West Hertfordshire Hospitals NHS
NHS Trust

Agenda 131/10

ANNUAL H&S REPORT

2009 – 2010

PURPOSE OF THE REPORT

This report aims to set out the key achievements and H&S issues that the Trust faced during 2009/10. It will be submitted to the H&S Committee and then to the Integrated Risk and Governance Committee in May 2010 and finally to the Trust Board in September 2010 as part of the SFBH requirements on Health and Safety.

1 KEY ACHIEVEMENTS AND ACTIONS

1.1 Slips Trips and Falls (STFs)

Whilst general reports of STFs over the year are comparable to those of 2008, the number of incidents resulting in serious outcome (RIDDOR reports i.e. fractures), has been dramatically reduced by 42%**.** RIDDOR reports for STFs came down to just 26 in 2009 (14 staff; 12 patient) compared to 45 in 2008 (29 staff and 16 patient) *NB: Calendar years*.

These amazing reductions provide West Hertfordshire Hospitals NHS Trust with its best ever set of accident figures, showing remarkable reductions of incidents with serious outcome. Such reductions cannot be achieved without the support and efforts of staff that have helped to make our workplaces safer for the benefit of all.

However, we need to be cautious of complacency and must continue our efforts to reduce the overall number of falls, particularly the 945 to our patients. The overall general reports for STFs amounted to 1056 reports of which just 26 had a serious outcome. Whilst attention to changes in cleaning regime and removing tripping hazards has a positive effect, we must remember that good fortune also played its part in that 1030 incidents resulted in only minor bumps and scratches, but every one of them carried the potential for serious injury. Further reductions are possible when identified by risk assessment, and investigation to identify causes, but departmental managers are submitting little evidence that they are undertaking these roles.

The HSE are also focusing on the reduction of STFs (Health Services are industry's 3rd highest reporter) with their Shattered Lives initiative to reduce figures during 2010/2011. It is recommended that the Trust does likewise using the full support of the Executive Directors to set and drive assessment and investigation targets down through the management structure together with goals of reducing the annual number of occurrences by 20-40% over the coming year. Supported by sustained 'top down' pressure and monitoring, such targets are well within our reach.

1.2 Accident Incident rate (AIR)

The end of 2009 calendar year RIDDORs (serious reportable incidents) confirm that West Hertfordshire Hospitals NHS Trust reported its lowest number since 2005. This provides the Trust's with its best end of year Accident Incident Rate (AIR) a major Key Performance Indicator that demonstrates the real time effectiveness of H&S prevention measures. The AIR is based upon the number of RIDDOR reports made in one calendar year and expressed as a number of serious incidents occurring per 1000 staff.

The 2009 calendar year sees the largest overall drop, some 38.8%. This is not the result of a reduction in reporting as the overall number of incident reports for the year is up by 78 incidents (1.13%) of the previous year (6904 in 2008, 6982 in 2009). In the face of that

increase overall RIDDORS (staff & patient), are down by 38% - and 25% below the National Average for the Health Service Industry!

This should reflect the benefit of a financial saving for the Trust in reduced claims and litigation and compensation payouts over the next few years.

1.3 Communication

Following the NHSLA recommendations the Board should now be receiving assurances via the Integrated Risk and Governance Committee (IRGC) regarding the effectiveness of the monitoring and performance of health and safety. Quarterly reports which detail H&S performance against an agreed set of key indicators were instigated by the H&S Committee any concerns are escalated to IRGC by exception, an annual report will be submitted to the IRGC.

The dashboard for this report has now been modified to streamline the data into an easier and more readable format that eliminates heavy text and the overall size of the document. Whilst the bulk of the document has now reduced, the performance figures against key indicators are now much clearer.

2.0 HEALTH & SAFETY EXECUTIVE AUDIT

The Health and Safety Executive visited over 3 days in October 2009 to undertake a further audit to chart our progress since their 2007 audit. Three of the original seven focus points were selected for comparison:

- Violence and Aggression
- Manual Handling
- Workplace Stress/well-being.

Feedback on these individual focus points is provided under specific headings within the body of this report.

As a result of the audit, the HSE submitted their report and provided within it a series of prioritised requirements to be used as the basis of an Action Plan. HSE monitor the Trust's progress against the action plan on a two-monthly basis and have provided an overall expectancy for completion of two years.

This is a very different approach by the HSE and is an alternative to conventional enforcement action. The approach is intended to be more constructive in assisting the Trust to attain compliance. However, the requirements come with a stern warning that improvement notices could have been served and, should the requirements not be addressed to HSE satisfaction within a timely period, more conventional enforcement action will be taken.

