The Royal Wolverhampton NHS Trust	
Trust Board Report	
Meeting Date:	27th July 2015
Title:	Health & Safety Annual Report
Executive Summary:	This report informs the Board of the activities undertaken in relation to Health & Safety and the Health and Safety Steering Group during the year April 2014 to March 2015. These activities were based upon achieving implementation of the Trust health and safety strategy. The report has been produced using the Health & Safety Executive (HSE) guidance Managing for health & safety (HSG65). The new model treats health and safety management as an integral part of good management generally, rather than as a stand-alone system. The activities with all specialty areas (e.g. Estates, Fire, Infection Prevention, Occupational Health etc.) undertaken during 2014/15 have provided a baseline risk profile across the Trust, which can now be built on in the next financial year via Health & Safety Steering Group.
Action Requested:	For information and assurance
Report of:	Activities of the Trust Health & Safety Steering Group
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Resource Implications:	None identified
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	Patient Safety, CQC Registration, NHSLA
Appendices/ **References/** **Background Reading**	Annual report 2014/15
NHS Constitution:	

(How it impacts on any decision-making)	

Background Details

1

As stated in the last report HSG 65 Guidance has been reviewed and it is the new version that has been used to structure this Annual Report.

The areas to highlight from the report are as follows:

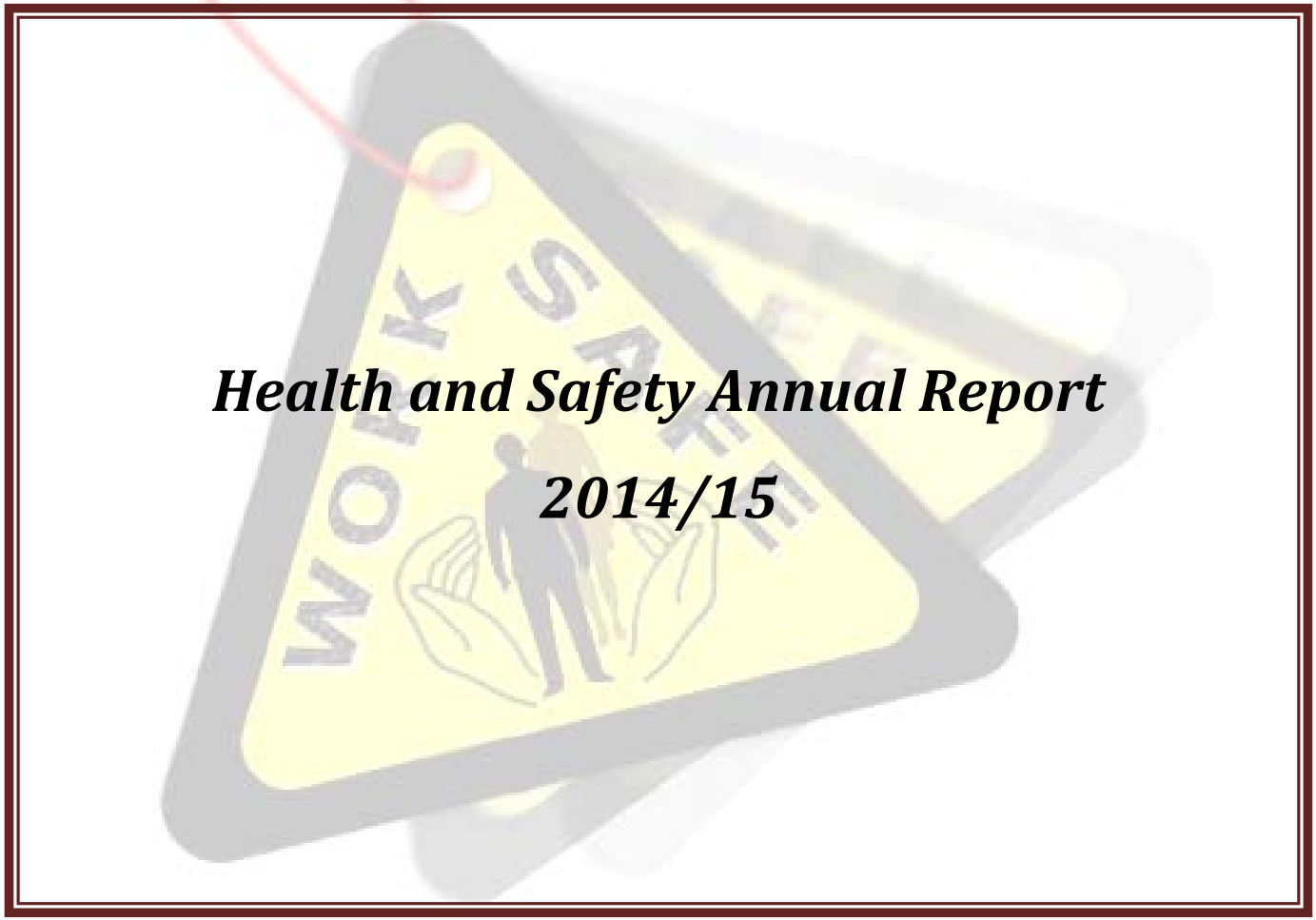
- Trust Risk Profiling baseline.
- Progress with the annual health and safety audit which provides assurance of compliance with obligations under Health and Safety at Work Act
- Staff Competency
- Policy reviews to continue to comply with NHSLA /CQC /HSE
- Monitoring of incidents including RIDDOR
- Moving forward – action plan to work towards full compliance.

Appendices provide more detail on each area of compliance to assure the Board what we are doing to meet the requirements of legislation and guidance good practice.

Emerging risks from the report that will remain high on the agenda for 2015/16 are:

- Successful claims for:
  - Needlestick (Sharps) injuries – this is currently a hot topic with the HSE
  - Slips Trips & Falls
  - Contact injuries
  - Manual handling
- Co-operation:
  - Time availability for safety reps to undertake H&S duties is not ‘protected’

These are included in the 15/16 annual action plan.



Health and Safety Annual Report

2014/15

Contents:

1.0 Introduction

It has been an interesting and busy year for health and safety at The Royal Wolverhampton NHS Trust with the acquisition of Cannock Chase Hospital and subsequent changes to services. The completion of the annual health and safety audit demonstrated marked improvement in completion of risk assessments held within each department and improved review and monitoring through local governance and/or health and safety meetings.

This year has seen a move to improve the risk profiling of the organisation using the HSE (Health and Safety Executive) Health & Social Care guidance which has improved reporting to the Health and Safety Steering Group (HSSG) from corporate areas leading on wider aspects of Health and safety a summary of which you will see included in the report. To enable this change, the health and safety team have worked with departments to populate SharePoint electronic system with all locally held health and safety documentation; this has enabled a shift from rigid audit undertaken in conjunction with departments to a mixed approach of self-assessment and independent spot checks by the health and safety team. The spot checks are being identified using a risk based approach (e.g. with areas that have increased health and safety incidents/RIDDORs or where areas have self-assessed as compliant.) This means that the health and safety officers have been working with the corporate leads identified and reviewing the regulations with those leads to establish compliance.

Appendix 1 provides a status of the actions identified following the 2013/14 annual report (June 2014).

In order to improve reporting and monitoring, safety alerts are being moved to the Datix module, this work has been on-going during this year and is due to go live June 15.

During 2014/15 the Trust has received no enforcement notices from the Health and safety Executive (HSE). Although there has been interest following two incidents no further action has been taken as they have been satisfied with the Trust actions undertaken. Prior to acquisition of services from MSFT on the 1st of October 2014 there were three HSE Improvement Notices imposed on Cannock Chase Hospital, these were in relation to:

- Systems and processes for the management of records for the transfer of patients to wards/hospital sites
- Systems and processes for the management of falls of patients within the Trust.

These were complied with in April 2014, HSE have not planned a further review to date.

