To:	**Trust Board**
From:	**Chief Nurse**
Date:	**31 July 2014**
CQC regulation:	

Trust Board paper Q

Title:	**Annual Health and Safety services Report – 1st April 2014 to 31st March 2014**

Author/Responsible Director: Director of Safety and Risk

Purpose of the Report:

Annual performance for Health and Safety services that details Health and Safety, Local Security Management and Manual Handling for 2013/14

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Endorsement	X

Summary / Key Points:
A summary of the performance, challenges and targets for 2013/14.

Recommendations:
To approve the Health and Safety Annual Report

Strategic Risk Register **N/A**	**Performance KPIs year to date** **Yes**

Resource Implications (eg Financial, HR)
Y

Assurance Implications
Y

Patient and Public Involvement (PPI) Implications
N/A

Equality Impact
Considered and no impact

Information exempt from Disclosure
No

Requirement for further review?
Annually

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

ANNUAL HEALTH & SAFETY SERVICES REPORT

1st April 2013 to 31st March 2014

Nick Howlett

Health and Safety Services Manager

University Hospitals of Leicester NHS Trust
May 2014

CONTENTS

Section 1 – Executive Summary

Health and Safety

1.1 The Trust set a target of reducing the total number of RIDDOR incidents by 10% per year. This figure has been missed although overall we have had a reduction in injuries by 2.

1.2 During the year there were 49 incidents reported under RIDDOR. 24 of these reportable incidents were not reported within the time limits required by RIDDOR legislation. This is a compliance rate of 48%.

1.3 Reporting of RIDDOR notifiable incidents within 10 -15 days of the incident is a legal requirement and the we will be working to ensure that timely reporting improves in 2014/15.

1.4 Presently we are reporting that only **3.3%** of staff have received any form of Health and Safety training in 2013/14.

1.5 The HSS Team will develop and promote bespoke training programmes targeted at senior and departmental managers throughout the year. This will be informed by a training risk assessment that will be part of the overall approach to Health and Safety risk assessment throughout 2014/15

1.6 We will continue to offer courses on specific aspects of Health and Safety as informed by Local Risk assessment where there is an identified need.

1.7 The HSS team will actively promote the Health and Safety e-learning programme for all staff

1.8 It is our aim that in line with other required training elements, overall compliance will achieve **80%**

1.9 The HSE Improvement Notice 304661440 served against UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST on 25/03/2013 has now been complied with and officially closed on 21/06/2013.

1.10 This year the Health and safety quarterly report will be expanded to include additional items for performance measurement or benchmarking for onward measurement. These will be, RIDDOR reportable injuries, Number of need stick injuries reported, Numbers of staff who have completed some form of approved UHL Health and Safety training, Number of IRMER reportable incidents, Number of settled Employee/Public Liability Claims against the Trust.

1.11 A number of actions have been taken to update the Health and Safety and Manual Handling Webpages. This year with the incorporation of Security Management, there will be one Health and Safety Services webpage to cover all three

Manual Handling

1.12 There were 2 fewer RIDDOR reportable incidents in 2013/14, compared to the previous year and a 20% decrease in RIDDOR reportable days lost .This represents a dramatic turnaround compared to the increase we saw in both sets of figures 2 years ago. A concentration on practical assistance and particularly practical risk reduction methods has been particularly helpful in this regard.

1.13 We aim to reduce reportable days lost by 10% and maintain the low amount of incidents in 2014/15.

1.14 The servicing and maintenance of Manual Handling equipment and Clinical Weighing Scales continues to be of a high standard and certainly meets the minimum legal standards.

1.15 The cost of erroneous call-outs and repairs caused by negligent damage to NH equipment remains unnecessarily high and will continue to be recharged back to the Wards/depts.

1.16 It is anticipated that Health and Safety Services will retain the management of these contracts at least until April 2015.

1.17 This year, the Induction programme has seen greater numbers of course participants but the course continues to be highly rated although the formal feedback on MH 2 has ceased.

1.18 Overall training attendance for Manual Handling was just over 75% for 2013/14

1.19 We will be aiming for training compliance to hit 80% for 2014/15; an improvement of 5% on last years figures.

1.20 The International Nurse Induction will now be conducted separately from the General Induction programme

1.21 Additional, bespoke clinical training facilities at UHL are critical to the future of all practical based training.

1.22 There has been a marked increase in the Bariatric figures we report this year. It is representative of the National and international trends on Obesity and has meant that our Bariatric activity has never been busier.

1.23 The rate has remained the same in that we continue to see a rise of 10 extra admissions compared to the previous year.

1.24 Last year we saw a 15% increase in the total amount of in-patient days and this year that figure has increased by **25.3%.** Consequently, the average length of stay has increased by **2.5** days this year.

1.25 The average patient weight of the Bariatric referrals this year has increased by **20** kgs

1.26 Our information on recorded weight indicates that there are **22**% of patients referred to the service who have no recorded weight. This is an improvement on last years position where **40**% of patient's has no recorded weight and is definitely a step in the right direction.

1.27 The Trusts has had its biggest outlay for rented equipment since we started keeping records 7 years ago. It should also be noted that these figures are based on actual usage aligned to In–patients days. There have been an increasing number of occasions where Wards have failed to inform rental companies when the equipment is no longer needed and incurred costs for days rented that haven't been actually used.

1.28 Overall, the increase in Bariatric Length of Stay has lead to the increase in rented equipment. It is our view that this will continue to increase in 2014/15.

1.29 We will be looking to replace some of our Bariatric equipment as part of the Phase 3 programme for 2015/16 for Patient Surfaces Management. This recognizes that we have about 12 months of life left in the older Bariatric beds and there will be severe challenges to appropriate storage of these beds at the LRI due to the new ED plans and reconfiguration of services/storage.

Local Security Management

1.30 In 2013 the role of the LSMS was transferred to the portfolio of the Director of Safety and Risk (DSR) under the transfer of facilities management services to Interserve. In the interim period, the LSMS brief was supported temporarily by the Risk and Assurance management team.

1.31 To ensure resilience to this position the LSMS role has been combined with that of the Health and Safety Managers. This sits together with Manual Handling in the newly formed Health and Safety Services (HSS) team

1.32 To support the LSMS brief the most important aspect of our taking this forward is the resilience we create behind the overall responsibility. Therefore the HSS manager will undertake he NHS protect LSMS training in September to further support the current officers

1.33 The Annual Organisational crime profile indicates our overall score profile will not differ from last year which will be the following

Category 1 - Violence, Counter-Terrorism, Violence and Theft.

Category 1- Economic crime

This is typical of a large acute trust with a significant annual operating budget and extensive procurement activities.

1.34 As a result of consultation amongst NHS organisations the Work plan profile for 2014/15 is still under consideration and the latest information suggests that NHS protect will not issue the 2014/15 security standards until September 2014 with a submission date in November 2014.

1.35 Trust has trained 7,248 (1573 total in 2012/13) staff in various forms of conflict resolution training (split 2,286 face-to-face and 4,962 e-learning). This tremendous increase is a 400 % improvement on the previous year's figures

1.36 Together with the appointment of the Conflict Management Trainer post we will undertake a Trust-wide Risk Analysis of the training needs of our staff in relation to security issues

1.37 The last 2 years figures for reported assaults via DATIX have remained static in that 526 incidents were reported in both 2012/13 and 2013/14.

1.38 The Security management and Police Liaison committee has been re-established this year.

1.39 With the establishment of the new security management structure aided by the Security Management and Police liaison committee it is anticipated that accurate security incident figures from all 3 UHL sites will be forthcoming on a quarterly basis and form a benchmark for onward progress.

1.40 There is evidence that NIS Security Agency service costs the Trust £370K last year alone at the LRI. Many of the CMGs have a stated aim of reducing this commitment as part of their cost improvement plans and we will be working with clinical colleagues to progress this.

1.41 We are working with Interserve to resolve issues of vicarious liability for security staff to intervene at the request of clinical colleagues to assist in the medical treatment for patients deemed to lack mental capacity.

1.42 There were 2 freedom of Information request this year concerning" Attacks on Spiritual Rooms" and "Patient on Patient Attacks".

Section 2 - Introduction

2.1 This is the first combined report that reflects the services that now come under the Health and Safety Services Umbrella. This report provides information on the performance of the organisation for the period 1st April 2013 to 31st March 2014.

2.2 The report is presented in sections for ease of reference and includes indications of assurance levels in each area and recommendations for actions.

2.3 The Health and Safety Services team aim to develop a safety culture based on realistic assessment of risk and introduction of control measures that are practical and achievable as well as compliant.

2.4 In September 2013, the Health and Safety team, Manual Handling Service and the Security Management brief were amalgamated under one team now known collectively as Health and Safety Services

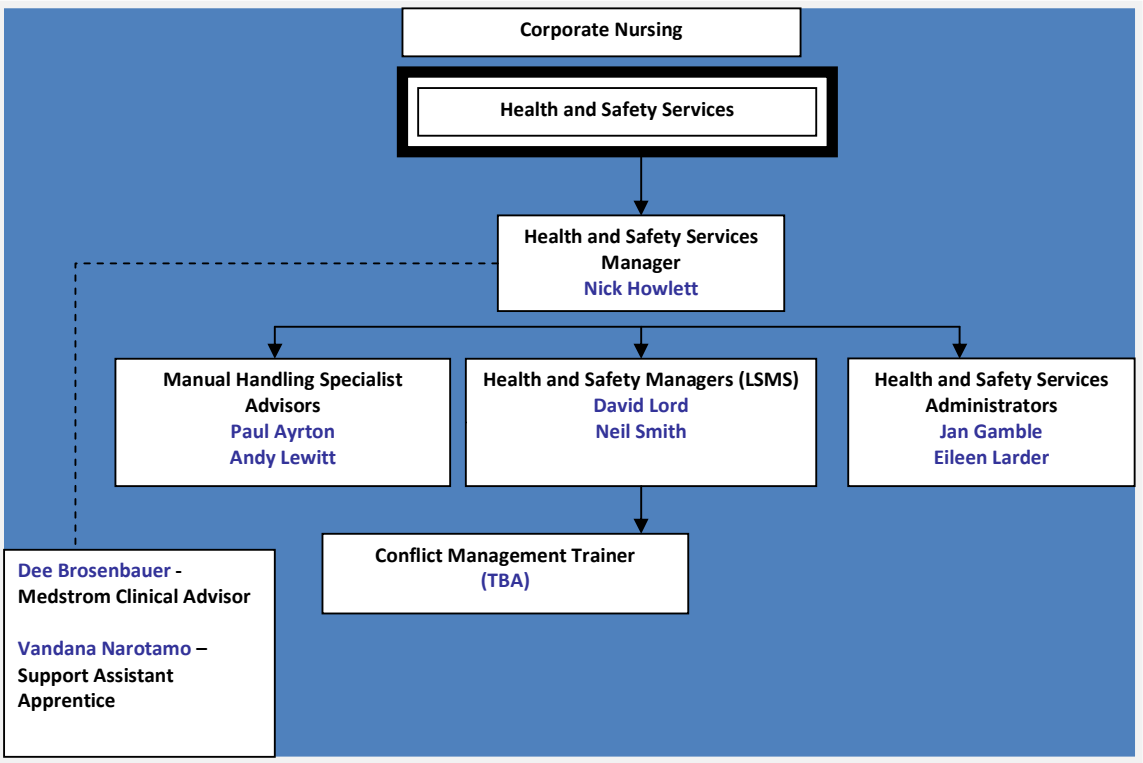
2.5 The reorganization recognized the need to amalgamate the existing team so best utilize existing resource whilst supporting the Introduction of Security Management into the Safety and Risk portfolio.

2.6 This was partly due to the management of change but also a design to give greater support and resilience to all three agendas. The current structure (see below) is still not complete. At the time of writing we are looking to actively recruit to the Conflict Management Trainer post and are also actively looking at a support role for the newly created H&S/LSMS roles.

