Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
1st May 2014

TITLE	**Health and Safety Report**
EXECUTIVE SUMMARY	This half-yearly report has been prepared to provide assurance to the Trust Board that it is managing its health and safety risks and thereby complying with its statutory duties.
BOARD ASSURANCE (Risk) IMPLICATIONS	The relatively low number of incidents continues to provide assurance that effective measures are in place to protect staff, visitors and patients.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	A good health and safety record provides assurance to patients and other stakeholders that the Trust takes its responsibilities seriously to protect its patients, staff and visitors. Health and Safety mandatory training provides all staff with awareness of key issues which enables them to work safely and avoid accidents.
LINK TO STRATEGIC OBJECTIVE	SO1: Best Outcomes; SO3 Skilled, motivated teams
EQUALITY AND DIVERSITY ISSUES	None
LEGAL ISSUES	Potential for litigation if the Trust fails in its duty of care to staff, patients and visitors.
The Trust Board is asked to:	Note and obtain assurance from the report.
Submitted by:	Chris Bell, Associate Director, Estates and Facilities, on behalf of Valerie Bartlett, Deputy Chief Executive
Date:	14th April 2014
Decision:	For Assurance

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Health and Safety Report

1. PURPOSE OF PAPER

The purpose of this paper is to provide assurance to the Trust Board that it is managing its health and safety risks and thereby complying with its statutory duties.

2. INTRODUCTION

This paper sets out key areas of Health and Safety issues and highlights current performance, incident levels and action taken to mitigate risk.

3. HEALTH AND SAFETY HALF YEARLY SUMMARY

There have been three key areas of activity in the six months. These are summarised below:

3.1 RIDDOR

There have been seven RIDDOR reportable incidents in the last six months. The details are:

Job title	Incident	Injury	Action Taken
Sub-Contractor	Sub-Contractor fell from a ladder.	Fracture	Detailed investigation by prime contractor led to improvements in H&S arrangements.
Staff Nurse	Staff nurse strained her arm assisting a patient who was falling.	Strained arm. >7 days	Advice given by the Manual Handling Team on how to safely deal with a patient falling.
Health Care Assistant	HCA was assisting a patient who fell	Strained back. >7 days	Advice given by the Manual Handling Team on how to safely deal with a patient falling.
Staff Nurse	Staff Nurse slipped on spillage.	Strained arm. >7days	Staff reminded to clean up spillages immediately or display warning signs.
Patient	Patient climbed onto canopy above Abbey Wing entrance and fell through glass roof.	Fracture	Serious incident investigation and review have been completed. Recommendations being implemented.
Medical Records Clerk	Tripped over transit box.	Fracture	Area cleared of obstructions and local staff reminded to keep walkways clear.
Maternity Assistant	MA strained finger pushing a bed.	Strained finger.>7 days	MA reminded how to safely move a bed.

All the incidents have been investigated and where lessons have been learnt changes have been implemented to prevent recurrences such as changing manual handling techniques. No enforcement action was taken by the Health and Safety Executive.

3.2 MANDATORY TRAINING

An important aspect of a good health and safety culture and an effective way to minimise accidents is training. Currently the percentage of staff compliant with Health and Safety training remains high at **97.2**%. Methods of delivery of the training are continually being developed to ensure that it remains relevant and effective.

3.3 MANUAL HANDLING

Manual handling remains a high risk activity for healthcare staff and the manual handling team are constantly identifying areas for improvement. Currently they are engaged in a major exercise to address the risks associated with handling patient records. Transportation and storage of medical notes is multifaceted and involves many disciplines including medical records, transport, clinical coding, porters, ward clerks and clinicians. A LEAN event was organised on 27th January and was facilitated by the Manual Handling Team supported by a member of the project management office. Staff from all areas of the Trust were involved and mapped the process from beginning to end. A collaborative approach was adopted and the participants developed an action plan to be implemented over the coming months to minimise the number of patient record movements. Attention is being concentrated on equipment, unnecessary record movements and compatibility with the new electronic document system.

4. INCIDENT REPORT

The following five tables demonstrate the number of incidents in the key health and safety high risk areas. These figures include near misses.