2.1 2009 Security/Violence and Aggression

One of the issues raised by the October HSE Audit was the poor amount of security resources available to the Trust. This issue was highlighted in the HSE's 2007 audit and resulted in Chris Bartram, of Bedford NHS Trust, being appointed under an SLA as Local Security Management Specialist (LSMS). He commenced on 1st January 2008 attending this Trust two days per week.

The HSE considered 2 days to be insufficient and recommended that the Trust should, ideally have a full time LSMS. This had already been pursued by the Trust and it was found that there are very few available people trained to fill all the available positions nationwide. It was therefore agreed to extend the current SLA for September 2010 to 4 days a week.

A primary concern was an Improvement Notice from the HSE requiring a more rounded view of security. This has included collecting security risk assessments for a Trust wide proactive approach to managing security. The additional time allocated also allows faster

detection of issues and assistance to staff reviewing their work areas for security weaknesses.

3 Full crime reduction surveys in conjunction with the police have been completed, one for each of the hospital sites. Remedial work has been identified and prioritised, much of which will require capital investment and a business case for funds has been raised. A further 6 surveys have been conducted at the request of the staff within the area, again these have been prioritised for action.

To enable the Health & Safety Committee to monitor security incidents and training these have been included in the Health & Safety performance report presented each month at the H&S Committee.

This year's challenges will be the introduction of the national database SIRS (Security Incident Reporting System) which is an addition to the back end of Datix. This will capture the true cost of crime to the NHS and allow specific targeting of problem areas both within the Trust and nationally.

We will also need to add a 'Lockdown' procedure within the Major incident plan. This is to secure the site against untoward attacks and protect staff, patients, visitors and property in the control of the Trust.

2.2 Stress Management/Well-Being

Work related stress absences have declined by over 30% during 2009/10 but nevertheless this finding from the staff survey suggests there is still more to be done.

We have changed the way managers refer staff to Occupational Health who have expressed that they have a stress related illness or concern. The care pathway for staff who indicate they have a stress-related condition has been agreed by the JCC and incorporated into the absence management policy. This permits managers to refer their member of staff to Occupational Health and the Employee Assistance Programme (EAP) at the very earliest stage of the illness. It is expected that this will reduce the longevity of some of these conditions and allow staff to return to work more quickly.

We are developing our own in house stress management trainers to support staff to identify stressors in their home and work lives.

We have employed an external company to work in specific high pressured areas in the Trust to support staff's health and wellbeing and to look to develop a more resilient workforce.

We are revising the Stress Management policy to provide clearer guidance to managers and to ensure it is aligned with the very best practice from the HSE.

We are continuing to develop our Staff Health and Well Being offers.

2.3 Moving and Handling

Priority recommendations raised by the October 2009 HSE Audit were:

a providing resources to support the Moving and Handling Service,
b refining the arrangements for hoist and sling provision, reviewing the moving and handling training,
c providing appropriate information and training to enable specific staff to undertake moving and handling assessments,
d implementing a system for undertaking and monitoring risk assessments, and
e developing and implementing a Trust-wide system for the safe handling of bariatric (obese) patients.

A resource plan was submitted in December 2009, and information on the amount of financial support the service will receive to action the resource plan was given on April 26th 2010. In March 2010, the HSE Inspector gave the Trust 2 months to confirm and implement the arrangements for the provision of hoist and slings, failing which an improvement notice will be served. A strategy has been drafted with the Head of Estates, however the greatest challenge that we face is that the maintenance contract with Arjo has ended, with no finite renewal date. The Moving and Handling Manager is working fervently to address this and other key challenges.

Sickness absence days relating to Musculoskeletal Disorders (MSDs) have increased by 30% during 2009/10, although work-related stress absence has declined by the same amount. The highest increases have been in Medicine and Surgery & Anaesthesia. The MSD assessments and referrals to the Moving and Handling Service suggest that some of the main reasons for the increase include, extended exposure to work-related stressful situations, lack of understanding of the benefits leading to failure to undertake the MSD risk assessments in the local environment, 90-day waiting time from referral to assessment, and financial and other resource constraints. Human Resources, Occupational Health and the Moving and Handling Services have met to discuss a more triangulated approach to addressing the MSD increase, with specific focus on the Divisions showing the highest increase.

Moving and handling training increased for the month of March 2010 from an average of 77 contracted hours to just over 100 hours, as the Training Department requested additional training. Additional hours were also contracted to reduce the waiting time for moving and handling assessments.

