Ashford and St. Peter's Hospitals
NHS Foundation Trust

TRUST BOARD
31 October 2019

AGENDA ITEM	15.2
TITLE OF PAPER	Health & Safety Report
Confidential	NO
Suitable for public access	NO
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN SUBMITTED	
None	

STRATEGIC OBJECTIVE(S):		
Quality Of Care		The report covers quality and safety issues related to non-clinical risks.
People		This paper provides assurance to patients that Ashford and St Peter's is a safe place to visit and receive healthcare and to visit
Modern Healthcare		The relatively low numbers of incidents continue to provide assurance that effective measures are in place to protect patients, staff and visitors. The relatively low number of safety incidents is a testament to the skill and dedication of those at the Trust who motivate and lead their teams.
Digital		Nil
Collaborate		This paper provides assurance to CCGs, CQC, Monitor, HSE and other agencies that the Trust is meeting its Health and Safety responsibilities.
EXECUTIVE SUMMARY		
		This half-yearly summary has been prepared to provide assurance to the Trust Board that it is managing its Health & Safety risks and thereby complying with its statutory duties RIDDOR related incidents have seen a sharp rise in Q1 & Q2 fractures from slips and trips resulting in falls are the most common injury. The Trust has further enhanced measures to support staff dealing with

	aggression and physical assaults despite an increase in incidents. Fire safety and staff well being are now included within this report
RECOMMENDATION:	The Trust Board is asked to note the report.
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	The report covers quality and safety issues related to non-clinical risks.
Patient impact	This paper provides assurance to patients that Ashford and St Peter's is a safe place to visit and receive healthcare.
Employee	This paper provides assurance to its staff that Ashford and St Peter's is a responsible employer providing a safe place to work.
Other stakeholder	This paper provides assurance to CCGs, CQC, Monitor, HSE and other agencies that the Trust is meeting its Health and Safety responsibilities.
Equality & diversity	There are no specific equality and diversity issues.
Finance	There is potential for expensive litigation if the Trust Board breaches Health and Safety legislation.
Legal	There is potential for enforcement action if the Trust Board fails in meeting its Health and Safety duties
Link to Board Assurance Framework Principle Risk	
AUTHOR	Chris Bell Director Estates and Facilities
PRESENTED BY	Simon Marshall Director of Finance and Information
DATE	22nd October 2019
BOARD ACTION	Assurance

1. Summary of approval sought

This half-yearly summary has been prepared to provide assurance to the Trust Board that it is managing its Health & Safety and Fire risks, thereby complying with its statutory duties. The Board is asked to receive assurance from the report.

2. Background and scope

The purpose of this report is to bring to the attention of the Trust Board all the key issues associated with Health and Safety, Fire and staff wellbeing in order to promote the actions and plans to address areas of concern. It sets out key areas of issues and highlights current performance, incident levels and action taken to mitigate risk.

3. PERFORMANCE HIGHLIGHTS

3.1 RIDDOR

Between the 1st April 2019 and 30th September 2019 10 RIDDOR reportable incidents were recorded across the Trust. This is equal with the number reported in the last two quarters of 2018/19. The details are:

Job title	Incident	Injury	Action Taken
Registered Nurse	Tripped on uneven surface of entrance to car park.	Fractured shoulder blade	Initial location of incident was vague & could not be identified. Once established surface was not considered high risk but levelled to prevent re-occurrence
Consultant	Moving bed laden with equipment from ITU to Urology sustained muscle injury to leg pushing bed up slope	Injury to leg – over 7 day injury	Scene visited, incident reconstructed. Risk assessment completed by moving and handling team. Recommendation for battery assisted unit to move bed more easily reducing effort and strain
Administrative Officer	Slipped and fell on a wet floor	Dislocated shoulder – over 7 day injury	Investigation showed that pool of water had just been mopped up. "A" boards were displayed and surface water was waiting to dissipate – all cleaning

			protocols correctly adhered to.
Member of public	Patient making her way to toilet escorted helped by relative. Patient slipped and fell hitting head which proved fatal. (Details redacted due to patient confidentiality – full details known to author of report)	Fatal	Investigation showed no contributory factors and the matter was referred for investigation being supervised by the CQC
Member of public	Stumbled and tripped on a joining strip across the floor in the main outpatient's café. Sustained a fractured neck of femur.	Fractured neck of femur	CCTV reviewed & incident identified. It appeared that the joining strip had worked loose creating a small lip that induced the fall. Reported as a SIRI - recommendations for monthly health and safety inspection to address "housekeeping issues" and floor joining methods to be considered for projects to show due diligence to methods used.
Bank Porter	Was at the rear of three linen cages being pulled by an electrical tug. A further trolley had been lashed to the back of the "train" this caught a buttress protruding from a wall which flipped it into the air hitting the Porter in the back	Significant muscle and tendon damage to shoulder blade – over 7 day injury	Purchase of an extra electrical tug would have enabled the linen to be moved more effectively / safely. New electrical tug purchased to prevent repetition.
Member Of Public	Attended eye clinic but was seated on a swivel chair for examination. Due to lack of sight, stood up, seat of chair swivelled which meant she lost her balance and fell	Fractured Arm	Scene visited. Swivel chairs removed where not needed and replaced with static chairs.

