Meeting Date	**4th March 2019**	**Agenda Item**	**3.1**
Report Title	**Neath Port Talbot Delivery Unit Health and Safety Committee Report**		
Report Author	Angharad Higgins, Quality Safety and Improvement Manager Susan Jones, Head of Operational Services		
Report Sponsor	Brian Owens		
Presented by	Susan Jones, Head of Operational Services		
Freedom of Information	Open		
Purpose of the Report	To provide the Health and safety Committee with an overview of Neath Port Talbot Hospital's systems for managing health and safety and to provide a summary of key issues, risks and plans to address them.		
Key Issues	Neath Port Talbot Delivery Unit comprises of a mixture of community and in patient services across all Health Board sites, therefore the management of Health and Safety poses a series of unique challenges. The Unit has in place, an established Health and Safety Group, working to an annual delivery plan. The group is chaired by the Head of Operational Services and reports directly to the Unit Management and Delivery Board.		

Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	

Recommendations	Members are asked to: • **NOTE** the report

NEATH PORT TALBOT DELIVERY UNIT
HEALTH AND SAFETY ASSURANCE REPORT

1. INTRODUCTION

This report is to provide the Health and Safety Committee with an overview of Neath Port Talbot Hospital's systems for managing health and safety and to offer assurance of our compliance with health and safety matters affecting staff, patients and visitors using our services

2. BACKGROUND AND ASSURANCE

Performance 2018/19 (Q1,2,3)

- **Mandatory training compliance @ January 2019**

Staff Group	Assignment Count	Reviews Completed	Reviews Completed %
Add Prof Scientific and Technic	266	217	**81.58**
Additional Clinical Services	331	273	**82.48**
Administrative and Clerical	202	165	**81.68**
Allied Health Professionals	300	270	**90.00**
Healthcare Scientists	10	9	**90.00**
Nursing and Midwifery Registered	361	304	**84.21**
Grand Total	**1,470**	**1,238**	**84.22**

Staff Group	Assignment Count	Reviews Completed	Reviews Completed %
Medical and Dental	29	26	**89.66**
Grand Total	**29**	**26**	**89.66**

- **Annual work plan**

Neath Post Talbot Hospital has an annual Health and Safety work plan that incorporates the key elements of Health and Safety management and feeds into the Delivery Unit Health and Safety meeting.

- **Violence and aggression**

There were 62 incidents of violence and aggression towards staff during the Q1,2 and 3 compared to 65 during the same period in the previous year. There are higher rates of violence and aggression within our general medical wards (B2, C and D), where our cognitively impaired patients are cared for.

There has been one incident resulting in moderate harm, namely Inc 94763 , B2 where a member of staff was concussed through being head butted by a patient. The patient was subsequently moved to a mental health setting.

It is recognised that the HSE inspection noted violence and aggression incidents within the Neuro Rehab Unit – these are historical with all issues addressed. A bespoke training programme was developed subsequently which was rolled out to other areas within the hospital.

- **Fire**

An annual Health and Safety plan includes fire evacuation exercises. Through the course of the year these exercises are undertaken both in and out of hours, within wards and departments and in admin and clerical areas. The Health Board fire officer is in attendance at most of the exercises and the local fire brigade will sometimes participate. Each exercise ends with a debrief session for staff as well as learning shared at the Delivery unit Health and Safety Group.

A fire risk assessment review group is held quarterly between the Health Board and PFI partners with an action log maintained The Health Board fire officer is in attendance

- **Manual Handling**

Manual handling incidents do not feature within our Datix register. The delivery unit had new moving and handling equipment in 2018 and an ongoing assessment of the remaining items is in place by the ward and department leads.

It is to be noted that midwifes have some unique manual handling challenges and these are addressed within the “Maternity Clinical Skills Manual Handling and Ergonomics” document.

- **Falls**

There were 97 Patient falls resulting in harm during the period, of these 3 resulted in major harm, these were as follows:-

- ID87558- Ward C- Fractured neck of femur- Investigation found that due to previous high number of falls patient should have had increased supervision
- ID89551- Ward E- Fractured neck of femur- Investigation found no HB failures
- ID96442- Ward C- Fractured neck of femur- Investigation under review

All patients who fall more than once have a root cause analysis investigation undertaken to establish whether there are underlying causes for the falls. Furthermore, all falls resulting in significant harm are presented to a peer scrutiny group to establish if there are failures requiring mitigation.

The total number of falls resulting in harm in the Unit has increased by 27 harmful falls on the same period in the previous year. This could in part be because the patient profile within the hospital has changed since 2017/18. The introduction of new services, such as TOCALS and Early Supported Discharge has meant that patients who are more independent and less unwell are discharged from acute sites or as soon as possible after transfer to Neath Port Talbot. Therefore, the remaining patient group within the medical wards in the hospital has a higher proportion of frail elderly people at higher risk of falls.

From April 2019 the Unit will host the Health Board wide falls reduction work-stream and will look to develop innovative ways to reduce falls resulting in harm in the context of promoting safe mobilisation.