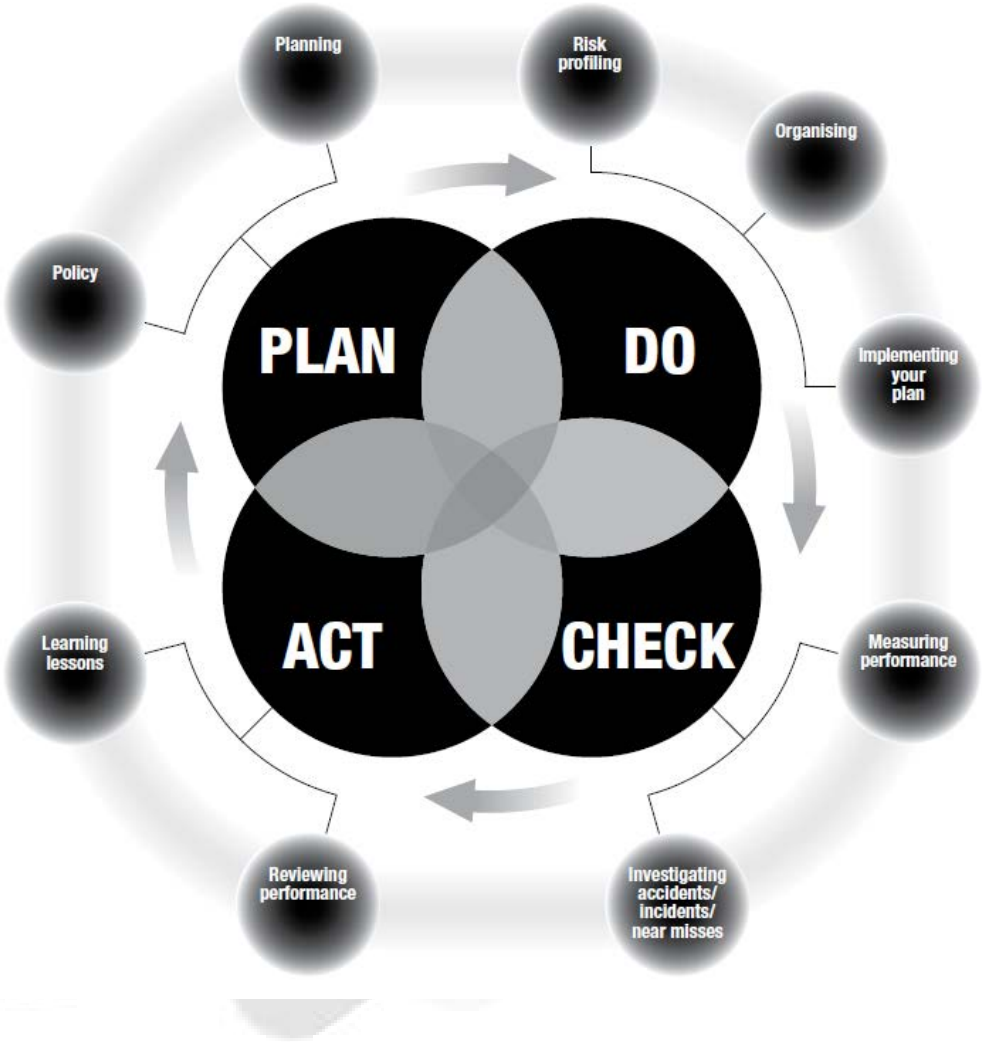
A Memorandum of Understanding (MoU) between Health and safety Executive (HSE) and Care Quality Commission (CQC) came into effect on 1 April 2015, to reflect the new enforcement powers granted to the Care Quality Commission (CQC) by the Regulated Activities Regulations 2014. It replaces the 2012 Liaison Agreement between CQC and the Health and Safety Executive (HSE) that applied solely to healthcare.

The purpose of this MoU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public visiting these premises. It is one of the measures taken by Government to close the 'regulatory gap' identified by the Francis Report into failings at the Mid Staffordshire NHS Foundation Trust.

It outlines the respective responsibilities of CQC, HSE and Local Authorities (LAs) when dealing with health and safety incidents in the Health and Adult Social Care sectors, and the principles that will be applied where specific exceptions to these general arrangements may be justified. It also describes the principles for effective liaison and for sharing information more generally.

This report provides analysis of health and safety performance across the Trust for the year April 2014 to March 2015 and is structured using the HSE model of managing health and safety as described in HSG65, the four elements are: Plan, Do, Act, Check.

The ultimate aim for the health and safety team is to work towards providing a Trust wide profile assuring a safe site, safe plant and equipment for our staff and service users, although this work is on-going it will continue throughout the new year, we have made huge steps towards achieving this goal.


Planning
Risk profiling
Organising
Implementing your plan
Measuring performance
Investigating accidents/ incidents/ near misses
Reviewing performance
Learning lessons
Policy
PLAN
DO
ACT
CHECK

2.0 PLAN

The following policies have been reviewed in the last year:

Policy No	Policy Title	Reason for update	Date Updated	Revision Date	Compliance
HS01	Management of Health and safety	General review and update of legislation: COSHH change of symbols Addition of new procedures: Management of Contractors & Young Workers	Nov 14 approved Feb 15	Feb 18	See 4.1
HS03	Sharps Safety Policy	Minor update to include Cannock and update of attachment 1.	Jan 15 minor amendments only	Apr 17	See 9.0 and Appendix 2 Infection Prevention
HS07	CAS Policy	Full review change in process instigated by MHRA/Dept of Health Policy renamed to Management of Safety Alerts	Jan 15	Jan 18	Section 7
HS10	Waste Management Policy	3 yearly review.	Oct 14	Oct 17	Appendix 2
HS22	Asbestos Policy	3 yearly review	Feb 15 approved May 15	May 18	Appendix 2

Health and safety Strategy

The Health and Safety Strategy is currently under review following an extension of the review date due to the acquisition of Cannock Chase Hospital and subsequent move to include risk profiling of the Trust as a whole. It is expected to be completed by September 2015.

3.0 DO

3.1 Risk Profiling:

Every organisation will have its own risk profile. This is the starting point for determining the greatest health and safety issues for the organisation. In some businesses the risks will be tangible with easily identifiable safety hazards, whereas in other organisations the risks may be health-related and it may be a long time before the illness becomes apparent. Health and safety risks also range from things that happen very infrequently but with catastrophic effects (high-hazard, low-frequency events, such as a medical gas explosion) to things that happen much more frequently but with lesser consequences (low-hazard, high-frequency events e.g. verbal aggression due to illness). Clearly a medical gas explosion has potential to close the hospital and would therefore have a high priority in a risk profile.

A risk profile must examine:

- the nature and level of the threats faced by an organisation;
- the likelihood of adverse effects occurring;
- the level of disruption and costs associated with each type of risk;
- the effectiveness of controls in place to manage those risks;

The outcome of risk profiling will be that the right risks have been identified and prioritised for action, and minor risks will not have been given too much priority. Risk profiling also informs decisions about allocation of resources in terms of control measures.

Progress of risk profiling at RWT

2014/15 has seen the Trust working towards the development of its organisational health and safety risk profile. To achieve this we have used the HSE guidance on risk profiling for health and social care organisations. Each item that is relevant to the Trust has been assessed and a current position status identified. A specialist lead has been appointed to each area to provide specialist input as the Trust considers the guidance, current compliance and management of any risks; progressively working towards full compliance of Regulations and Guidance. Appendix 2 below provides more detail on the current Trust status, including current management activity/controls and RAG rating.

The following is a summary of the risk profile that has been established to date using the Health and safety Executive guidance to create a baseline assessment of the main risks faced by a Health & Social Care Organisation:

Asbestos Management (Control of Asbestos Regulations 2012)	**Medical Gas Systems** EU Pharmacopeia Regulations	**Ventilation / LEV Testing** HTM Control of Substances Hazardous to Health Regs 2013(COSHH) – EH40/2005	**Contractors** Construction Design Management Regulations 2015	**Diathermy & surgical smoke** COSHH & HSE Guidance	**Waste** Controlled Waste (England and Wales) Regulations 2012,3 **Various HSE Guidance docs**
High Voltage Systems Authorisation Process (Elec. Health Technical Memo 06-03)	**Medical Air Quality Compliance** HTM 02-01 A & B	**Lifting Equipment** and handling including hoists Lifting Operations and lifting Equipment Regs 1998 (LOLER)	**Falls from windows** Falls from windows or balconies in health and social care (HSE Info 5) MHRA Safety Alert EFA/2012/001	**Equipment safety – medical equipment** Provision & Use of Work Equipment Regs 1998 (PUWER) Lifting Operations and Lifting Equipment Regulations (LOLER)	**Workplace violence** EU Directive HSE Management of health and safety @Work Regs 1999 Local Security Management Services
Low Voltage Systems (Electrical) (Elec. Health Technical Memo 06-03)	**Medical Gas** Compliance and Authorisation of Processes HTM 02 MHRA	**Pressure Systems** Pressure Systems Safety Regulations 2000	**Patient handling including Bariatric** Manual Handling Operations Regulation 1992	**Fire Safety** Regulatory Reform (Fire Safety) Order 2005	**Workplace Transport Safety HSE Guidance** Safe Site Safe Vehicle Safe driver
PAT Testing Electricity at Work 1989 HTM 06	**Water Safety** Control of Legionella 2012 (L8.)	**Quality, Safety & Environmental Management** Implementation of Premises Assurance Model (PAM)	**COSHH** Control of Substances Hazardous to Health Regs 2013	**Infection Prevention** DoH Infection Prevention Guidelines	**Driving for Work (Community Drivers)** HSE Guidance

Fire Alarm Testing	Air Conditioning Plant.	Slips, trips and falls	Cytotoxic drugs	Sharps injuries	First Aid
Regulatory Reform (Fire Safety) Order 2005	Legionella 2012 L8	HSE Guidance INDG225	COSHH HSE Guidance Safe Handling of Cytotoxic Drugs in the Workplace	EU Directive compliance Health and Safety (Sharp Instruments in Healthcare) Regulations 2013	Health and safety (First Aid) Regulations 2013

RAG Rating Key

RED	AMBER	GREEN
Many gaps/areas of concern	**Some gaps/areas of concern**	**Fully compliant with Legislations, HTM's, Guidance**

Summary Highlights

The above summary (provided by the specialist leads) is a current assessment of Trust compliance of the various Health and safety regulations/ guidance. There are several areas assessed as amber which acknowledges that there are some gaps, however, there is significant work underway to achieve full compliance. More detail from the Leads is available in **Appendix 2.**

Estates & Facilities is working towards implementation of the Premises Assurance Model (PAM) standards which is currently assessed as Amber. The 2014 NHS PAM represents an updated version of a previous model that is more comprehensive incorporating 'soft' facilities management services aligned with post-Francis regulatory requirements. This model brings together compliance with quality and safety standards and efficiency.

Waste has improved significantly, with the newly appointed team now in place good progress is being made. The Fire team have made excellent inroads to improving compliance for fire safety and completion of fire risk assessments.