Registered Nurse	Alighting from hopper bus at Ashford, turned his ankle over	Fractured Ankle	Person concerned & witnesses spoken to no fault in procedures or environment found
Clerical Officer	Making her way across gravel car park, stumbled and fell causing injury to foot. Unable to illicit further how incident had happened	Fractured foot	Scene examined no fault found. Incident identified on CCTV and simulated the following day by cross referencing footage with live CCTV. No fault found in area where incident happened.
Matron	Bricks had been used to prop open a door during a meeting. Door slowly closed so when opened again bricks were in the doorway. Member of staff left room and tripped over bricks	Severe bruising – over 7 day injury	Scene visited, bricks removed

Figure 3.1 RIDDOR

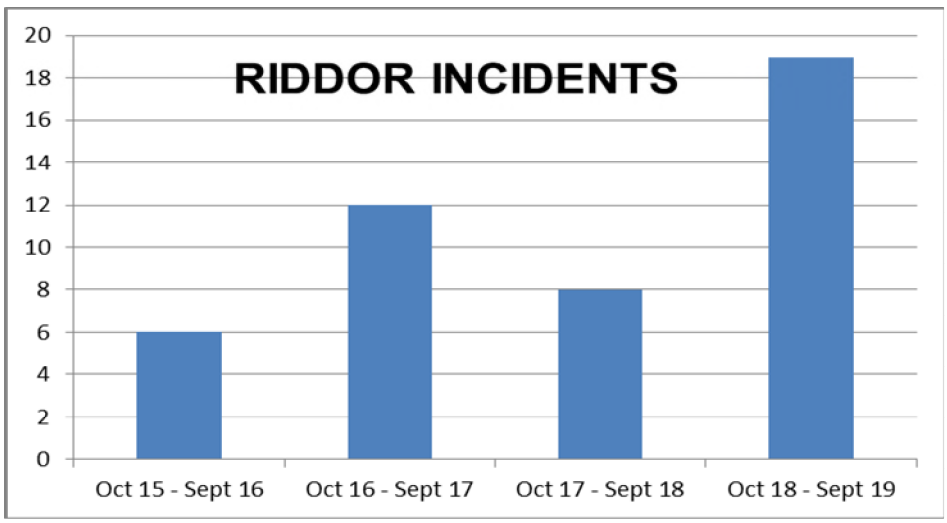


Figure 3.1 above illustrates the annual trends associated with RIDDOR reporting from October 2015 to September 2018

There has been a sharp increase in RIDDOR reported incidents, over double that of the previous year. The long term trend suggests that the Trust reports 12 RIDDOR related injuries per year, on average. Fractures to limbs, from slips and trips, remain the most common injury sustained, reflecting the broad UK trend. Avoiding slips and trips resulting in falls are constant themes in induction / mandatory training which have an average of 92% attendance rate, the highest in the Trust.

There has also been one fatality in this reporting period, where a patient fell while being escorted by a relative causing a head injury. Again this has been the subject of a rigorous investigation and appears to have been a very unfortunate incident that was unforeseeable. (Details redacted due to patient confidentiality – full details known to author of report)

Each RIDDOR incident has been thoroughly investigated, being subject of a scene visit and a close examination of the circumstances to help identify any unsafe conditions and place necessary interventions to prevent repetition. CCTV continues to be a key tool in investigating incidents and a further raft of enhanced CCTV coverage was put in place at the end of September 2019 to add cameras and update existing ones.

One RIDDOR related injury (June 2019) drew close scrutiny from the Health & Safety Executive (HSE) who required to see evidence of the Trusts response and investigation. On receiving the information the HSE decided not to launch an investigation of their own, this indicates that they were happy with the organisational culture when responding to incidents and of the seriousness placed on them by the Trust.

The Trust continues to report incidents through the Healthcare Risk Management Group, comparing trends with other NHS Trusts and private healthcare providers in the South East. The data collected is passed to the Health & Safety Executive (HSE) to help identify regional and national trends that may affect our workforce.

Despite the sharp rise in reported incidents, it is hard to quantify additional measures that need to be put in place to reduce the numbers of incidents. As stated, each incident was the subject of a bespoke investigation; however, without identifying any concurring themes the evidence suggests that they are isolated events.

3.2 Violence and Aggression

Violence and aggression remains a key staff concern, particularly the perception of violence. The numbers of physical assaults saw a significant rise in Q1 of 2019 before tailing off in Q2 back to more stable levels.

The main perpetrators of assaults remain the same, people with cognitive impairment, particularly the elderly. Again, insulting and derogatory language towards members of minority communities has been noted. Unfortunately elderly people with imbedded attitudes that do not reflect modern values would appear to be the main focus of these incidents.