2.7 Within this structure it was crucial that security management be invested with a longer term commitment then previously managed. NHS Protect is the national body responsible for work on that identifies and tackles crime across the Health Service. They are specific that in that to support the Local Security Management Director, NHS organizations must have a qualified Local Security Management Specialist (LSMS). The previous post-holder has moved to another NHS organization and this inadvertently left the Trust without the support it required.

2.8 To support the ongoing management of this role the current Health and Safety remit was expanded to include that of the LSMS. The pursuance of this aim is described in detail in the Security Management report.

2.9 The Health and Safety Services (HSS) Manager has an active role in the Patient Surfaces Management Contract (PSMC). Part of the support for the day-to-day running of the contract is administered by two Medstrom Support personnel They are both line managed by the Medstrom Area manager but have some line management responsibility to the HSS. This dual role line management has worked well to date and will continue this year.


Corporate Nursing
Health and Safety Services
Health and Safety Services Manager
Nick Howlett
Manual Handling Specialist Advisors
Paul Ayrton
Andy Lewitt
Health and Safety Managers (LSMS)
David Lord
Neil Smith
Health and Safety Services Administrators
Jan Gamble
Eileen Larder
Conflict Management Trainer
(TBA)
Dee Brosenbauer - Medstrom Clinical Advisor
Vandana Narotamo – Support Assistant Apprentice

Section 3 - Health and Safety Annual report

1.1 Annual Health and Safety Audit

The Health and Safety Audit is a systematic review of the health and safety systems and processes in place. It is designed to assess the performance, effectiveness and reliability of health and safety measures in place, report on areas of vulnerability or concern and assist management in the development and planning of corrective actions and an improving safety culture.

1.2 Process

The Annual Health and Safety audit is administered on our behalf by the CASE team. The audit for 2013 was cancelled and this years audit will take place in September 2014.

1.3 Critical review

Through the process of the management of change and the reorganisation of the Divisional/CBU structure in to clinical management groups a tremendous amount of upheaval occurred. This lead to a realignment of roles, change in management and responsibilities not only within the team but throughout the organization.

1.4 The audit needs a clear commitment to be fully applied so that it represents the true picture of Health and Safety practice at a local level. At the time this change occurred the audit was due to be launched and it was felt that that in the climate at the time, the audit was not feasible

1.5 The current audit tool has remained unchanged since its inception in 2002. With the pace of change in healthcare and the changes in prevailing legislation, this year we have decided to review, amend and update the audit tool so that we get a much better reflection of the issues, challenges and areas of good practice in UHL.

1.6 The audit this year will be refocused to give a better understanding of the Health and Safety requirements of each area so that as team we can target deficiencies as well as highlighting areas of good practice.

1.7 The new look audit will focus on evidence based questions that ensure that positive responses can source the required level of information and/or demonstrate the rationale. The emphasis will be on an open and honest response that allows help those areas that most need our assistance

1.8 It is crucial that we get a “warts and all” picture of Health and Safety at a local level. It will only be then that we can truly assure ourselves concerning levels of compliance

1.9 As in previous Audits, we will undertake a comprehensive analysis of the data so that CMGs can be appraised of their performance and deficiencies. Health and Safety managers will then visit each CMG to advise and assist managers to identify and prioritise risk factors and develop plans for corrective actions.

1.10 The audits will be subject to verification by a series of planned “spot” audits by the HSS team to compare the returned findings with the available evidence. This will enable us to comment on our level of confidence with the audit findings.

1.11 This year saw the incorporation of a number of new services and personnel into UHL managed under the banner of the “Alliance”. I anticipate that the Alliance will be

incorporated into the Audit pending some ratification on roles and responsibilities concerning Health and Safety management arrangements with our Community based colleagues.

2.0 Accidents and Incidents reported via Datix

2.1 Accidents to staff within UHL across all sites have resulted in a total of 1028 staff incidents reported on Datix in the twelve months to March 2014. A comparison of accident categories trust wide can be found below

2.2 The top categories of accident which have resulted in the greatest number of reports are: Needle-sticks and Slips, Trips, Falls. This is the same as the previous year and shows that these remain the highest risks to staff at UHL. This year, Violence to staff is reported separately within the Security Management Report

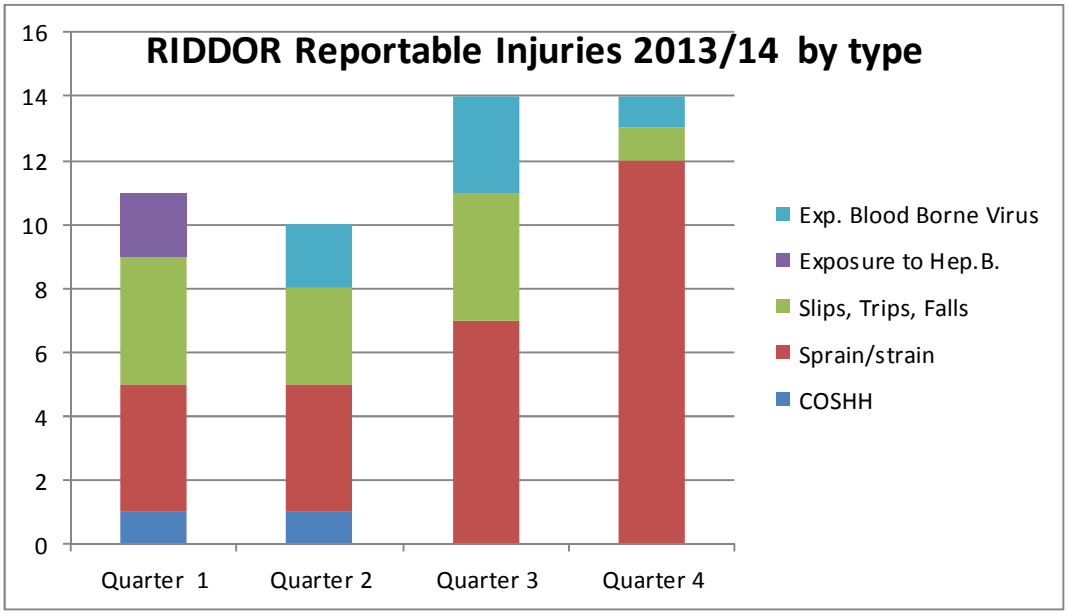
2.3 The heading 'Accident caused by some other means' is the highest reported category with 390 reports. However it is difficult to analyse the accident causation without significant time investment. A similar situation exists with the categories 'Injury by physical or mental strain' and 'Exposure to electricity, hazardous substance etc', The category 'Lifting Accidents' infers manual handling accident rates, yet with only 54 reported is clearly not representative of the real manual handling accident rate.

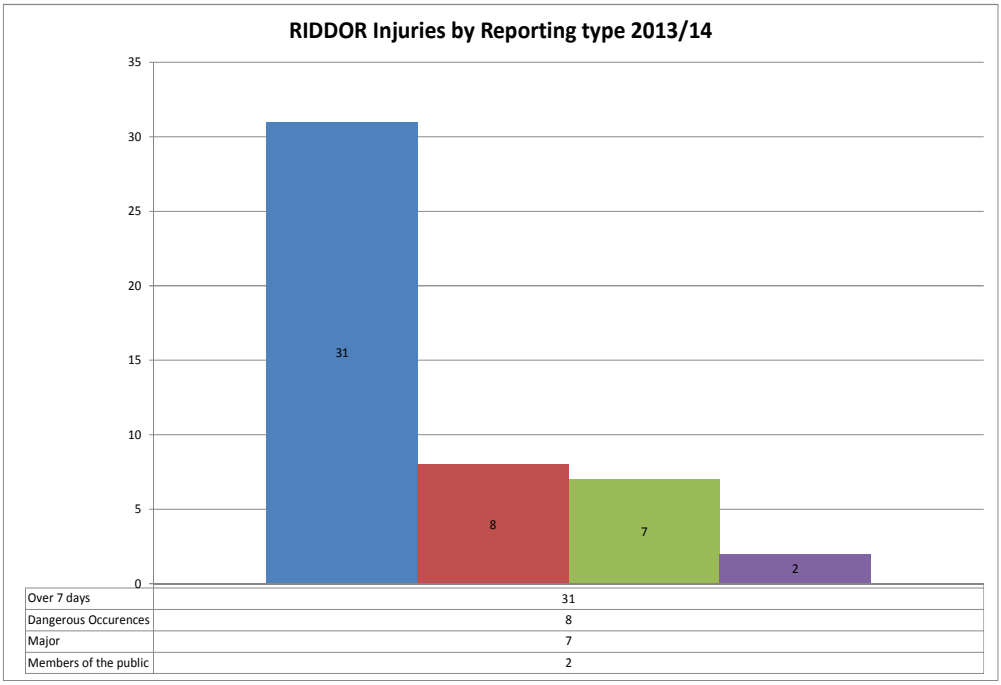
2.4 Needle-stick injuries are categorised in greater detail quarterly by the Occupational Health department and classified as either avoidable or non-avoidable. ***Over 90% of all needlestick accidents are avoidable.***

ACCIDENT TYPE (Datix Categories)	TOTAL 2011/12	TOTAL 2012/13	TOTAL 2013/14
Slips, trips, falls and collisions	**212**	**193**	**211**
Needlestick injury or other Sharps incident	**251**	**257**	**225**
Lifting accidents	**86**	**57**	**54**
Injury caused by physical or mental strain	**102**	**77**	**80**
Exposure to electricity, hazardous substance, etc	**65**	**71**	**60**
Accident caused by some other means	**244**	**420**	**398**
TOTAL:	**960**	**1075**	**1028**

3.0 RIDDOR Incidents Reportable to the Health and Safety Executive

As required under current legislation, **48** workplace accidents were notified to the Health and Safety Executive (HSE) by the Trust's Health and Safety team.





Comparison of RIDDOR Incidents Over 6 Years

Financial Year	Major Injuries	Over 3 day Injuries	Industrial Diseases	Dangerous Occurrences	Public	TOTAL
2008 - 2009	7	85	0	6	-	**98**
2009 - 2010	3	56	1	0	-	**60**
2010 - 2011	2	44	5	9	-	**60**
2011 - 2012	11	39	0	5	2	**57**
		Over 7 day Injuries				
2012 - 2013	6	23	14	7	0	**50**
2013 - 2014	7	31	0	8	2	**48**

3.1 **Performance Indicator**

The Trust set a target of reducing the total number of RIDDOR incidents by 10% per year. This figure has been missed although overall we have had a reduction in overall injuries by 2. We will continue to work to the Trusts 10% reduction target and therefore our aim is to reduce this number to no more than 43 reported incidents in 2014/15.

3.2 **Recommendations:**

- The Health and Safety Team will continue to aim for a 10% reduction in RIDDOR reportable incidents in the reporting year 2013 – 2014.

- The Health and Safety managers will visit all CMG's managers to advise on their priority risks identified in the audit analysis and assist with the development of action plans.

3.3 **RIDDOR Compliance with statutory reporting timescales**

During the year there were 49 incidents reported under RIDDOR. 24 of these reportable incidents were not reported within the time limits required by RIDDOR legislation. This is a compliance rate of 48%. Although an improvement on last year, this is not acceptable and UHL must make a significant improvement on this or else the HSE could take enforcement action.

3.4 **Recommendations:**

It is a requirement of RIDDOR legislation that all incidents falling within reportable categories are reported to the HSE as soon as practicable and in any event within 10 or 15 days of the accident depending on the category. To meet this deadline it is preferable that reportable incidents are notified to the Health and Safety team within 7 days of the incident. It is recommended that the following actions are completed to ensure compliance with reporting requirements, so far as is reasonably practicable.

a) Management Actions:

- Ensure all managers / Datix handlers are familiar with the categories of reportable incidents and timescales for reporting RIDDOR.
- All incidents that are reportable to the HSE are notified to the Trusts Health and Safety team within 7 days of the incident.