4.1 Inoculation Injuries

Fig 4.1
2013/14

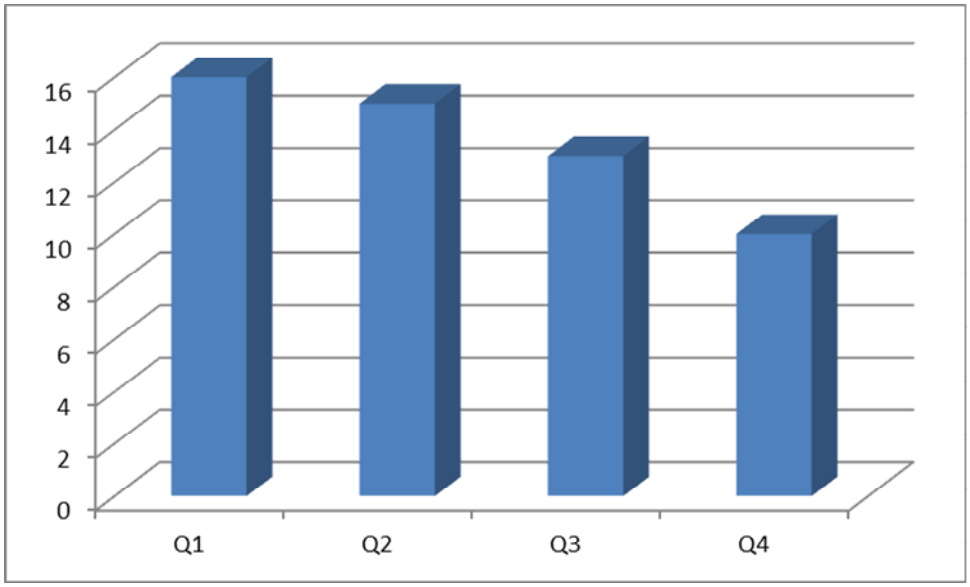


Figure 4.1 This table demonstrates that the number of inoculation injuries is decreasing and provides assurance that preventative measures are being effective. However, the majority of incidents remain avoidable and caused by a failure to follow good practice. All incidents are reviewed by Occupational Health Department where issues around bad practice have been addressed.

4.2 Manual Handling

Fig 4.2
2013/14

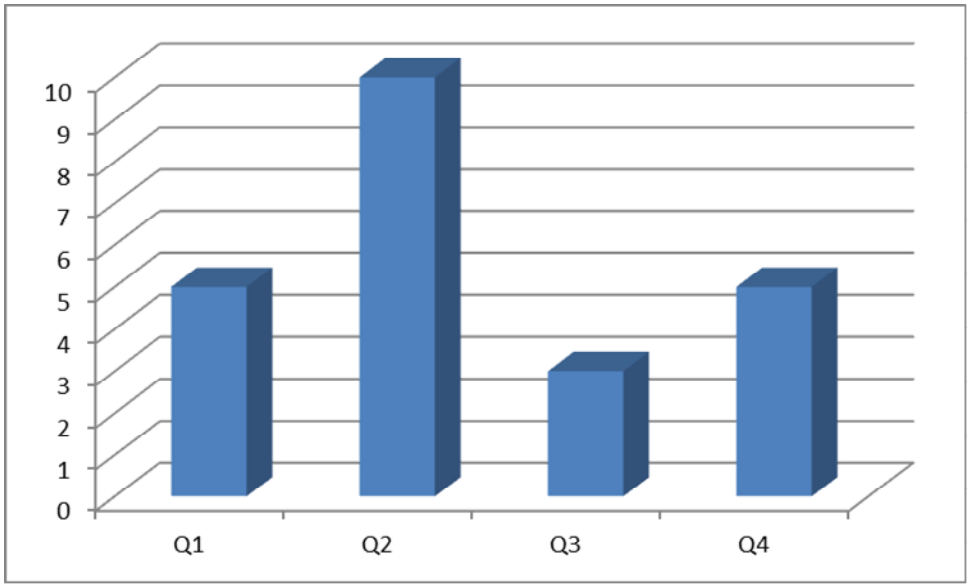


Figure 4.2 shows the number of manual handling incidents remaining relatively low and relate mostly to mobilising patients who react in an unpredictable manner.