A gap has been highlighted this year relating to an assurance check of the safety of the vehicles staff use whilst undertaking their role e.g. District nurses use their own vehicles for work related travel. The Health and Safety at Work Act requires employers to take appropriate steps to ensure the health and safety of their employees and others who may be affected by their activities when at work. This includes the time when

they are driving or riding at work, whether this is in a company or hired vehicle or the employee's own vehicle. This is a priority for 2015/16 workplan.

Sharps, although improving, now has a 12 month project group (Safer Sharps Steering Group) to complete the implementation of safer sharps (by end March 2016) this is now moving forward at a more significant pace.

3.2 Organising for health and safety:

Organising for health and safety is the collective label given to activities in three key areas that together promote positive health and safety outcomes (Co-operation, Communication and Competence).

There are 178 departmental health and safety representatives across the Trust (this changes on a daily basis due to leavers and new starters). A full training programme is available for all safety reps along with advice and support from their relevant H&S Officer. The H&S Team run a Safety Representatives (reps) Forum to keep reps up to date with policy, legislation, priorities within the Trust and refresher training sessions. This is very well attended and enables the safety reps to raise any concerns/issues they may have and seek advice to address these from the group. The forums are held quarterly and are scheduled covering both Acute and Community venues.

3.3 Co-operation & Communication

The safety representatives work closely with their managers identifying risks, undertaking assessments and sharing information with their teams this is confirmed by the improved audit compliance for 2014/15. Safety Reps and Managers are used as the first point of contact for communicating messages and providing information to staff, disseminating it throughout their department.

3.4 Competence

A variety of training sessions are provided for all staff with specific training for safety reps and managers to support them in their roles. This training has been very successful with the majority of the safety representatives having completed all training offered.

A gap has been highlighted in relation to Basic Health and Safety training for all staff, the training is offered in a variety of ways e.g. face to face, electronic and presentation/questionnaire, however staff survey/chat back results indicate staff are not undertaking the training offered. This is not currently part of the mandatory training programme, it is planned therefore to obtain mandatory status for basic health and safety for 2015/16 for all staff.

Training/Awareness provided	Target group	Compliance/ attendance	Places offered	No. of Trained Staff
Training programme including risk assessment, DSE, manual handling risk assessments, stress, role of the safety rep, workplace inspections RIDDOR	Safety representatives (All departments have at least 1 safety rep)	49 attendees + 13 Chartered Institute of Environmental Health (CIEH) H&S In the Workplace Level 2	Approx. 60 + 36 CIEH	At least 95% have completed, most training now is new reps and refresher training
First Aid training	Nominated First Aid Reps refer section 5 for compliance Only **2** areas of the 53 Directorates identified to require first aiders do not currently have a trained person	First Aid at Work x 22 Emergency First Aid at Work (EFAW) x 27 Electrical First Aid x 13 Princes Trust EFAW x 13	FAW – 24 EFAW – 30 + dept. specific sessions	137 fully trained first aiders plus 42 Emergency first Aid trained Healthy lifestyles staff
Manual Handling inanimate objects (induction/mandatory)	As per Training Needs Analysis(TNA) – OP41	95.3% Compliant as at 31/3/15	Compliance rate 95% as per NHSLA requirement	
Manual Handling (people) (induction/mandatory)	As per TNA – OP41	89.1% Compliant as at 31/3/15		
General health and safety training (Basic H&S)	All staff	51 attendees	Approx. 100	Mar 11 – March 15 280+ staff have completed

3.2 Implementing

HS01 Management of Health and Safety Policy was reviewed and re-launched in February 2015, this provides the documentation and tools for safety reps and managers and others to manage health and safety. Risk assessments are taken through governance processes to ensure they are approved by management then shared for implementation to all relevant staff. All departments work to build a risk profile for their specific service to support the management of health and safety by undertaking the hazard assessment as outlined in HS01and where appropriate completing a formal risk assessment. Health and Safety folders are held in all areas for access by all staff at any time and now required to be uploaded onto SharePoint for monitoring.

4.0 CHECK

4.1 Measuring performance – Active Monitoring

HS01 sets out the annual health and safety audit process, the programme advises on levels of compliance to each area and provides a progress report of compliance to HSSG quarterly. The annual audit programme finished in October 2014 with any non-compliance being followed up with the areas until complete.

As at 31st March 2015 the Trust had 156 departments who were audited throughout the year
Each department has 17 mandatory topics to consider for risks of which they may have more than 1 risk assessment under each topic.

Departments showing they have more than 1 amber score (see below for RAG status):

Risk Assessments	Division 1 (57)	Division 2 (65)	Corporate (21)	Estates & Facilities (13)
RED	2	3	1	1
AMBER	9	16	1	3

This is a significant improvement on last year a breakdown of results can be seen in **Appendix 3.**

Some risk assessments require a pre-assessment form completing which help the area to identify all hazards prior to completing the risk assessment. Completion of these by the areas has been historically poor, however this year shows significant improvement:

Pre-Assessment/check lists	Division 1 (57)	Division 2 (65)	Corporate (21)	Estates & Facilities (13)
RED	**1**	**6**	**1**	**2**
AMBER	**6**	**10**		**3**

Appendix 4 shows a breakdown of division v risk assessment topic.

Following the annual audit the H&S Officers monitor any area not fully compliant (Red/amber scores) and revisit areas to provide support and advice (RED within a month AMBER within 3 months). Non-compliance is reported to Divisions on a quarterly basis.

RAG Status key for Risk Assessments/Pre-Assessments

Any item missing from audit (e.g. pre assessment/risk assessment)	**RED**
All items in place but requires improvement e.g. too generic, incorrect form, actions not SMART, overdue actions	**AMBER**

Cannock Chase Hospital (CCH) – From the 1st May 2014 (prior to the full acquisition of Mid Staffordshire Foundation Trust (MSFT)) there was a request by MSFT to provide support at CCH. A baseline audit was undertaken in line with RWT annual audit and this was reported to Mid Staffs FT (MSFT) H&S Committee prior to the acquisition. Following the completion of the acquisition RWT policies were formally launched and implemented to assist them in fulfilling this requirement.

No. Departments total 27	**Current status**
8	Awaiting Audit
14	Work underway making good progress
5	Green

All will have been audited against the RWT full audit process by the end of July 15.

4.2 Pro-active monitoring

Maternity Developments Projects (New Cross site) – During the report period there were several projects being run together across developments and facilities to improve the building specification to be able to manage the projected increased service levels following CCH acquisition. Health and safety intervention was requested as there was concern raised around the safety of users, staff and contractors with the projects all running at the same time, both the H&S and Fire team have undertaken regular (daily where possible) inspections of the building with the contract managers. No serious issues have arisen.

4.3 Reactive monitoring activity

Pharmacy Move – Staff moved from various locations into the refurbished Histopathology building (C31) – here there was a change in working from sitting position to standing. Staff had been consulted on the new way of working and concerns were recorded. Following some intervention some adjustments were made, some seating was provided and the team continue to adjust to the changes.

Site Inspections – regular inspections (minimum of one per month) of the site are undertaken and concerns informed to Estates to support their maintenance and repair programme.

4.4 Accidents, Ill health and Dangerous Occurrences

The Trust follows the practice described in HSG65 to have procedures in place for investigating injuries, ill health, property damage, near misses with investigations being proportionate to the event, with all incidents reported within the Trust being monitored through HSSG bi-monthly. The criteria for reporting an incident is an occurrence that has caused injury/ill health to anyone or damage to property or nearly happened (near miss) so captures all levels of health and safety incidents.

In addition, in accordance with the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995, RIDDOR, certain incidents must be reported to the HSE within appropriate timescales.

The Trust Risk Management and Patient Safety Policy (OP10) sets out the investigation & escalation process for serious incidents (including RIDDOR). Health and safety Incidents (including RIDDOR) are monitored by the HSSG.

A total of 1286 incidents categorised on Datix as health and safety have been reported during the period of April 14 to March 15, this figure includes RIDDOR's and near misses, this indicates a 2% increase in the number reported for the same period 13/14.

Year	TOTAL Incident Nos.
14/15	1286
13/14	1260
12/13	1249

The top 5 incidents reported reviewing the 1286 incidents above for the period **April 14 to March 15** are:

Category		13/14	14/15	% Change	Direction
Violence & Aggression	(1)	447	490	9%	
STF	(3)	191	231	21%	
Sharps	(2)	224	200	11%	
Contact	(4)	148	160	8%	
Manual Handling	(5)	145	112	23%	

((X) position last year)

RIDDOR Reporting:

A RIDDOR incident is a certain category of incident that has occurred and caused a member of staff to take over 7 days absence from work or an incident involving the public/service users that was caused by the Trust's actions.

2012 saw the change to RIDDOR reporting timescales from over 3 days to over 7 days absence and included a requirement to record over 3 days absences as well as over 7 days. All incidents are recorded, however we do not stipulate if they are over 3 day but less than 7 day absences.

The number of RIDDOR incidents for this reporting year has increased in comparison to the same period in the previous 2 years showing a 52% increase on last year. To try and ascertain the reason for this increase a review of the last 3 years incidents to look for trends and areas of concern, this review only highlighted an issue with waste bags being lifted up and out of bins by housekeeping. There were several incidents relating to this and to address the issue, front opening bins have been procured which we expect to result in a reduction in this type of incident during this year. There are a couple of slip trip fall incidents in community settings which we are unable to control due to it being patient property. There is an element of human error to be considered, at least 4 incidents where staff have fallen off chairs on castors even after warnings, guidance and instruction for use has been provided. It can only be surmised that the increase is due to the increase in activity and staff across the Trust. Having asked regional group members, RWT does not appear to be an outlier in terms of not experiencing a reduction.