- Where incidents are re-categorised at the approval stage, the Health and Safety team are notified.
- Where managers are unsure of the category, advice is sought from the Health and Safety team.
- Incidents that are brought to the attention of managers outside the 10 day deadline are notified to the Health and Safety team forthwith.

b) Health and Safety Team Actions:

- Advise CMG/Department/Ward managers of the above
- Support managers to identify and categorise RIDDOR reportable incidents where the status may appear unclear
- Challenge CMG managers on RIDDOR reportable incidents that are notified to the HSS team outside of 10- 15 days as to the reasons why this has occurred

4.0 Health and Safety Training

4.1 There is a legal duty on employers to provide Health and Safety training. The Health and Safety team provide a range of Health and Safety courses to support managers and staff and enable them to deliver safer services. Similar to previous years, the Health and Safety Managers have provided a series of core training courses. Attendance on training has improved over the previous twelve months. Details can be found in Appendix 2

4.2 The compliance figure has markedly improved from last year, although looking at the previous years figures; it remains steadfastly low as a proportion of the entire Trust population. There is a requirement for managers to assess the risks to staff and others and ensure sufficient staff receive health and safety training competencies to identify and manage the hazards and risks within their service areas. Presently we are reporting that only **3.3%** of staff have received any form of Health and Safety training in 2013/14.

4.3 It is our opinion that a significant gap in knowledge and skills is evident in 2 key areas;

4.4 The knowledge and skills that managers require to ensure they are compliant with prevalent Health and Safety legislation in their area. Suitable training in this subject equips the manager to recognize Health and Safety risks and put control measures into place. Enabling managers to systematically review their risks would lessen the amount of untoward incidents and firmly place the ownership of risk where it belongs at a local level. This approach will allow Health and Safety services to better, pro-actively manage risk in the organisation making better use of our limited resource

4.5 All staff working in an organization need a basic understanding of Health and Safety legislation, their roles and responsibilities and actions necessary. This underpins the manager's responsibilities. Although this training has been delivered effectively in the past, it has been sporadic and not systematically embedded in the required training programme.

4.6 **Progress**

It was reported last year that he Health and Safety team will review their training programme with a view to developing E-learning packages where appropriate. I am pleased to report that there has been significant progress in this area. The development of a bespoke, UHL based Health and Safety training programme has been developed by the team in conjunction with OCB Media. This gives a basic overview of the required elements of an introductory course that firmly delivers the messages that health and safety is everybody's business.

4.7 The course went "live" 3 days before the end of this reporting period. However, early indications suggest that there has been a significant uptake to date.

4.8 Health and Safety training was not included in the required training report for 2013/14 but there will be a requirement this year. In effect this means that training will have to meet certain compliance targets and for this year that will be 80 %.

4.9 **Actions and Recommendations**

4.10 The HSS Team will develop and promote bespoke training programmes targeted at senior and departmental managers throughout the year.

4.11 This will be informed a by training risk assessment that will part of the overall approach to Health and Safety risk assessment throughout 2014/15

4.12 We will continue to offer courses on specific aspects of Health and Safety as informed by local Risk assessment where there is an identified need.

4.13 The HSS team will actively promote the Health and Safety e-learning programme for all staff

4.14 This will included a mandatory requirement that as part the General Trust Induction programme the Health and Safety e-learning module must be completed.

4.15 A reminder will be sent to all staff that this a required training element this year

4.16 The HSS team will gain editorial rights to ensure that the programme is kept up-to-date and reflects any changes in Legislation, and practice arrangements at UHL.

4.17 The HSS team will commit to ensuring that overall Health and Safety training compliance reaches the Trust target of 80% by March 31st 2015.

5.0 Health and Safety Executive Enforcement Action

5.1 Following an incident where a member of staff contracted active TB at work whilst treating patients, the Health and Safety Executive (HSE) carried out an investigation on 14-15th March 2013. This resulted in the HSE serving an Improvement Notice.

There were three main failures identified by the HSE and these are addressed in the action plan below:

1. **Material breach - Failure to report under RIDDOR regulations the other 10 cases of staff latent TB.**

2. **Failure to provide a suitable and sufficient risk assessment to protect staff in high risk areas of developing TB. It is important that UHL understands that the requirement is for ALL airborne contaminates, not just TB.**
   Risk assessment - Failure to adequately assess the risk of exposure, identify risk areas and implements suitable control measures required to reduce risk of harm to staff and others.

3. **Management failure to take swift action to protect staff once TB had been confirmed on the renal unit.**

CURRENT POSITION IN RELATION TO COMPLIANCE

Notice 304661440 served against UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST on 25/03/2013

Notice Type Improvement Notice

Description IN - You have failed to undertake a risk assessment to identify the work activities and areas within the Trust that present a high risk of exposure to inhale micro-organisms which may include tuberculosis.

Compliance Date 21/06/2013

Result Complied with

6.0 Reporting Structure

6.1 The Health and Safety committee structure has undergone transformation to reflect a proper line of reporting to through to the Trust Board.

6.2 This has resulted from the change management that took place when the estates and facilities function of the Trust was taken over by our partners Interserve. Beforehand, the estates team had actively managed and serviced the committee structure and reported issues onward to relevant Trust committees.

6.3 With the revision of the trust committee structure and the lack of clarity over Health and safety Committee roles, responsibilities and servicing, a process of review took place resulting in the present structure which has now been ratified and in place since November 2013. (Appendix 1)

6.4 This committee structure has been revised to ensure

- Each committee has an established representative and relevant membership
- The terms of reference are clear on the aims and objectives of each committee
- The Chair, Vice-chair and quorate arrangements are in place
- The line of reporting is clear and established
- The committees are adequately serviced with administrative support

6.5 I am pleased to report that the committee structure has been re-established and is once again fit-for-purpose. In this regard I am grateful to the Director of Safety and Risk for her hard work and commitment in enabling this to happen.

7.0 Quarterly Health and Safety reports

7.1 It is mandated that the Health and Safety Service Manager reports on a number of Health and Safety related topics, targets and issues for the Local and UHL Health and Safety Committees every quarter. Additionally this report is submitted to the Quality Assurance Committee.

7.2 In recent months this has come under close scrutiny with a suggestion that the reporting lines should be set against a number of Key Performance Indicators that for benchmarking.

7.3 The reporting of RIDDORs and the measurement of this against targets has taken place for the last 7 years. However, other topics are reported on when and if there are issues reported but have never been set against measurable targets.

7.4 This year the Health and safety quarterly report will be expanded to include additional items for performance measurement or benchmarking for onward measurement. These

will be, RIDDOR reportable injuries, Number of need stick injuries reported, Numbers of staff who have completed some form of approved UHL Health and Safety training, Number of IRMER reportable incidents, Number of settled Employee/Public Liability Claims against the Trust.

8.0 Communication

8.1 It has been identified that both the Health and Safety and the Manual Handling Webpages, currently on INsite need to be updated. Some of the previously implanted links don't work or connect to out-of-date documents. Some of the pages don't reflect the current working arrangements under the HSS banner and navigation can be difficult

8.2 It is crucial for effective communication that our webpages are constantly updated and are fit –for-purpose

8.3 In the interim, we have done much work to remedy the immediate problems, particular in relation to accessing the most up-to-date guidance and policies. We have updated the names and roles on the system and removed some of the old information.

8.4 Our long term plan will be to not only combine the current webpages under the Health and Safety Services title but to expand that to include the Security role. The aim is to have a "one stop" page that provides all the relevant information for all services under our remit.

8.5 As we have identified and actioned the priorities for the services in this years action plan then this will be reflected in the make-up of the new Webpage

8.6 <u>"Safety Matters".</u>

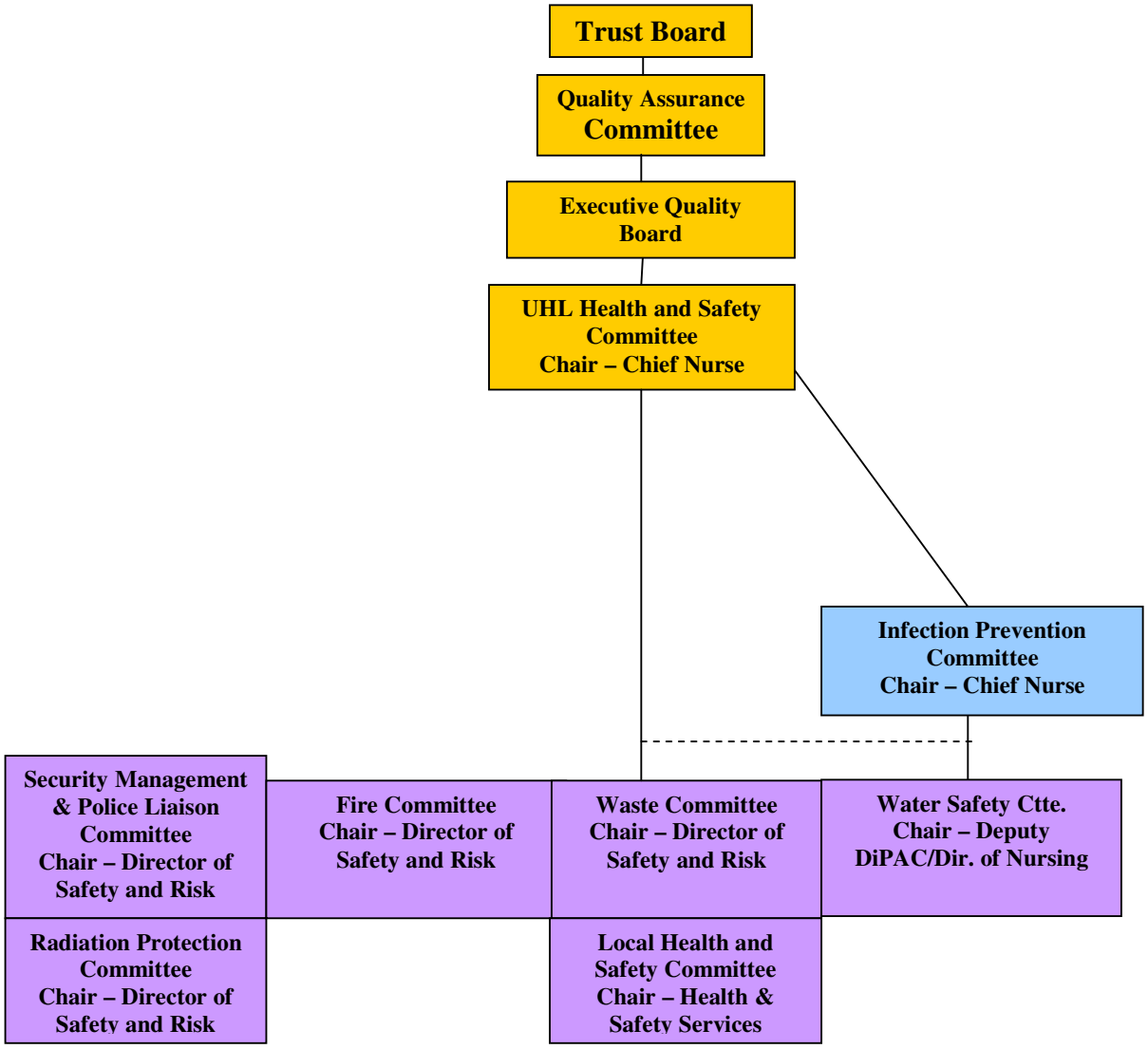
We are still committed to promoting all safety issues through the Trusts "Safety Matters" staff magazine. This is currently being issued every 2 months and is designed to further promulgate important messages to the organisation as a whole.

8.7 It is encouraging to see it is actively being used by all departments throughout the Trust in relation to their own Health and Safety items. We will continue to actively promote and support the on-going work of "Safety Matters" in the forthcoming year.

