (BTHFT warning letters for unacceptable behaviour and a Police community resolution order).

The top five reporting areas (AED, AMU, Ward 6, ICU and F6) have been identified and focussed V&A risk assessments will be undertaken in year.

The Security Management team and the dedicated Police Community Support Officers will focus patrols in these areas to provide a visible deterrent, encourage better reporting from staff, as well as supporting staff in dealing consistently with challenging behaviour as well as the development of management plans for individual patients to support a reduction in levels of V&A.

Whilst table 6 indicates that V&A (threatening behaviour/verbal abuse) has significantly increased this year, this is as a direct result of the work conducted by both the Risk Management and Security Management Teams to focus on improved reporting within the Trust. The previous year's figures were low and as a result of anecdotal evidence which suggested that staff significantly under reported V&A, including physical assault. Work is still ongoing with the Risk Management Team and known 'hot spot areas' to support and encourage staff to improve reporting to provide a realistic view of the level of risk.

The security management team have been working closely with key workers within the accident and emergency department (AED), supporting staff to report incidents and updating them on the progress of anyone who has been arrested and charged with an offence.

The security management team have also implemented Criminal Behaviour Diaries within the AED which help staff record the relevant information for both frequent and regular attenders who abuse the services and where appropriate BTHFT considers withdrawal of treatment and/or banning orders are imposed by both the hospital and West Yorkshire Police.

The security management team works closely with specific wards that often have IVDU patients, alcohol withdrawal patients, those patients presenting with mental health issues and patients who display inappropriate behaviour (not clinically related). They continue to work closely with key staff, safeguarding teams and police to support the management of this varied group of patients. There is significant work required to reduce the incidences of V&A in these areas but will be a focus of the management of clinically related challenging behaviour initiative.

The annual physical assault report and Annual Security Report 2017/18 are prepared for presentation at the Quality Committee on 27 June 2018.

Contamination incidents

The Trust has a Sharps Injury Prevention group (SIPG) which meets on a quarterly basis with the purpose of proactively reviewing trends in sharps injuries and surveillance and reports to the CHSC on risk reduction. The SIPG review the Organisations reported sharps and body fluid contaminations statistics collated by Occupational Health on a quarterly basis. There is work ongoing within the group to raise awareness at ward level for sharps injury prevention. All the sharps bins that BTHFT uses are supplied by Frontier. They meet with the Chair of the SIPG and the Environment and Sustainability Manager. They conduct annual audits of Sharp safe at each of the hospitals connected with BTHFT. The latest audit was conducted in January 2018 and the result was 84.92%.

The audit looks at a number of things including;

- Are safety posters clearly displayed?

- Can a member of staff describe correct disposal procedure?
- Are safe sharp trays visible and in use?
- Are safe sharp containers available at the point of use?
- Can a member of staff describe the procedure to be adopted following a needle stick injury?
- Are all containers locked when finished?
- Are syringes disposed of correctly?
- Is there a sharps assessment in place?

Training - The ward/department area whose scores were low will receive individual training from Frontier on the aspects that they did not score well on. Frontier has provided a Safe sharps bin video which is being shared on the sweeper (training) days. Safe sharps are also covered by infection control on the organisational induction. SIPG has a dedicated risk register which is reviewed at the quarterly meetings of the SIPG.

Staff, slip, trip or fall on the same level

Staff slips on wet floors accounted for 14 of these incidents, although there were no incidents reported relating to patients slipping on wet floors.

There was a wide range of causes of the floors being wet; spillages, recently mopped floors, splashes from a sink, contaminated surface (external), leakage.

One other example was an issue with the main entrance of BRI, namely the flooring leading to the top of the stairs. The flooring was becoming wet as a result of pedestrians walking in from the rain. This area is partially covered by matting designed to reduce this slip risk. Upon inspection it has been decided to extend this matting further towards the stairs and to widen it ensure all pedestrians entering the hospital walk on matting. This action will reduce the likelihood of pedestrians walking on wet floors in this area. There were two slip incidents caused by leakages; both sources of the leaks have been identified and repaired.

There were three incidents reported involving slips on mopped/washed floors. Although this is a relatively low figure, slips of this type are widely recognised across all sectors and in particular in healthcare, as a significant risk and have resulted in a number of high profile cases. As a result the Risk Department are scheduled to review the floor washing methods to ensure there are as effective as possible.

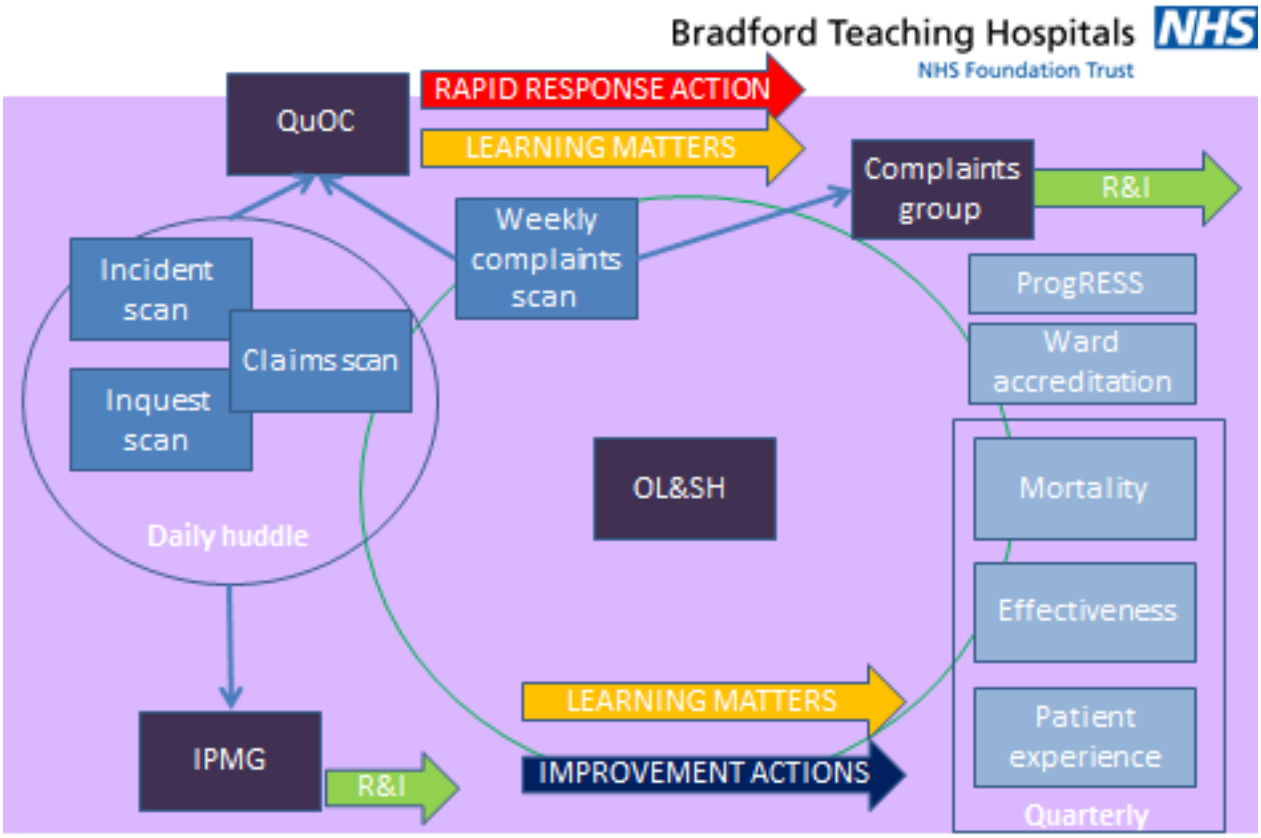
4.2 Learning from health and safety precursor incidents

There is learning from most health and safety precursor incidents. These precursor incidents can be identified from many sources including claims, complaints, serious incidents, patient and staff feedback etc. This learning can be organisation wide (and beyond) or related to individuals or individual sets of circumstances. The Trust has a Quality Oversight System, where any precursor incident is evaluated both in terms of the level of investigation required (see figure 1), this system is set up to ensure that knowledge about and learning from these precursor incidents is managed in a way that maximises its effectiveness and impact. Table 2 provides a summary of Trust wide feedback mechanisms and Figure 2 provides a diagrammatic representation of the mechanisms to support Trust-wide learning.