Year	No. of RIDDOR Reported	Direction of change
Apr 14 to Mar 15	44	
13/14	29	
12/13	40	

A further check of data for the four years prior to the 2012 change in reporting times showed:

Year	No. RIDDORs reported
2011/12	54
10/11	56
09/10	50
08/09	56

which indicates RIDDOR's, regardless of reporting times, have reduced.

Appendix 5 shows a breakdown of RIDDOR Incidents by Directorate and Category for the reporting period April 14 to March 15. The high RIDDOR reporters are highlighted. The H&S Officers work with all departments following individual incidents to review risk assessments as part of the incident investigation including identifying any further controls. A detailed review of the incidents relating to the 3 high reporting areas is due to be completed during quarter 1 of 2015/16 to identify any trends/lessons learnt. This will be included on the 2015/16 action plan.

4.4 Claim Monitoring – 2014/15

Table 1 shows claims received during the reporting period with associated costs, table 2 gives a comparison of the number of claims received 13/14 v 14/15

Table 1

Subtype	Number of claims	Damages (Quantum)	Claimants Costs	Defence costs	Total
		£	£	£	£
Contact Injury	4	4820	12695	3632	21147
Manual Handling	5	16291	14900	1086	32277
Needlestick	8	9850	22132	3328	35310
Other	3	12750	44500	2700	59950
Sharps	1	1500	1080	0	2580
Slip, Trip, Fall	15	91458	120467	31053	242978
Total	**36**	**£136,669**	**£215,774**	**£41,799**	**£394,242**

Table 2

	13/14	14/15	
Contact Injury	12	4	⬇
Equipment Injury	2	0	⬇
Manual Handling	11	5	⬇
Needlestick	19	8	⬇
Other	4	3	⬇
Sharps Injury	2	1	⬇
Slip, Trip, Fall	30	15	⬇
Violence and Aggression	1	0	⬇
Totals:	**81**	**36**	⬇

2014/15 has seen a 55% decrease in the number of personal injury claims received, although there is an increase in the number of RIDDOR reportable incidents we have seen a decrease in the number of claims relating to those incidents.

2 claims have been successfully defended and 3 claims were dormant for 3+ years deeming them inactive.

The Health and safety Team on a weekly basis review all incidents reported relating to slips trips and falls, sharps and RIDDOR to ensure investigation forms are completed fully and as timely as possible. Having this information readily available is contributing towards the Trust being able to defend some claims where appropriate.

Reports from personal injury claims are shared with the team, these are followed up with the relevant area to ensure action has been taken to prevent further incidents and communicated via the Safety Rep forums and newsletters

4.5 Investigate the causes of accidents, incidents or near misses;

There have been 2 serious incidents (SUIs) that the H&S team have been involved in investigating during 2014/15 the results of which have been :

1) Emergency pull cords – the H&S team have supported the relevant department in updating their risk assessment and also highlighting the issue with other areas and ensuring their risk assessments and controls are suitable and sufficient. Some areas have changed their cords to poles and switches. This is also being reflected in the new Emergency Services build and other development work.
2) Near miss jump/fall from multi-storey car park – the H&S team revisited the risk assessment, identified with the security team that the controls in place are rigid to prevent further attempts.

5.0 ACT

In the context of HSG65 requires the Trust to review performance and take action on any gaps highlighted and also take action on lessons learned.

5.1 Performance review:

Personal Injury claim closure reports are reviewed and where relevant any lessons learnt are shared with departments either via email or through the safety rep forum with instruction being given for risk assessments to be undertaken /reviewed to incorporate these lessons.

All RIDDOR incidents are investigated, investigations are reviewed to identify learning and any lessons are shared within appropriate areas, we

also use SUI reports to highlight risks that could occur in other areas and how they have been managed, working with other specialist teams to support and address issues raised.

Issue highlighted with internal Transport/TUGs by a member of the executive team led to a wider piece of work to not only look at plant equipment in one area but several across the organisation and the re-introduction of checklists, maintenance, pre-planned maintenance and training for users.

5.2 Learning from other organisations

HSSG review enforcement notices issued by the HSE, and where applicable instigate preventative actions to ensure the same does not happen within our Trust. Details of the 2014/15 Notices are details below:

No. of Notices	Type of Notice	Impact to organisations
32	Enforcement	Financial implication (Fee for Intervention(FFI)), Reputation
3	Prohibition	Interruption to service Financial implication (FFI) Reputation

Regulations Breached
Health and safety at Work Act
Management of H&S
Sharps
Asbestos
COSHH

A total of 35 Notices across 17 healthcare organisations.

Details of the Notices are sent to the relevant department for information and action where relevant.

The H&S team have access to a Regional Group, attending meetings and sharing good practice. Anything useful from here is shared with departments /management. We are constantly receiving news bulletins via the HSE and Gov.uk website again reviewing information and actioning where relevant.

5.3 Learning from audit/inspection reports

The emerging risks from 2013/14 have been updated see **Appendix 1**

NHSLA policy reporting continues via HSSG bi-monthly and 6 monthly to QSAG.

6.0 Relevant Legislative consultations/changes during 2014/15

Regulation	Review	Action
ACOP L22 Provision & Use of Work Equipment, L112 Safety of Pressure Systems, L114 Woodworking machinery	Review closed Oct 14	Awaiting outcome
ACOP L113 LOLER (lifting operations & lifting equipment Regs)	Review closed Oct 14	Awaiting outcome
ACOP L101 Working in Confined Spaces	Review closed Sept 14	Awaiting outcome
Construction Design Management Regs	reviewed	Implemented April 15 CDM Reg Changes communicated to relevant area for action.

7.0 Safety Alerts:

The Trust policy Management of Safety Alerts (HS07) sets out the process for monitoring compliance with all Safety Alerts the results are monitored by HSSG and reported to Quality Standards Action Group (QSAG). Overdue alerts are escalated and monitored by Patient Safety Improvement Group (PSIG).

The Trust monitors the implementation of safety alerts received and reports regularly on the compliance rate. The final report for April 14 – Mar 15 is shown in fig 1

The CAS database is monitored by external organisations in particular NHS England; it can also be viewed by the public wanting to see the Trust's compliance with all safety alerts. To improve reporting and monitoring of safety alerts the Safety Alerts Module in Datix is being populated and due to be launched for use June 15. This will allow staff to update their response to an alert via a central system and enable better compliance reporting and monitoring of action plans to closure.

In May 2015 the CQC Intelligence Monitoring Report there was no elevated risk for compliance with closure of alerts. Given that the timescales on NHS/PSA alerts are now very short, during 2014/15 the Trust performed well in closing alerts within given timescales compared to last year.

Fig 1.(Apr 14 – Mar 15)

Safety Alert status up to end of March 2015

Alerts received (March)	
MDA's	7
EFN's	1
NHS/PSA/	1
EFA	0
DH	0
Total	9

YTD received (financial year)	
MDA's	52
EFN's	53
NHS/PSA/	16
EFA	3
DH	4
Total	128

YTD Closed	
MDA's	51
EFN's	53
NHS/PSA/	15
EFA	3
DH	2
Total	124

YTD Open	
MDA's	2
EFN's	0
NHS/PSA/	1
EFA	0
DH	1
Total	4

Open (YTD & Previous years still open)	
MDA's	2
EFN's	0
NHS/PSA/	1
EFA	0
DH	1
Total	4

Overdue Alerts x NHS PSA	0
Overdue MDA alert	0

Key :

Alert name	Full title
MDA	Medical Device Alert
EFN	Estates Facilities Notice
EFA	Estates Facilities Alert
DH	Department of Health Notice
NHS/PSA	NHS Patient Safety Alert

8.0 Moving Forward 2015/16

The Health and Safety Team Action Plan for 2015/16 is shown in **appendix 6**, the priority is the completion of the Trust risk profile, along with monitoring that departments maintain their level of compliance with the mandatory element of H&S Regulations.

The risk profiling project has seen the H&S Officers being tasked with working with specialist leads to provide assurance on where the Trust is with the relevant legislation. Appendix 2 illustrates the leads for each topic (this is not exhaustive and changes as need arises).

Implementation of the newly developed H&S Indicators with the aim of improving implementation of risk assessment control measures thus reducing incidents.

The approach being taken for the new financial year includes:

Activity	Lead	Expected Outcome
1) Quarterly self-assessment by departments	Department Managers/dept. H&S Lead	Provide assurance departments continue to monitor and improve their health and safety
2) Store all H&S documents on Governance SharePoint	Managers/safety reps/H&S Officers	Enable easy access to audit documentation and compliance with policy
3) H&S knowledge questionnaire to staff – random selection	H&S Officers	To test understanding of H&S across the Trust for further assurance of knowledge.
4) Topic specific project work – looking at HSE requirements, where we are and how we are managing any related risk	H&S Officers working with specialist lead for risk profile topics	Identify risk areas to develop the Trust H&S risk profile. Providing assurance that we are managing and working to reduce risk.

The information collated from each of these activities will highlight any risk areas/departments and enable prompt action to address.

Estates and Facilities have been requested to complete the NHS Property Assurance Management System (PAMS) which will allow the team to score themselves against their peers within the NHS. The document is a comprehensive questionnaire which is scored in house by the team. It is proposed to create an action plan for all of the issues identified with the documentation with the communication of information being a priority. This will be achieved through an Estates maintenance policy and an integrated management plan to communicate how the Estates team delivers the corporate requirements.