4.3 Physical Assaults

Fig 4.3

2013/14

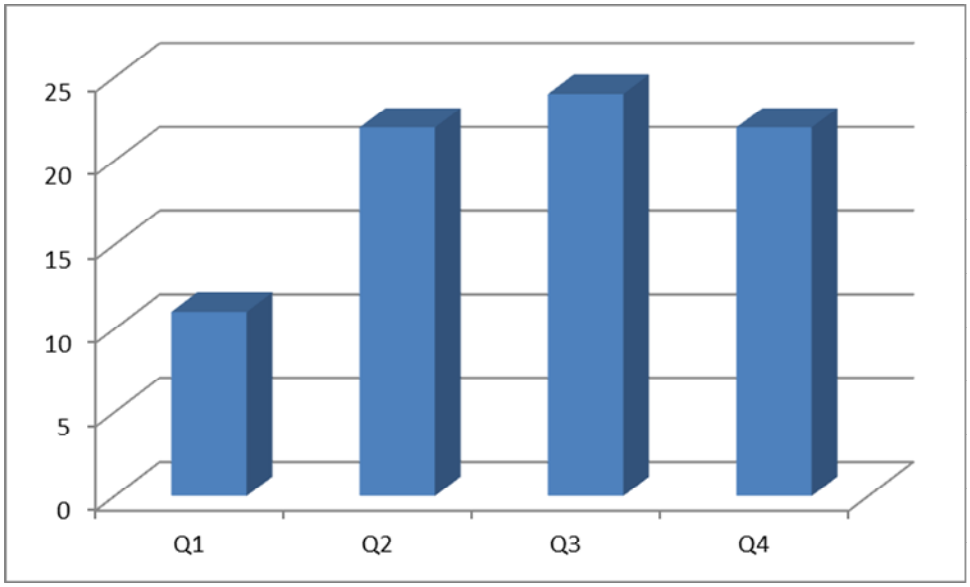
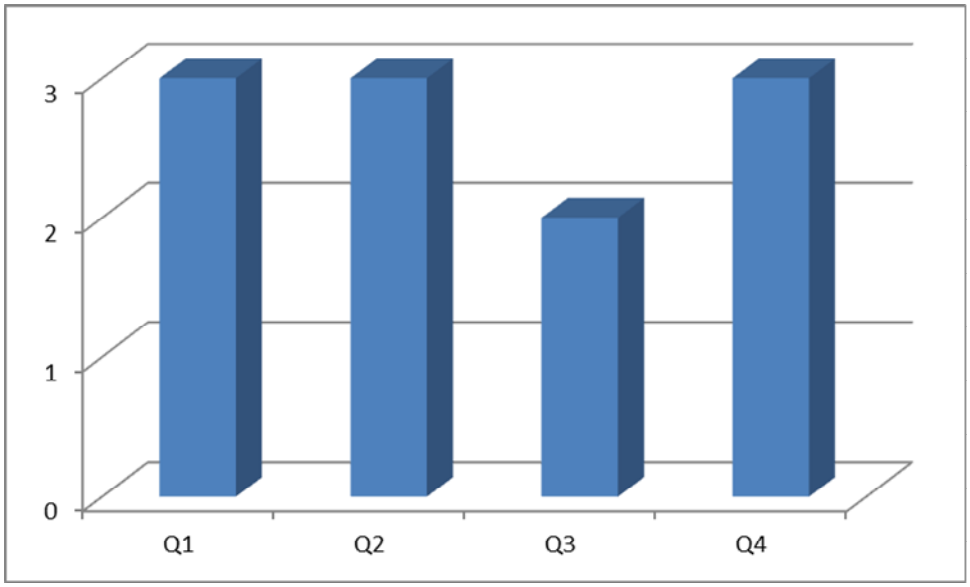


Fig 4.3 shows the number of physical assaults over the last year. The vast majority of assaults on staff come from confused patients and work continues to help staff in understanding this type of behaviour. This is supported by new training material provided by NHS Protect in the form of videos showing how to successfully care for confused and distressed patients.

4.4 Struck Equipment

Fig 4.4



The numbers in fig 4.4 are for minor injuries resulting from bumping into furniture/equipment etc. None of these were serious but communication about such risks is continually given to staff to reduce the likelihood of them recurring.

