Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Health and Safety Quarterly Report: July – September 2023**

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Confidential:	**Yes**
Key Purpose:	Assurance

Executive Summary

1. This report provides the Trust Management Executive with information relating to the management of health and safety at Oxford University Hospitals NHS Foundation Trust (OUH) for the period 1st July 2023 – 30th September 2023.
2. The Trust was successful in achieving re-certification to the prestigious ISO 45001 Standard following an audit at the Churchill Hospital (CH) in July 2023. ISO 45001 is globally recognised as the benchmark standard for Occupational Health and Safety Management Systems; to have retained last year's initial certification is a fantastic reflection of the Trust's combined efforts and focus on continual improvement.
3. The audit in July noted significant improvements in the OHSMS compared with the certification audit in April 2022 (6 nonconformities compared to 17 in 2022). Further continual improvement of the Occupational Health and Safety Management System (OHSMS) in progress is the delivery of actions to address the six nonconformities raised and the wider implementation of processes to meet the ISO 45001 standard in readiness for a planned audit at the John Radcliffe site.
4. The audit in July provided external validation for improvements in the Trust's OHSMS and clear evidence of the positive health and safety culture developing in all areas of the Trust. All teams approached to be involved with the audit (some at the auditor's specific request, e.g. some departments previously audited) and others to fulfil general requests from the auditor (e.g., any departments within a PFI managed area) readily agreed and, due to time constraints, many more departments volunteered than were able to be seen; the areas not audited often expressing disappointment at not having the opportunity to showcase the improvements in health and safety that they have made!
5. The Health and Safety Team continues to support other teams and departments to align the ISO 45001 Standards with improvements in other business processes, such as: the procurement of goods and services with consideration for health and safety requirements; the management and control of external contractors on OUH premises; and collaboration with internal and external partners and organisations such as Good Shape to identify and then to target reductions in levels of work related absence and sickness due to H&S incidents.
6. As required by ISO 45001, opportunities for continual improvement of the OHSMS have been identified including the current form of reporting. Reporting will be improved to provide better summary reporting including, for example, a performance dashboard and supporting comments. It is intended that this summary approach will provide more focussed and effective management review of H&S performance compared to the current extended narrative report. It is planned to commence the summary reporting format for Q3 report.

Recommendations

7. The Trust Board is asked to note the content of the report.

Contents

Health and Safety Quarterly Report: July – September 2023

1. Purpose

1.1. This report is intended to provide the Trust Management Executive with information about Health and Safety (H&S) for the period July – September 2023.

2. Background

2.1. This report provides a summary of the most significant updates from the Health and Safety team during the reporting period and signposts any new or emerging risks. A summary of key points is provided as a narrative and remaining information is contained within a table aligned to the ISO 45001 Standards (which form the framework for the Trust's Occupational Health and Safety Management System). This table illustrates the requirements of the standards and the work that has been implemented against these requirements during the reporting period.

2.2. This report provides updates from the Health and Safety team and the following contributors:

2.2.1. Divisional Health and Safety Groups:

- CSS
- MRC
- NOTSSCaN
- SuWON

2.2.2. Corporate Departments:

- Fire Safety
- Fit Testing
- Infection Prevention and Control (IPC)
- PFI Contracts Team
- Radiation Safety
- Security
- Centre for Occupational Health and Wellbeing.

2.3. The Estates and Facilities team continues to report through other routes and are not included in this report.

3. Health and Safety Team report

3.1. The Trust's Occupational Health and Safety Management System (OHSMS) is aligned to the ISO 45001:2018 Standards, which is globally recognised as the benchmark standard for Occupational Health and Safety Management Systems and sets out the legal requirements, other requirements and the processes that a management system meeting these standards must have in place.

3.2. The ISO 45001 requirements are applicable across all areas of the Trust (for non-clinical processes), i.e., the scope of the OHSMS does not include clinical and medical processes involving the actual treatment of patients but within clinical areas does include:

3.2.1. Provision of safe plant and equipment

3.2.2. Ensuring that materials are used, handled, stored and transported safely

3.2.3. Provision of information, instruction, training and supervision to enable staff to work competently and safely

3.2.4. Ensuring that workplaces are safe, including safe access and egress

3.2.5. Provision of facilities and arrangements for employees' welfare at work

3.2.6. Ensuring that work related activities (other than clinical procedures) are risk assessed and risks are controlled

3.2.7. Reporting health and safety related incidents and Trust incident management processes

3.2.8. Evaluating compliance with statutory requirements.

3.3. The Trust was successful in achieving re-certification to the prestigious ISO 45001 Standard following a Surveillance Audit at the Churchill Hospital (CH) in July 2023. Only 6 nonconformities (NCRs)(Table 1) were raised compared to 17 NCRs for the initial Certification Audit in 2022, with the audit report highlighting significant improvements in the OHSMS:

3.3.1. 'Some significant efforts to improve the OHSMS have been made since the Certification Audit. System improvements at Divisional level (including to the Divisional OH&S Groups, appointment and training of H&S Champions, other training, migration to SharePoint for H&S information & records) are evidence of a growing maturity of the system. The OH&S Management System Manual has been revised and continues to provide a very clear summary of arrangements to users.'