Table 6 Trust wide feedback mechanisms

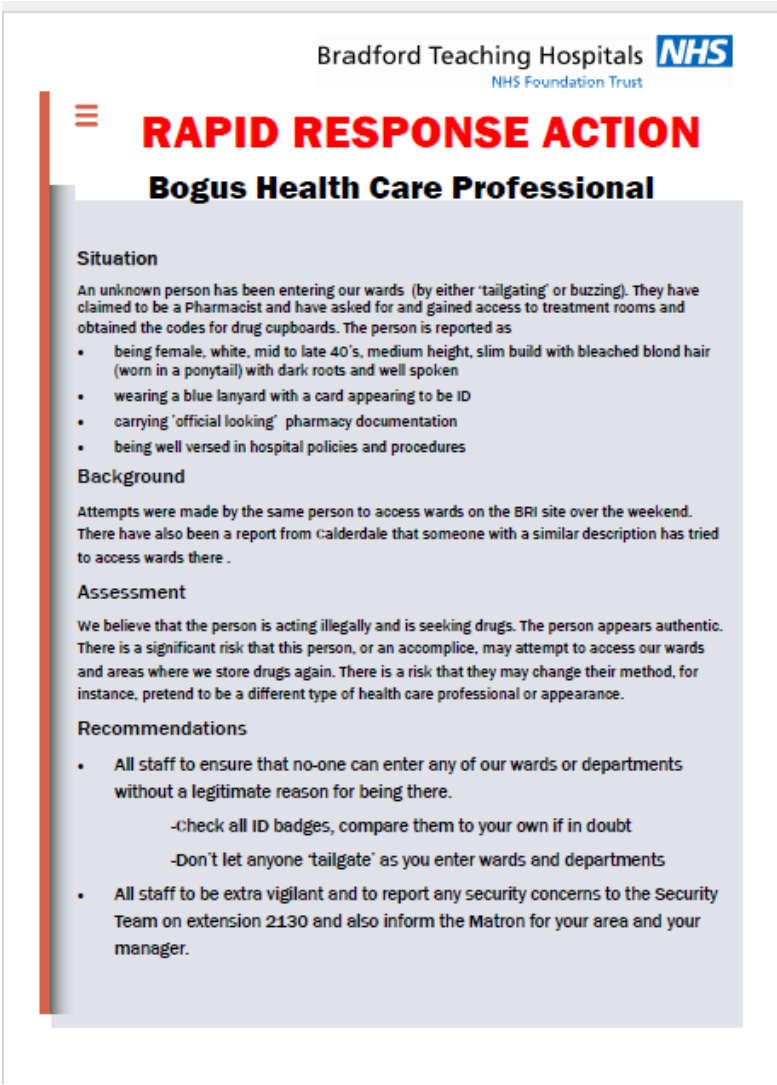
	Type	Content	Responsibility
Bounce-back	Contemporaneous feedback to reporter (part of incident management process)	Acknowledge report filed (e.g. automated response) • Debrief reporter (e.g. telephone debriefing) • Provide advice from safety experts (feedback on issue type) • Outline issue process (and decision to escalate)	Division Risk Management Complaints
Rapid response actions	Action within local work system	• Measures taken against immediate threats to safety or serious issues that have been marked for fast-tracking • Temporary fixes/workarounds until in-depth investigation process can complete (withdraw equipment; monitor procedure; alert staff)	QuOC Divisions
Risk awareness information	Information to all frontline personnel	• Safety awareness publications 'Learning matters' (posted/online bulletins and alerts on specific issues; periodic newsletters with example cases and summary statistics)	Learning and surveillance hub Divisions
Publicising actions taken	Information to all personnel	• Report back to reporter on issue progress and actions resulting from their report • Widely publicise corrective actions taken to resolve safety issue to encourage reporting (e.g. using visible leadership support) 'Responding and improving (R&I)	Divisions Risk Management Team/Assurance team
Improvement actions	Action within local work systems	• Specific actions and implementation plans for permanent improvements to work systems to address contributory factors evident within reported incidents • Changes to tools/equipment/working environment, standard working procedures, training programs, etc. • Evaluate/monitor effectiveness of solutions and iterate	Divisions Learning and Surveillance Hub ProgRESS team

Figure 2 the learning management system



Examples of learning

A rapid response action alert was issued Trust-wide following an incident where a bogus health care professional gained access to wards and clinical areas.



Bradford Teaching Hospitals NHS
NHS Foundation Trust

RAPID RESPONSE ACTION

Bogus Health Care Professional

Situation

An unknown person has been entering our wards (by either 'tailgating' or buzzing). They have claimed to be a Pharmacist and have asked for and gained access to treatment rooms and obtained the codes for drug cupboards. The person is reported as

- being female, white, mid to late 40's, medium height, slim build with bleached blond hair (worn in a ponytail) with dark roots and well spoken
- wearing a blue lanyard with a card appearing to be ID
- carrying 'official looking' pharmacy documentation
- being well versed in hospital policies and procedures

Background

Attempts were made by the same person to access wards on the BRI site over the weekend. There have also been a report from Calderdale that someone with a similar description has tried to access wards there .

Assessment

We believe that the person is acting illegally and is seeking drugs. The person appears authentic. There is a significant risk that this person, or an accomplice, may attempt to access our wards and areas where we store drugs again. There is a risk that they may change their method, for instance, pretend to be a different type of health care professional or appearance.

Recommendations

- All staff to ensure that no-one can enter any of our wards or departments without a legitimate reason for being there.
  - -Check all ID badges, compare them to your own if in doubt
  - -Don't let anyone 'tailgate' as you enter wards and departments
- All staff to be extra vigilant and to report any security concerns to the Security Team on extension 2130 and also inform the Matron for your area and your manager.

RIDDOR reporting – how can this reporting procedure be improved?
The Trust was aware of a number of concerns in relation to RIDDOR reporting, from late reporting to RIDDOR report forms not being attached to Datix. Changes have been made to the RIDDOR reporting procedure to remedy the situation, and an awareness campaign has been developed and implemented using posters, conversations and screen savers.

Combined risk audit – is it effective/who should do it?
The combined risk audit is completed bi-annually by Ward Managers/Sisters. This audit process could be improved by reviewing the questions in it, and taking it away from the wards so it is completed by trained staff and that the audit is undertaken annually.

Datix reporting system – the importance of categories.
Having categories that are easily understandable to staff reporting incidents is essential to ensure correct categories are selected. An example of this was numerous sharps injuries were being wrongly categorised. Changes have been made to the categories which will ensure staff select the correct one.

Learning from external incidents
In November 2016 Norfolk and Suffolk NHS Foundation Trust was fined £366,000 and ordered to pay costs after pleading guilty to breach of S3 (1) of HSWA 1974 when a 78 year old patient suffering from dementia was found face down in a bath full of water having been left unsupervised on the ward.