4.5 Staff Falls

Fig 4.5

2013/14

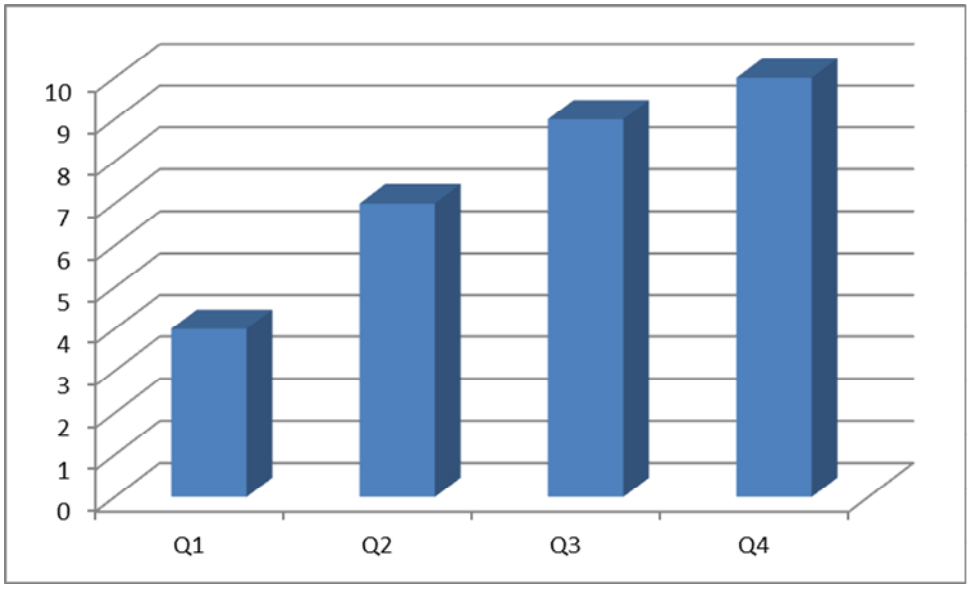


Fig 4.5 shows staff falls. It is disappointing to see an increase in numbers in the last year. The causes of the falls are broken down as follows:

Fell from ladder	1
Slipped on wet floor	7

Fell from chair	1
Tripped over object	6
Fainted	1
Other	3

In order to make staff aware of the risks of falls staff are reminded at mandatory training to immediately clear up spillages and to keep walkway clear of objects. Regular audits of areas are carried out to ensure hazards are removed.

5. SUMMARY OF ALL STAFF INCIDENT INJURIES

The following table illustrates the full level of incident injuries sustained by staff including the five high risk areas and others.

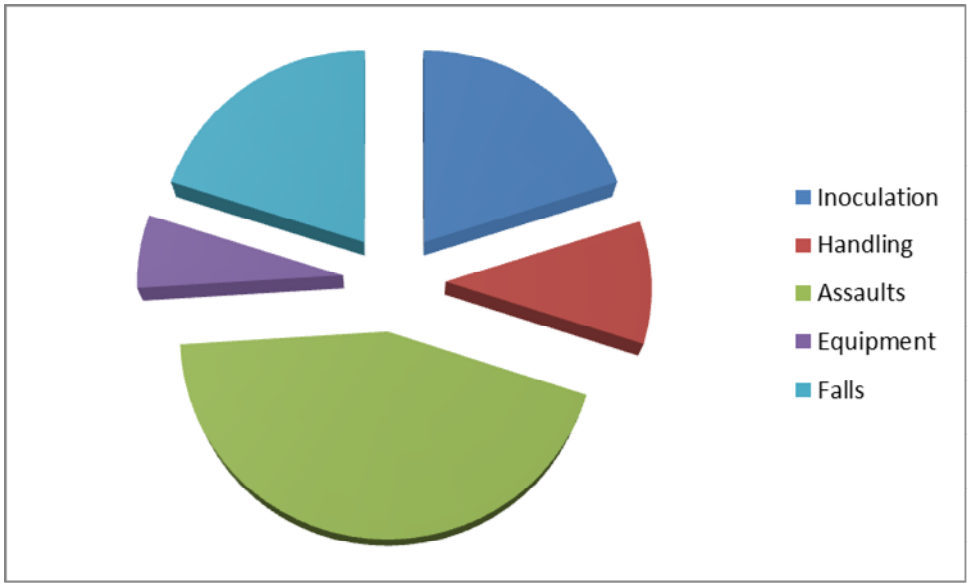
Summary of Staff Injuries

Staff Incidents	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Inoculation injuries	16	15	13	10
Manual Handling	5	6	3	5
Physical Assaults	11	21	24	22
Struck Equipment	3	2	3	3
Staff Fall	4	6	9	10
Exposure to body fluids	1	5	1	2
Exposure to hot/cold substances	0	0	1	1
Exposure to other harmful substances	1	1	0	0
Sharps (non-contaminated)	3	0	4	4
Radiation	1	0	0	0
Hit by falling object	2	2	0	2
Electrical discharge	0	0	0	0
Latex issue	0	0	0	0
Trapped by something	0	0	1	0
Other	10	12	16	12
Total (staff)	57	70	75	71

Fig 5.1 below shows the breakdown in pie chart form.

Fig 5.1

Summary of staff injuries by cause



6. CONCLUSION

The following conclusions can be made from this report:

The number of incidents remains relatively low and this will be benchmarked against other similar acute hospital trusts when data becomes available from the other Trusts in the near future. Whilst it is unlikely that accidents will ever be completely eliminated the Trust is being effective in reducing the number of injuries and their severity.

The teams responsible for health and safety remain determined to effectively communicate their message by maintaining high levels of training compliance and by being proactive, such as carrying out the Medical Records LEAN event to identify risk areas which can be addressed.

7. RECOMMENDATION

The Board is asked to note and obtain assurance from the contents of this report.