Table 1: The 6 NCRs and actions to address these.

NCR	Process	Finding	Actions to address
1	Management Review	Agenda items for the last ISO Management Review (Jan 2023) included all mandatory inputs required by ISO45001. However, where attendees should have considered trends in actual OH&S performance since the previous review, in some cases only the system processes themselves were considered, not the outcomes.	Collate data for ISO Management Review to enable consideration of information on OH&S performance including: 1. incidents, nonconformities, corrective actions and continual improvement. 2. monitoring and measurement results. 3. results of evaluation of compliance with legal requirements and other requirements. 4. audit results 5. consultation and participation of workers. 6. risks and opportunities
2	Control of contractors	At Clinical Engineering, some visiting technicians / engineers are treated as employees and covered by 'honorary contracts', working under the direction of Clinical Engineering (with suitable arrangements for mandatory H&S training etc). However, for others, use of a separate procedure or use of 'SkyVisitor' system is planned but not yet implemented.	Clinical Engineering team to produce a documented control of contractors procedure. Once in place, the procedure can be implemented via the electronic Sky Visitor system.
3	H&S Objectives	Objectives are now clearly defined at Trust	H&S team to support the development of a

		level. The Trust has committed to 10% year on year reductions in incidents (causing moderate harm and above) for the following key themes: violence and aggression; slips trips and falls; manual handling; needle stick and sharp injuries. However, at the time of the audit, no plan of action have been defined and documented for the current year, in order to achieve these goals.	coherent documented plan for achieving the strategic objective. Plan to include all trust level initiatives and local initiatives that will contribute to the 10% year on year reductions (at moderate harm or worse).
4	Control of Nonconformity	At this visit considerable difficulty was encountered when trying to close out some nonconformities raised at the previous visit, where actions were not the direct responsibility of the Health & Safety Department. An effective process of escalation, when responsible parties fail to act, was not demonstrated.	H&S team to help develop and implement a process for recording of nonconformities within the Ulysses Action Tracker module. This will facilitate assignment of action owners, automated email notifications for actions and automated escalation to senior management for failure to respond to notifications.
5	Legal & other Requirements	A wide variety of compliance review mechanisms exist, including AE Audits, Integrated Performance Report; H&S Dept fire safety compliance report; RPS/RPA audits, H&S Dept and Divisional Workplace inspections etc. However, it was not demonstrated that these various compliance strands are	H&S team to collaborate with ISO Management to develop compliance dashboard report to inform Management Reviews and reporting to senior management.

		pulled together into a coherent report on legal compliance status for the Management Review meeting.	
6	Procurement / statutory inspection	A small wheeled powered lifting device has been purchased to reduce manual handling risk when transferring approx. 10 kg boxed bags of fluids to the Renal Replacement Machine. In itself, this represents good awareness of manual handling operations risks and a positive risk reduction measure. However, this equipment is not a medical device and therefore falls outside of the stated remit of Clinical Engineering. At the time of the audit, it was unclear how the procurement of such devices (and their ongoing maintenance / Statutory Inspection) is suitably controlled.	H&S team to collaborate with Procurement team to develop a robust process for ensuring suitable arrangements for planned preventative maintenance (PPM) and statutory inspections where equipment is sourced and procured by local departments (i.e. Not by medical devices or operational estates routes). Both parties to develop and disseminate communications Trust wide for awareness of the revised process.

3.4. Findings from the ISO 45001 audit have been communicated to relevant interested parties, including all Divisional Health and Safety groups, to enable process improvements or contributions towards actions to address NCRs to be planned and delivered in a timely manner. The audit findings have also been incorporated into to updates for Health and Safety training for Managers and for Health and Safety Champions.

3.5. Further continual improvement of the OHSMS is in progress in readiness for a planned audit at the John Radcliffe site (2024) and continued implementation of processes across all OUH sites, in line with the H&S Strategy (2020 – 2025). This work remains the focus of the Health and Safety Team and for the wide range of Health and Safety groups and

forums now established in all Divisions across the Trust and through collaboration with key partners such as the PFI and Oxford University.