The Trust undertakes a raft of measures to support staff, these are summarised below:

- Violence and aggression figures collated monthly for the attention of the Director of Workforce

- Conflict resolution training targeted at areas most susceptible to incidences of violence

- Re-design of waiting areas to make them more secure

- CCTV coverage has been enhanced to provide more integrated coverage of vulnerable areas.

- Where appropriate, risk assessments have been conducted on staff to lessen the likelihood of them becoming targets from specific individuals.

- Formal debriefs are held on a group and one to one basis for serious incidents of violence and aggression by an external provider.

In addition to these, during the first half of 2019 the following measures have also been introduced:

- Security staff have undertaken the first of three courses, through an accredited provider, in restraint and compliance training. Effectively harmonising techniques and providing a standard for restraint techniques. This has also embedded a degree of resilience for the Trust in the event of an investigation or litigation. Security staff will also undertake Security Industry Accreditation training to further enhance and standardise practises.

- All 65 members of ITU staff will have been trained in conflict resolution by the end of December 2019, a direct response to the violence they faced from two families in 2018.

- A&E staff are now engaging with conflict management and compliance training, with three courses being run up to December 2019, with a proposal for further courses in 2020.

- Body worn cameras (BWC) are scheduled to enter service with the Trust in November 2019. Four pilot areas have been identified for the trial, each with a proven history of suffering from violence and aggression. BWC's not only provide evidence of incidents but also have a proven deterrent effect on any would be perpetrators.

- Working in partnership more effectively with the Police and mental health services to place controls where specific risks have been identified.

- Addressing the behaviour of people with them directly and asking them to reflect on the impact of their words / behaviour.

- Car park lighting has been enhanced in the temporary staff car parks to help tackle the fear and perception of violence when returning to cars late at night.

4. INCIDENTS

Violent and aggressive behaviour is often brought into the hospital and is difficult to control, as an issue it will probably not decline, therefore the Trust is demonstrating that this is taken seriously by implementing all of the above measures when and if required.

Figure 4.1

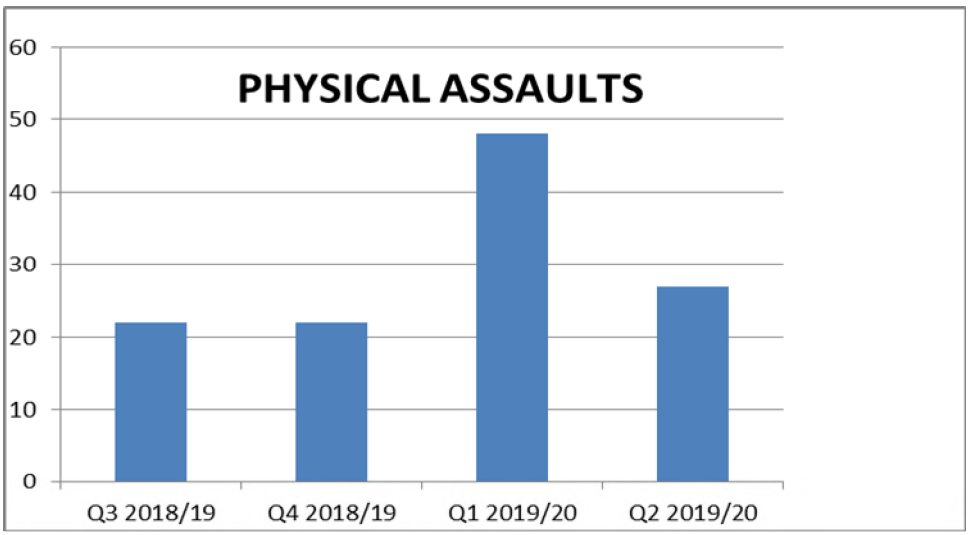


Figure 4.1 illustrates the trend in assaults over the year 2018/19

4.2 Inoculation Injuries

The number of innoculation injuries has taken a significant down turn since Q1 of 2017/18 to an average of about 10 incidents per quarter. However Q2 of 2019 has seen this figure double (Figure 4.2) bucking the long term trend.

The incidents for Q2 have been examined and it is hard to identify any generic causes. A brief analysis of the reports suggests that the following aggravating factors may assist in the likelihood of an injury occuring:

- Haste
- Leaving sharps unguarded when they are finished with, particulalry when being returned for sterilisation.
- Intervening factors e.g children becoming upset

In order to address this further a meeting has been arranged with the new Infection Prevention Control lead on the 4th November 2019. The aim of this meeting will be:

- To establish the predominant causes and areas where injury occurs
- Examine the use of Personal Protective Equipment to ensure it is being used correctly and mitigates risks sufficiently
- Ensure Safer Sharps regulations are being followed.
- How to review information from Datix to provide better intelligence on sharps injuries.

Again the Trust submits data to the HSE via the Healthcare Risk Management Group to ensure accurate reporting and receive feedback that will help tackle any problem areas.