APPENDIX 1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UHL HEALTH AND SAFETY COMMITTEE STRUCTURE



APPENDIX 2

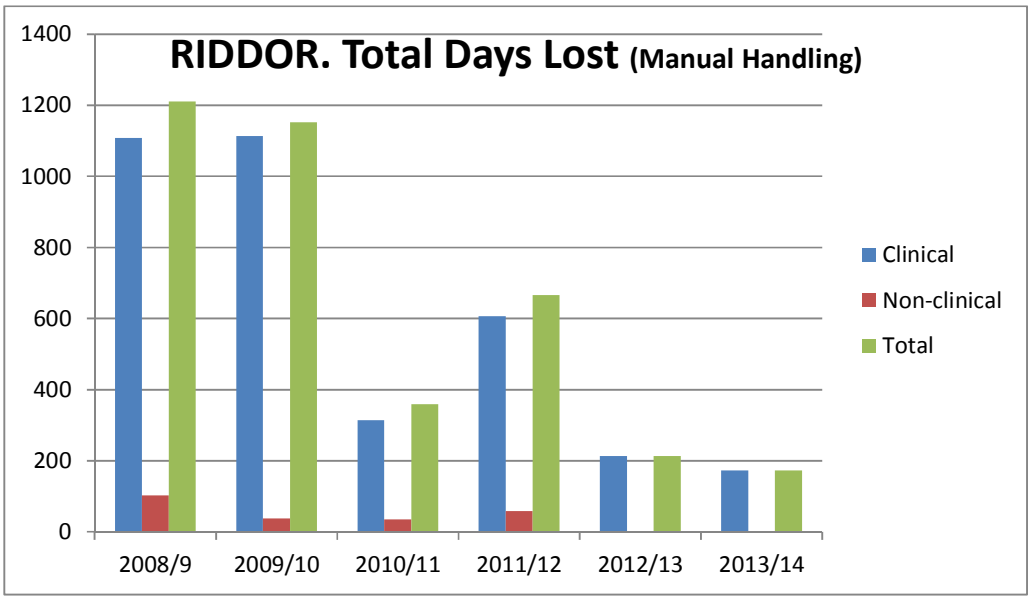
TRAINING FIGURES FOR 2013/14

Health & Safety	Admin and Clerical - Non Clinical	Allied Health Professionals & Healthcare Scientists	Doctors	Non-Qualified Nurses	Qualified Nurses and Midwives	Total
H and S - COSHH (controls of Substances Hazardous to Health) Risk Assessment	5	9	0	1	5	20
H and S - Display Screen Equipment Risk Assessment	9	3	0	2	3	17
H and S - Risk Assessment	3	6	0	1	22	32
Health and Safety (eLearning-OCB) (Mandatory Training)	7	1	1	3	12	24
Latex Allergy Training	5	3	0	32	0	40
Risk Assessment - (eLearning)	11	32	11	26	81	161
Risk Assessment (eLearning - eUHL)	0	0	0	0	0	0
Risk Assessment training	0	0	0	0	0	0
Stress Management and Emotional Resilience for Managers	13	41	4	1	47	106
Totals	**53**	**95**	**16**	**66**	**170**	**400**

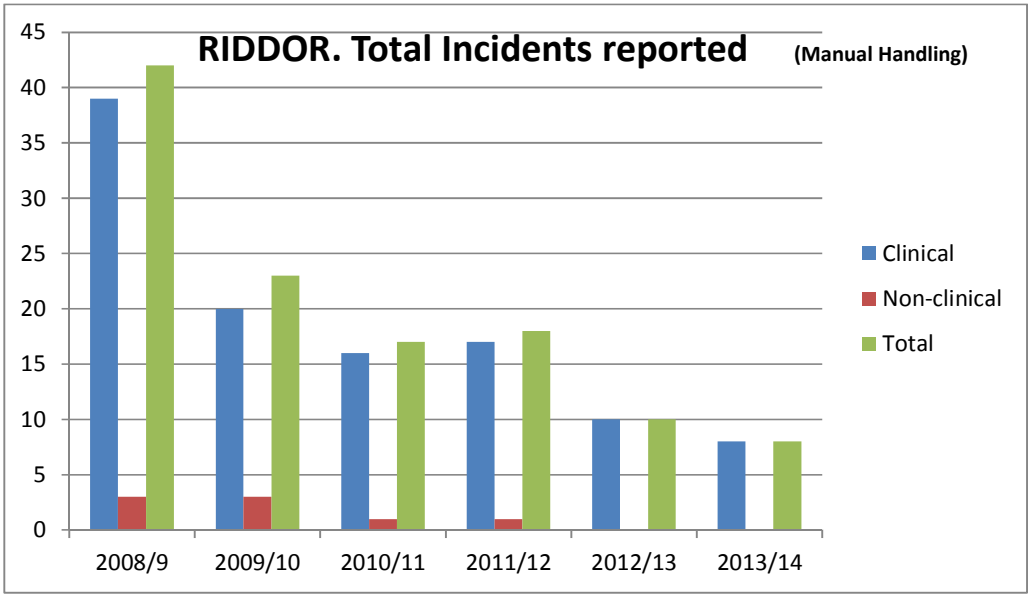
Section 4 - Manual Handling Annual Report – 2013/14

1. Accidents and Incidents

RIDDOR Reportable Incidents. 2013/2014.



PREVIOUS TRAINING FIGURES FOR THE LAST 2 YEARS									
	Risk Assessment	COSHH Assessment	DSE Assessment	Working Safely	Stress Management	Stress Awareness	Latex / Other	H&S Management	Total
TOTALS 2011-2012	20	9	15	14	38	0	495	0	591
TOTALS 2012-2013	22	12	14	2	7	13	30	88	188



(As clinical areas have undergone various name changes in the last 6 years, this classification is for all areas that currently sit under clinical management groups but were previously listed under divisions , directorates or Clinical Business Units)

1.1 The figure for RIDDOR Reportable Incidents (the most serious injuries or incidents) indicates a fall this year. There were 8 reported incidents compared to last year's figure of 10.

1.2 Last year, the total had decreased to 214 days lost. This year that figure fell further to 171. This represents a **20%** decrease in days lost and is the lowest this figure has been in the last 6 years.

1.3 For the second consecutive year we have zero reported incidents in the non-clinical divisions. However, a substantial amount of staff previously reported under UHL have moved to either Interserve or NHS Horizons employment and therefore figures are reported via these employers instead.

1.4 2 years ago, figures were alarming in that previously to this, we had seen a annual decrease in the amount of RIDDOR reportable incidents and days lost. As a result there was a refocusing from the team to concentrate on practical risk reduction methods. This impacted on the reduction seen last year and I am pleased to report that this trend has continued this year. One again the support lent to those areas dealing with Bariatric patients has proved very worthwhile. Timelier referral for patients of this type has allowed us to put systems into place before staff are getting injured. The embedding of a safer culture by emphasising, reinforcing and facilitation of good practice is essential to safer manual handling. The efforts of the Manual Handling advisors in this regard cannot be ignored either.

1.5 The Manual Handling service is always vigilant to any trends or themes that may occur in the RIDDOR injuries we investigate. There has been a lot of remedial work as a result of the injuries investigated. Short-staffing coupled with workload is always a high risk and the Trust must be aware of the risks taken when activity is high and staffing is low.

1.6 It is worth noting that RIDDOR reportable injuries changed so that incidents only become notifiable after 7 days. I reported last year that this had the potential to skew the figures for this and future year reports. However, I am confident that the incidents reported this year would have been the same if the 3 day reporting system was still in place. Therefore, we can be confident that there has been a real terms reduction in RIDDOR reportable injuries this year.

Summary

1 **There were 2 fewer RIDDOR reportable incidents in 2013/14, compared to the previous year**

2. **There has been a 20% decrease in RIDDOR reportable days lost in 2013/14, compared to the previous year**

3. **The above represents a dramatic turnaround compared to the increase we saw in both sets of figures 2 years ago**

4. **A concentration on practical assistance and particularly practical risk reduction methods has been particularly helpful in this regard.**

5. **We aim to reduce reportable days lost by 10% and maintain the low amount of incidents in 2014/15.**

Recommendations

6. To maintain success of injury reduction we have seen in the previous year.
7. To keep supporting the risk reduction culture by providing practical help and advice to the Trust
8. Maintain our role in RIDDOR investigation with a view to exploring any trends and taking appropriate action.

2.0 Servicing and Maintenance of Clinical Weighing Scales and Manual Handling equipment.

2.1 The estates and facilities management contract with Interserve had as a plan to have absorbed the current contracts for Weighing Scales and Manual Handling equipment. This still has not materialized and therefore I have extended the contract with our current provider CareTech UK Ltd and Scaleways by 12 months. For the Budget assertions in 2014/15 it was confirmed that the current arrangements would not be subject to change until the 2015/16 budget at the earliest

2.2 We have continued to enjoy the excellent service we have been accustomed to from CareTech and Scaleways Ltd and I foresee this continuing in 2014/15. I am very grateful for all there help and assistance and look forward to maintaining this excellent relationship in the forthcoming year

2.3 Planned replacement of motors and parts is still on-going although financially this will not be as big a problem as last year.

2.4 Having reviewed the situation, this year we will be recharging costs of this nature back to the clinical areas. Paying for avoidable damage is not only untenable but it is rewarding those areas that continually abuse the care of their equipment. I have already undertaken work to put this into place and let managers know of their responsibilities.

2.5 The Manual Handling service continues to communicate with the Trust to ensure that the use and care of the equipment is kept continually kept in mind. The reiteration of how equipment should be managed and used is very important to ensure that user errors in all respects are reduced.

2.6 Last year, I reported that I had reduced the stock of Manual Handling equipment by **4%**. Decommissioned equipment is used for spare parts by our servicing and maintenance partners. This year the stock has slightly increased with the net addition of 5 extra pieces of

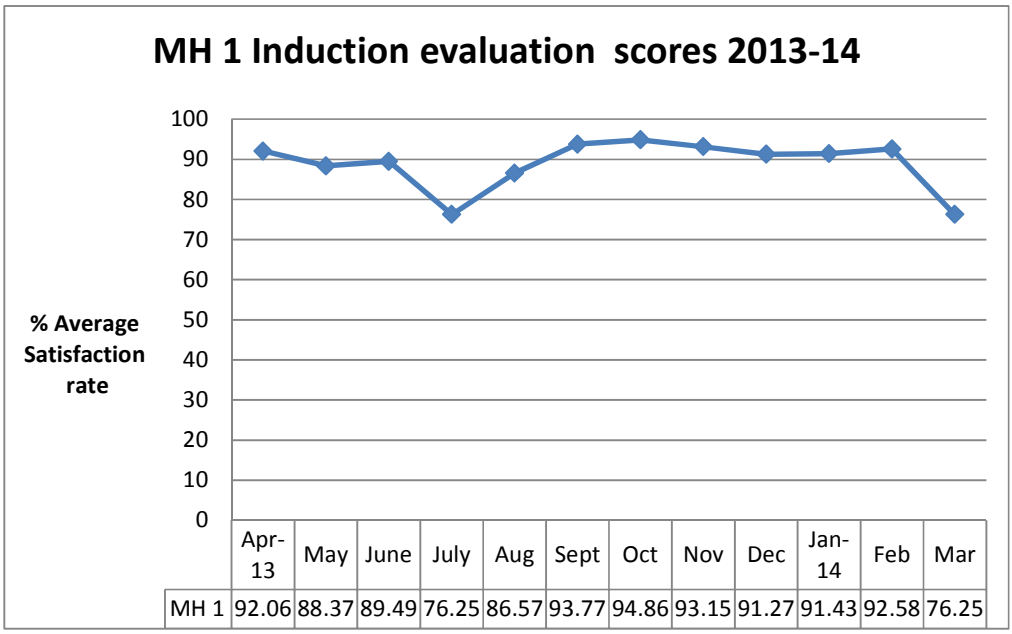
equipment. I am still confident that we have the right equipment in the right areas to ensure the continuance of safer practice.