3.6. The ISO 45001 requirements have continued to provide a ‘Golden Thread’ across all Divisions for a coordinated approach to continual improvement of the OHSMS and integration with other business processes, including:

3.6.1. Collaboration with a number of teams to seek information about numbers of health and safety related incidents resulting in sickness and absence (to benchmark this information and plan future monitoring and actions to reduce such incidents and the associated financial costs)

3.6.2. Collaboration with the Occupational Health team to review arrangements for the safe use of sharps, including risk assessment and incident reporting

3.6.3. Updating of the annual Health and Safety audit in response to user feedback (to reduce user time spent on the audit, the H&S has reduced question sets and produced 6 x ‘mini audits’ (bi-monthly) to reduce time required at each session; targeted compliance with H&S legislation and Trust H&S Policy and Procedures; and has provided ‘preview’ information and guidance to assist in improving compliance and in reducing actions raised that require follow up after the audit

3.6.4. Continued support to Divisional Health and Safety Groups to strengthen health and safety processes such as hazard identification (through increased workplace inspections), risk assessment and incident reporting / reviewing

3.6.5. Development of the Workforce H&S Group to include H&S Champion representatives as well as Union representatives

3.6.6. Training for managers (1636 completed new course to date) and Health and Safety Champions (96 trained to date)

3.6.7. Development of the new H&S Intranet site (which was amongst the first to go ‘live’) to provide improved access to documentation, guidance and sources of information.

3.7. The current reporting format has been reviewed and it is recognised that the current extensive narrative format does not lend itself to simple retrieval of the most relevant and pertinent information. It is intended to provide a more summary report from Q3, with a dashboard and summary comments providing a more focussed and effective management review of H&S performance.

3.8. It is intended, too, that a dashboard / summary comments approach could provide a platform for Divisional H&S Groups and key teams such as Estates and Facilities, to be included in H&S performance data for aspects such as:

3.8.1. Progress for H&S objectives

3.8.2. Evaluation of statutory compliance

3.8.3. Actions raise by external reports (e.g., Authorising Engineer (AE) reports provided to Estates and Facilities)

3.8.4. H&S incidents (including RIDDOR)

3.8.5. Core skills and role based training compliance

3.8.6. Audit and inspection results

3.8.7. Risks and opportunities.

3.9. Other new or significant activity conducted by the Health and Safety team during the reporting period is summarised in Table 2 below. Table 2 shows activity aligned to the 'Plan, Do, Check, Act' cycle and to ISO 45001 requirements (clauses 4 – 10 are audited by the external ISO 45001 auditor).

Table 2: Health and Safety achievements (July – September 2023)

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	***4.2 Understanding the needs and expectations of workers and other interested parties***	***4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)***	***4.4 OH&S management system***
Some health and safety related hazards arise from ageing buildings and infrastructure. Workplace inspections and site inspections have been increased with the involvement of a number of different inspecting groups, including: • H&S Team • Estates Team managers • Departmental H&S Champions • Trust Internal Audit (ISO 45001) forum • Assurance Team Internal Auditors • Executive tours.	The H&S team has collaborated with the Trust Voluntary Services to support them with risk assessment of their activities and to support with training for carrying out local workplace inspections. In September, the H&S Team hosted a meeting for Workforce Health and Safety Representatives, attended by H&S Champions and Union Representatives. These joint representatives meetings are planned to be regular quarterly events, with Union representative meetings continuing monthly in addition.	The scope of the OHSMS is defined by the sites that are within the audit for ISO 45001 (even though the OHSMS is implemented across all sites as far as possible). The current scope is: *The Occupational Health and Safety Management System in operation at the Churchill Hospital and John Radcliffe Hospital covering the non-clinical activities*. The extension of scope to include the John	The Health and Safety Management System has continued to be developed to meet the requirements of ISO 45001. Particular focus has been directed towards: • implementation of workplace inspections • implementation of internal audits • development and implementation of a new H&S Intranet site • review and updating of documentation, including risk assessments and safe systems of work • review, updating and delivery of health and safety

This expansion of workplace inspections has supported increased identification of hazards related to ageing building infrastructure and systems with a resulting increase in reporting of defects to Estates Helpdesk. The H&S team has supported Divisional H&S groups to escalate significant hazards (that cannot be addressed promptly, e.g. by Helpdesk /Estates engineers) through relevant forums, for example the Estates Compliance Committee, to seek actions to address the hazards, or to escalate to relevant risk registers.		Radcliffe Hospital is in line with the Health and Safety Strategy (2020 – 2025) and the planned extension for ISO 45001 certification at the JR.	training for managers and department Health and Safety Champions • planning to address findings of external ISO 45001 audit.
ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles, responsibilities and authorities**	**5.4 Consultation and participation of workers**
Due to operational pressures during the reporting period Executive H&S tours were postponed and rescheduled,	There have been no changes to the H&S Management Policy and it has continued to be implemented according to the current version.	There were no changes regarding organisational roles, responsibilities	The Health and Safety Committee (HSC) continued to be very well attended and provided an important and