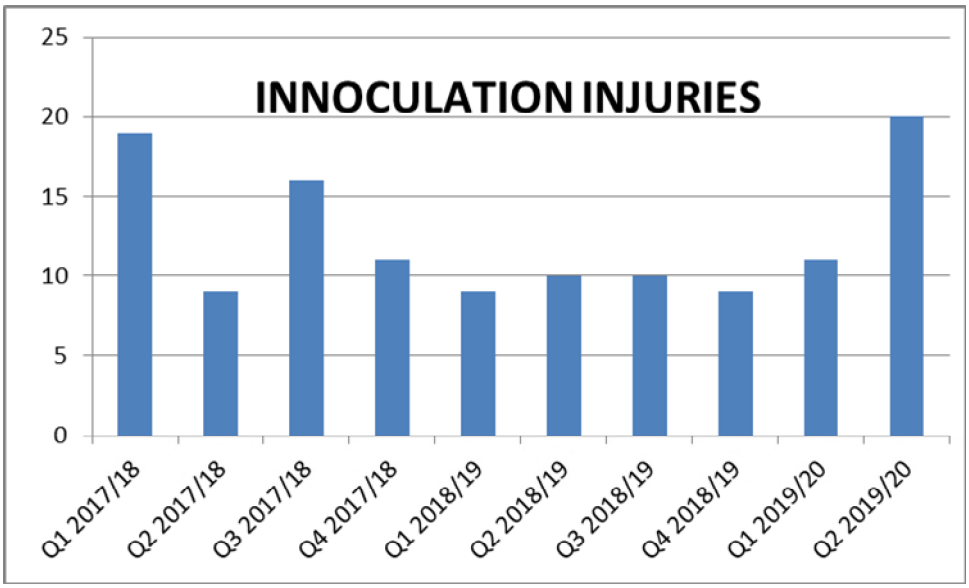


Figure 4.2 demonstrates the trend in inoculation injuries since 2017

4.3 Staff Falls

Analysis of the long-term trend shows that the numbers of incidents remains generally low. However the severity of the injury sustained can be disproportionately high. In some cases, age and medical conditions exacerbate the degree of injury sustained. Seven of the ten RIDDOR incidents related to trips resulting in falls. Fractures are the most common injury. Each investigation has failed to identify a common theme / area where they are more likely to occur.

As a result of a recent SIRI a monthly inspection of high footfall areas is to be conducted to address any minor defects before they develop into hazards where the likelihood of a fall becomes greater.

In one incident a member of staff slipped on a wet floor and sustained a dislocated shoulder. The work process in responding to and clearing the water was examined in detail. This was found to be very robust both in timeliness and cleaning protocols.

CCTV footage has shown that aggravating factors that lead to falls are inattentiveness, distraction and haste.

Generally, trips resulting in falls are more prevalent outside in areas such as car parks and when slippery conditions can arise. Inside areas are less susceptible; this can be attributed to good cleaning regimes and effective contractor management for scheduled works etc.

To reduce the risk of any falls the following actions are undertaken:

- Wet floors are correctly marked by staff
- Proactive monthly inspections to identify hazards e.g. potholes and lighting
- The top ten lighting and pothole problems are targeted for repair.
- Pathways are kept clear of leaf and other debris by the groundsman and cleaning teams
- Weekly meetings are set up with contractors engaged in large scale works, to manage the interface between the works and the Trust with the aim of minimising the potential for adverse incidents to take place.
- There are approximately 8 sets of major building works across the Trust at this time, no adverse reports have yet been received about trips and falls happening as a result of these works.
- In anticipation of adverse winter weather supplies of grit are held in reserve within estates, together with tools to assist in snow / ice clearing
- On the 21st October 2019 a site survey was conducted with the Trust gritting contractor to ensure all high risk areas would be the subject of gritting in the anticipation of winter weather.

Slips and trips resulting in falls are a constant topic for delivery in mandatory and induction training, alerting staff to be aware of potential trip/slip hazards.

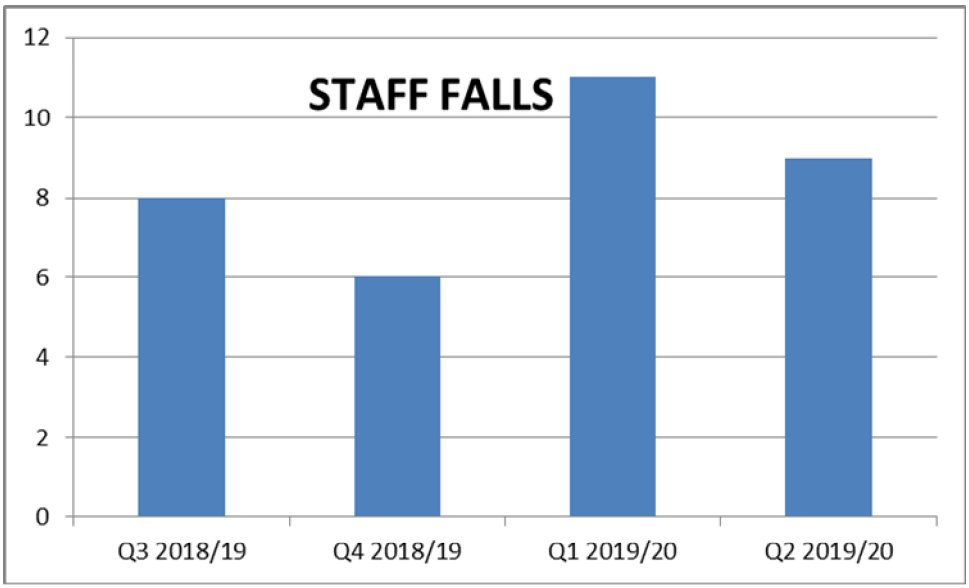


Fig 4.3 demonstrates the number of slips and trips resulting in falls for the last four quarters