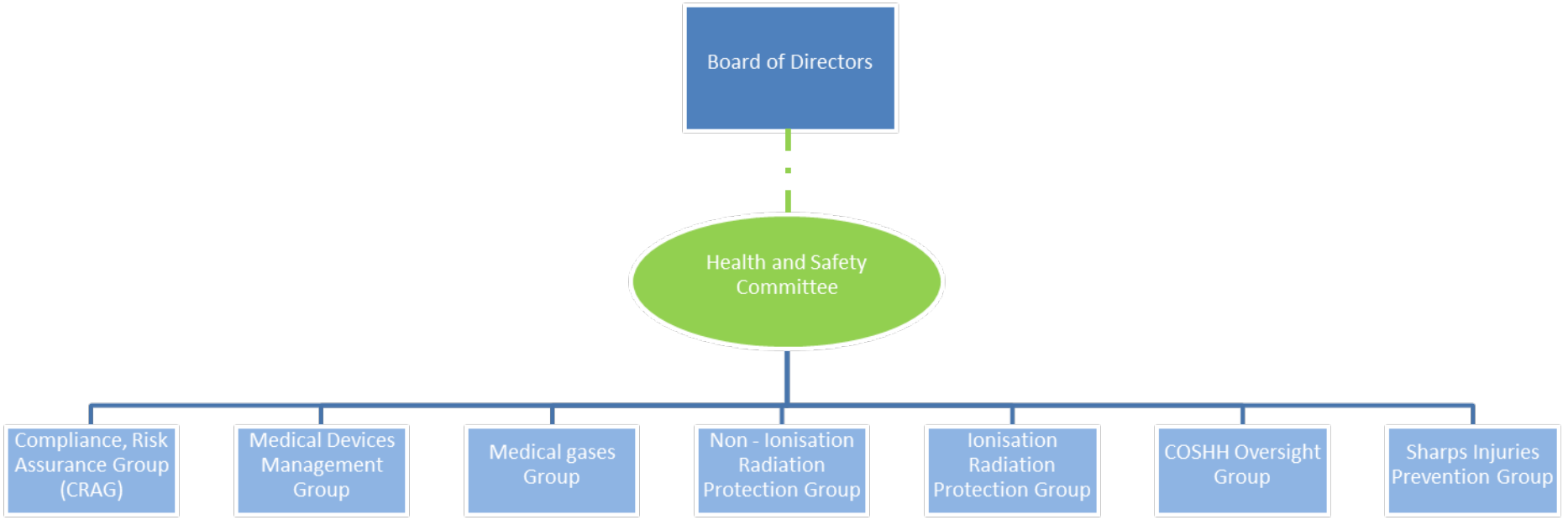
Although BTHFT doesn't have any mental health units, it will at times receive patients with mental health issues, such as dementia, learning disabilities. The risks that these patients pose to themselves and others will be assessed and controlled by way of their care plan. However this enforcement action does raise the issue of self-harm, particularly attempted suicides.

The risk of patients accessing roofs/high points has been assessed, but an area that may require further attention is the identification of ligature points.

Recommendations: develop a system to identify and assess ligature points, and identify areas of the hospitals which need to be assessed.
This could be done as a generic assessment focusing on areas where there is a combination of low observation and ligature points. These are typically toilets, bathrooms and bedrooms.
This doesn't need to be too onerous as it is unlikely that many environmental changes will be made. For example toilets will have numerous ligature points, so there is little point in removing some ligature points, unless you remove them all, and is that practical. In addition, some equipment, such as stand/sit aids in disabled toilets will be ligature points, but these are needed to support standing/sitting.
In practice these assessments are likely to highlight controls, such as, better observation, and good identification of vulnerable patients. (AP21)

PLAN	DO	CHECK	ACT

Appendix 1: Governance for Health and Safety: Organogram



Appendix 2: Trust-wide Health and Safety Policies

Ref no.	Policy title	Current status	Expiry date	Comments
RM41	Health and Safety	Reviewed March 2018		To be approved at H&S Committee in June 2018
RM09	Fire Safety	In date	February 2019	
IC43	Infection Prevention and Control	In date	December 2018	
OP02	Staff Blood borne viruses	In date	January 2020	
RM23	Moving and Handling	In date	June 2019	
RM26	Slips, trips and falls	In date	November 2018	
CP22	Ionising radiation protection	In date	December 2019	
RM06	Display Screen Equipment	In date	November 2019	
17091912	RIDDOR procedure	Reviewed March 2018		To be approved at H&S Committee in June 2018
No policy no.	Estates – Lone working procedures	In date	July 2019	
No policy no.	Estates – Confined space entry	In date	March 2019	
No ref	Estates – Pressure systems	In date	March 2020	
No ref	Estates – Work at height	In date	February 2019	
No ref	Estates – Electrical safety	In date	March 2020	
No ref	Estates – Management of contractors	In date	July 2018	
CP42	Estates – Prevention of scalding and burns injuries	In date	November 2019	
No ref	Estates – Water safety	In date	June 2019	
RM29	Violence and aggression	Under review		
Ref no.	**Policy title**	**Current status**	**Expiry date**	**Comments**
RM46	Estates – asbestos			The policy has been reviewed and sent out to all CRAG members for comment (as of 30th April 2018)
No ref	Estates - Medical gas	Under review		Policy going through for final approval
PP31	Stress at work	Under review		
CP47	Protection of Lone workers	Under review		
No ref	Estates Lone worker procedure	In date	July 2019	
RM04	C.O.S.H.H.	Overdue for review	December 2017	This issue has been escalated
Working at height –Trust wide		No policy at present		Included in Trust work plan for 2018/19
First Aid protocol		No policy at present		Included in Trust work plan for 2018/19
Driving at Work		No policy at present		Included in Trust work plan for 2018/19

Appendix 3: Objectives and progress 2017/18

Objective	Progress/comments	Status	Recommendation
Set up a system for monitoring Trust-wide risk assessments for Health and Safety	Risk management has developed a central repository to store all health and safety specific risk assessments. This has begun to be populated. In practice, most of the assessments being added to this repository are clinical and site specific.	Partially completed	Produce a suite of generic assessments on common risks, which are stored in the repository and made available to staff in all areas
Undertake specific risk assessments as agreed at the Health & Safety Committee	Specific risk assessments have been completed and fed back to the Health & Safety Committee. Although a more structured approach is needed to ensure appropriate risk assessments are being carried out across the Trust.	Partially completed	Develop an evidence based work plan and provide guidance to managers as to which risk assessments they need to complete
Undertake planned safety inspections with Staff-Side Representatives	One area has already been inspected in conjunction with the trade union Safety Representative.	Partially completed	Re-commence the programme of inspections
Audit the action plans following the HSE visits 2015-2016, Microbiology (HG3) and sharps Injuries	**HG3:** The action plan for HG3 incident has been reviewed. However due to the change in pathology providers, there needs to be a review/audit of the joint ventures procedures to ensure they meet, both the requirements of the BTHFT and Leeds Teaching Hospital's element of the HSE's action plans relating to the HG3 release incident. **Sharps action plan:** This plan is being reviewed by the "Sharps Injury Prevention Group"	Action completed	Require the Joint Venture to provide assurance that they meet the element of the HSE's action plans Obtain confirmation that the Sharps action plan has been reviewed by the "Sharps Injury Prevention Group" NB: This has been added to the 2018/19 work plan
Work with Divisions to promote RIDDOR reporting	The Risk Management department has responded to requests for ad-hoc RIDDOR reporting training. The RIDDOR awareness screensaver campaign recommenced 26 February 2018 and the updated RIDDOR posters and leaflet were circulated to coincide with the screensaver campaign.	Action completed	
Produce guidance on RIDDOR	A brochure has been produced and has been added to the Trust Health & Safety page. In addition the brochure has been attached to the Datix reporting system to provide guidance to staff regarding RIDDOR reporting	Action completed	
Produce guidance for staff on Workplace regulations	Guidance has been developed and ratified at the Health and Safety Committee	Action completed	
Produce guidance for staff on	Guidance has been developed and	Action	

PLAN	DO	CHECK	ACT

Objective	Progress/comments	Status	Recommendation
Driving at Work	ratified at the Health and safety Committee	completed	
Work with the Waste Manager on compliance with the Transport of Dangerous Goods Act	A working group, reporting to the Health and Safety Committee, has been set up to ensure the Trust is compliant with the relevant regulations	Action completed	
Complete the action plan from the Health and Safety Internal Audit review April 2017	Four of the six recommendations in the report have been completed in full. There are elements of the other two which require further work, both of these relate to RIDDOR reporting.	Partially completed	