with tours planned for October (Chief Digital and Partnership Officer at the NOC) and November (Chief Nursing officer at Horton General Hospital). The Chief Nursing Officer (CNO) and the Director of Regulatory Compliance and Assurance have provided Executive level oversight and leadership for health and safety throughout the reporting period, with both meeting regularly with the Head of Health and Safety to receive updates for actions in progress to address H&S risks and opportunities and to seek assurance regarding H&S arrangements. The Director of Regulatory Compliance and Assurance has led actions to address ISO 45001 audit findings relating to an objective to reduce H&S incidents (see section 6.2). Divisional Directors of Nursing, or their nominated	Awareness and compliance with the H&S Management Policy has been included as part of a review and update for the H&S annual audit due to be issued to departments in October via the OUH Assurance Hub within Ulyssess.	and authorities in this reporting period.	effective forum for the consultation and participation of workers. During the reporting period, all clinical divisions reported concerns to the HSC regarding the ongoing prevalence in the Trust for incidents involving violence and aggression, with some Divisions identifying an increase in staff to staff aggression. These areas have started to identify initiatives to address this, with updates to follow in future reporting. Workforce Health and Safety Group (WHSG) meetings have continued, attended by Union representatives and by H&S Champions. Both groups have been involved with workplace inspections and raised issues around these requesting advice and support from the H&S team for how to address some findings (e.g., how to mitigate manual handling risks, and guidance for Workplace H&S Regulations relating to supply, maintenance and storage of PPE; workplace temperatures and office

deputies, continued to provide excellent leadership for health and safety in each of the Divisional health and safety groups. They have been extremely supportive to implement processes required to meet ISO 45001 Standards, particularly to ensure that the (usually monthly) workplace inspection process is being carried out by departments and to ensure required documentation is in place.			space). The H&S team provided advice and guidance requested and updated H&S Champions training to include these and similar topics.
ISO 45001: 6. Planning			
6.1 Actions to address risks and opportunities		**6.2 OH&S objectives and planning to achieve them**	
A key process to eliminate or reduce health and safety risks is 'Hazard Identification'. During the reporting period, a number of staff from across the Trust were trained as Health and Safety Champions, bringing the total trained to almost 100. One key role of these Champions is to support department managers to carry out workplace inspections to identify workplace hazards and take action to address these. Divisional H&S Groups have continued to review H&S related risks and opportunities as standing agenda items at their monthly meetings. Where required, risks have been escalated to other relevant groups for actions to address (e.g., estates Compliance Committee) or have been escalated to relevant risk registers		This reporting period has seen objectives and planning to achieve this focus on the Trust strategic H&S objective to reduce H&S incidents* (resulting in moderate harm and above) to reduce by 10% year on year. The Director of Regulatory Compliance, working in conjunction with the Health and Safety team, produced an Action Plan for this objective, identifying Trust level initiatives and local (Divisional / departmental) initiatives that will continue to the targeted reduction. Once all local initiatives have been identified (closing date in October 2023), the plan will be implemented.	

so that risks can be suitably mitigated and monitored whilst barriers to eliminating or further reducing risks are addressed. All departments have been requested to review and update as required all risk assessments, particularly the General Workplace Risk Assessment which captures risks associated with the work environment, work activities and any specific risks in a department. The Health and Safety team and Fire Safety team have continued to attend a working group for the SUWON Delivery Suite Nitrous Oxide and Ventilation project and have worked closely with Estates and local departments regarding recent risks relating to lifts in Critical Care and for sewage leaks impacting a number of areas to ensure that suitable H&S arrangements have been implemented during periods of disruption.	Planning to address other findings from the July ISO 45001 Surveillance Audit is in place with actions in progress. The Head of H&S team recently met with HR Informatics team lead and Head of IT regarding one annual objective to seek data on the staff who are absent due to H&S incidents. This discussion raised a number of interesting points that will need further exploration around ways to align staff self-verified reports of work related incidents with actual incidents captured in the Trust incident reporting system. The H&S team is seeking further information for this with a small working group from relevant departments and will update in future reporting. A similar piece of work is in progress to seek information about the costs of civil claims associated with health and safety related incidents (with a view to benchmark these costs and then set objectives to reduce these over time). The H&S team is awaiting information from NHS resolution following an FOI request submitted by the Head of Legal Services for data on this. An update will follow in future reporting. *Incident reductions targeted to key categories of incidents related to: manual handling (and musculoskeletal injuries); slips, trips and falls; violence and aggression; and sharps, needle sticks and splashes.

ISO 45001: 7. Support			
7.1 Resources	**7.2 Competence**	**7.3 Awareness** **7.4 Communication**	**7.5 Documented information**
Resources currently provided to implement the Trust's	Training to support Health and Safety Champions continued	Awareness and communications for health and safety processes	The H&S team continued development of a SharePoint based H&S Intranet