4.4 Manual Handling

The manual handling team are now up to strength and remain pro-active in minimising the number of lifting and handling actions undertaken in daily work routines. This has shown a benefit in reducing the number of manual handling injuries during Q1 & Q2 of 2019.

Reducing the amount of lifting operations reduces the stress on lower backs and limbs this repays the Trust with less sick time and the individual without chronic conditions, increasing longevity on behalf of both. This has the benefit of reducing the potential for injury to occur.

Currently the manual handling team are / have:

- Assessed the way in which theatre instruments are delivered to Ashford from St Peters. This has resulted in the ordering of another specialist trolley to prevent overloading of existing ones. This reduces weight which reduces the impact on the staff concerned.

- In response to a RIDDOR related incident the team have assessed how patients are moved from ITU to the Cardiac Unit and are currently putting a plan in place to mechanically assist beds being pushed up a slope whilst laden with equipment

- Proactive in training staff in evacuation procedures using ski pads

- Providing a better means of access and egress from the Cardiac Unit to assist other partners in evacuation and manual handling.

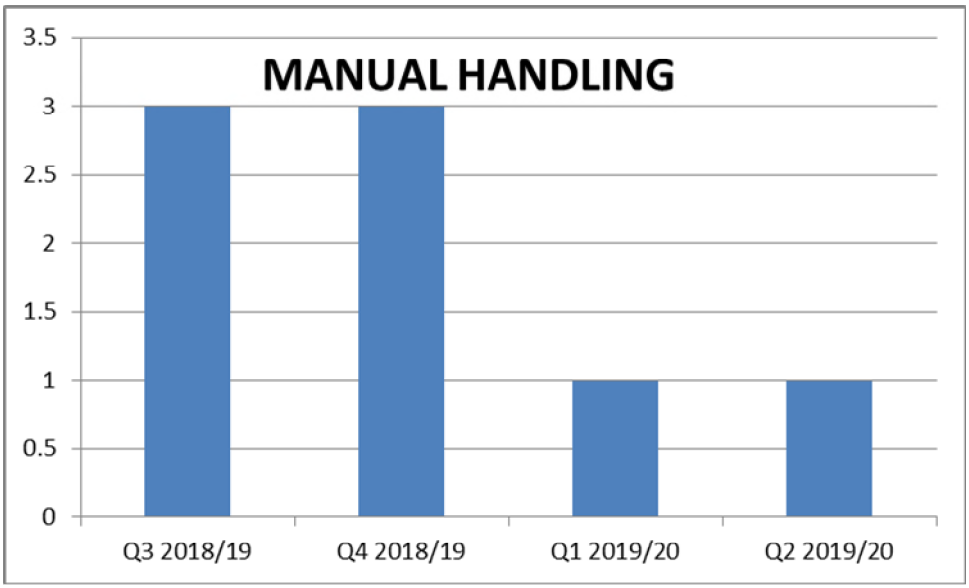


Figure 4.4 shows the number of maunal handing injuries sustained in the last four quarter

4.5 Struck By Equipment

Figure 4.5 demonstrates the number of members of staff who have been struck by equipment, this has seen a significant decline in the last quarter. Incidents have been examined and it is hard to establish any concurring themes. All incidents appear to be minor in nature with haste or momentary inattentiveness being an aggraviating factor.

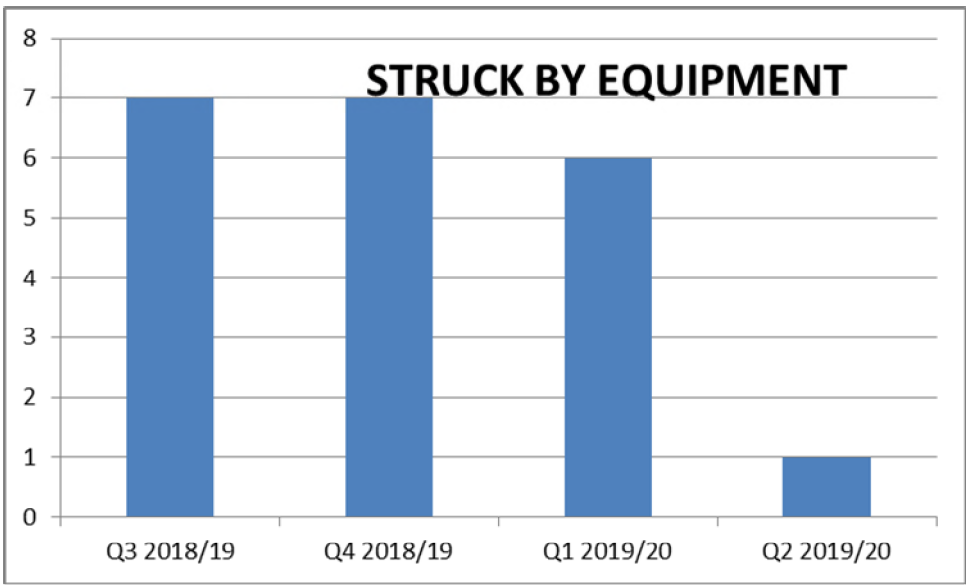


Fig 4.5 Staff indicates the number of staff struck by equipment.