Summary

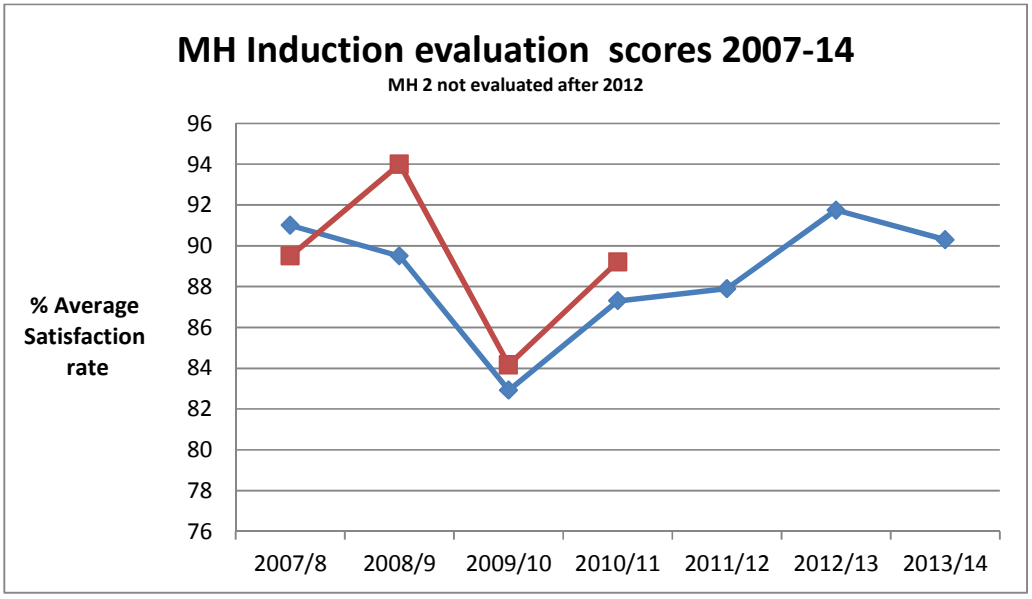
- **The servicing and maintenance of Manual Handling equipment continues to be of a high standard and certainly meets the minimum legal standards.**
- **We continue to maintain and improve on our impressive stock of Clinical weighing machines. There is a multiplicity of differing scales allowing us to accurately weigh patients (in accordance with the prevailing standards).**
- **The cost of erroneous call-outs and repairs caused by negligent damage will continue to be recharged back to the Wards/depts.**
- **It is anticipated that Health and Safety Services will retain the management of these contracts at least until April 2015.**

3.0 Manual Handling Training

Manual Handling on the UHL Induction training programme.



	Apr-13	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-14	Feb	Mar
MH 1	92.06	88.37	89.49	76.25	86.57	93.77	94.86	93.15	91.27	91.43	92.58	76.25



3.1 We continue to receive formal feedback on a monthly basis in relation to Manual Handling 1, and I am pleased to report that overall the satisfaction rating was 90.3% over the year. To be clear, this means that the course has been evaluated at over 9 out of 10 consistently throughout the last 12 months.

3.2 This year saw the last of the Induction in its present format. From April 1st 2014, the new style induction programme commenced. Manual Handling 1 has been replaced with a requirement to complete the online manual handling e-learning programme as a pre-requisite for those going onto to do Manual handling 2; the patient handling session. In collaboration with our HR colleagues, we have been working to ensure that there is adequate provision of courses so that staff access training in a timely manner. This has meant the laying on of extra courses. To date, there have some initial problems, particularly with adequate practical skills training space. We will continue to work with HR training to refine the programme to maintain the overall quality.

3.3 Training for Trainers programmes

Number of Trainers

2005/6 - 199
2006/7 - 169
2007/8 - 173
2008/9 - 172
2009/10 - 218
2010/11- 188
2011/12- 165
2012/13 - 162
2013/14 - 171

3.4 As of May 2014, we have 171 practicing trainers in the Trust. This represents an increase on last year and furthers our aim of having the right trainers in the right place. I would like to take this opportunity to thank all our cascade trainers who continue to provide high quality safer handling programmes despite the pressures on their time. I am continually impressed

by their ability to deliver high quality training, risk assessments and advice in very challenging times with so much pressure on their time

3.5 Figures from e-UHL indicate that the entire Manual Handling Training* compliance dramatically increased from last years figure of 60% to 78% this year. This is in due in part to the refocusing on training compliance that the organisation has taken on key, core skills. Supported by a targeted campaign of awareness and the conversion and updating the Manual Handling e-learning course by OCB Media has helped achieve that figure. The aim will be to have Manual Handling training compliance at 80% by the end of March 2015.

*Taken from the 38 different Manual Handling courses on currently on offer throughout the Trust and listed on e-uhl

Other courses

3.6 We continue to support the volunteer induction programme with our "Back Injury Prevention" session. Once again the session has been very well received by the course participants. Volunteer services have now pioneered a training video in which we have taken part. We will continue to support this course.

Income generation

3.7 Medical Students

Despite the fact we have never received any **direct** income for this, our commitment to medical student training continues. The numbers have increased this year and we are lead to believe that the increase in service will continue. Once again Leicester University report that this session receives excellent reviews from the students.

We have recently reviewed training provision for Manual handling to Leicester University students. In line with some of the curriculum changes to Medical Student training it is likely that the type of provision, and frequency of delivery will change. At the time of writing, this work is in its very early stages and the impact on the service is as yet, unknown.

3.8 We have maintained the current business relationship we have with Rainbows charity, and various Private care agencies.

3.9 This year we have generated close to £1100 through private training particularly on the Training for Trainers course.

E-learning courses.

3.10 As reported earlier we have completely revised the e-learning Manual Handling course. This has allowed us to update the content and prepare the package for use on the new General Induction programme.

3.11 This year we will take complete control of this and (and other e-learning courses) by having administrator and editorial rights. This will allow us to reflect changes, update content and keep the courses relevant in a timelier manner. This level of control will be essential to in maintaining the overall quality of the course content.

3.12 This year we aim to build on the success of this course by putting on additional "bolt-on" courses that build on the current course as a foundation. Although, this is still to be confirmed, the risk assessment process and principles of inanimate load handling seem to be the current direction we will be taking.

International Nurse and "Bulk" Recruitments

3.13 In line with trusts requirement to recruit at certain times of the year and to source staffing form abroad there have been extra demand place on Training requirement for new

starters. Whereas the Manual handling service is always willing to support the training requirement it has proved very difficult to adequately plan do this in our existing workload.

3.14 Recruitments such as these have to be planned for in terms of adequate training space for clinical skills and this has been very difficult to facilitate this year. At times we have struggled to accommodate such requests.

3.15 There have been numerous discussions as to how best address this in the future and our conclusions lead us to believe that;

a) The International Nurses should be treated as a separate Induction. They are often well qualified but pose training challenges because of custom and practice learnt elsewhere. This means that the training input is greater than that of the general induction programme. It is our belief that International Nurses have their own "Bespoke" Manual Handling Induction course. It is not acceptable for them to be slotted onto the General Induction.
b) There is a tremendous strain on training resources and it is becoming even more evident that the UHL needs more clinical training space to support the demand. At the time of writing I am lead to believe this is being considered at a strategic level. This will be critical to supporting staff training need in the future.
c) Better communication between Nursing and Human resources is needed to identify peak periods of recruitment during the year. I am please to report that this is beginning to happen and therefore we will now be in a better position to accommodate such requests.

Summary & challenges for 2014/15

- **This year, the Induction programme has seen greater numbers of course participants but the course continues to be highly rated although the formal feedback on MH 2 has ceased.**
- **As of May 29th 2014, we have 171 practicing cascade trainers in the Trust**
- **The provision of Manual Handling Training programmes must not be compromised despite the change in Mandatory update requirements**
- **The reformatting of the first Manual Handling, e-learning course has been very successful**
- **We will be aiming for training compliance to hit 80% for 2014/15, an improvement of 5% on last years figures.**
- **International Nurse Induction should be conducted separately from the General Induction programme**
- **Additional, bespoke clinical training facilities at UHL are critical to the future of all practical based training.**

4.0 Bariatric report.

Patients requiring use of the specialist Bariatric equipment

ALL FIGURES EXCLUDE ANY PATIENTS USING WARD BASED 250KG BEDS, WIDE CHAIRS OR WIDE COMMODES AS THESE ARE NOT MONITORED BY M.H. SERVICE

	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
Bariatric patients admitted	40	76	92	128	91	77 (+ 10 ***)	87	96	106
In-patient days	973	1253	1445	1702	1410	1197 (+ unknown **)	1104	1185	1586
Ave. length of stay	24.3 days	16.4 days	15.7 days	13.3 days	15.5 days	15.5 days	12.1 days	12.3	15
Ave. number of patients/day	2.6	3.4	3.9	4.6	3.9	3.2	4.0	3.2	4.3
Ave. weight of patients using equipment	Not monitored	158.9kg	181.3kg	166.72	163.8kg	162.57kg	162.35kg	151.67kg	173.43kg

* Note: usage less known Bariatric surgery patients in ( ) – approximate figures only

** Note :- waiting list gastric bypass patients no longer recorded as wd 22 has its own beds and chairs for 2009

*** For 2010/11, 40 wide chairs were introduced across the trust which were not monitored, although pts were included in the figures when known about. Therefore 10 pts have an unknown length of stay. 30 patients in the 2011/12 figures were not included as there was no recorded weight.

Commentary on Bariatric Figures

4.1 There has been a marked increase in the figures we report this year. It is representative of the National and international trends on Obesity and has meant that our Bariatric activity has never been busier. The rate has remained the same in that we continue to see a rise of 10 extra admissions compared to the previous year. This figure only relates to those patients referred to the Manual Handling Service and does not include those that are managed without our intervention; this usually applies to the Gastric Bypass patients at the LRI.

4.2 Last year we saw a 15% increase in the total amount of in-patient days and this year that figure has increased by **25.3%.** Consequently, the average length of stay has increased by **2.5** days this year.

4.3 The average patient weight this year has increased by **20** kgs

4.4 Our information on recorded weight indicates that there are **22**% of patients referred to the service who have no recorded weight. This is an improvement on last years position where **40**% of patient's has no recorded weight and is definitely a step in the right direction. However it is important to reiterate that it is essential information when patients are referred to us as this informs the advice we give. We will continue the message about having an accurate weight on all in-patients.

4.5 There has been no new Bariatric stock in the UHL since we took delivery of 2 new Bariatric beds in November 2012. The stock is actively managed by us and serviced by our partners Medstrom Ltd. However, at least 3 of the beds are coming to the end of their useful working lives and there has been a subsequent increase in downtime for repairs. Due to the increase in admissions and the lack of available equipment there has been a large rise in rental equipment this year.

4.6 The figures below represent the trust biggest outlay for rented equipment since we started keeping records 7years ago. It should also be noted that these figures are based on actual usage aligned to In–patients days. There have been an increasing number of occasions where Wards have failed to inform rental companies when the equipment is no longer needed and incurred costs for days rented that haven't been actually used.

No. of pts admitted	Total no. of in pt. days	Ave length of stay	Ave no. of pts/day using equipment
106	1586	15 days	4.3

The costs indicated are SAVINGS on rental, with actual rental costs in red

	No. of episodes (R=rental)	Days used (Inclusive of rental)	Rental days used	Pts/day using equipment	Potential cost (actual rental cost)
XL chairs	23 (1)	252	21	0.69	£9061.25 (£434.70)
XL shower/commode	7 (0)	85	0	0.23	£2340.85 (£0)
Hoists	10 (0)	139	0	0.38	£7,822.40 (£0)
Mattresses	21 (0)	292	0	0.8	£3211.24 (£0)
Rise/recline chair	4 (4)	137	137	0.37	£0 (£4,507)
Proaxis bed	14 (0)	97	0	0.26	£7,440 (£0)
1080 bed	28 (0)	362	0	0.99	£37,005 (£0)
460/560 bed	4 (0)	60	0	0.16	£4,320 (£0)
Baros bariatric bed	21 (15)	361 (262)	262	0.99	£7074 (£24,872)
Total Care bed	0 (0)	0	0	0	£0 (£0)
Wide Cefndy commode	6 (0)	109	0	0.29	£1876.50 (£0)
TOTAL COSTS	-	-	-	-	**£80,151.24** **£29,813.70**

4.7 As with every report for the last 9 years I include a report on the costs of Bariatric equipment We now have 7 years worth of these figures. We have spent **£76,150** on various pieces of Bariatric equipment over the last 6 years. When securing such funding I constantly sell the potential savings on purchase over rental. It is therefore incumbent on me to prove that this is so. We can demonstrate that when this equipment is used, we are not renting and this has meant we have saved **£651,641** over the past 6 years. **This means the equipment we have bought has paid for itself *8.5 times* over.**

4.8 With the increase in rental and delay in timely notification of the rental company for removal, there have been serious problems in the rental companies being paid in a timely fashion. Often the wards requesting have no idea of the relevant ordering codes or how to generate an order number on CEDAR. This year we have instituted a rental "call-off" system that has

helped to address this issue. It is an amendment to the BEM contract and allows the timely rental of equipment by using a list of pre-approved order numbers. This is accessible through the Manual Handling team and the Duty-managers and managed by Patient Surfaces Contract manager. At the time of writing, this system has only just been embedded but we anticipate that this will lessen the amount of erroneous day's rental and ensure the timely payment to the rental companies. In turn, this will drastically reduce the amount of wasted staff hours we have seen with this issue in the past.