OHSMS have been reviewed and are adequate at this time, and some areas have been identified that could provide some cost savings going forward. The Head of H&S will keep the Chief Nurse's Office updated on this and will include any significant amendments in future reporting. A review of resource needs included future costs relating to external audit of the Trust's Health and Safety Management System. External audits (currently provided by the ISO 45001 Auditors to a recognised international standard) are crucially important to provide the Trust Board and Public with assurance that the Trust's H&S arrangements are adequate, suitable and effective and that the Trust is compliant with legal and other requirements. The Head of H&S has provided an overview of future	with approximately 30 staff trained during the reporting period, bringing the total to almost 100 members of staff across Divisions trained since April. Updates to the Managing Health and Safety Course are in progress and planned for release October / November. These updates include amendments in response to user feedback, learning from incidents and audits, as well as updates for current Trust context and priorities. Currently over 1600 Managers from a mapped audience of 2300 have completed the most recent course hosted on My Learning Hub. Any manager required to complete the training receives notification to do so once their two-year 'refresher' period expires from any previous training (which accounts for many of the approx. 700/2300 yet to complete the new course). The H&S Champion's and Manager's courses include similar content (amended for	and requirements has been achieved in a number of ways, including: • The Health and Safety Intranet site • The Health and Safety committee • Divisional H&S groups • Workforce (Union) representatives' group • Health and Safety Champions group • Microsoft Teams Channels • Corporate Communications - Staff Bulletins • Use of VIVA Engage ('Yammer') platform for OUH email addresses • Collaborations (e.g. PFI; Oxford University) and through H&S awareness sessions for groups on request.	site and was able to 'go live' with this on the Trust launch date (1st September) for the new Trust Intranet. The new H&S site provides improved user experience with simpler access to documentation and guidance and also enables updates and current news / items of interest to be added to the site more easily and quickly than previously.

external audit costs to the Chief Nursing Officer for review. It is hoped that these costs can be approved at the earliest opportunity to secure the current favourable rate provided to the Trust by the auditing organisation (SGS).	the different responsibilities) and this includes: • Awareness of key H&S legislation • Hazard Identification • Workplace inspection process • Risk Assessment process (based on the Health and Safety Executive's '5 steps to risk assessment' model) • Reporting incidents and nonconformities • Signposting to guidance and resources.		

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**
The H&S team has continued to attend a wide range of H&S related groups to support operational planning and control of H&S related matters for departments across the Trust. including: • Trust H&S Committee • Divisional Health and Safety Groups • Estates and Facilities Health and Safety Group • Estates Compliance Committee • Estates Health Technical Memorandum Groups • PFI H&S meetings (all PFI providers at all sites) • Oxford University H&S Group • Internal Audit forum meetings	The Divisional H&S groups have included Service Continuity Plans (SCP) on their meeting agendas and all have requested their departments to update these as soon as possible. There has been some significant progress in some Divisions but all are maintaining focus on these plans with the intention of achieving improved compliance. Divisional Directors of Nursing, or nominated leads for the Divisional Groups, have requested to be informed of any barriers to updating or completion of plans in order to provide support if required. Where there have not been barriers identified, all Divisional Leads have reiterated the need for compliance to be raised in as timely a manner as possible.

• Capital Programmes meetings • Working Groups (e.g. SuWON Delivery Suites Entonox and Ventilation Group) • Clinical 'harm free' meetings, SIRI meetings and After Action Reviews • Safety Action Groups (e.g. needlesticks and sharps) • Workforce H&S Group. The H&S team provided support to the Clinical Engineering team to close out an ISO 45001 audit finding, which required Clinical Engineering to develop and implement a documented procedure for the control of contractors. This has included a process to monitor contractors whilst working, to ensure that they are working in accordance with their stated risk assessments, method statements and permits to work. The H&S team has collaborated closely with Clinical Engineering to achieve this and a documented procedure and process is now in place and will be developed further to include use of the electronic 'Sky Visitor' system (as used by Estates) in due course – an update will follow in future reporting.	The Emergency Planning Officer has also been supportive to offer assistance to departments to update the SCP plans. Many plans have been tested and / or updated during recent periods of industrial action.

CHECK		
ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**
The H&S team has continued to routinely monitor and measure health and safety related incidents, reviewing some incidents daily, to identify the need for further investigation, statutory reporting and actions to prevent recurrence.	The Workplace Inspection checklist used for monthly inspections has been adapted by the Assurance Team to develop four 'local internal audits'. These local audits have been shared with the ISO 45001 trained internal auditors in divisions. The Internal Audits have commenced in departments at both	The requirements of the Management Review Process are set out in detail by the ISO 45001 Standards. The recent surveillance audit noted that the Management Reviews completed to date had …'*demonstrated capability to ensure the continuing suitability, adequacy and effectiveness of the management system'.* However, the audit noted that…' *in some cases*

Analysis has included the effectiveness of operational controls and the need to modify or introduce new controls. For example, reviews of some manual handling activities identified a need to amend tasks (e.g. break down loads to smaller loads), to use lifting equipment where possible (e.g. trolley or powered lifting devices) and to provide refresher training for some staff. Evaluation of H&S performance has been collated from a variety of sources, including incidents, RIDDOR notifications and compliance with training requirements.	the Churchill and John Radcliffe Hospital sites. The results will be reviewed by the Internal Audit Forum once all Divisions have completed their audits.	*only the system processes themselves were considered, not the outcomes. Examples include trends in nonconformity and the results of legal compliance evaluation'.* The Management Review process is in development to ensure future reviews include trends and other outcomes for H&S performance.
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.1 General**	**10.1 General**
Department managers have been supported to be more proactive in providing required information following incidents to support more timely investigations (especially for potential RIDDOR incidents) and to implement actions, including corrective actions, to address immediate and root causes. The workplace inspection process has supported improved hazard identification, especially those arising from building or environmental issues, and reporting of these for remedial actions (e.g. reporting to Estates Helpdesk).	Department managers have been supported to be more proactive in providing required information following incidents to support more timely investigations (especially for potential RIDDOR incidents) and to implement actions, including corrective actions, to address immediate and root causes. The workplace inspection process has supported improved hazard identification, especially those arising from building or environmental issues, and reporting of these for remedial	Department managers have been supported to be more proactive in providing required information following incidents to support more timely investigations (especially for potential RIDDOR incidents) and to implement actions, including corrective actions, to address immediate and root causes. The workplace inspection process has supported improved hazard identification, especially those arising from building or environmental issues, and reporting of these for remedial actions (e.g. reporting to Estates Helpdesk).