4.6 Hit By Falling Object

In the first two quarters of 2019 incidents of being hit by falling obects have increased by 2 over the last two quarters in 2018/19. Again there are no concurring themes, and the most serious incident concerned a shelf holding 14 IV pumps collapsing. This was assessed and the fixings had worked loose over time, coupled with the weight of the pumps and staff holding onto the shelf when using the foot stool. The shelf has been removed and the pumps stored on a lower shelf with better stability. This reduces the liklihood of injury occuring.

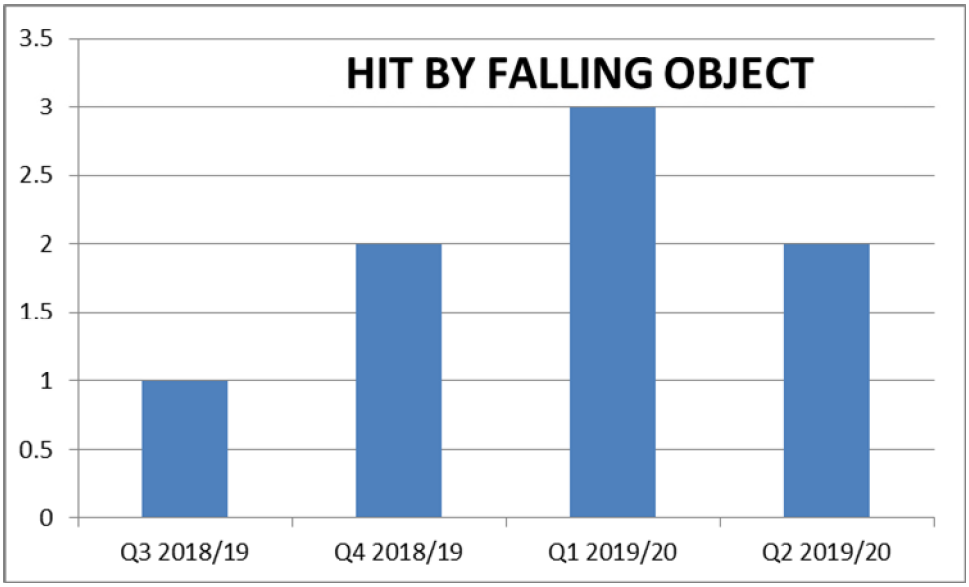
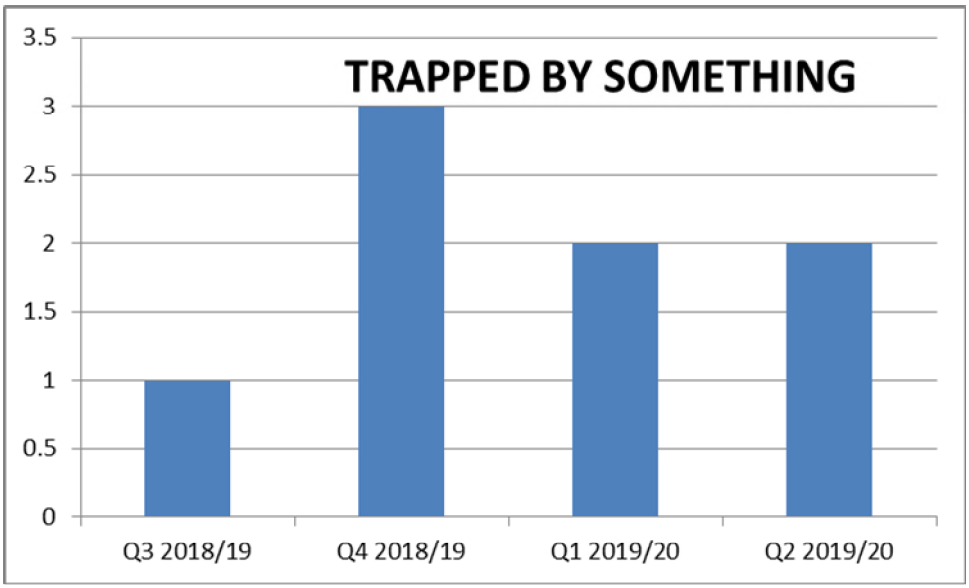


Fig 4.6 Indicates the number of staff hit by falling equipment

4.7 Trapped By Something

A total of 4 instances of persons being trapped by sometihng have been recorded in Q1 & Q2, this accords with the last two quarters of 2018/19. One of which was a RIDDOR reportable incident moving the bed from ITU to the Cardiac Unit, again this has been fully assessed by the moving and handling team and a risk assessment completed with recommendations for mechanical assistance when pusihng a bed in circumstances such as these. Other incidents recorded under this category are minor in nature and in some circumstances have been filed under the wrong datix headings.