Appendix 4: Trust Wide Health and Safety Work-plan 2017/18

Item	Responsibility	Status	Recommendations
Risk Assessments			
Waste Compound	Non Clinical Risk Manager	Completed	
Therapy Kitchens	Head of Non Clinical Risk	Completed	
Ward 24-sharps	Non Clinical Risk Manager	Completed	
Ward 30 floor	Non Clinical Risk Manager and Ergonomic Advisor	Completed	
Cladding	Non Clinical Risk Manager	Completed	
Maternity Security	Non Clinical Risk Manager	Completed	
Storage ward 19	Non Clinical Risk Manager	Completed	
Mortuary	Non Clinical Risk Manager	Completed	
Thickening agent	Non Clinical Risk Manager	Completed	
Neonatal ventilators	Non Clinical Risk Manager	Completed	
Hep B shortage	Non Clinical Risk Manager	Completed	
Royal Visit	Non Clinical Risk Manager	Completed	
Disposal of waste bins containing sharps	Non Clinical Risk Manager	Completed	
First Aid risk assessments	Non Clinical Risk Manager	Not completed	Areas to be assessed are identified in the protocol
Pathology Risk assessment	Non Clinical Risk Manager	Not completed	To be rolled over to 2018/19 Trust wide work plan
Waste	Non Clinical Risk Manager	Not completed	To be rolled over to 2018/19 Trust wide work plan
Policies/ procedures			
Health and Safety Policy	Head of Non Clinical Risk	Completed	To be approved at Executive Management Committee (June 2018)
Workplace Procedure	Head of Non Clinical Risk	Completed	
RIDDOR Procedure	Non Clinical Risk Manager	Completed	
Driving at work procedure	Non Clinical Risk Manager	Completed	To be presented to Health & Committee as part of the ratification process (June 2018)
First Aid protocol	Non Clinical Risk Manager	Completed	To be presented to Health & Committee as part of the ratification process
Trust wide working at height	Non Clinical Risk Manager	Not completed	To be rolled over to 2018/19 Trust wide work plan
Moving and Handling Policy	Ergonomic Advisor	Completed	
Training			
Moving and Handling Training Proposal	Heads of Risk and Ergonomic Advisor	Completed	
Health and Safety and Risk Training proposal	Heads of Risk	Completed	
Produce Health and Safety Training	Head of Non Clinical Risk	Not completed	To be rolled over to 2018/19 Trust wide work plan
Reports			
Annual Health and Safety Report	Interim Non-Clinical Risk Manager	Completed	
Quality Account Report	Head of Non Clinical Risk	Completed	
Project work			

PLAN	DO	CHECK	ACT

Item	Responsibility	Status	Recommendations
RIDDOR awareness	Head of Non Clinical Risk	Completed	
Centralisation of Risk assessments	Heads of Risk	Completed	
Purple Bags Task and Finish Group	Non Clinical Risk Manager	Completed	
Dangerous Goods Act Task and Finish Group	Non Clinical Risk Manager and Waste Manager	Completed	
Latex	Head of Non Clinical Risk and Assistant Director of Pharmacy	Not Completed	To be rolled over to 2018/19 Trust wide work plan
Action Plans			
Internal Audit	Head of Non Clinical Risk	Completed	
HSE action plan (sharps)	Head of Non Clinical Risk	Completed	Being reviewed by the Sharps Injuries Prevention Group
HSE action plan (HSG3)	Head of Non Clinical Risk	Not Completed	To be rolled over to 2018/19 Trust wide work plan

Appendix 5: Risk profiling 2017/18

Risk	Controls	Compliance with legislation/guidance
Fire	There is a Fire Safety Policy and Procedure in place. **Fire risk assessments:** There is an on-going programme of fire risk assessments (FRA's), which the West Yorkshire Fire & Rescue Service has confirmed they are satisfied with. Recommended actions from the FRA's are dealt with locally, where possible, via Estates jobs. If major concerns are identified, these are brought to the Estates Health & Safety Group, the Fire Systems Review Group; and can be escalated to CRAG. **Evacuation plans:** There are evacuation procedures, bespoke for every part of the Trust, which are included in the local fire logbook. The Fire Safety team visit wards to audit the logbooks and to question staff about their knowledge of evacuation procedures. **Evacuation drills:** Evacuation drills are performed where possible, and table top exercises are used to test the evacuation procedure. **PEEPs:** PEEPs are explained at induction and mandatory training, and there are PEEPs pro-formers included in the logbook. Concerns have been raised that PEEPs are not being completed in all areas. **Training:** Training is, wherever possible, bespoke to the type of role that staff undertakes, or the area in which they work. A mixture of lectures, walk thoughts, table top exercises are used as well as interactive theoretical scenarios. **Recommendations**: Add the PEEP form and guidance notes to the patient's records on EPR. Print a copy of the patients PEEP form and attach it to the end of the bed. (AP5)	RRFSO 2005 HTM 05-01
Asbestos	There is an Asbestos policy and procedure in place. The measures to control the risks of asbestos on Trust premises are as follows: • There is a four year asbestos management plan is in place (2014-2018) • There is an asbestos register which details the location and type of asbestos on Trust premises. • Areas containing asbestos are graded red/amber/green. • A programme of risk assessments is undertaken for all relevant areas. • The Trust also commissions external contractors to conduct annual Reassurance Air Testing within amber and red zones, **Training:** A half day training session is provided for all workers who are likely to encounter asbestos, this includes external contractors working on site.	Control of Asbestos Regulations 2012

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
	The Trust was awarded the “MICAD Asbestos award” in September 2017, for having the most compliant asbestos module in the UK, which averaged 99% over the year Further details can be found in the annual asbestos report of 2017/18 which was presented to the Trust Health and Safety Committee **Audit process:** An internal audit of the Trust’s management of asbestos was carried out in July 2017 by Audit Yorkshire, it concluded that the Trust has appropriate controls in place to manage asbestos risks	
Legionella	There is a Water Safety Policy in place. The Trust has a management plan for water safety; it consists of: **A Water Safety Steering Group**, this group aims is to ensure the safety of all water used by patients / residents, staff and visitors, and to minimise the risk of infection associated with waterborne pathogens **A Water Safety Working Group,** this group meets on a monthly basis with the objective of providing assurance, monitoring for BTHFT risk systems along with completing the risk assessment review process and documenting this review. **The Water Safety Plan** This plan defines the operational procedures, routine maintenance, routine monitoring, and emergencies for all BTHFT risk systems. **Audit process:** An annual water risk management audit is undertaken by the Authorising Engineer. The audit report includes recommendations for improvement and forms part of the Legionellosis risk management system	Control of Substances Hazardous to Health Regulations 2002 HTM 04-01 (safe water in healthcare premises)

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Scalds from hot water	There is a Prevention of Full Immersion Scalding & Burns Injuries Policy in place. The policy contains the following information/guidance: • All patient baths, showers and bidets are fitted with a fail-safe thermostatic mixing valve • Hand wash basins considered to be in high risk areas have also been fitted with a fail-safe thermostatic mixing valve • The temperature setting and fail safe operation are routinely checked every six months for each mixing valve and records of the checks kept in a log book. • Staff assisting patients in bathing, should ensure that water is at a suitable temperature before the patient tests the water themselves or proceeds to full/partial immersion. ***Recommendations**: confirmation is needed to ensure that where there are vulnerable individuals and whole-body immersion, widely-recognised professional bathing practice involves testing of outlet temperatures using a thermometer to provide additional reassurance. (AP7)*	HSE information sheet, HSIS6: Managing the risks from hot water and surfaces in health and social care
Burns from hot surfaces	There is a Prevention of Full Immersion Scalding & Burns Injuries Policy in place. All in patient areas have radiator guards installed and high risk pipework sections have been securely boxed in/or covered and insulated to prevent the risk of burn injury. Unauthorised access to kitchens is controlled with key coded entry systems, although some kitchen doors are wedged open. For this reporting period there haven't been any incidents reported involving a person being burned from a hot surface. **Recommended actions:** staff to be reminded of the importance to keep ward kitchens doors closed to ensure patients cannot access the hot surfaces inside. Also all ward kitchen doors will be fire doors, so need to be kept closed for fire safety purposes. (AP8)	HSE information sheet, HSIS6: Managing the risks from hot water and surfaces in health and social care