	actions (e.g. reporting to Estates Helpdesk).	

H&S team - new and emerging risks and opportunities (April – June 2023)

3.10. Table 3 below shows risks and opportunities currently being addressed by the Health and Safety team in collaboration with relevant departments.

Table 2: H&S team - new and emerging risks and opportunities

H&S team **New and emerging risks** **Specific issue(s)**	**Measurable outcome**	**Is this achievable?**	**How is this relevant?**	**Timescale for completion**	**Who needs to carry out the actions?**	**What evidence / success criteria is required?**	**Action completed and evidenced (date and details)**
Audits and workplace inspections have noted that some items of electrical equipment was not in date for Portable Appliance Testing (PAT), including for IT equipment such as laptop	External audits (ISO 45001) and Internal Audits or inspections (Assurance Team, Divisional Internal Auditors and H&S team) do not identify portable electrical equipment out of date for Portable	Yes. The H&S team has supported Divisional H&S Groups to include PAT as part of workplace inspection process.	Although PAT is not a legal requirement, this is an effective means of ensuring suitable inspection of equipment provided for work purposes and could incorporate equipment used	Departments to identify own equipment requiring PAT and book inspections via Estates team. All inspected equipment to be in date for PAT.	Department managers. Supported by relevant Divisional H&S leads and Estates team / external contractors (procured by Estates team).	All relevant portable electrical equipment is in date for PAT when inspected.	

H&S team New and emerging risks Specific issue(s)	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
charging leads, docking stations etc.	Appliance Testing (PAT).		in OUH buildings and for remote workers (at home and elsewhere).				
Reports to the H&S team have highlighted that there are significant numbers of Computer Carts that have become defective due to age and are no longer adjustable. Also known as 'Computers on Wheels' (CoWs) and Ergotron (Brand name).	All computer carts are adjustable and fully functioning. As an interim measure, the Head of IT has scoped a solution where all defective carts are to be identified and locations where fixed height carts can be used,(e.g. as a 'desk' type platform); a relocation	Yes, but there are significant funding requirements so a phased replacement programme will be required (costs are approx. £4,500 per new cart and there are circa 1000 carts in the Trust).	The lack of adjustability presents a risk of musculoskeletal (MSK) injury to users. This risk has been shared with the Head of IT who is aware and is scoping an interim replacement programme and mitigations to support staff safety.	Full replacement programme circa 5 years + (2023 – 2028+) Update on Interim programme to be reported to Health and Safety Committee 23rd June 2023.	Head of IT, with support from Occupational Health team ergonomist and Back Care team Manual Handling lead (to carry out local assessments and training) and from H&S team to monitor risks and MSK incidents.	All computer carts function as intended (non-adjustable) carts are altered to fixed height or can be adjusted). Long term success criteria is for all existing stock to be replaced by newer version of the equipment.	

H&S team New and emerging risks Specific issue(s)	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
These machines are used in clinical areas.	programme will then reallocate carts to static and mobile carts areas as required.						
The Divisional Health and Safety Groups established in Clinical Divisions are not in place for	A Corporate Divisional H&S Group is established.	Yes. A new H&S Committee Representative for Corporate Division recently	There is a risk that the Health and Safety Management System is not effectively implemented in	Q4, 2023 – 2024 (subject to information from Assurance team and Department	Corporate Division Representative, Assurance team to provide departmental	A Corporate Divisional H&S Group is established. Evidenced by	

H&S team New and emerging risks Specific issue(s)	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
Corporate Division.		appointed, will support with this. To achieve this, there will be a need to accurately understand the departments and contacts within Corporate Division (this work is in progress via Assurance Team for internal audit purposes).	Corporate Division.	leads engage in project).	information. H&S team support.	meeting records.	
Low compliance for completion of the H&S Annual Audit (of	Compliance is at least 60% (2023 – 2024).	Yes. H&S team have amended the audit so that it	The H&S audit is aligned to Health and Safety	Revised audit to be available via Ulysses by	H&S team to revise audit content.	Revised audit issued via Ulysses audit module and	

H&S team **New and emerging risks** **Specific issue(s)**	**Measurable outcome**	**Is this achievable?**	**How is this relevant?**	**Timescale for completion**	**Who needs to carry out the actions?**	**What evidence / success criteria is required?**	**Action completed and evidenced (date and details)**
Policy and Procedures).	from 24% (2022 – 23)	is more user friendly and utilised Ulysses Assurance Hub Audit Module to automate and track actions.	legislation and to Trust Health and Safety policy and procedures.	1st October 2023.	Assurance team to establish Ulysses audit module and to upload H&S audit to this system when operational.	completion data shows increased compliance (at least 60%).	