4.7 Indicates the number of staff being trapped by something

4.8 Near Misses

Assessment of near misses is a good barometer to illicit organisational health in relation to safety. Assessing near misses has a key effect of preventing organisational risk aversion, whereby they are lulled into a sense of false security by relying on data for incidents alone.

Since 2009 Datix has reported 601 near misses within the Trust, the last being in 2017. Ultimately when a Datix is inputted the option for near miss is combined with an actual incident. However when the datix is closed after investigation, there is an option for the handler to classify it as a near miss, if appropriate. This is clearly not being done or the overiding culture is to report incidents and not near misses.

Ultimatley Datix can cater for and report back on near misses, so the issue appears to be one of staff education around the use of the datix system. Tenative enquiries have been made with the Quality Team and the first suggested approach is to put out a guide through an Aspire bulletin. The results can then be monitored, assessed and reported on.

RIDDOR also clasifies "Dangerous Occurences" as near misses and provides a host of incident catagories that would meet this requirement. There were no RIDDOR related dangerous occurences in this reporting period.

5. SUMMARY OF ALL STAFF INCIDENT INJURIES

The following table illustrates the full level of incident injuries sustained by staff including the eight high risk areas and others. Most categories of incidents remain stable across the reporting periods. The biggest fluctuation arises from the numbers of physical assaults that are reported and as can be seen from paragraph 3.2 the Trust has a robust range of methods to support staff and challenge unacceptable behaviour. There is also evidence of

an overall strong reporting culture allowing the Trust to analyse where their critical health and safety areas are.

Summary of Staff Injuries

Staff Incidents	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20
Inoculation injuries	10	9	11	20
Manual Handling	3	3	1	1
Physical Assaults	22	22	48	27
Struck Equipment	7	7	6	1
Staff Fall	8	6	11	9
Exposure to body fluids	3	1	1	1
Exposure to hot/cold substances	1	1	0	0
Exposure to other harmful substances	0	1	1	0
Sharps (non-contaminated)	2	0	2	2
Radiation	0	1	0	1
Hit by falling object	1	2	3	2
Electrical discharge	0	0	0	0
Latex issue	0	0	0	0
Trapped by something	1	3	2	2

Injured by animal	0	1	0	0
Other	0	0	0	0
Total (staff)	58	57	86	66

6. FIRE

On the 26th September 2019, during the Trust Board Meeting, the Chief Executive asked that a Fire report form part of the half yearly Health & Safety Report (this report). A board report was a statutory requirement of Healthcare Technical Memorandum 05-01, managing healthcare fire safety, however this requirement was removed and the need for a board report ceased. However in response to several key events across the UK (Grenfell Tower, Weybridge Hospital) fire safety needs to be reported on as a key component of organisational safety.

6.1 Fire Incidents

The below table illustrates the number of fire related incidents that have been reported in Q1 & Q2 of 2019/20 and their causes:

Date	Incident	Location	Cause
03.04.19	Fire alarm activated at nurses station	Bradley Unit Woking	No fire – dust entering detector
12.04.19	Fire alarm activated in corridor	Bradley Unit Woking	Investigated cause not found – sensor working properly
24.04.19	Food trolley plug overheated & smelt of burning	BACU	Possible overload of electrical system – checked and rectified by electricians
15.05.19	Patient pressed emergency alarm call point on exiting A&E	A&E	Human error
29.05.19	Building dust set off alarm	OPD Woking	Building dust set off alarm
02.06.19	Alarm activated for no apparent reason	OPD at SPH	Sensor fault
19.06.19	Fire alarm activated	Bradley Unit Woking	Investigated - cause not found – sensor working properly
27.06.19	Burning trees close to hospital	Grounds of	Trees being burnt close to buildings, contractors

		SPH	advised
01.07.19	Fire alarm activated	OPD Woking	Set off by workmen
12.07.19	Burnt toast set off alarm	Cardiology SPH	Burnt toast
16.07.19	Small fire at rear of Ashford Mortuary	Public Place	Extinguished – believed discarded cigarette was cause
20.07.19	Burnt toast set off alarm	May Ward	Burnt toast
31.07.19	Fault on alarm	Old Ramp Area	Sensor set off for no known reason may be due to smoker in vicinity
05.08.19	Mobile phone charger caught fire	Maple Ward	Fire extinguished - fire infrastructure checked in the bay afterwards as a matter of good housekeeping
14.08.19	Fire alarm theatres SPH	Theatres SPH	Inappropriate activation from fire call point
16.08.19	Fire alarm activated	OPD Woking	Steam from shower activated alarm
09.09.19	Fire alarm activated	Walk In Centre Toilet Woking	Deodorant activated alarm
17.09.19 x 2 calls	Alarm activated in plant room	Plant Room	Room excessively hot due to heat wave, doors opened and fan placed inside to cool room down
17.09.19	Alarm set off	Pathology Corridor	Contractors dust set off alarm
18.09.19	Alarm set off	Pathology Corridor	Contractors dust set off alarm
24.09.19	Pre alarm set off in MRI Unit	MRI Unit - SPH	Contractors dust set off alarm

In response to the above fire incidents the following actions have been or are in the process of being undertaken:

- National Health Property Services are fitting a new alarm system into Woking Community Hospital this is due to be finished by the end of November 2019.