4.9 **Overall, the increase in Length of Stay has lead to the increase in rented equipment. It is our view that this will continue to increase in 2014/15.**

4.10 Replacement of Bariatric equipment under the management of the Patient Surfaces Management Group (PSMG) is tabled as a regular item on the monthly contract review meetings. It is recognized that we need to replace existing bed stock and perhaps increase our overall Bariatric fleet.

4.11 At the time of writing, the options being considered are;

a) Replacing equipment as part of the Phase 3 programme for 2015/16
b) This recognizes that we have about 12 months of life left in the older Bariatric beds and there will be severe challenges to appropriate storage of theses beds at the LRI due to the new ED plans and reconfiguration of services/storage.

Summary & challenges for 2014/15

- **To continue the good work produced to date and promote and resolve Bariatric issues**
- **To emphasise the importance of weighing patients on admissions so that the Trust achieves a better compliance in timely accurate information.**
- **Monitor the new Rental ordering system for effectiveness and the reduction in erroneous costs**

APPENDIX 1

Reporting of Manual Handling training Compliance by Staff Group 2013/14

Staff Groups / Report Code	Admin and Clerical - Non Clinical	Allied Health Professionals	Doctors	Non-Qualified Nurses	Qualified Nurses and Midwives	Total
Moving and Handling	1496	985	699	1303	2392	6875

Manual Handling Training Courses available to UHL in 2013/14

- Imaging Directorate - Non Patient Manual Handling
- Lincoln Renal Unit Manual Handling (for patient handlers)
- Loughborough Dialysis Unit Manual Handling Update (for patient handlers)
- Manual Handling
- Manual Handling (Part of Mandatory Training Day)
- Manual Handling - Annual refresher update
- Manual Handling - Clerical and Administration
- Manual Handling - Medical Records Staff ONLY
- Manual Handling - Non Patient Handlers (part of Mandatory Training Day)
- Manual Handling - Patient Handlers (part of Mandatory Training Day)
- Manual Handling - Patient Handlers - Acute Care Division
- Manual Handling - Patient Movers - SERCO Staff Only
- Manual Handling - for the Infection Control Team - UPDATE
- Manual Handling 1 (as part of UHL Corporate Induction)
- Manual Handling 2 (as part of UHL Corporate Induction)
- Manual Handling Update
- Manual Handling Update (Pharmacy Only)
- Manual Handling Update for Consultants in Renal and Urology
- Manual Handling refresher for Transplant Laboratory staff
- Manual Handling Principles for Non-Patient Handlers (eLearning)
- Manual handling refresher for AICU GH
- Medical Physics & Pathology Mandatory Manual Handling Training (inanimate loads)
- Moving & Handling - Bank only nursing staff
- Moving & Handling - Cascade Trainers - Non-Patient Handlers Update 1/2 Day
- Moving & Handling - Cascade Trainers Update - PATIENT HANDLERS - 1 Day
- Moving & Handling - Health and Safety Week (Medical Students ONLY)
- Moving & Handling - Training for Trainers - Non-Patient Handlers 2 1/2 Days
- Moving & Handling - Training for Trainers - PATIENT HANDLERS - 5 Days
- Moving and Handling
- Moving and Handling For Non-Patient Handlers (eLearning-OCB)
- Musculoskeletal Directorate Manual Handling Update 2008
- Musculoskeletal Directorate Manual Handling for Admin and Clerical Staff
- Musculoskeletal Manual Handling (eLearning)
- Musculoskeletal Moving & Handling - (eLearning)
- Occupational Therapy - Moving & Handling UPDATE
- Pharmacy - Manual Handling
- Transplant Laboratory Manual Handling Update

Required Staff Groups:
- Admin and Clerical - Non Clinical
- Allied Health Professionals
- Doctors
- Non-Qualified Nurses
- Qualified Nurses and Midwives

Section 5 – Local Security Management Annual Report 2013/14

1. Introduction

1.1 The responsibilities of the Local Security Management Specialist (LSMS) sit outside the day-to-day security structure and include development of procedures, oversight of security functions and implementation of national policy by direction of NHS Protect, who monitors crime across the health service.

1.2 At the start of 2013 with advent of the Interserve Managed Facilities contract and the creation of NHS Horizons, the existing support structure had gone.

1.3 New arrangements for Security personnel now employed by Interserve, the Security Management and Police Liaison group stopped meeting and the systems that had been in place were left unsupported

1.4 These events coincided with the cessation of the Conflict Resolution Training (CRT) programmes offered by the Leicestershire Partnership Trust which came to an end in December 2013. This was the only training on various levels of Conflict Resolution that the trust had access to.

1.5 In 2013 the role of the LSMS was transferred to the portfolio of the Director of Safety and Risk (DSR) under the transfer of facilities management services to Interserve. In the interim period, the LSMS brief was supported temporarily by the Risk and Assurance management team.

1.6 To ensure resilience to this position the LSMS role has been combined with that of the Health and Safety Managers. This sits together with Manual Handling in the newly formed Health and Safety Services team

1.7 We have since been progressing the work needed to ensure that the UHL is compliant against the standards expected by NHS protect who are the strategic body responsible for work that identifies and tackles crime across the Health Service.

2 Local Security Management – Responsible Persons for the UHL

2.1 NHS protect are very specific in relation to roles and responsibilities under the Local Security Management Agenda. Officers nominated for the Trust have to be recognised by NHS Protect as being suitably qualified. There is also an expectation that the Trust will have a named person at Executive level who will take on the role of Security Management Director

2.2 As of November 2013, Rachel Overfield, Chief Nurse, has taken on the responsibility of the Security Management Director role for University Hospitals of Leicester

2.3 When combining the LSMS role as part of the Health and Safety mangers role both existing post-holders were seconded to the NHS Protect (LSMS) training programme as part of their formal appointment. I am pleased to report that David Lord has now completed his training and that Neil Smith is currently undergoing the LSMS course.

2.4 The combination role of Health and Safety Officer and Local Security Management Specialist is currently undergoing a review through the Job Evaluation process. The

Job description and Person specification has been agreed and signed off by the current post-holders, the HSS Manager and the Director for Safety and Risk. We are awaiting the outcome of the Job Evaluation panel.

2.5 There have been some discussions on what other personnel will be required to best drive the Health and Safety Officer and Local Security Management Specialist (H&S/LSMS) role forward. The outcome will partly be informed by the Job evaluation, the financial envelope for further developments and the likely support this role requires.

2.6 What is known that is that we will be recruiting a conflict management trainer (CMT) This post is currently being verified by the Job Evaluation panel. We anticipate that when this role has been approved, we will recruit quite rapidly.

2.7 In taking on the LSMS brief the most important aspect of our taking this forward is the resilience we create behind the overall responsibility. Therefore the HHS manager will undertake he NHS protect LSMS training in September to further support the current officers

3 Organisational Crime Profile and Security Management Work plan - 2014/15

3.1 It is a requirement from NHS Protect that all NHS organisations submit an Annual Organisational crime profile (The full template can be seen in Appendix 1). At the time of reporting there are still some parts of the profile that need populating.

3.2 Despite the incomplete data this will not alter our overall score profile from last year which will be the following

Category 1 - Violence, Counter-Terrorism, Violence and Theft.
Category 1- Economic crime

3.3 This is typical of a large acute trust with a significant annual operating budget and extensive procurement activities. It is also reflective of the geographical size and location of the trust properties and the amount of staff employed. The categories are an indicator of the scale of activity we should be taking in order to safeguard patients, staff, funds and other assets. This rating is therefore, in line with other large acute NHS organisations.

3.4 As required by the NHS Protect Agency Standards for providers. 2014/15 (security management), the Health and Safety Services team will be completing the Security Management Work Plan for UHL

3.5 The Annual Security Management Work Plan details the management and organisational arrangements fro security activities and requirements.

3.6 There are 15 criteria that are assessed on the following 4 categories

1 Strategic Governance
2 Inform and Involve
3 Prevent and Deter
4 Hold to account

3.7 Last years report represented a new format for reporting in this way. Nationally, this has created much debate as to best answer, evidence and populate the work plan. As a result of consultation amongst NHS organisations the Work plan profile for 2014/15 is still under consideration and the latest information suggests that NHS

protect will not issue the 2014/15 security standards until September 2014 with a submission date in November 2014.

3.8 This will act a template for organising and action our resources to meet the NHS protect requirements. In effect this is a Trust- wide Risk Assessment that we will utilize to compose a Trust- wide action plan.

There will be 3 main themes that develop from this work

1. Identify deficiencies in our security management compliance
2. A Trust wide training needs analysis that identifies risks and also best training measures needed for individual wards and departments.
3. Immediate actions for trust compliance

3.9 A longer term plan to meet our compliance requirements for security management will also result together with the result of the job evaluations

4. Conflict Management Training

4.1 During 2013/14, the Trust has trained 7,248 (1573 total in 2012/13) staff in various forms of conflict resolution training (split 2,286 face-to-face and 4,962 e-learning). This tremendous increase is a 400 % improvement on the previous year's figures but should be treated with caution.

4.2 A large proportion of the Training was delivered by the Conflict Resolution, e-learning programme that was developed in conjunction with OCB Media.

4.3 There were 3 factors affected our decision to use this as learning tool.

1. It forms one of the 10 core subjects that comprise the Required Training programme for all staff employed by UHL
2. The withdrawal of training services previously delivered by our LPT colleagues
3. Our inability as a result of the LPT withdrawal to offer alternative and approved NHS Protect training courses.

4.4 As an interim position it was agreed that all staff could access the e-learning module as it met the training requirement and a decision was take that some information giving was beneficial to staff rather than the alternative of nothing

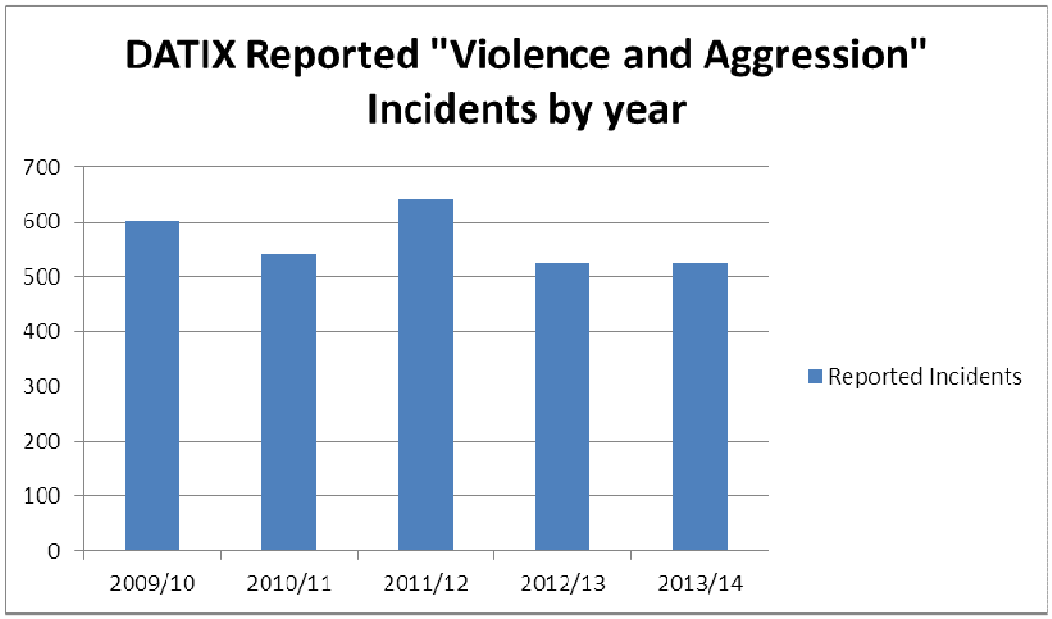
4.5 It is clear that NHS protect will not tolerate this as a medium, or long-term solution The training profile for the UHL should be based on assessment of the risk. It is clear that some staff that are exposed to higher levels of verbal and physical assault and would need a greater level of training input and support than can be had by an e-learning course.