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Falls from windows	There is a Prevention of falls from windows maintenance procedure in place. • All windows within the Trust are fitted with window restrictors • Maintenance of windows within this Trust is carried out annually and recorded • Staff are encouraged to report any window restrictor that has been removed, to the Estates Department. DH alert: EFA/2012/001: window restrictor issue Integral side-stay mechanism window restrictors fitted with plastic spacers and used in many window applications. Action: examine these window restrictors: this action has been completed	Workplace (Health, Safety & Welfare) Regulations 1992 HSE information sheet: HSIS5 Falls from windows or balconies in health and social care
A person accessing roofs/high points on Trust premises; Risk is falling/jumping	A risk assessment has been undertaken which has assessed the risk of a person accessing roofs or high points at Bradford Royal Infirmary and St Luke's Hospital. The assessment identified those areas which could be accessed and made recommendations to reduce this risk. A quotation has been obtained from an exterior contractor to address the higher risk rated areas.	Management of Health and Safety at Work Regulations 1999
Medical gases	There is a Medical Gas Operational policy and procedure in place **Medical gas pipeline system (MGPS):** Competence: All Competent Persons (MGPS) are crafts persons registered and employed by Specialist contractors Training and assessment are refreshed every three years. Estates maintenance craftsmen are authorised as competent to carry out weekly maintenance checks – **Cylinder gases:** The Portering Department are responsible for the on-site logistics management and Delivery of portable medical gas supplies to all wards. Training: Any Porters with particular responsibilities will require specialist training for Medical gas cylinders. Annual refresher training courses shall be attended.	Pressure Systems Safety Regulations (PSSR) 2000 HTM 02-01 - Medical gas pipeline systems HSE guidance leaflet: INDG459
Medical equipment	There is a Medical equipment and devices policy in place • The Medical Device Safety Group (MDSG) is responsible for setting the overall strategy and policy • The Devices Safety Officer is responsible for reporting adverse incidents to the MHRA and acting as a first point of contact for matters of device safety. • The Medical Device Leads are based at ward level and work with the Head of Clinical Engineering to manage the equipment and devices in their area. • The Clinical Engineering Department has responsibility for the maintenance and repair of equipment and medical devices within their remit. • The department also maintains the equipment inventory for the Trust	Provision and Use of Work Equipment Regulations 1998

Risk	Controls	Compliance with legislation/guidance
	• The department will not deploy items of equipment to wards and departments unless staff members in those wards and departments have had the appropriate training. The MDSG monitors: • Completeness of training records as well as evidence that non-attendees are followed up. • Competency assessment records and updates for staff who have been absent from the organisation or who work in area that has received new equipment. It is not currently possible to ascertain the numbers of staff who have completed medical equipment training. This has been recognised and added to the Medical devices risk register. **Assurance:** The Clinical Engineering Department undertakes an annual review which is forwarded to CRAG. In February 2015 Clinical Engineering made the transition from ISO9001:2008 to ISO9001:2015 certification. They became one of the first Clinical Engineering departments nationally to achieve this. They have since been visited by several other Trusts for help and guidance with their own transitions to the new standard.	
Noise and Vibration	Data gathered from noise surveys of plant rooms, machinery and equipment is used as part of the risk assessment process. The assessments can be accessed via the Estates intranet page. Noise measurement data is stored on the Casella Insight data base and is readily available for inspection. **Training:** 79% of operatives have received specific vibration awareness training. All Estates gardeners have received training. 75% of operatives have received specific noise awareness training. Additional training is planned for May/June 2018 for those that couldn't attend.	Control of Vibration at Work Regulations 2005 The Control of Noise at Work regulations 2005
Ventilation	There is a Ventilation systems policy in place A Ventilation working group meets on a quarterly basis **LEV:** Local extract ventilation systems located in the Estates workshop areas are thoroughly examined and tested at least on a 14 monthly basis. Monthly checks are in place to ensure COSHH personal protective equipment (PPE) stocks are maintained and local exhaust ventilation (LEV) systems continue to operate satisfactorily in between the above statutory inspections. **General ventilation:** All maintenance systems are subject to inspection and maintenance annually.	Workplace (Health, Safety & Welfare) Regulations 1992 HSG202 – General Ventilation in the Workplace HTM 03 01

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
	All ventilation air handling units (AHU), plant, ductwork and systems shall be included in PPM **Training:** Personnel carrying out maintenance of Ventilation Systems must receive suitable training, which includes information about any significant hazards arising due to their maintenance activities which may either affect them personally or any other person who may be affected by their actions or omissions. **Monitoring:** Compliance with the Ventilation Policy will be monitored by the Deputy Director of Estates – Operations, who reports quarterly to the Designated Person	
Managing contractors	The Estates Department has a policy for the management of contractors This policy sets out how they control the risks of contractors being on site. This involves the contractor providing the evidence to ensure they are competent and will control their own risks. In addition the Estates Department provides information to the contractor about the potential risks to their workers whilst on site. **Training:** All contractors attend a health and safety induction programme which includes a bespoke video on safety on the hospital grounds as well as a questionnaire to test learning.	The Construction (Design and Management) Regulations 2015
Waste management	There is a policy in place for the management of healthcare waste, although this was due for review in December 2016 The purpose of this policy is to ensure waste is segregated, stored and disposed of correctly. **Training:** Training is available via a Waste Disposal E learning package and guidance is also contained within the Infection Control section of the Trust Induction. Appropriate training is given to all staff involved in the handling of waste. The Facilities Manager ensures that waste staff have Hepatitis B immunisation **Audit process:** The policy requires annual waste audits to be undertaken to ensure compliance with legislation. Every ward and department will be undertaken annually on a rolling basis.	The Controlled Waste Regulations 2012 HTM 07-01

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Moving and handling (patient & non-patient)	There is a moving and handling policy in place **Risk assessment:** There are risk assessment forms available for inanimate loads and pushing/pulling which can be found on the Trust website. **Training:** There are two types of moving & handling training available to the staff, which reflects the level of risk they could be exposed to (medium/high and low). All staff receives training at induction, and then a competency assessment is carried out every three years for the high and medium risk groups. All non-attendances will be followed up. Each high/medium risk workplace will have at least one trained moving & handling trainer. Compliance levels for 2017/18: Low risk training – 89% Med/high training – 63% Changes have been made which will result in training being provided centrally in place of the training provided by localised Key Trainers. **Hoisting patients:** There have not been any incidents reported in 2017/18 relating to hoisting of patients. Concerns have been raised that patient handling assessments are not being completed across all areas. This report could also not find evidence that these assessments are being audited. **Monitoring:** The bi-annual combined audit includes questions related to the staff's competency assessments as well as questions about the assessment of loads and checks on hoisting equipment. **Recommendations:** Add patient handling assessments to the combined risk audit (AP9)	Manual Handling Operations Regulations 1992 LOLER 1998
Violence & aggression to staff	There is a violence and aggression policy in place **Risk assessment:** Each year the top five reporting areas are identified and a violence and aggression risk assessment is undertaken in those areas. **Training:** All staff are expected to attend conflict resolution training. For 2017/18 the attendance rate for this training was 87% There is also a Local Security Management Specialist (LSMS) in post, who has a team of Security Officers operating 24/7.	Management of Health and Safety at Work Regulations 1999

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
	Amongst their other security related duties, they will support staff in the prevention and management of violence and aggression. The number of incidents reported as threatening behaviour and verbal abuse have slightly increased from the previous year, whilst physical assaults has decreased slightly. The Datix reporting system has recorded a number of incidents whereby security staff have been summoned and attended situations in which staff are being subjected to violence or aggression.	
Lone working: Trust wide staff:	There is a Trust wide policy for the protection of lone workers The policy identifies which job roles could be lone working A risk assessment is undertaken for each defined lone worker (the results of the assessment will determine if the worker is provided with a "Lone Worker device") The risk assessments are forwarded to the Security Steering Group This device has a number of functions; • it allows the user to send an alert to a monitoring centre • the monitoring centre can listen into conversations • it can use GPS to identify the location of the staff member **Audit process:** A random sample of two lone worker risk assessments per Division will be audited annually **Recommendations:** add lone working onto the combined risk audit. Questions to include: • Have you identified all lone workers in your area • Have you completed a risk assessment for each lone worker • Are there any outstanding risks to the staff related to lone working (AP10)	HSE guide INDG73(rev3): Working alone Management of Health and Safety at Work Regulations 1999
Lone working: Estates staff:	The Estates Department have produced a Lone Working procedure for their own staff. The Estates Department has identified which of their staff could be lone working Lone working areas have been identified (see confined spaces register) There is system in place to monitor lone workers, which involves the use of text messaging	HSE guide INDG73(rev3): Working alone Management of Health and Safety at Work Regulations 1999