- Thermographic testing of electrical wiring to be carried out to identify heat sources in walls etc
- Tighter control of contractors with regards to isolating fire sensors.
- Aspire articles during "National Fire Door Week" giving general fire advice and guidance.

6.2 Fire Capital Budget

The allocated fire capital budget for 2019/20 is £200,000, this is in the process of being spent on the following items:

1. New fire panel Prince Edward Wing - £100,000
2. Main Theatres & Duchess Of Kent Fire Doors (from survey) - £40,000
3. Duchess Of Kent Wing fire compartmentation - £40,000
4. Fire Dampers (from survey) - £20,000

6.3 Fire Education

- The following actions have been taken to promote fire safety in Q1 & Q2 of 2019
- Fire risk assessments paying attention to higher risk areas
- Monthly fire evacuation exercises
- Dedicated slot on A&E education days to do mandatory training and fire evacuation exercises
- Aspire articles during National Fire Door Safety Week to promote fire safety
- Mandatory Training
- Offer to visit wards and departments who cannot release staff more readily for training and provide on-site training

6.4 Fire Surveys

Two surveys have been undertaken and the recommendations are being used to assess risk and tackle areas of priority. These are in relation to fire doors and fire dampers, however, the work can only be undertaken under the allowed budget constraints and will be part of a rolling programme of repair.

6.5 Fire Doors

The Trust owns and maintains a large number of fire doors that form an integral part of fire safety. Generally fire doors in new or refurbished areas are in a good state of repair. However those in high footfall areas are more susceptible to fair wear and tear, as well as significant damage when trollies / cages and beds are pushed through them without due care.

The fire door survey has shown that the majority of fire doors need minor adjustments and repair to maintain their integrity. A smaller number are not compliant with current standards and require major repair or replacement. Fire doors are very expensive being manufactured on a bespoke basis and need to be integrated into the existing fire infrastructure.

Significant investment is needed to address the issue in its entirety (a set of double fire doors costing about £10,000)

£40,000 of the 2019/20 budget has been allocated towards fire door integrity; however the following actions have been taken to address significant areas of risk;

- As a result of the fire door survey, fire door integrity has been placed on the Divisional Risk Register to ensure it has a high profile and issues are worked through
- Fire doors have been replaced in the Duchess Of Kent Wing and Theatres
- A&E / Paediatric A&E are in the process of having new fire doors fitted
- General repairs
- Pro-activity in ensuring new fire doors are included in Capital projects
- An "Aspire" campaign was launched in September 2019 to promote fire door safety, during National Fire Door Week
- Pop up banners have been purchased to place next to doors susceptible to damage, asking that people respect the integrity of that particular door, with the aim of reducing the potential for damage

6.6 Future Fire Activity

The proposal for the following year is to replace fire panels at the rate of one per year and concentrate on the recommendations of the fire door survey and fire damper survey. This will be combined with raising staff awareness of fire procedures through training and drills.

A new "Fire Watch" form has been developed to form part of an Aspire bulletin when alarm systems develop faults and are waiting repair. This is to inform staff to be on heightened vigilance in the specified areas until the fault is rectified.

7. Staff Well Being

On the 26th September 2019, during the Trust Board Meeting, the Chief Executive asked that measures to support staff well-being were also reflected in the Health & Safety Report. This was raised as an agenda item in the Health & Safety Committee of the 18th October 2019. Unlike Health & Safety and Fire, quantifying staff welfare might not be as clearly definable. How staff wellbeing should be reported was taken back as an action by the Director of Workforce and will form a part of future board reports.

8. MANDATORY TRAINING

An important aspect of a good Fire and Health & Safety culture and an effective way to minimise accidents is training. Currently the percentage of staff compliant with Health and Safety training is the highest in the Trust and fluctuates between 89% - 92% per month**.** The Fire training figures have been re-adjusted as the system did not compile accurate results for the different levels of fire training. Currently fire training stands at 75% however standardisation of training is due to commence in November 2019 to allow the figures to be accurately reported.

9. CONCLUSION

The following conclusions can be made from this report:

The Trust maintains a robust approach towards its Health & Safety and Fire obligations and continues to develop strategies to keep patients, visitors and staff safe whilst on Trust premises.

The Trust is asked to note the concerns highlighted around physical assaults and inoculation injuries and the steps taken to mitigate the risks presented.

10. RECOMMENDATION

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