A Safe System of Work is to be updated via the use of a "Permit to Work" for all high risk work being undertaken. The Permit to Work is to be managed by internal resources and a managed documentation control system.

An audit program is to be provided to cover the maintenance elements and inspections of all Estates areas of responsibility (Plant Rooms, Accommodation) The audit is to be completed in the first 6 months of the action plan. (September 2015)

All health and safety documentation is to have a document control reference which will be managed centrally by E&F, this will avoid duplication and assure staff that documents are current.

Infection Prevention

Innovation and a proactive approach will continue, in line with the city wide Strategy for Infection Prevention. An ambitious and challenging annual programme of work for 2015/16 is being presented to Infection Prevention Control Group April 2015 for approval. Audit and capture of surveillance data will continue as a foundation for the service to provide the necessary positive and negative assurances. Expansion of surgical site infection surveillance into day case surgery is expected once IT systems to support this are implemented in 2015/16.

Waste Management

2015/16 will see the introduction of annual waste duty of care audits conducted by Senior Sister/Charge Nurse and Department Managers. The information collated from these will help identify high risk areas and assist to improve any short comings, helping the team to continue to work towards waste compliance.

The Trust will be working to improve waste and recycling hierarchy by increasing domestic waste recycling, reduce landfill, increase revenue and reduce disposal costs.

It will continue to develop the waste and recycling staff and develop a new training module for KITE.

It will also continuously monitor and improve the waste service to ensure excellent patient and visitor experience and to assure RWT that the waste collection and disposal service is fully compliant with regulations.

Security

The next 12 months we will be continuing to provide support as well as additional conflict resolution training (CRT) sessions to all staff. CRT is being progressed to become mandatory for all staff.

Team members have attended Physical Intervention Restraint Trainers course (NVQ 3) to enable a bespoke training package to be developed for those areas that have high incidences of violence and aggression (V&A).

Fire Safety

Progress of the following key issues will continue to be the focus at Fire Safety group meetings during the next year:

- **Passive Fire Protection** (compartmentation). Development and introduction of working protocols for the management of' fire stopping', and the installation, testing and maintenance of fire dampers.
- **Fire Policy HS-26** Due to the number of significant changes within the organisation the fire policy will be amended during 2015/16
- **Reducing Unwanted Fire Signals** Commitment to further reduce false fire alarms significantly during the next 12 months
- **Training** to introduce a method of desktop exercises that will ensure all clinical areas undertake an evacuation exercise at least once per year.

Note: For further information refer to the Annual Report of Fire Safety 2014

Summary

2014/15 has seen an improved focus on the wider health and safety risks of the Trust. As the report demonstrates health and safety of the Trust is now in a position to progress both maintenance of the management of health and safety (i.e. local risk assessments etc.) and improving the monitoring and reporting of the baseline risk profile and where appropriate expand the profile.

9.0 APPENDICES:

2013/14 H&S Audit Emerging Risks

APPENDIX 1

Emerging Risks identified within this report:	Potential impact (including regulation)	Actions	Current status
Non-completion of pre-assessment forms	Policy compliance /NHSLA requirement	H&S Audit and implementation of interim KPIs to monitor.	Item 4 of this report evidences significant improvement – action closed.
Consideration of pre-assessment forms to inform risk assessments	Policy compliance /NHSLA requirement	H&S Audit and implementation of interim KPIs to monitor.	Continue use, to improve quality of risk assessments. Action closed
Assurance of relevance of 'Not Applicable'	Breach of various HSE Regs	Review of areas where N/A returned underway.	H&S Officers challenge and ensure a true response. – Action closed
First Aid training funding ends March 2014	Breach of First Aid Regs	Funding identified for 13/14. Business Plan completed for 15 onwards.	Funds identified 14/15 plan submitted for 2016 onwards.
Sharps safety mechanisms unsuitable	Breach of HSE Sharps Regs	Re-instatement of Sharps Safety Group to review mechanisms and implement.	Safer sharps start and finish group re-launched. 12 month programme for this financial year underway.
Incident reporting categories – increasing incidents: • Hazardous substances • Occupational Health • Manual Handling (inanimate objects)	HSE/NHSLA Financial implications – personal injury claims	Implementation of new investigation forms for all high risk areas and KPIs for monitoring. Increase awareness and lessons learnt through newsletters, education and All User Bulletins.	RIDDOR investigations undertaken /SUI's 'SPOT' newsletter issued quarterly. Email used for urgent information communication and quarterlyRisky Business newsletters. Safety Rep Forums used to reiterate. Action c/f 15/16
Co-operation: Time availability for safety reps to undertake H&S duties is not 'protected'	Breach Safety Reps Regulations	Communicate to Divisions requirement.	Communication completed however little improvement reported by H&S Reps. Action c/f 15/16
Lack of training records for statutory training topics	Unable to evidence the Trust provides the training	Centralisation of training records for statutory training.	H&S Team recording training sessions – improved c/f 15/16
Successful claims for following high			Specific forms for sharps & STF's

Emerging Risks identified within this report:	Potential impact (including regulation)	Actions	Current status
risk areas: • Needlestick (Sharps) injuries • Slips Trips & Falls • Contact injuries • Manual handling	HSE/NHSLA Financial implications – personal injury claims Potential for HSE intervention.	Implementation of new investigation forms for all high risk areas and KPIs for monitoring. Increase awareness and lessons learnt Review of all high risk incidents via HSSG and/or specialist group	generic form/RCA for other topics. RIDDORS checked for relevant investigation level. Lessons learnt shared as stated in section 4 above. Incidents reviewed bi-monthly HSSG and other specialist groups KPI's developed to monitor due June 15. c/f 15/16
Monitoring of RIDDOR more than 3 days but less than 7 days absence	Potential HSE intervention	Continue to raise awareness and add to KPI when developed.	Further work required. c/f 15/16

HSE Compliance Assurance – Risk Profile

Appendix 2

Topic	Lead	Activities	Emerging Risks identified	Action taken to manage as at :	Where monitored/ reported	Risk grading as key blow
Estates & facilities It has been a challenging year with many changes due to the addition of Cannock. The Report overall has been scored as an amber with the area identified for the management of Quality, Safety and Environmental as a red, this being due to the lack of an easily auditable system to validate statutory compliance in all areas. The estates department has also seen considerable change and improvement within the past twelve months with a management and shift review being completed putting the backbone of the department in place. This will allow the team to move forward supported by a compliance manager to put process and procedures in place to improve: - Consolidation of assets - The appointment of persons into formal Authorised Person roles for all key areas. - Communication of how the estates are managed including governance responsibilities in support of the Corporate and Legislative requirements. - Pre-Qualification and the management of contractors. Vast improvements have been made in the area of management of Water systems which has involved an enormous amount of work to improve the management system, this good work shall be carried forward into the next 12 months, to close out all the identified actions from the L8 Risk Assessments and legislative changes. The community areas (including Cannock) are now being directly managed by the Estates Team at New Cross which has also involved changing the way the estates team works taking on responsibility of the wider community in and out of hours being able to respond to this service.						
Asbestos Management CAR 2012, HSWA	Deputy Head of Estates	Revision of the Asbestos policy has been approved. Asbestos management plan to	Following approval of policy the management plan requires development and a refresh of the asbestos register is needed to bring all sites onto a single document.	The Trusts asbestos register is being refreshed to include Cannock Chase Hospital and Community properties within a single document. Completion August 2015	Health and Safety Group (HSSG) Estates Governance	**Amber**

		Communicate the Asbestos policy and manage the asbestos being drafted. 30% Complete Addition of Cannock and Community properties Asbestos information to be combined into central database for ease of access by all staff. 65% Complete	Management to communicate the Asbestos Policy for the management and the control of the asbestos within the Trust. A number of properties overdue a review of their survey results due to not being completed on handover or due after the handover of the facilities. The Trusts asbestos register not complete. The register does not include all the information in one location. Appointment of a Responsible Person to manage asbestos within Estates with suitable certification BOHS P405 Training following revision to policy.	An Asbestos Management plan being prepared in order to communicate the requirements of the asbestos policy and the management controls. August 2015 Asbestos surveys and reviews being progressed. Completion August 2015 Asbestos register under review to align all survey results into one register. Completion Aug 2015 Cannock Chase Hospital and Community properties within a single document. Completion August 2015 The training for the appointment of an Asbestos Responsible Person with BOHS P405 certificated training to be arranged. Completion November 2015		

Topic	Lead	Activities	Emerging Risks identified	Action taken to manage as at :	Where monitored/ reported	Risk grading as key blow
Decontamination CFPP 01-**06**	Technical Manager	A program of maintenance, Inspection and Testing provided. An Authorised Engineer and Authorised Person Identified. RWT Policy for decontamination available. New Decontamination facilities being brought on line for Cannock. Completed May 2015 Maintenance by in house engineers and contracted accredited suppliers. Testing undertaken by third party accredited	A fully encompassing local maintenance policy and management plan for the provision of this service may be required to provide additional governance assurance that adequate processes and procedures are in place. The persons appointed to the roles of Authorising Engineer and Authorised Person Decontamination Appointments not formally appointed. The Safe System of Work system requires review. Deputy AP required.	A policy supported by a management plan and procedures to be developed. Completion April 2016 A Due Diligence Audit to be undertaken to confirm compliance of the management system in accordance with CFPP 01-06 Completion September 2015 Audit to include appointments and selection of suppliers. Completion September 2015 Appointment of persons to roles to be reviewed as part of the due diligence audit Completion August 2015 The Safe System of Work to Be reviewed. Completion July 2015 Training of another AP	Decontamination Group Estates Governance	**Amber**

		suppliers. A safe system of Work in use. (Permits)		required to act as Deputy. Completion April 2016		
Contractors	Head of Developments Head of Estates	Building and construction projects from £10,000's refurbishments to multi-million £ new builds: Urgent & Emergency Care Unit Pharmacy Refurb Installation of 28 bed ward Remodelling Cannock Endoscopy Unit	Risks assessed for all projects and risk register competed. Change to CDM Regs – responsibility transfers to Principal Contractor & Principal Designer No significant incidents	CDMC always appointed Adhoc site inspections by external Consultant company. Working with contractors on transitional arrangements, some projects affected not all depends on timeframe. Developing new Contractor Control policy – currently in draft with a 3mth timeframe to completion. Ongoing process of improvement	Department Governance	Low Amber. (Yellow)