- **Sharps injuries**

There have been 3 'dirty' sharps related incidents for staff members in Q1,2,3 , compared to 4 in the same period the previous year. These are

- Inc 84744- Ward C,staff injured by insulin pen
- Inc 88501- Obstetrics, staff injured by needle having taken bloods
- Inc 95168- Ward D, staff injured by insulin pen that had not been disposed of appropriately by agency nurse

- **Lone working**

The midwives are required to provide services to women out of hours - particularly when they are 'on call' at night. On occasions, this can mean responding to calls to attend emergency or unplanned clinical situations alone and to families that they have no prior knowledge of before attending. Some of these families may have safeguarding concerns linked to them, which the midwife may not be not aware of. Staff are trained prior to working in the community and are issued with mobile phones. There is also a 'calling in' system in place to ensure that other staff know where a midwife is and there are systems in place to ensure that any known risks are communicated.

There have been no reported incidents relating to lone working within community midwifery during the period, however this represent a significant risk to staff health and safety.

- **RIDDOR reportable incidents**

There have been 6 RIDDOR reportable incidents in Q1,2 and 3; 2 relate to patient aggression and 4 to staff falls/ lifting injuries.
Learning from the incidents includes

- the importance of accurate handover information when patients are transferred to NPTH
- consideration to be given to psychiatric review prior to transfer in certain circumstances
- importance of storing equipment safely when not in use
- the importance of following patient manual handling risk assessments

Concern and good practice

Neath Port Talbot is a diverse unit with a broad portfolio. Our Health and Safety Group membership reflects the range of services within the unit including Midwifery, General Medicine, Minor Injuries Unit, Pharmacy, Therapies and Nurse Bank. Given the breadth and diversity of the services, it is not meaningful to consider a 'top 3 areas' in any context. However, the Unit Health and Safety Group explore themes and trends arising from incidents occurring across our services and encourages shared learning.

As noted previously, the change in patient profile following the introduction of changes to support patients returning to their usual place of residence earlier means that our general medical wards are facing increasing numbers of patients with cognitive impairment, who are frail and elderly and at risk of falling. The Unit has visited Tonna Mental Health ward to learn from their experience where incidents of violence and aggression against staff were significantly reduced as a result of a change of model, in order to ascertain what learning can be applied in this unit. The Unit has developed a proposed alternative model of care based on the learning from Tonna that is planned for implementation later this calendar year, subject to further internal scrutiny.

- **Unit Health and Safety Risks[1]**

There are currently 7 risks relating to Health and Safety on the unit risk register, these are monitored though our Quality, Safety and Improvement Group, these are as follows:-

Title	Unit	Specialty	Risk (in brief)	Rating (current)
Violence and Aggression	Neath Port Talbot Hospital	Elderly Medicine	Risk of harm to staff caused by violence and aggression from patients, which could result in physical harm to staff and poor staff experience.	9
Contamination MIU NPTH	Neath Port Talbot Hospital	Minor Injury Unit	Risk of patient and staff harm as a result of patients who have been exposed to chemical/ contaminants attending the MIU department.	5

[1] The Unit also reports risks over 16 and/or those requiring support from the Executive Team through the corporate Risk Management Group.

Breach in fire compartmentalisation	Neath Port Talbot Hospital	Hospital Management	Breaches in the fire compartmentalisation have been noted creating a risk to patient, staff and public safety.	8
Transporting of liquid nitrogen WFI	Neath Port Talbot Hospital	IVF	Asphyxiation to staff Manual handling Cold burns Public, staff and patient safety.	10
Infant abduction by family member or stranger	Neath Port Talbot Hospital	Obstetrics	Risk of a parent or family member removing a new-born from the maternity wards, when there are potential safeguarding issues and social services involvement. This can be when families are in dispute with birth plans or when social services have not yet agreed plans. Delays with Social Services increases the risk. More frequently now plans are put in place for the baby to remain with the mother in hospital until a suitable placement can be found and there are expectations that maternity services will provide 24 hour supervision.	12
Aggression or violence to community staff	Patient's Home	Obstetrics	There is a an risk of violence and aggression towards the community midwifery staff. The midwives are required to provide services to women out of hours -	9

			particularly when they are 'on call' at night. On occasions this can mean responding to calls to attend emergency or unplanned clinical situations alone and to families they have no prior knowledge of. Some of these families may have safeguarding concerns linked to them which the midwife is not aware of.	
Back injury to midwives	Patient's Home	Obstetrics	Increased risk of back injury to midwives following introduction of birthing pools, divan beds in midwifery led units, and promotion of home births.	9

Neath Port Talbot Hospital Health and Safety Priorities for 2019/20

Assurance systems

- **Reporting systems**
  Monthly Delivery Unit Health and Safety Group
  Attendance at the Health Board Health and Safety Committee
  Risk register review

- **Unannounced audits**
  Monthly Health and Safety activities including name badge audits, fire evacuation and general H+S walkabouts including Health Board and PFI colleagues.

3. RECOMMENDATION

Members are asked to:

- **NOTE** the report