4. Contributor reports

4.1. The cross-reference links below enable navigation directly to each of the contributor reports:

- CSS Report
- MRC Report
- NOTSSCaN Report
- SuWON report
- Fire Safety Report
- Fit Test Team Report
- Infection, Prevention and Control (IP&C) Report
- PFI Contracts Team Report
- Radiation Protection Committee Report
- Security Report
- Centre for Occupational Health and Wellbeing (COHWB) Report

5. Divisional Health and Safety Group reports

CSS Report

5.1. Submitted by: Lucy Parsons, Divisional Director of Nursing, and Angela Hobbs, Divisional Business and Performance Manager; Risk submitted by Edward Fraser, CGRP.

5.2. CSS - Executive Summary

5.2.1. Following on from the external ISO40001 surveillance audit at the Churchill site in Q1, the focus for Q2 was on sharing the learning from the report and addressing any findings. The main forum for this was within the Divisional H&S meetings which have been held monthly with good representation from the Directorates. Discussion has included areas of good practice as well as details of the non-conformities which has helped in planning the approach for the internal audits on the JR site during Q2 and 3.

5.2.2. An achievement has been the significant improvement in updating the Service Continuity Plans, with a current completion rate of 89% and plans for the remaining ones to be addressed by November.

5.2.3. An area of concern remains the number of incidents relating to violence, aggression, and harassment across the Division with staff health and wellbeing a key priority within each of these.

5.3. CSS report comments

5.3.1. Objectives for CSS:

- To continue with ward to board reporting in the four categories of violence and aggression; slips trips and falls; needlestick, sharps & splashes; and manual handling, outlining actions taken and to work towards a 10% reduction in incidents year on year.
- For Health and Safety to be regular agenda item at Directorate Management meetings

- To ensure equipment and medical devices procured outside of clinical engineering process, is managed and maintained accordingly
- For the Business, Performance and Projects manager to continue to support OSMs and leads to review and complete service continuity plans to achieve 100% compliance.

5.4. Table 3: CSS Division achievements

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	**4.2 Understanding the needs and expectations of workers and other interested parties**	**4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)**	**4.4 OH&S management system**
The monthly Divisional H&S meeting is now established and provides a forum for regular updates from the Trust's Health and Safety team on organisational priorities as well as escalation of any H&S related issues from Directorates. Successful outcomes have included the repair of window frames and replacement flooring. The Division continues to focus on achieving full compliance with service continuity planning.	Discussions and learning from the external surveillance audit at the Churchill site continue to be shared in the Divisional H&S Group and support is given to meet the needs and expectations of staff and other interested parties	Continue the emphasis on H&S champions and importance of these roles within departments to support managers. Continue to await a Trust wide solution to a document management system.	The Divisional Business, Performance and Projects Manager and the Corporate H&S Training and Projects Manager working collaboratively to highlight and fulfil any gaps in staff management training and H&S champion training
ISO 45001: 5. Leadership and worker participation			

5.1 Leadership and commitment	5.2 OH&S policy	5.3 Organizational roles, responsibilities and authorities	5.4 Consultation and participation of workers
Monthly Divisional Health and Safety meeting chaired by Divisional Director of Nursing and attended by members of Directorate management teams. Divisional Business, Performance and Projects Manager has allocated time to support this agenda. Attendance at Trust Health and Safety Committee by Director of Nursing and/or Lead Clinical Governance Practitioner.	New Corporate H&S SharePoint link has been shared with Directorate colleagues to encourage easier access to policies and relevant documents.	Divisional Team contributes to compliance with Trust Health and Safety Policy.	Health and safety Champions - encourage all colleagues with an interest to attend the monthly divisional meetings.

ISO 45001: 6. Planning	
6.1 Actions to address risks and opportunities	**6.2 OH&S objectives and planning to achieve them**
Monthly workplace inspection checklists and risk assessments are completed. Check on this and areas of concern raised at Monthly Health and Safety meeting. All incidents are reported appropriately and escalated when necessary. Estate related risks are reported to Estates helpdesk or escalated to relevant forums such as the Estates Compliance Committee or added to the relevant risk register.	Continue with Internal audits across the JR site in preparation for the external audit planned for 2024. Proposed peer review approach to develop knowledge and skill and learning. Ensure regular H and S discussion at Directorate meetings.