ELECTRICAL SAFETY	**High Voltage Systems Authorisation Process** HSWA HTM	Electrical Manager	A Safe system of work in place. (Permits) An Authorised Engineer and Authorised Persons appointed Assets identified into the PPM Operating Procedures available Maintenance undertaken by Estates supported by Contracted Suppliers	A fully encompassing local maintenance policy and management plan for the provision of this service may be required to provide additional governance assurance that adequate processes and procedures are in place. Management plan for Electrical Safety.	A policy supported by a management plan and procedures to be developed. Completion April 2016 Due diligence audit of the electrical management system to confirm compliance to the management system and the legislative requirements. August 2015	Health and Safety Group Estates Governance	Green
	Low Voltage Systems HSWA HTM	Electrical Manager	A Safe System of Work in place for the controlling the Work with Low Voltage Electrical Assets.	See comments above	See comments above.	Health and Safety Group Estates Governance	Green
Gas safety **Medical Gas Systems** EU		Head of Estates	Maintenance program monitored monthly and reported to Report to Estates	A fully encompassing local maintenance policy and management plan for the provision of this service may be required	A policy supported by a management plan and procedures to be developed. Completion April 2016	Health and Safety Group Estates Governance	Green

Pharmacopeia Regulations **Medical Air Quality Compliance** HTM 02-01 A & B **Medical Gas Compliance and Authorisation of Processes**		Management Monthly All medical gas air systems and plants maintained by independent supplier. Testing and Air Quality undertaken by independent Quality Controller. The management of the medical gas system audited by the Medical Gas Authorising Engineer and managed by the Estates Authorised Person's The last report provided by the AE gave excellent feedback. Maintenance monitored monthly BOC currently completing a full compliance / due	to provide additional governance assurance that adequate processes and procedures are in place. Verification of Appointments and documentation of the Medical Gas Management System not confirmed. Pre-Qualification of Suppliers	Appointment of persons to roles to be reviewed as part of the due audit		

		diligence audit in the Trust actions will form emerging risks once identified.				
Falls from windows	Grounds Manager	Checking compliance with safety alert and HSE guidance	*Awaiting feedback from specialist area*			**Amber**
Water Safety Compliance to the statutory requirements of L8.	Head of Estates	Moving all records onto the COMPASS system to provide additional assurance in reference to our statutory requirements, currently all records are logged on planet. Development of an electronic system (Compass) for the management control of the water. 80% Complete Use of Hand Held Devices to record	The existing management controls operate within two electronic systems which involves a list of two methods of identifying the assets which are not compatible for identification and use within the two systems. *(Planning for the work Planet. The recording of results and tracking of the maintenance Compass.)* Test results recorded manually man power intensive risk of inaccuracy when recording and when inputting results into	The use of a common Asset numbering system to identify the water assets across the two data bases. Completion July 2015 The use of mobile hand held devices to record the testing and maintenance of the water outlets Completion August 2015. Estates are working with Capital development to resolve the risks identified and a bid for £60,000 allocated 2014-2015 financial year to reduce the urgent and high risks across the Trust. A further allocation of £60k the financial year 2015-	WSG IPCG Estates Governance	**Green**

		test results. 70% Complete The close out of the reactive work identified from the L8 risk assessments for the three main areas of responsibility *(New Cross, Cannock, Community)* 4687 total defects. Identification of Assets via the use of Bar coding the asset. 70% Complete	data systems Defects have increased to 4677 from 4143 13% increase mainly due to the addition of Cannock Chase & Community properties. The risks are13% are classed as urgent down 1%, 24% high up 1% and 63% medium.	2016, submitted Completion Jan 2016		
Pressure Systems Pressure Systems Safety Regulations 2000	Mechanical Manager	Pressure systems assets included in the PPM. Monitored monthly Report to Estates Management Monthly. Review of all Pressure System Assets being undertaken to confirm the assets accurately recorded now that	A fully encompassing local maintenance policy and management plan for the provision of this service may be required to provide additional governance assurance that adequate processes and procedures are in place. Location of all Pressure System related assets not confirmed.	A policy supported by a management plan and procedures to be developed. Completion April 2016 A Due Diligence Audit to be undertaken to confirm compliance of the management system in accordance with the Pressure Systems Safety Regulations 2000 and ACOPL122 Completion Sept 2015	Health and Safety Group Estates Governance	Green

		Cannock and Community form part of the maintenance program. Inspection of condition by Independent Third Party Insurance (TUV & Zurich)	Verification of Written Schemes for the various systems not confirmed.			
LOLER LOLER regulations	Mechanical Manager	A list of the assets which fall into the LOLER Legislation identified into the PPM Status of the inspection Testing and Maintenance reported monthly at the Estates Governance Meeting.	A fully encompassing local maintenance policy and management plan for the provision of this service may be required to provide additional governance assurance that adequate processes and procedures are in place. Location of all LOLER related assets not confirmed.	A policy supported by a management plan and procedures to be developed. Completion April 2016 A due diligence Audit to be undertaken to verify the assets too which the LOLER regulations are applicable	Health and Safety Group Estates Governance	**Amber**
Slips, Trips & Falls	Estates Facilities Housekeeping Estates Manager	Additional mopping of entrances on wet days, and request an all user communication reminding all staff to report any areas		• Umbrella Bags • Barrier Matting • Response to calls of spillages	Hotel Services Risk Management Group	Amber

	H& S Team	of concern.				
Quality, Safety & Environmental Management Document control, Risk Assessments Environmental **Quality, Safety & Environmental Management** Continued	Head of Estates Estates Quality Manager	Estates have a Maintenance Charter as the lead management document. A number of processes in place to aid the service delivery. Risk Assessments in place for work being undertaken. Procedures for the management controls available. A Safe System of Work being developed. Training recorded on the KITE System and the Estates Training Data Base, managed by the Office Manager and Line Managers.	A fully encompassing local maintenance policy and management plan for the provision of this service may be required to provide additional governance assurance that adequate processes and procedures are in place. A requirement of the NHS PAM's documentation. Formal document control. The Identification, notification and the communication of safety weak. Inadequate Risk Assessments and Supporting Assessments. Formal communication of the management system. Safe System of Work	A policy supported by a management plan and procedures to be developed. Completion April 2016 An Integrated Management Plan to be provided in support of the Estates Policy, to enable communication of the management and operational procedures for Quality-Safety and Environmental WITHIN Estates. Completion May 2015 The identification and provision of up to date risk assessments to support the service delivery of the Estates business. These to be in the RWT Format with a supporting means of communicating the contents of the assessments to the users. A Pre-Qualification procedure for the selection and management of contractors to be reviewed.	Health and Safety Group Estates Governance	

			weak due to the lack of understanding by all parties involved. The pre-Qualification of Contractors. The communication of information with regards to Quality- Safety- Environmental management.	Completion Sept 2015 A due diligence Audit to be undertaken of the management operating system for the whole of the estates team, with an action plan provided to close out any discrepancies June 2015 The safe System of Work to be reviewed to ensure that the persons who are managing or operating the system fully understand their responsibilities.		
Fire Safety Team During the twelve month period from 1st January until 31st December 2014, The Royal Wolverhampton NHS Trust has **significantly** improved its fire safety provision in relation to current legislative requirements **Note**: For further information refer to the Annual Report of Fire Safety 2014						
Fire Safety	Fire Manager	Deficiencies in the level of structural passive fire protection which could (in the event of fire) compromise evacuation.	Breaches of compartmentation identified in 4 buildings identified as requiring' fire stopping' works in order to safeguard fire strategy and protect evacuation routes	Work has commenced to resolve issues within The Women's and Neonatal unit, surveys and revised strategies being developed for the other buildings. Fire safety management including training, desktop exercises etc. delivered to wards to mitigate the risk	Fire Safety Group (FSG)	Amber
		Risk Of Arson Endangering Life	Offsite: Wolverhampton Eye	Following internal fire and subsequent rescue of three	FSG	Amber

			Infirmary – Compton Road	homeless people. Security barriers installed to prevent entry and robust security patrols introduced.		
		Management of Fire Safety Risks	Some areas have not received their fire risk assessments/manuals therefore not able to take effective action to minimise fire risks	Predominantly Cannock Chase Hospital. Considerable progress has been made	FSG	Low amber/Yellow
Security Training is provided to all levels of staff within the organisation, including CRT, Lone Working and Prevent, A bespoke receptionist security awareness package was created by Rich Jones, The service held 2x security awareness days on site, rolling out to Cannock this month. CCTV maintenance provider Baydale control systems were terminated due to poor performance. The service was audited by NHS Protect against the standard contract and was rated green. V&A incidents for the year ending 1013/2014 were 65, 5 of which were classed as intentional assaults on staff, the remaining 60 were of a clinical nature. This year has shown an increase in reported incidents, the management team feel that the rise in incidents is attributed with multiple incidents relating to individual patients as well as a push for reporting to enable a detailed account for other purposes. The team continue to respond to the areas that are identified on a monthly data analysis as having higher levels of incidents of V&A.						
Workplace violence	Security Manager	Security & Management of V&A	No emerging risks	The security management team review statistics and figures in relation to V&A incidents and target those areas to provide advice guidance and support to staff and managers Continue to respond to high incident reporting areas		

Waste Management

2014/15 saw some significant changes within Waste Management for the Trust and there has been some improved in the service.