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Driving at work	There isn't a policy in place for driving at work, but it is scheduled to be written in 2018/19 There are two main groups of drivers who drive in the course of their work, these are: • Those who drive in vehicles provided by the Trust to enable them to carry out their duties (e.g. staff visiting patients at home in their "virtual wards") • There is another group of drivers who use their own vehicle in the course of their work. These are often referred to as the grey fleet. **Recommendations:** begin with writing the policy, which will detail what needs to be done, who by and what types of checks need to be undertaken. NB: this has been added to the 2018/19 work plan	Management of Health and Safety at Work Regulations 1999 HSE guide INDG382(rev1): Driving at work
Vehicle/pedestrian segregation on Trust premises	There are designated pedestrian routes throughout the Bradford Royal Infirmary (BRI) site. Most car parks, on the BRI site, have designated pedestrians routes marked out, but one, which is situated on rough ground, has none. St Luke Hospital has pavements within the hospital grounds, but there are still areas where pedestrians have to walk across vehicle routes. One of the main car parks has a hard-core surface which makes it difficult to mark out pedestrian routes. Although there are long barriers in this car park which guide pedestrians towards the main hospital building, rather than walking between parked cars. The car parks are audited on an ad-hoc basis. In a recent study (9/5/18), it was noted that some pedestrians were not using the designated routes in the car park, opposite BRI in Smiths Lane. As a result these routes have been reviewed to ascertain if modifying them would reduce the numbers not using the pedestrian routes.	Workplace (Health, Safety & Welfare) Regulations 1992 HSG136

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Workplace transport	There is an information sheet ("notice to all official vehicle drivers") which covers the main areas of driving for the Trust. The three main factors to ensure workplace transport is safe are: **A safe site:** Both main hospital sites have defined pedestrian routes which are designed to ensure effective vehicle/pedestrian segregation. There is also a maximum speed limit of 5MPH on site. **A safe vehicle:** Workplace transport consists of a number of commercial vehicles and vans which are used on Trust sites and on public roads. All vehicles are maintained by the leasing company. In addition the drivers complete a pre-use check sheet. **A safe driver:** All drivers attend a driver training course to assess their driving competency The drivers licence is checked annually Issues that have been highlighted include: • Some drivers jumping up onto/ off of the vehicles tail lift • Reversing with the tail lift lowered • Not using the tail lift flaps (fitted to the tail lift) whilst raising/lowering it **Recommendations:** discuss with drivers, the issues raised regarding operating a tail lift Obtain assurance that banksmen are used for vehicles reversing on hospital sites. (AP11)	Workplace (Health, Safety & Welfare) Regulations 1992 HSG136
Working at height	There is an Estates specific working at heights policy in place. A Trust wide working at height policy is scheduled to be written this year. All work height other than work on low-level podiums and stepladders is covered under a permit-to-work system. Training: Estates staff receive the appropriate training, information and instruction to both satisfy legal requirements and to ensure competence External training providers provide training for all access equipment which is used by estates staff. All work at height tasks carried out by Estates staff have been risk assessed	Work at Height Regulations 2005

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Bed rails	There is a Slips, trips & falls policy in place, which contains the Bedrails policy The procedure is that a bedrails assessment will be completed for all patients who are identified as a risk of falling. **Training:** Education on the use of bedrails is included in the Clinical moving & handling training. "Bedrails" have been added to the "contributory factors" section of Datix.	Management of Health and Safety at Work Regulations 1999 HSG220 MHRA device bulletin DB 2006(06)
Slips, trips and falls	There is Prevention of slips, trips and falls policy in place **External areas:** Slip/trip hazards A member of the Estates Department conducts a visual inspection of external areas at both hospital sites to ensure any slip/trip hazards are identified and dealt with **Snow/ice**: There is a gritting plan in place for the hospital sites which identifies when, and which areas need gritting **Internal areas:** More information is needed as to the agreed procedures for floor washing and dealing with spillages **Monitoring/audit:** The bi-annual combined risk audit contains a series of questions related to slips, trips and falls **Recommendations:** obtain assurance that risk assessments have been undertaken to identify what floor washing methods are used for all types of areas. The objective is to prevent, if at all possible, people from walking/slipping on wet floors. Hierarchy of measures: 1. Use floor washing machines which leave the floor dry 2. Where this isn't possible, wet/dry mop the floors using barriers to prevent people from walking onto wet floors 3. Where barriers aren't practical, use wet floor signs (warning notices can be placed on doors, at face height, to alert people of wet floors beyond the door) Also review the footwear being worn by the cleaning staff. Wash floors during times of least footfall. (AP12)	Workplace (Health, Safety & Welfare) Regulations 1992 Management of Health and Safety at Work Regulations 1999

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Patients falls	There Is a RCA Panel which reviews all patient falls investigations. There is a Falls Prevention Group which is essentially a steering group which gives direction to the Trust Upon admission all patients over the age of 65 and those that present a risk of falling are assessed for risk of falling. All patient falls, which result in harm should be investigated Concerns were raised that patients falls assessments were not routinely being undertaken across the Trust **Monitoring/audit:** The bi-annual combined risk audit contains a series of questions related to slips, trips and falls **Recommendations:** add patient falls assessments to the combined risk audit (AP13)	Workplace (Health, Safety & Welfare) Regulations 1992 Management of Health and Safety at Work Regulations 1999
COSHH	There is a COSHH policy in place although it was due for review in December 2017 The Trust website contains a dedicated section on COSHH. This provides information for staff, including templates, and also a database where copies of COSHH risk assessments and associated documents are held. This COSHH section appears overly complicated and most of the assessments in it are around two years old. It is also questionable, what the purpose is in holding detailed assessments etc. centrally in this manner. A system which is widely used across the NHS to manage COSHH (called Sypol) is being trialled shortly during 2018. **Training:** There are several training sessions for COSHH Assessor training throughout this calendar year. **Recommended actions:** Replace the existing system of managing COSHH with the Sypol system Ensure a physical COSHH file is held locally (AP14) Provide information and/or training for managers regarding their health & safety responsibilities	Control of Substances Hazardous to Health Regulations 2002
Cytotoxic drugs	There is a procedure in place for the Management of Cytotoxic chemotherapy spillages & contamination, although it was	Control of Substances

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
	due for review in February 2018. Cytotoxic spillage kits are available on wards and theatres which use cytotoxic drugs. There have been no incidents involving cytotoxic drugs reported during 2017/18 **Training:** Training for cytotoxic spillages will be provided to all relevant staff This will be provided on commencement of employment and at two yearly intervals.	Hazardous to Health Regulations 2002
Stress at work	There is a management of stress policy in place There is a Stress Steering Group which meets on a quarterly basis where it discusses and assesses the initial findings from the analysis where the HSE Stress Analysis Tool has been used. The Workplace Health and Well-Being Centre is there to advise/support managers and to provide advice, treatment and support to staff The Trust has procured an Employee Assistance Programme through CIC, which provides a free, independent and confidential advice service to staff The HSE Stress Analysis Tool is used for teams where stress has been identified Individual risk assessments will be carried out where staff are returning to work having been on sick leave due to stress-related issues. **Recommended actions:** Take an overview of sickness absence data in the Trust. High levels may indicate a problem, particularly if the high levels are in a specific class of employee or in a specific work area. Investigate the reason for the absences to check whether working conditions are causing increased levels of work-related stress, which in turn is leading to sickness absence. (AP15) This will demonstrate a more proactive approach, as presently the HSE Management Standards are being applied reactively.	HSE Management Standards
Ionising Radiation	There is an Ionising Radiation policy in place The Trust has a Radiation Protection Committee that monitors the use of all types of ionising radiation throughout the Trust. The Radiation Protection Adviser (RPA) advises Trust management on all matters of safety relating to the use and	The Ionising Radiation Regulations 2017