4.6 Together with the appointment of the CMT post we will undertake a Trust-wide Risk Analysis of the training needs of our staff in relation to security issues.

4.7 This will the give us a template of what training is needed, by whom and when. The consequence of this is compiling and delivering a targeted, fit-for-purpose portfolio of courses that best meets the Security needs of our staff

4.8 Conversely it would also highlight those low-risk areas that have minimal exposure and may need very little training or any.

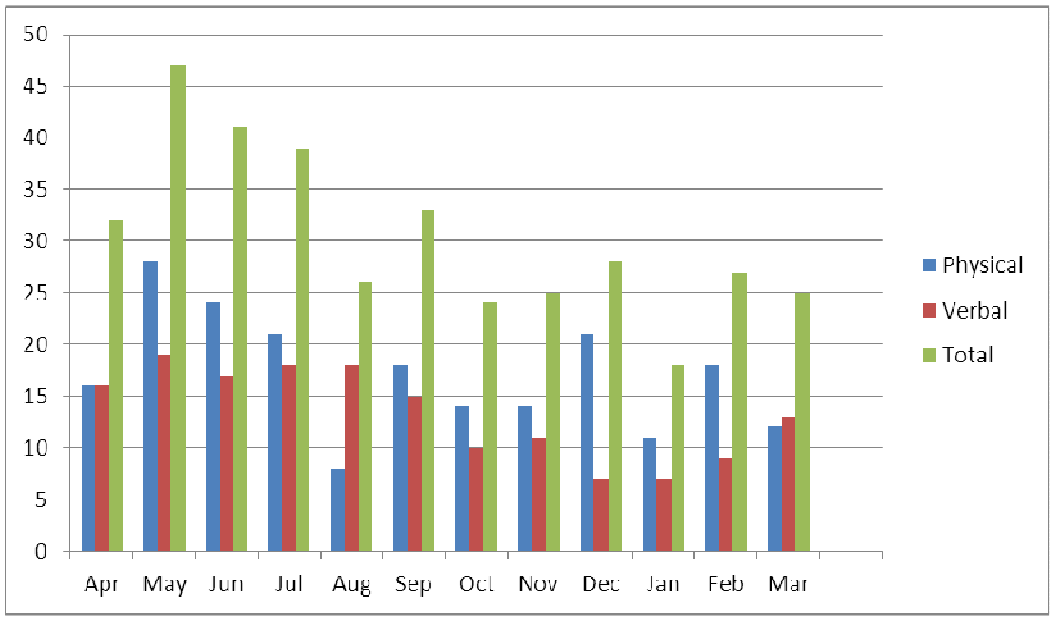
5 Reported DATIX figures for the amount of incidents per year.



5.1 The amount of reported incidents represented in the above graph are the annual totals of reports listed under the DATIX heading “Violence and Aggression” and therefore encompasses a whole range of incidents that include Physical and Verbal assault . This figure does not discriminate between those incidents that are deemed to be have been caused by the patients physical and mental wellbeing either.

5.2 The last 2 years figures have remained static in that 526 incidents were reported in both 2012/13 and 2013/14.

DATIX reported “Violence and Aggression 2013/14”



5.3 There is a requirement of Interserve management to provide figured on security interventions in the Trust. The reporting of security incidents encountered by the

security officers including breakdown of the type of incidents and intervention required has been sporadic this year and largely been form the LRI only.

5.4 This has occurred because of the changes in Interserve personnel but there is now an established structure to support the process in the future.

5.5 With the establishment of the new security management structure aided by the Security Management and Police liaison committee it is anticipated that accurate figures from all 3 UHL sites will be forthcoming on a quarterly basis and form a benchmark for onward progress.

5.6 **Communication to staff who have reported Assaults via DATIX**

5.7 It is stated in the NHS Protect 2013/14 Security Management Work plan under 2.7 that , "All staff who have been a victim of a violent incident have access to support services should they require it"

5.8 This year we have instituted a system whereby all staff who have reported verbal or no-verbal assaults will get a follow-up letter sent to them. The verbal assaults are signed by the HSS manager and the physical attack victims have a letter that is sent from the Chief Executive. (Appendix 2)

5.9 This is a commitment to our staff that all incidents of this nature are treated seriously. It also gives practical advice on whom to contact should they wish to discuss the incident further and also what the Trust offers in terms of support and counselling should they require it.

5.10 Last year we sent out 312 letters. Although those that replied were in the minority we have had 27 communications thanking us for our support and expressing gratitude that somebody has acknowledged the trauma that they suffered

5.11 We plan to continue this service in 2014/15 as it not only complies with NHS protect standards but more importantly it is in keeping with the Trust values and beliefs concerning care of our staff.

6 Security Management & Police Liaison Committee

6.1 The Security management and Police Liaison committee has been re-established this year. This follows a period where membership was uncertain and therefore attendance was poor. Consequently, the remit to oversee Security issues within the Trust dwindled.

6.2 The committee now has a confirmed membership that brings in the views and expertise form the key stakeholders around security issues. Chaired by the DSR, it has representatives from NHS Horizons and Interserve and as well as the Community Police responsible for the areas that cover Trust buildings. This is supplemented by members of the HSS team and representatives from security for LPT.

6.3 Since reconstitution, the terms of reference for the committee have been redrafted so that the there is a clear understanding of the work that it oversees and the scope of responsibilities and powers to promote a safer and secures environment for UHL.

6.4 We are very grateful to have the support form Ian Crowe, Non-Executive Director, who has taken a particular interest in Security issues. It is enormously helpful to have his guidance and expertise to help drive our Agenda through in the forthcoming year.

6.5 The committee meets on a quarterly basis and is part of the UHL Health and safety Committee Structure with direct reporting lines to the UHL Health and Safety Committee and onwards.

7. NIS security and use of Interserve Security for Medical Interventions

7.1 Although it difficult to predict what priorities will be highlighted in the Annual Security Management Work Plan, there are 2 issues that will be addressed this year.

7.2 The use of the NISE Security agency. This agency provides staff to monitor and sit with confused/agitated patients throughout the Trust. We will be exploring if this provides the best care available for this service based on

1 Are private security guards the best equipped personnel to provide this service?
2. Do we get best value for money?
3. What are the viable alternatives?

7.3 There is evidence that this service cost the Trust **£370K** last year alone at the LRI. Many of the CMGs have a stated aim of reducing this commitment as part of their cost improvement plans and we will be working with clinical colleagues to progress this.

7.4 We are working with Interserve to resolve issues of vicarious liability for security staff to intervene at the request of clinical colleagues to assist in the medical treatment for patients deemed to lack mental capacity.

(Risk register ref.2325. *There is a risk to patient and staff safety caused by security staff employed by Interserve not assisting with the physical restraint of patients that require essential clinical intervention when they lack capacity*.) Presently this is a service that Interserve argues they are not covered for or is contracted for within the present service arrangements

7.5 A task and finish meeting has been convened to address and resolve the matter urgently. The first meeting took place on the 28th April and work is progressing to fully understand the issues and agree a mutually convenient way forward. To date a paper on the progress is being drafted for EQB.

7.6 The basis of the report will detail the work that has been done so far and will include the downgrading of the risk rating to 15 for patients and staff in regard to the actual reported occurrences on DATIX. This is far fewer than thought although does raise the issue of timely and appropriate reporting

7.7 There are on going discussions between the HSS team, Interserve management and the Trusts legal team to progress this forward.

8 Freedom of Information requests and Media Coverage

8.1 The following requests were made under the freedom of Information in 2013/14

F.O.I. 16769 - Attacks on Spiritual Rooms
F.O.I. 16769 - Patient on Patient Attacks

Detailed response can be found in (Appendix.3)

8.2 There was one media enquiry concerning the rise in staff assaults submitted by University Hospitals of Leicester to NHS Protect for 2013/14. This was specifically concerning non-verbal attacks on staff that came from patients whose physical/mental condition was not considered to be an underlying factor.

8.3 This lead to a Radio interview on the subject that was conducted on behalf of the Trust by the Health and Safety Services manager.

APPENDIX 1

NHS Protect

Organisation Crime Profile

BRIBERY, CORRUPTION, FRAUD, UNLAWFUL ACTION

19.	What is the total combined annual value of NHS Standard Contracts and NHS funding from all Clinical Commissioning Groups and other types of NHS bodies? *(Please select from list)*	Over £400 million
20.	Please list the names of Clinical Commissioning Groups and NHS bodies the contracts are held with (for multilateral contracts, please name only the lead commissioner). *If this list is extensive, please provide in a separate Microsoft Word or Excel document*	See Tab: Q20
21.	What is the value of NHS funds that are allocated to payroll? *(Please select from list)*	Over £240 million
22.	How many procurement exercises are undertaken directly by the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert number)*	Approximately 10 including mini-competitions on frameworks.
23.	What is the total value of procurement exercises undertaken directly by the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert value)*	Approximately £3m (this can change year to year)
24.	How many procurement exercises are undertaken by external providers on behalf of the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert number)*	Approximately 10 although Supply Chain would be able to provide more detail.
25.	What is the total value of procurement exercises undertaken by external providers on behalf of the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert value)*	Approximately £3m (this can change year to year)
26.	What is the organisations threshold above which quotations or formal tenders must be obtained? *(Please insert value)*	£50,000.00
27.	How many procurement exercises were carried out above that level, but below Official Journal of the European Union limits annually? *(Please insert value)*	16 in total
28.	What is the total value of procurement exercises undertaken in excess of the organisations formal quotation and tender threshold limit, but below Official Journal of the European Union limits annually? *(Please insert value)*	£1,130,099.00
29.	How many invoices does the organisation process annually (if processing has been outsourced to an external provider, please state how many are processed by them on the organisation's behalf)? *(Please select from list)*	Over 100,000
30.	What is the value of the invoices processed annually (if processing has been outsourced to an external provider, please state the value of invoices processed by them on the organisation's behalf)? *(Please select from list)*	£30 - £60 million
31.	Are invoices processed internally or outsourced to an external provider? *(Please select from list)*	Internally
32.	How many fraud, bribery and corruption allegations involving NHS funds has the organisation received in last financial year? *(Please insert number)*	34 referrals received with 15 carried over from 2011/12
33.	How many fraud, bribery and corruption allegations involving NHS funds developed into full cases and were investigated by the organisation within the last financial year?	16 full Investigation cases for the 2012/13 Financial year
34.	What is the value of the organisations known NHS losses as a result of fraud, bribery and corruption within the last financial year? *(Please insert value)*	£198,556.00
35.	What is the value of the organisations NHS recoveries as a result of fraud, bribery and corruption investigations conducted within the last financial year? *(Please insert value)*	£8,939 (the majority is ongoing recovery)

NHS Protect

Organistion Crime Profile

VIOLENCE

10.	Does your organisation provide 'out of hours' services? *(Please select YES or NO)*	YES
11.	How many sites do you provide services from? *(Please select from list)*	10 or less
12.	What is the total number of reported staff assaults involving physical contact your organisation has received between 1st April 2012 and 31st March 2013? *(Please select from list)*	200 or more
13.	How many incidents of violence and aggression were 'RIDDOR' reportable between 1st April 2012 and 31st March 2013? *(Please select from list)*	1 - 10
14.	How many 'serious untoward' incidents of violence and aggression did you organisation have reported in the period 1st April 2012 to 31st March 2013? *(Please select from list)*	0