An emergency evacuation business case has been drafted and submitted to various committees, and following approval, training provided by the Fire and Moving and Handling Services will commence.

2.4 Health & Safety Management

Although this was not a declared focus point of the audit, the HSE feel it is an integral part of any audit and included a number of recommendations, but only one of major priority.

As with the focus points of Security and Manual Handling, the HSE believe that the Trust's resources for the provision of Health and Safety advice are too low for the size and complexity of the Trust and are anxious that existing resources receive further support.

In partnership with the Manual Handling service a resource plan for additional H&S resources was submitted in December 2009. Confirmation that additional resources would be provided was given on April 26th 2010. Whilst the increase is a major improvement, the current financial constraints mean that the amount of resource will remain below that expected by the HSE and will require further review when finances improve.

3 COSHH (Control Of Substances Hazardous to Health)

COSHH regulations require an organisation to:

- 'know' what substances it has on its premises, quantities and where;
- To assess the risk levels of those substances and maintain assessments up to date;
- reduce the use of high risk substances by substituting with those of lower risk;
- reduce the number of environmentally harmful products, again by substitution.

A new COSHH Administrator joined the Trust in August 2009 and has achieved excellent progress not just to update the assessments of most of the individual departments Trustwide, but also to provide and maintain a regular updating service. This new service ensures that all departments receive the latest copies of the assessments for the products they use. There are still a few smaller/newer administrative areas that need to be identified and entered onto the system, but the Trust can now have confidence in being around 85%-90% compliant with COSHH legislation in contrast with around 20% compliant last year when a large number of areas had not received updates since 2003.

The Trust's system holds all COSHH data centrally on a hosted database and enables reports to be produced on all substances used within the Trust. Using these reports, the Trust can identify it's high risk substances and where they are used. In response to these reports our primary focus now is to reduce the risk of exposure to staff by reducing the number of high risk substances. Work is now underway in liaison with departments to identify safer substitutes. In some areas, this may simultaneously allow substitution where products on the high risk list also appear on the list of environmentally harmful substances.

4 REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCE REGULATIONS (RIDDOR)

TABLE 1 - RIDDORs Reported Apr 2009– Mar 2010 Comparison

	2008/09		2009/10	
Type	**No.**	**%**	**No.**	**%**
Slip, Trip or Fall	**39**	**58.2**	**31**	**73.8**
Manual Handling	12	17.9	4	9.52
Hit By Moving Object (ie trolley)	4	6.0		
Assault	2	2.9		
Hit By Falling Object (ie files)	2	2.9	2	4.76
Dangerous Occurrence (Chem, falling glass)	1	1.5	2	4.76
Equip Failure	1	1.5		
Hit Against Object	1	1.5		
Hit fixture (sink unit)	1	1.5		
Other (stood on nail sharp protrusion)	1	1.5	1	2.38
Sharps	1	1.5		
Trapped in lift	1	1.5		
Asthma exacerbated	1	1.5	1	2.38
Suicide			1	2.38
TOTALS	**67**		**42**	

Although there has been a reduction in falls by 20%, the proportion of falls resulting in reportable injuries has increased due to representing a larger proportion of an overall smaller quantity. Overall reduction in reportable injuries is 37.3%

TABLE 2

2009 Quarter comparisons

(No of RIDDOR reports per quarter)

Apr/Jun	Jul/Sep	Oct/Dec	Jan/Mar
10	10	9	13

TABLE 3

Accident Incident Rate (A.I.R.)

(Incidents per 1k staff Jan/Dec)

	2006 AIR	2007 AIR	2008 AIR	**2009 AIR**
A.I.R.	15.3	17.3	14.9	**9.33**
No of incidents	69	78	67	**42**

The Accident Incident Rate (AIR) is a key indicator of safety performance and shows how well our safety procedures are performing against a National Average. It is usual for the AIR to be calculated over the calendar year (as opposed to financial year). Table 3 shows a lower rate in 2006 than 2007 and this is believed to be a result of poor identification of Reportable Incidents at that time.

5 SLIPS, TRIPS AND FALLS (STFs)

STFs remain a major focus for the Trust, as well as for all NHS Trusts nationwide.

Based on in-house reporting, Table 4 shows that although the Trust's overall STF incidents are reducing year by year, the reduction achieved during 2009/10 was significantly less than previous reduction and this despite a 20% reduction in slip incidents. Table 7 shows increases in falls from bed, trips and loss of balance that are the most likely reason for this and indicate that attention needs to be given to these areas of falls if the Trust is to maintain control of these preventable incidents.