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
	monitoring of ionising radiation within BTHFT. The Radioactive Waste Adviser (RWA) ensures that an appropriate EPR permit is maintained in relation to the holding and disposal of radioactive materials. The Medical Physics Experts (MPE) will advise BTHFT on the requirements for the protection of patients and research volunteers undergoing medical exposures to include dose optimisation, patient dosimetry, quality assurance, development Radiation Protection Supervisors (RPS) will supervise the work with ionising radiation in the areas for which they have been appointed. **Training:** All managers must ensure that all members of staff who work with ionising radiation are familiar with the local procedures and protocols for such work and include this as part of staff induction to a new work area and new practices. **Monitoring:** **-** Regular review by Operational/Clinical Services Managers and RPSs under the guidance of the RPA - The RPA will carry out a biennial audit of compliance with legislation - External audit is carried out by the appropriate regulatory authority such as the Environment Agency, Health & Safety Executive, Care Quality Commission and the Medicines Control Agency.	
Infection, Prevention & Control - staff	There is an IPC policy and procedure in place (The policy is monitored via the IPCC Assurance Framework). The Infection Prevention and Control Committee (IPCC) is responsible for ensuring the Trust is compliant with the policy. The structure is: **Director of IPC/ Chief Nurse** – accountable to the Chief Executive **Nurse Consultant** – ensures that the heads of nursing and matrons are taking the lead in IPC **Lead Nurses** - provides specialist and nursing expertise in the prevention and control of healthcare associated infections **Senior IPC Nurse** - identify and control infection outbreaks **IPC Nurse** - in collaboration with the matrons, participate in IPC post-infection reviews and contribute to changes in clinical practice as a result these reviews **IPC Link Workers** - liaise between their clinical area and the IPC team **Training for 2017/18:** 100% of staff have attended induction training in IPC (level one) 74% staff have completed IPC (level two) training All identified staff will be offered Hepatitis B vaccination	Control of Substances Hazardous to Health Regulations 2002 (COSHH). HSE guidance , blood borne viruses INDG342

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
	Monitoring: The IPCC reports to the Trust's Quality Committee. The Trust Quality and Safety Committee receives a report at each meeting and annually, detailing compliance with infection prevention measures, infection rates and information on outbreaks of infection The IPCC produces an annual plan detailing actions for the forthcoming year, with outcomes reported in the annual report. It also produces a risk register.	
Sharps safety	There is a contamination incident policy The structure: **IPC Committee** - receive minutes from the Sharps Injury Prevention Group **Sharps Injury Prevention Group** – reviews incident data **Workplace Health and Wellbeing Centre** - provide support, advice following a contamination incident There is a poster (which can be printed off from the Trust website) which describes what to do in the event of a sharps injury Approximately a third of incidents involving needle sticks were wrongly categorised. This will be addressed by changes to the categories in Datix. **Audit process:** a sharps injury audit is undertaken	Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
Decontamination	There is a Decontamination of Medical Devices Policy in place Sterile Services Department (SSD), provided by B Braun, provide decontamination services to the Trust **Audit process** SSD is subject to external audit	Provision and Use of Work Equipment Regulations 1998
First aid	A first aid protocol has been written (this is the first one), pending ratification by the Health and Safety Committee. The protocol details which areas need to complete a first aid needs assessment. Without this protocol in place, it is unlikely that these assessments are being undertaken with any kind of regularity **Recommended actions:** Ensure a first aid needs assessment is undertaken for all areas in which the protocol identifies [It is a requirement of the Health and Safety (First-Aid) Regulations 1981, to carry out such an assessment] NB: this has been added to the 2018/19 work plan	The Health and Safety (First-Aid) Regulations 1981

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
New & expectant mothers	There is a New & expectant mothers policy in place (it is contained within the Maternity/Paternity policy) The policy contains a link to the risk assessment process for new or expectant mothers. The risk assessment form has an escalation procedure to follow, to reflect differing levels of risk **Recommended actions:** To monitor compliance, add this risk assessment to the combined risk audit (AP16) The risk assessment of new & expectant mothers to be part of a training session for managers	Management of Health and Safety at Work Regulations 1999 HSE guide INDG373: New and expectant mothers who work
Young persons at work	There is a work experience policy in place Young persons on work experience will attend an induction on the first morning of placement. The policy includes a list of what activities work experience students can be involved with, and what areas they are not allowed to access. There are currently only six young persons employed by the Trust. Four of these are apprentices who are supervised as part of their training agreement. The other two are employed in Cleaning Services where they will be supervised as part of their terms of supervision.	HSE guide ING364(rev1) Young people and work experience

PLAN	DO	CHECK	ACT

Risk	Controls	Compliance with legislation/guidance
Using computers	There is a DSE Policy in place This policy details the procedure for the manager to follow, from identifying who should be assessed, to the provision eye sight tests, and includes the assessment forms and eyesight reimbursement forms. **Audit process:** this process is audited as part of the bi-annual combined risk audit. In the most recent audit of 2016 it was found that: • A high number of areas required their workstations assessing. • A high number of areas are unaware of the DSE policy. • Some staff were unaware of the Trust's arrangements for eye sight testing. **Recommended actions:** **1.** To simplify the process, consider merging the DSE checklist and DSE risk assessment forms **2**. Develop the Risk management website to include a health & safety information section for staff to access; this should include guidance on DSE as well as the forms they will need to complete **3**. Also consideration should be given to develop an e-learning training programme to support managers in their role. This should be bespoke to the Trust (AP17)	The Health and Safety (Display Screen Equipment) Regulations 1992
CAS alerts	There is a Central Alert System (CAS) policy in place The procedure is as follows: 1. All safety alerts come into the Assurance & Regulations Department 2. Alerts are disseminated to relevant areas 3. Confirmation that alerts have been actioned comes back to this department. 4. Any areas that do not confirm alerts have been actioned, are followed up and escalated to the Department's Manager and if necessary to Director of Governance and Corporate Affairs All alerts for 2017/18 have been actioned. Additional assurance is sought as required.	
Environmental risks to staff working in non-Trust owned or controlled premises	There is a designated person in the Estates Department who oversees the management of the environmental risks in third party properties. There is a matrix which clearly demonstrates how the various issues such as asbestos, water safety and electricity are being managed/controlled.	Management of Health & Safety at Work Regulations 1999

PLAN	DO	CHECK	ACT

Appendix 6: Recommendations from internal audit March 2017

Recommendation	Progressed/ comments	Action
Recommendation 1 The Trust Management should look to re-establish the Sharps Injury Prevention Group.	The Sharps Injury Prevention Group was re-established during the middle of 2017	Action completed
Recommendation 2 The Trust to ensure they have appropriate mechanisms in place to determine reporting requirements and ensure they are incorporated them into the Health and Safety Committee work plan.	The results of the bi-annual combined risk audit are reported to the Trust Health and Safety Committee, and progress of it is tracked as it will be included in the Trust wide health and safety work plan The annual health and safety report will be completed by the end of June 2018	Action completed
Recommendation 3 Management should consider reporting to the Health and Safety Committee on a periodic basis the outcome of the risk assessments and progress of the associated actions.	To meet this recommendation , the procedure is as follows: 1.risk assessments are completed 2. significant risks are added to the relevant sub committees risk register 3. Any risk assessment with a risk score of 8-12 are escalated onto the divisional risk register. 4. Any risk assessment risk scores of 15 or more are escalated to the Corporate (Trust) risk register. In addition to this the bi-annual combined risk audit includes a check on Environment/health and safety risk assessments and subsequent action plans. A report of this audit is produced for the Trust Health and Safety Committee. By these means the Trust Health and Safety Committee will have sight of these risk assessment action points, and will be able to monitor and scrutinise the progress. The current procedure is for risk assessments to be completed and copies forwarded to the Risk Management Department and added onto the risk assessment repository.	Action completed,

PLAN	DO	CHECK	ACT

Recommendation	Progressed/ comments	Action
Recommendation 4 The Trust should ensure all RIDDOR reportable incidents are reported to the HSE within 15 days.	For 2017/18 only four of the 12 RIDDOR incidents were reported to the HSE within the required timescales. **Actions taken to comply with recommendation:** The Datix system has been amended to auto- email the manager when a "Y" is entered into the RIDDOR box, reminding them they have 10 days to report the RIDDOR to the HSE	Action completed, but requires ongoing monitoring
Recommendation 5 The Trust should review and report its performance at an appropriate level against the requirement to report incidents to the HSE within 15 days.	The performance regarding the reporting of RIDDOR reportable incidents on time, is now included in the annual health and safety report, which is presented to the Trust Health and Safety Committee.	Action completed,
Recommendation 6 – (split into two actions) Copies of all RIDDOR forms to be uploaded to Datix.	Seven of the12 incidents reported had a copy of the RIDDOR report form uploaded to Datix.	Partially completed
Recommendation 6 Associated action plans to be uploaded to Datix.	Actions taken to mitigate the risk are recorded in the "actions taken to prevent recurrence" box of the investigation section of the Datix report. **Actions taken to comply with recommendation:** Datix has been amended so that the "recommended actions to prevent recurrence" section of a Datix (RIDDOR) report becomes a mandatory requirement.	Action completed, but requires ongoing monitoring