A dedicated waste team is now in place, and they are working to strict guidelines, a full training programme has been implemented along with Standard Operating Procedures.

All equipment used by the waste team is now fully compliant with LOLER and PUWER and a service regime put in place.

The waste containers are being modified and sought to suit the needs of the service.

Through internal audits staff are recognising the importance of waste segregation.

External third parties are audited to ensure they have the correct licences permits extra to give RWT assurance we are complying with our Duty of Care responsibilities.

Waste collection and disposal at ward level	Waste Manager	Waste segregation	Hazardous is not being segregated from domestic waste, incorrect sack holders are on the wards.	Audits have been carried out. A new annual duty of care waste audit has been produced and will be presented at the next available Senior Nurses Operational Group meeting.		Amber
Waste container cleaning	Mechanical Manager	Disinfect and clean clinical waste containers in accordance with Clinical EPT 5.07	The containers were identified as not being cleaned during ward waste audits and several complaints therefore not complying with EPR 5.07	Originally the risk was amber then reduced to yellow after a meeting with the relevant managers. The washed containers are now identified on the incinerator burn sheets.	Quarterly audits. Reports from waste and recycling staff to waste team leader.	Yellow
Waste mobile compactor	Waste Manager	Waste removal from site	Failure to remove waste from site not able to	Possibly modify the container to suit third party	Waste collection service is	Yellow

			meet the service provisions.	vehicle, got quotes from other waste removal companies that are capable to pick up and empty the container. Looked at alternative collection methods, static compactor rather than mobile. Current third party contractor will provide an open container when required.	monitored daily,	
Clinical waste container locks are faulty	Waste Manager Mechanical Manager	All clinical waste containers should be lockable; many of the container locks are faulty.	Failure to comply with EPR 5.07 and hazardous waste regulations	38 additional waste containers have been ordered which will provide more rolling stock enabling the older damaged containers to be maintained.	All damaged waste containers should be reported through to the helpline and logged in the waste teams portacabin	Yellow
Failure to meet recycling targets	Waste Manager	Collection of domestic waste streams. Segregation of waste to reduce, reuse, recycle and recover.	Failing to conform to the waste hierarchy, increased disposal cost and not reducing landfill.	Cardboard, metal, WEEE, soft plastics and paint recycling introduced. A dedicated recycling waste mangers group has been established, Seek out best practice. A visit to Aintree Hospital involving relevant RWT managers. Committed waste and recycling team employed. Tender for a dedicated recycling company to assist with the	Waste transfer reports and ERIC.	Yellow

				process		
Clinical						
Bariatric Patient handling		Project undertaken by Rehab and Ambulatory Care team to identify gaps and use identified monies to procure specific equipment. The funding was spent but no further action has been taken to address risks	Insufficient equipment within the Trust to cater for patient intake	To be picked up 2015/16 workplan	HSSG/Divisional Nurses	

H&S Team						
COSHH	H&S Team	Risk Assessments undertaken PPE identified and supplied Incidents monitored Policy	No emerging risks	Continue to monitor incidents and ensure risk assessments reviewed and updated	All Departments & HSSG	Green

Pharmacy - All COSHH assessments for cytotoxic drugs have been updated - No areas of concerns were highlighted from the external audit (EL(97) Farwell) of the aseptic unit - Most oral cytotoxic drugs are now supplied via Boots pharmacy resulting in cost savings for the Trust						
Cytotoxic Drugs	Assistant Director of Pharmacy-Aseptic/Cancer Services	-Replaced 2 out of the 5 isolators used for the preparation of aseptic products including cytotoxic drugs. -E prescribing system (Chemocare) for chemotherapy drugs purchased by Trust	-Due to the faulty isolators in the aseptic unit, there is a reduced capacity for the preparation of cytotoxic drugs -Implementation of e prescribing system (chemocare) for chemotherapy drugs	-Outsourcing some cytotoxic drugs to commercial suppliers, business case submitted to replace 2 isolators in 2015/16 and 1 isolator in 2016/17. -Pharmacist post advertised to facilitate the implementation of Chemocare.	Pharmacy Governance meeting E prescribe project group	Amber Amber
			-The use of safety needles for the reconstitution of cytotoxic drugs leading to more sharp injuries in the aseptic unit.	-The Trust sharps group has approved the use of non safety needles for reconstituting cytotoxic drugs. The long term plan is to move to needle free devices for cytotoxic reconstitution.	Pharmacy Governance meeting	

			-The increase demand for cytotoxic drugs due to the development of oncology/haematology clinics at Cannock Hospital	-Pharmacy Staff trained at Cannock hospital to dispense some oral chemotherapy drugs. Plans in place to open a Boots Pharmacy at Cannock. No IV chemotherapy service is in place for Cannock Hospital, planning for this service is hindered by the lack of information on this service development	Pharmacy Management meeting	
Theatres						
Dyathermy & surgical smoke	**Theatres/H&S Officer**	Used to undertake procedures during surgery Within the theatre environment, air is changed 24 times an hour. Amount of surgical smoke produced by the procedure is negligible	risk is identified as low Risk assessment not available on Sharepoint	Theatres Directorate have a risk assessment in place for diathermy Specific LEV is not deemed necessary.	LEV has been considered as a control measure, different methods have been trialled/ considered but it was not reasonably practicable to install due to high costs & very low level of risk	

Medical Physics						
Equipment safety – medical equipment	**Rob Millard**	Management, maintenance and provision of medical devices HS11	Staff are not reporting faulty equipment onto the Medical Physics helpdesk or taking it out of service in some instances	Further training to be cascaded Info on how to use helpdesk reissued AUB's Train the trainer for F2 to allow for cascade training Comms via Safety Rep Forum	Medical Devices Group	
			Lack of safe and secure storage facilities	All medical equipment not in use to be returned to CERL Use F2 to facilitate	Medical Devices Group	

Infection Prevention

It has been a challenging year for Infection Prevention performance for the Organisation. Despite having exemplary Board engagement with this patient quality and safety aspect, achievement of trajectory was unachievable. A peak in performance since September 2014 has resulted in trajectory being breached for *Clostridium difficile* toxin positive cases and the zero tolerance approach for MRSA bacteraemia. This however is not unique to Wolverhampton with cases of *Clostridium difficile* having risen regionally. Work to combat this began early in 2014, with the development of new treatment options for *Clostridium difficile* which were implemented Autumn 2014 – to include a new oral antibiotic therapy and Human Probiotic Infusion (faecal transplant)**.** This highlights how Wolverhampton remains contemporary and innovative in our approach to Infection Prevention and control.

New reporting guidance was published '*Clostridium difficile* infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation' (NHSE, 2014), which outlines definitions and guidance for determining unavoidable or avoidable outcomes for each case of *Clostridium difficile*, which will be utilised by Commissioning bodies when identifying any sanctions to be imposed on acute Providers. Royal Wolverhampton has been reporting to the Infection Prevention and Control Group, Wolverhampton CCG and the NHS Trust Development Authority utilising this guidance since April 2014.

The 2 cases of MRSA Bacteraemia attributed to the acute Trust during 2014/15, were both deemed to be unavoidable following completion of the Public Health England Post Incident Review process. These incidents were investigated and reported utilising the NHS England Zero tolerance - guidance on the post infection review (NHSE, 2014).

The toolkits, related action plans and unavoidable outcome determinations were accepted by the Commissioners. The action plans including lessons learnt were cascaded throughout the Organisation via the directorate Governance routes for Trust wide learning.

Several incidents occurred throughout the year which posed their individual challenges and responses, to include Ebola preparedness, CPO, Mucormycosis, Listeriosis and TB. These incidents were managed in line with Trust policy/ protocol and reported via the appropriate Committee/Group forum.

Compliance with NICE guidance was monitored and investigated throughout the year 2014/15, to include NICE QS49 (Surgical Site Infection). In response to the release of the guidance, a Trust wide GAP analysis was undertaken, and audits have been completed as assurance and to provide a position statement. The related action plans post audit have been reported to IPCG and progressed via the relevant divisional governance routes.

The acquisition of Cannock Chase Hospital on 1st November 2014 posed challenges for the IP service; Trust policies and practices have been reviewed to incorporate Cannock processes alongside an educational programme for staff. Environmental concerns continue to be raised and addressed. Surgical Site Infection Surveillance was implemented as per Royal Wolverhampton's model for SSI on 1st November 2014. IT processes to support this have yet to be implemented but are expected within 2015/16.

Ratification of a City wide Strategy for Infection Prevention in September 2014, was supportive in underpinning the strategic objectives across Wolverhampton, and has been utilised as a foundation for the 2015/16 annual programme of work.