TABLE 4 - incident Totals for year Apr 2009 – Mar 2010 with comparative

Category	2007/08	2008/9	2009/10	Comment
Incidents for year	6942	6829	**7276**	(Clinical & Non-Clinical)
STFs for year	1079	1009	**1001**	
STFs as % of total	15.54	14.77	13.75	

Common belief is that numbers for STFs are expected to be high in healthcare as patients are unwell and fall for a large number of reasons. This would certainly seem to be indicated by Trust's overall STF reporting as shown in Table 6 below:

TABLE 5 - Distribution of Groups Susceptible to FALLING for year Apr 2009 – Mar 2010 with comparative

Group	2008/9	2009/10	Movement
Patients	935	916	Down
Staff	67	80	Up
Environmental	0	2	Up
Relatives/visitors	4	0	Down
Contractors	3	3	Even
Totals	**1009**	**1001**	**Down**

National figures are based only on RIDDOR reported incidents. For the Trust, the RIDDOR STF figures (Table 6) show that it is in 2009/10 staff incurred less injuries than patients. This is the first time that the number of staff STF injuries has been recorded blow that of patients with the West Hertfordshire Hospitals NHS Trust.

TABLE 6 - Distribution of RIDDOR STFs

Group	2008/9	2009/10	Movement
Staff Falls	23	15	Down
Patient Falls	16	16	Even
Others	4	0	Down

It is also a common belief that many falls cannot be prevented. This is <u>not</u> a view upheld by the HSE who recommend that investigation should be undertaken of all occurrences to determine the true causes. Once the causes are revealed, so the means of controlling them become more apparent.

TABLE 7 shows causes that have been indicated by incident reporting alone and provides suggestions as to how each cause might be controlled. The suggestions provided are only a guide and not presented as either an exhaustive list of control measures or as legal requirements.

Even with controls in place, it is recognised that falls will still occur, but their numbers will be reduced and maybe also the severity of resulting injuries.

TABLE 7 - Causes for STF's Apr 2009 – Mar 2010

(NB: The following classifications are best estimates based on available information)

CAUSE	INCIDENTS		CONTROL ACTION
	2008/9	2009/10	
C = Patients' **Condition**	412	411	Check for Falls Care Plans
U = **Unexplained**	205	111	More detail on reports & Investigations
S = **Slip** on Floor	162	118	Review floor types and spillage control
B = Loss of **Balance**	105	128	Check for Falls Care Plans
E = From **Equipment** (ie: bed, chair, commode etc)	86	75	Review furniture upholstery
H = From **Height** (ie: bed, chair, commode etc)	83	103	Check for Falls Care Plans, lower beds, check bed rails
T = **Trips**	47	55	Clear floor areas, repair floor coverings etc
TOTAL	1009	1001	

All Trusts, are required to reduce their incidence of STFs by each of the HSE, the NHSLA and the Care Quality Commission. The Trust therefore needs to establish targets for reduction that it believes are attainable. The Trust should cascade targets for reduction and investigation via its Divisional performance management framework and individual appraisal processes. This focus will ensure that:

- assessments, inspections and investigations are carried out;
- preventative and control measures are identified and implemented to ensure those targets are communicated and met; and
- evidence is accumulated to confirm its compliance.

The support and commitment of the Board and Executive Team is sought to drive and promote the associated staff education, inspections, assessments and implementation of identified control and prevention measures in accordance with the Trust's Slips Trips and Falls policy.

5.1 Flooring Survey

A contract was issued during 2009 with expiry in August 2010 to Surface Control. This was in response to HSE pressure to undertake assessments of the slip resistance and condition of flooring in all hospitals as part of their current campaign. The survey measures the slip resistance of hard floor coverings at specifically identified points around the three hospital sites in both wet and dry conditions. To reflect our user groups the Trust has adapted HSE guidance on slip resistance of floors (a discussion paper is available on request), making it more onerous. This generates a RAG analysis on the likelihood of a slip under wet and dry conditions for the Trust's floors.

The survey also examines treatment and maintenance procedures where these may affect the slip resistance of the flooring materials. Where issues such as detergent residues are noted, changes in maintenance materials/procedures have been recommended and actioned with the co-operation of Medirest.

The survey found that since March 2010 (when Medirest's full support for the pilot scheme was achieved) there have been significant improvements in the slip performance of floors with only one still in the "red" when wet, though there are still a number in the amber "concerning" bracket. Surface Control stress that the floors should be cleaned as recommended by the floor surface manufacturers, which includes use of detergent in a controlled way.

Natalie Forrest
Director of Nursing April 2010