Recommended actions:
Advise RIDDOR reporters (Managers etc.) to enter the generic Risks Depts. email address instead of their own. This will result in the copy of the report being sent to the Risk Department, where they can monitor RIDDOR reports, and attach a copy to the Datix report (AP6)

PLAN	DO	CHECK	ACT

Appendix 7 Recommendations and action points to be addressed during 2018/19

Ref no.	Action point	To be actioned by	By when
AP1	The Trust Health and Safety Committee: Ensure the nominated deputies attend in the absence of committee members and that all future committee meetings achieve the quorum. Ensure a Non-Clinical Risk Manager attends all committee meetings.	The Trust Health and Safety Committee	September's meeting of the Committee
AP2	Develop a revised education programme for those with health and safety responsibilities (e.g. Ward Sisters, Ward Managers and Heads of departments)	Non-Clinical Risk Manager	30th September 2018
AP3	Risk assessments: Phase one Create generic risk assessments for all tasks which are common across the organisation. (e.g. slips, manual handling)	Non-Clinical Risk Manager	30th September 2018
	Phase two Create a list of risk assessments which are required for each type of workplace. These can be held centrally and made available to all areas. (e.g. clinical, admin, communal)	Head of Non-Clinical Risk	31st October 2018
AP4	Re-start the Risk- TU workplace inspection programme.	Non-Clinical Risk Manager	30th September 2018
AP5	Ensure PEEPS are being completed; consider the potential for adding the PEEP form and guidance notes to the patient's records on EPR. Print a copy of the patients PEEP form and attach it to the end of the bed.	Non-clinical Risk Manager	31st December 2018
AP6	Advise RIDDOR reporters (Managers etc.) to enter the generic Risks Department email address instead of their own. This will result in the copy of the report being sent to the Risk Department, where they can monitor RIDDOR reports, and attach a copy to the Datix report	Non Clinical Risk Manager	31st July 2018
AP7	Confirmation is needed to ensure that where there are vulnerable individuals and whole-body immersion, widely-recognised professional bathing practice involving testing of outlet temperatures using a thermometer is being followed.	Non Clinical Risk Manager	30th September 2018
AP8	Staff to be reminded of the importance to keep ward kitchens doors closed to ensure patients cannot access the hot surfaces inside. Also all ward kitchen doors will be fire doors, so need to be kept closed for fire safety purposes.	Heads of Nursing	30th June 2018
AP9	Add compliance with patient handling assessments to the combined risk audit	Head of Non-Clinical Risk	31st July 2018
AP10	Add compliance with lone working policy onto the combined risk audit.	Head of Non-Clinical Risk	31st July 2018

PLAN	DO	CHECK	ACT

AP11	Ensure drivers on site use tail lifts safely (e.g. do not reverse with tail lift down, do not jump up/down from tail lift) Ensure banksmen are used for vehicles reversing on hospital sites.	Facilities Manager	31st July 2018
AP12	Obtain assurance that risk assessments have been undertaken to identify what floor washing methods are used for all types of areas. The objective is to prevent, if at all possible, people from walking/slipping on wet floors.	Facilities Manager	31st July 2018
AP13	Add compliance with patient falls assessments to the combined risk audit	Head of Non-Clinical Risk	31st July 2018
AP14	Replace the existing system of managing COSHH with the Sypol system Ensure a physical COSHH file is held locally	Assistant Director of Pharmacy/ COSHH Oversight Group	31st December 2018
AP15	Stress: Continue to ensure that the impact of stress on staff is recognised through all available means, one to ones, appraisal, staff surveys and analysis of sickness absence data and appropriate action is taken	HR Department	31st December 2018
AP16	Risk assessment of new & expectant mothers: To monitor compliance, add this risk assessment to the combined risk audit The risk assessment of new & expectant mothers to be part of a training session for managers	HR Department	31st December 2018
AP17	DSE: To simplify the process, consider merging the DSE checklist and DSE risk assessment forms	Health and Wellbeing Department	31st December 2018
AP18	Add compliance with staff competency checks to the combined risk audit	Head of Non-Clinical Risk	31st July 2018
AP19	Undertake a health and safety climate survey on an annual basis and use the results as part of the KPI's for health and safety. This should include the number of completed surveys and the "scores" from them. This can then be used to view progress on a year by year basis, and could identify particular areas of concern	Director of Governance and Corporate Affairs	31st March 2019
AP20	Consider the production of a standard local induction procedure/form for all areas. Record completion rates. Add to combined risk audit.	Training Department	31st December 2018
AP21	Develop a ligature point assessment procedure	Clinical and non-clinical risk managers	31st March 2019

PLAN	DO	CHECK	ACT

Appendix 8: Proposed work plan for the Non-Clinical Risk Management Team 2018/19

Item	Responsibility	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Next year
Risk Assessments														
Mortuary	Non Clinical Risk Manager				■									
First Aid risk assessment	Non Clinical Risk Manager		■											
Pathology Penthouse	Non Clinical Risk Manager											■		
Security – programme of risk assessments	Non Clinical Risk Manager									■				
Emergency planning – Major Incident	Non Clinical Risk Manager							■						
Paediatric security	Non Clinical Risk Manager		■											
Policies/ procedures														
Driving at work procedure	Non Clinical Risk Manager			■				■						
First Aid protocol	Non Clinical Risk Manager			■										
Trust wide working at height	Non Clinical Risk Manager			■										
Training														
Moving and Handling Training Proposal	Heads of Risk and Ergonomic Advisor			■										
Health and Safety and Risk Training proposal	Heads of Risk			■										
Produce Health and Safety Training	Head of Non	■	■	■	■	■	■	■	■	■				

PLAN	DO	CHECK	ACT

Item	Responsibility	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Next year
	Clinical Risk													
Reports														
Annual Health and Safety Report	Head of Non Clinical Risk	✓												
Quality Account Report	Head of Non Clinical Risk	✓												
Project work														
RIDDOR awareness	Head of Non Clinical Risk	■			■			■			■			
Dangerous Goods Act Task and Finish Group	Non Clinical Risk Manager and Waste Manager	■	■	■	■	■	■	■	■	■				
Latex	Head of Non Clinical Risk and Assistant Director of Pharmacy							■						
Action Plans														
Internal Audit	Head of Non Clinical Risk													
HSE action plan (sharps)	Head of Non Clinical Risk													
HSE action plan (HG3)	Head of Non Clinical Risk													

Appendix 9: Key Performance Indicators 2018/19

Current H&S KPIs (2017/18)	Measurement
Number of RIDDORs reported	For information: No RAG
RIDDOR reportable incidents investigated formally by the HSE/CQC	For information: No RAG
HSE visits & Inspections (not related to reported RIDDOR)	For information: No RAG
HSE Enforcement actions	Any=red
HSE fee for intervention and action required	Any=red
% of RIDDORs reported within required Timeframe(15 days)	100% green 95% amber <95% red
No of RIDDOR forms attached to incident form	100% green 95% amber <95% red
Number of RIDDOR investigations completed	100% green 95% amber <95% red

Proposed: Additional H&S KPIs (2018/19)	Measurement
Combined risk audit % completed	100% green 90% amber <90% red
Combined risk audit % of audits with all actions taken to conclusion (either risks mitigated or added to a risk register)	100% green 90% amber <90% red
% of " Suite" of risk assessments completed (a proposal in the H&S report)	100% green 90% amber <90% red
Health and safety climate tool survey implementation across the Trust (using 'site tab')	50% of sites: green 40% of sites: amber 30% of sites: red
Health and safety climate tool survey outcome	To be confirmed
Number of workplace inspections completed as a % of those planned	100% green 90% amber <90% red