Infection Prevention	Nurse Manager Infection Prevention	**External targets** CDI and our performance against target Excluding Cannock - 48/36 (Avoidable = 10) Including Cannock - 51/38 WCCG - 86/67 MRSA bacteraemia RWT - 2/0 (both deemed unavoidable) WCCG - 2/0	Carbapenamase Producing Organisms (CPO) Risk or Outbreak of infection	Antibiotic Resistant Organism Policy IP03 updated to reflect requirements of national CPO toolkit (2014). Launch and implementation via Directorate Governance Meetings May 2015 Risk Register 1632 A dedicated decant facility remains a requirement to facilitate effective environmental cleans	Infection Prevention and Control Group Infection Prevention and Control Group	**Amber** **Amber**

		Internal targets MSSA bacteraemia Internal target - 34/18 DRHAB's Internal target - 63/60 MRSA acquisitions Number (no target) - 62 (prior year = 35)	Implementation of Safer Sharps EU Directive Compliance with the Health & Social Care Act (2008)	Sharps Working Group formed 2013 and progression made with implementation of safer sharp devices. Task and Finish Group re-established April 2015 to finalise compliance with this EU directive. Compliance with the 'Hygiene Code' is monitored via the Health Assure system. Positives and negative assurances are reported.	Health and Safety Steering Group Infection Prevention and Control Group	**Amber** **Amber**
Hotel Services **There has been a lot of activity to improve the condition of tugs in particular which were the cause for concern in the Trust. Safe practice has been introduced to maintain this.**						
Transport	Portering Manager	Tugs in use across the site for various activities, were deemed unfit for use following issues raised by Non-Exec Director.	Breach of HSE Legislation Risk of injury to drivers	Service contract put in place for all tugs for minimum twice yearly service. Repairs done to bring tugs to as near as possible to NEW. The fleet vans have all the necessary testing's for road worthiness and are checked daily by the drivers and serviced yearly. Driver awareness training provided at West Park for the OTs	Hotel Services Risk Management HSSG	**Green**

				2 x 7.5tn vehicles are checked on a 6 weekly basis as per the DVSA legislation and part of our operator's licence drivers are required by law to receive 35hrs training every 5 years to keep their licence. We are compliant with driver legislation regarding driver hours and vehicle safety. Driver training for tugs/FLT's undertaken in-house. User checks undertaken daily.		
Transport	Community Manager	Staff delivering community services	Lack of advice /policy to support drivers at work	Policy drafted – need to identify owner. c/f to 2015/16	HSSG	

RAG Rating Key

RED	AMBER	GREEN
Many gaps/areas of concern medium – high risk	Some gaps/areas of concern low level risk	Fully compliant with Legislations, HTM's, Guidance

Appendix 3

RA	Apr 2013 to Oct 2013 – 152 Locations			Oct 13 – Mar 14 - 153 locations			Apr 14 – Mar 15 – 156 locations			Comments
	Red	Amber	Green	Red	Amber	Green	Red	Amber	Green	
STFs	11	27	114	3	17	133	0	5	150	
MH (inc. Pts where applicable	3	22	55	4	17	66	0	4	82	2013/14 66 N/A 2014/15 70 N/A
MH Inan.	6	63	83	3	35	115	0	6	150	2013/14 0 n/a/ 2014/15 0 N/a
DSE	9	5	70	5	4	53	0	1	53	2013/14 – 91 areas N/A 2014/15 – 102 N/a
Work Equip.	11	39	30	4	25	100	0	6	124	2013/14– 24 areas N/A 2014/15 – 26 N/A
Work Environment	21	8	61	7	3	51	0	0	39	2013/14 – 92 areas N/A 2014/15 – 117 n/a
First Aid	6	47	42	2	31	64	0	0	98	2013/14 – 56 areas N/A 2014/15 – 58 n/a
COSHH	9	27	105	1	17	105	1	11	112	2013/14 - 30 areas N/A 2014/15 – 32 areas n/a
Sharps	6	18	78	5	15	85	0	12	96	2013/14 – 48 areas N/A 2014/15 – 48 N/a
Artificial Light	2	4	9	0	1	10	0	1	14	2013/14 – 142 areas N/A 2014/15 – 141 N/a
V&A	11	34	106	2	20	106	1	3	105	2013/14 – 25 areas N/A 2014/15 – 47 N/a
Lone Worker (where app)	9	8	49	2	10	56	0	2	68	2013/14 – 85 areas N/A 2014/15 – 86 N/a

Security	12	33	106	7	23	123	1	4	151	2013/14 – 0 areas N/A 2014/15 – 0 N/a
Fire	65	33	56	46	35	72	0	12	144	2013/14 – 0 areas N/A 2014/15 – 0 N/a
Working at Heights	18	13	60	7	12	69	0	3	83	2013/14 – 65 areas N/A 2014/15 – 70 N/a
PPE	3	10	115	5	2	115		4	115	2013/14 – 31 areas N/A 2014/15 – 37 N/a
Radiation	0	4	15	1	3	16	0	0	20	2013/14 - 133 areas N/A 2014/15 – 136 N/a

RAG scoring key:

Any item missing from audit (e.g. pre assessment/risk assessment)	**RED**
All items in place but requires improvement e.g. too generic, incorrect form, actions not SMART, overdue actions	**AMBER**
100% compliant with requirements, in date, actions actively being monitored and closed.	**GREEN**

Appendix 4

Pre-assessment/checklist requirement completed and in place of the 156 Locations for April 2014 to March 15; (XX) = previous report

Pre Assessment	(153) 156 Locations			
	No = Red	Part = Amber	Yes = Green	N/A
MH Inan.	(15) 0	(16) 5	(122) 151	
DSE	(10) 2	(15) 4	(107) 129	(21) 21
Work Equip.	(19) 2	(12) 4	(58) 86	(64) 64
Work Environment	(14) 1	(5) 4	(133) 150	(1) 1
COSHH	(2) 1	(21) 15	(115) 125	(15) 15
V&A	(50) 4	(2) 1	(100) 150	(1) 1
Security	(55) 3	(2) 0	(95) 152	(1) 1

(N/A = departments have identified this topic as 'Not applicable/ not a risk' to them so do not require pre-assessments or risk assessments.)

RIDDOR Incidents by Directorate and Category 2014/15 v 2013/14

Appendix 5

	contact		Hazardous substances		Manual handling activity		Occupational health		Patient - health		Property - damaged / lost / stolen		Sharps injury		Slips, trips & falls		Total	
	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15
Community Adult Services	0	0	0	0	2	3	0	0	0	0	0	0	1	2	1	1	5	6
Community Rehabilitation Services	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Acute Medicine	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1
Commercial	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		1
Critical Care	1	0	0	1	0	3	0	0	0	0	0	0	0	0	0	1	1	5
Diabetes	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	2	0
Elderly Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0
Estates Development	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Estates Management	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2	1	2
Facilities	2	4	0	0	1	5	0	0	0	0	0	1	0	0	1	2	4	12
Finance & Information	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
General Medicine	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
General Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Head and Neck	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1
IM&T Services	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0
Medical Physics	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1
Nursing & Quality	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
Obstetrics & Gynaecology	0	0	0	0	0	2	0	1	0	0	0	0	0	1	1	0	1	4
Oncology / Haematology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Paediatrics	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
Pathology Services	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
Pharmacy Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1
Renal	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1
Respiratory	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2	1	2
Therapy Services	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1
Totals:	3	9	2	1	6	14	2	1	4	0	0	1	2	4	9	14	29	44

Appendix 6

2015/16 Health and safety Action Plan

Action	Lead	Timeframe	Current status
Complete risk profiling project	HSIC	March 2016	Shown in section 2, aim to improve.
First Aid training funding ends March 2016	Breach of First Aid Regs	Sept 15	Funds identified 14/15 plan submitted for 16 onwards.
Development & Implementation of H&S Indicators	HSIC/Compliance Lead	June 2015 onwards for reporting	Ready to run first report
Work with high incident areas including RIDDORS to improve risk assessments controls and implementation	H&S Officers /Managers /reps	March 2016	On-going work RIDDORS, SUI's already revisited, High reporting topics to also be revisited.
Align RIDDOR's with claims for last 3 years and analyse data	H&S Team	October 15	Work due to commence 08/15.
Development of Safety Alerts Module – improved reporting for CAS	HSIC	Commence June 2015	Training outstanding
Manual handling equipment – insufficient bariatric equipment Inappropriate slide sheets Slide sheets not being used in some areas Broken equipment	HSIC	Sept 15	Various types of slide sheets being used. Staff complain inappropriate. Incidents still occurring Equipment not available due to broken.
Safe Drivers Driver protocols to be developed and implemented	HSIC/Community Mgt/Transport Manager	Sept 15	Draft policy needs to be progressed and a suitable lead identified

Action	Lead	Timeframe	Current status
Implementation of safer sharps mechanisms (Sharps Regs)	Safer Sharps Project Group	March 2016	Safer sharps start and finish group re-launched. 12 month programme for this financial year underway.
Co-operation: Time availability for safety reps to undertake H&S duties is not 'protected'	Divisional Management /Department Managers	March 2016	Communication completed however little improvement reported by H&S Reps. Action c/f 15/16
Lack of training records for statutory training topics	H&S Team	March 2016	Centralisation of training records for statutory training.H&S Team recording training sessions – improved c/f 15/16

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Keith Massen, Fire Safety

Rob Millard, Medical Physics

Richard Penberthy, Waste Manager

Paul Smith, Security

Sandra Tang, Pharmacy

Tina Tipton, Housekeeping

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