SECURITY PREPAREDNESS

15.	How many other 'security related incidents' has your organisation had reported in the period 1stApril 2012 to 31st March 2013? *(Please select from list)*	51 - 150
16.	How many other security related incidents were 'serious untoward' incidents in the period 1st April 2012 to 31st March 2013? *(Please select value)*	0

CRIMINAL DAMAGE, THEFT

17.	What is the total financial value of your NHS capital assets? *(Please select value)*	£500,001 or more
18.	What has been the total financial loss to the organisation through theft and criminal damage to NHS premises and property in the last financial year (excluding any involving a natural disaster)?(excluding any involving a natural disaster)? *(Please select value)*	Less than £5,000

NHS Protect

Organisation Crime Profile

BRIBERY, CORRUPTION, FRAUD, UNLAWFUL ACTION

19.	What is the total combined annual value of NHS Standard Contracts and NHS funding from all Clinical Commissioning Groups and other types of NHS bodies? *(Please select from list)*	Over £400 million
20.	Please list the names of Clinical Commissioning Groups and NHS bodies the contracts are held with (for multilateral contracts, please name only the lead commissioner). *If this list is extensive, please provide in a separate Microsoft Word or Excel document*	See Tab: Q20
21.	What is the value of NHS funds that are allocated to payroll? *(Please select from list)*	Over £240 million
22.	How many procurement exercises are undertaken directly by the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert number)*	Approximately 10 including mini-competitions on frameworks.
23.	What is the total value of procurement exercises undertaken directly by the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert value)*	Approximately £3m (this can change year to year)
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35.	What is the value of the organisations NHS recoveries as a result of fraud, bribery and corruption investigations conducted within the last financial year? *(Please insert value)*	£8,939 (the majority is ongoing recovery)

APPENDIX 2

Attachments: Staff Counselling Service (AMICA).doc

Dear

It has been brought to my attention, through the internal incident reporting system, you were the victim of a verbal assault on (DATE) whilst on duty on the (LOCATION) at the (HOSPITAL) and I very much regret any distress caused.

The Trust is committed to do everything it can to protect staff from such incidents and support staff who are the victims of abuse. To this end, I will be working with security colleagues to monitor the assault cases reported on the internal incident database to identify any trends or persistent offenders.

As part of the support service offered to staff, the Trust has an arrangement in place that enables you to access a confidential counselling service, independent of myself or your manager. Amica is a self referral, staff counselling service that provides telephone counselling, 365 days a year, with direct access to a qualified/ experienced counsellor. I have enclosed the contact details for this service for your information.

Once again, I am sorry that you have suffered this experience and if you would like to discuss any aspect of this incident please do not hesitate to contact me

Kind regards

Nick Howlett

Health and Safety Services Manager

Attachments: Staff Counselling Service (AMICA).doc

Dear

I am very sorry to hear you were a victim of a physical assault whilst on duty at (LOCATION) at the (HOSPITAL) on the (DATE) and I regret any distress this ahs caused

My executive colleagues and I recognise that our staff are our most valuable asset and where situations occur we need to provide support to you, and learn nay lessons we can to reduce the risk of further incidents. Where assaults have criminal intent we are fully committed to working with Police to bring about prosecution where appropriate, and manage or exclude the assailant in keeping with national guidelines

To this end, I have instructed our Health and Safety Services Team to manage this matter and ensure action as necessary is taken.

In the meantime, should you require any support in relation to this incident, please contact your line manager or access our independent counselling services, Amica who are available 7 days a week between 8.30am and 8.30pm by calling 0116 254 4388. Amica can provide both telephone based support and if required face-to-face counselling.

Again, please accept my apologies that you have been a victim in this situation

Yours sincerely

John Adler

Chief Executive

APPENDIX 3

HM/FOI/16769

1. Data concerning vandalism to religious/spiritual rooms and buildings in the hospital (e.g hospital chapels and prayer rooms) from January 2009 to as recently as possible.

I am advised that the Trust is not aware of any vandalism to religious/spiritual rooms and buildings across the three hospital sites.

2a.Please include a breakdown of the damage caused and the cost incurred, as well as the time period during which incidents occurred.

N/A

2b. Please also include any reports submitted by hospital staff and, where possible, data concerning assaults, intimidation or threatening behaviour towards hospital chaplains and other hospital staff employed in a spiritual or religious role.

I am advised that the Trust has no incidents recorded in relation to assaults, intimidation or threatening behaviour towards hospital chaplains and other hospital staff employed in a spiritual or religious role.

KR/FOI/16808

1. How many patient-on-patient attacks* have been recorded in the previous five calendar years (2009, 2010, 2011, 2012, 2013)
a) How many of these attacks resulted in an injury?
b) How many of these attacks did not result in an injury?

Please submit your data in the following tables:

2009				***2010***			
Total attacks	***Injury***	***No injury***	***Unknown if injury or not***	***Total attacks***	***Injury***	***No injury***	***Unknown if injury or not***
11	7	4	N/A	12	7	5	N/A

2011				***2012***				***2013***			
Total attacks	***Injury***	***No injury***	***Unknown if injury or not***	***Total attacks***	***Injury***	***No injury***	***Unknown if injury or not***	***Total attacks***	***Injury***	***No injury***	***Unknown if injury or not***
18	9	9	N/A	6	2	4	N/A	8	4	4	N/A

2. *Please give us a brief description of each attack, if possible within the cost limit.*

I am advised that it has not been possible to provide a brief description of each attach within the appropriate 18 hour limit provided for under section 12 of the Freedom of Information Act. Consequently the Trust will not be progressing this section of your request any further.

By 'patient-on-patient attacks' we mean a patient making a physical assault on another patient.

Section 6 – Health and Safety Services Action Plan – 2014/2015

Health and Safety Services Action Plan 2014 -15

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
Health and Safety					
To review and update the Health, Safety and Environment Risk Audit (HSER), to reflect Policy, Present practice and organizational change	▪ To critically review the present Audit tool, update the content and ▪ Verify validity of audit tool with CASE team.	July 2014	N. Howlett	D. Lord N. Smith	An agreed Audit tool that can be utilised across the Trust that accurately measures H&S performance
To measure the Trust's Management of Health and safety systems by re-launching Health, Safety and Environment Risk Audit (HSER)for all wards, departments and sites at UHL	Launch the Audit in September 2014 to all wards, areas and departments Help and engagement with Trusts CASE team to apply and collate the tool and collate the results	September 2014 September 2014	N. Howlett CASE Team	D. Lord N. Smith	Audit completed , results collated and supplied to the HSS team by October 6th 2014
A10% reduction in RIDDOR reportable incidents in the reporting year 2013 – 2014.	Targeted campaigns of work as informed by the HSER Audit to tackle areas of concern , higher risk activities and higher risk work areas The Health and Safety managers will visit all CMG's managers to advise on their priority risks identified in the audit analysis and assist with the development of action plans.	November 2014 – March 2015	N. Howlett	D. Lord N. Smith	At least 5 fewer RIDDOR incidents than that reported in 2013/14

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
To increase compliance rate of RIDDOR incidents falling within reportable categories are reported to the HSE as soon as practicable and in any event within 10 or 15 days. Target will be to increase timely reporting from 48% to a year end position of 75%	Advise CMG/Department/Ward managers of the above Support managers to identify and categorise RIDDOR reportable incidents where the status may appear unclear Challenge CMG managers on RIDDOR reportable incidents that are notified to the HSS team outside of 10- 15 days as to the reasons why this has occurred Monitor and report this in the Quarterly Health and Safety report	March 2015 Monitored quarterly during 2014/15	N. Howlett	CMG/Department/ Ward managers HSS Team	That there is evidence at the year end that compliance is 75% or more.
The HSS Team will develop and promote bespoke training programmes targeted at senior and departmental managers throughout the year.	Through the HSER we will identify the training needs of managers throughout UHL. To amend and redesign present managerial level Health and Safety courses. We will launch and conduct these courses throughout the year. We will conduct work to explore the feasibility of making this a Mandatory requirement for all Managers (to be defined) as part of their learning needs	January 2015	D. Lord N. Smith	D. Lord N. Smith N. Howlett	Suitable Heath and Safety courses for managers will be established and available by April 1st 2015.

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
The Health and Safety e-learning module must be completed on the Trust General Induction programme	It will be requirement that all new starters to the Trust will be have to complete the H&S E-learning module as mandatory requirement of completing the Induction programme	April 1st 2014. To be reviewed quarterly	N. Howlett	N. Howlett HR Training Administration	All new starters to be compliant with this requirement from April 1st 2014 as evidenced by the e-uhl training reports.
The HSS team will commit to ensuring that overall Health and Safety training compliance reaches the Trust target of **80%** by March 31st 2015.	Together with the above actions we will, Ensure that timely reminders are sent via e-UHL administration to ensure that staff are required to have completed Healthand safety training by April 2015 (If they haven't already done so) The HSS team will gain editorial rights to the available e-learning courses to assure that all information is up-to-date and relevant This issue will be actively promoted through the new HSS webpage and "Safety Matters".	To be completed by March 2015	N. Howlett D. Lord N. Smith	N. Howlett D. Lord N. Smith e-UHL administration	UHL Health and Safety Training will be 80% compliant with this requirement at April 1st 2015 This will be monitored in the quarterly H&S reports.

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
This year the quarterly report will include the following as regular items for performance measurement or benchmarking for onward measurement. • RIDDOR reportable injuries • Number of need stick injuries reported. • Numbers of staff who have completed some form of approved UHL Health and Safety training • Number of IRMER reportable incidents • No of settled Employee/Public Liability Claims against the Trust. (To be serviced by the Trusts Legal affairs team).	Collate figures for the quarterly Health and Safety report Comment on performance against targets or benchmarking.	August 2014	N. Howlett	N. Howlett	The UHL H&S Committee, Local Health and Safety Committee and the QAC are assured that this information is available and is an accurate reflection of the figures represented.

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
Manual Handling					
We will be aiming for training compliance to hit 80% for 2014/15, an improvement of 5% on last years figures.	It will be requirement that all new starters to the Trust will be have to complete the Manual Handling E-learning module as mandatory requirement of completing the Induction programme	April 1st 2014. To be reviewed quarterly	N. Howlett	P. Ayrton A. Lewitt HR Training Administration	All new starters to be compliant with this requirement from April 1st 2014 as evidenced by the e-uhl training reports
	Progress with Corporate Nursing, HR Training and strategic planning to identify additional, bespoke clinical training facilities at UHL are critical to the future of all practical based training.	By April 1st 2015	Strategic Planning	P. Ayrton A. Lewitt	The provision of bespoke, additional Clinical training facilities
	International Nurse Manual Handling Induction should be conducted separately from the General Induction programme	From June 2014	Corporate Nursing	P. Ayrton A. Lewitt	An established, bespoke course for International Nurses needs only
Replacing bariatric equipment as part of the Phase 3 programme bed and equipment contract for 2015/16	Identify appropriate Bariatric bed technology to replace current stock of Nightingale Pro-Axis beds .	November 204	Patient Surfaces Management Committee	N. Howlett	To have 3 new bariatric beds ready for delivery and install after April 1st 2015

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
To emphasise the importance of weighing patients on admissions so that the Trust achieves a better compliance in timely accurate information.	Reinforce the importance of weighing message throughout all manual handling course by updating course content Regular news –items to appear in "Safety Matters"	Throughout 2014/14	P. Ayrton A. Lewitt	P. Ayrton A. Lewitt	Accurate data on patient weight is seen in at least 80% of the bariatric referrals made to Manual Handling
Monitor the new Rental ordering system for effectiveness and the reduction in erroneous costs	Ensure that rental companies are paid in a timely manner Monitor rental usage on a monthly basis and report finding to the PSM Core group .	Monthly review	H. Walker – Patient Safety Services Contract Manager	P. Ayrton A. Lewitt	Erroneous non-clinical rental days cost to be cut by 50%
Objective	**Action Required**	**Timescales**	**Accountable Officer**	**Lead Officer**	**Outcome/Evidence**
Local Security Management					
Annual Security Management Work plan to follow					