ISO 45001: 7. Support				
7.1 Resources	**7.2 Competence**	**7.3 Awareness**	**7.4 Communication**	**7.5 Documented information**
Keep the H Keep the H&S Divisional teams channel up to date with the Divisional and Trust priorities.	The Divisional Business, Performance and Projects manager continues to provide support to departments to ensure they understand H&S requirements. Champion H&S training encouraged and supported. Ensure training and support is available to staff.	Encourage directorates to have H&S as a standard item on management meeting agendas	Maintain monthly divisional H&S meetings. Ensure attendance at Trust Health and Safety Committee and escalation of risks and updates on themes.	Keep an UpToDate action log and notes from all Divisional H&S meeting. Divisional MS Teams channel set up to enable Directorates to keep digital documentation of completed risk assessments, workplace checklists, etc.

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**
During internal audits the internal auditor has ensured that risk assessments are up to date. Ensure the IOS 45001 internal audit forms are completed after each audit has been carried out.	The Divisional business, performance and projects manager is working closely with the Trust EPRR team and directorates to complete all SCP's
CHECK	

ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**
Check progress and completion of all H&S risk assessments and checklists	All departments are aware of their participation in for the internal audits.	Good engagement from Directorate Managers with the Health and Safety Agenda. Ensure this occurs at CSU level. Provide communication and ongoing and support when necessary.
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
Continue to provide support, help and training on all H&S related topics. To evidence demonstrable improvement in Health and Safety for staff	Continue discussions around previous NCRs. Adopt a shared learning approach alongside policies and procedures. `	Consider CSS H&S performance measures to address any areas of concern in a timely manner with robust action plans in an endeavour to reduce all incidents by 10% year on year. Improve comms with Estates arising from H&S inspections/ internal audits to ensure issues are being fully resolved.

5.5. Table 4: CSS - new and emerging risks and opportunities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
There is a potential patient and staff harm resulting to lack of access to working lifts during transfer of critically ill patients.	1. Fire evacuation plan and equipment. 2. Improved SLA with contractors (two recent incidents have cause outage).	Yes	1. Staff need assurance that evacuation is possible in the event of a fire during lift downtime and to practice. 2. Improved SLA will reduce lift downtime.	1. 31 December 2023 2. 30 November 2023	Estates and Facilities	1. Evacuation plan and equipment 2. SLA	

MRC Report

5.6. Submitted by Nicola Richardson, Deputy Divisional Director of Nursing and Cat Gibbons, CGRP.

5.7. MRC - Executive Summary

5.7.1. MRC has continued to emphasise the importance of risk assessment, reviews, and the importance of utilising the risk register alongside appropriate escalation. We now have 2 Health and Safety lead auditors for the division who are completing walkarounds and assessments that are required. We are encouraging directorates to escalate health and safety concerns via the divisional group.

5.7.2. MRC has continued to emphasise the importance of robust risk assessment and reviews through effective utilisation of the risk register which is currently under review. Directorates are encouraged to escalate health and safety concerns via the divisional health and safety group. The areas of concentrated work are continuity planning, workplace risk assessments and violence and aggression.

5.8. MRC report comments

5.8.1. The division is supporting the clinical areas to review and complete their business continuity planning. Opportunities for tabletop exercises have presented themselves through management of industrial action. This remains a standing agenda item on the divisions monthly H&S steering group meeting, and we anticipate increased compliance and completion prior to next review.

5.8.2. Through successful embedding of the health and safety meetings, the division has been able to highlight and focus on emerging risks and areas of concern. Violence and aggression remain a key area of concern with directorate and divisional representation at the monthly violence and aggression meetings. Work underway to increase reporting and accurately reflect level of physical and psychological harm which is supported through PSIRF framework.

5.9. Table 5: MRC Division achievements

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	**4.2 Understanding the needs and expectations of workers and other interested parties**	**4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)**	**4.4 OH&S management system**
The division has undergone significant changes in leadership over the last quarter during a period of industrial action which has been well navigated to mitigate the impact on H&S. KPMG safe staffing levels have been reviewed in collaboration with finance team but short-term sickness and staffing vacancies remain a challenge. Work to reduce NHSP/ 545 and agency spend has been carefully balanced with maintaining safe staffing levels.	MRC Divisional H&S Group provides a forum for understanding the needs and expectations of team including clinical units, radiology and security leads and offers a collaborative forum for discussion.	NA	NA
ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles, responsibilities and authorities**	**5.4 Consultation and participation of workers**
The MRC Divisional H&S group – very strong commitment and leadership around H&S in the Division.	N/A in this reporting period.	H&S group is currently chaired by the Dep DDO and Dep DDoN (with a new representative in that role for the last 10 months). The chair attends and reports to	Health and safety champions have been encouraged from clinical units who undertake H&S reviews in their own areas and peer audits. The local H&S safety group is

		H&S Committee but currently advertising for an interim dep DDO to support.	open to whole of division but is locally escalated via matrons and OSMs into their directorate management exec meetings and governance forums. OxSCA process supports identification of areas for improvement.

ISO 45001: 6. Planning	
6.1 Actions to address risks and opportunities	**6.2 OH&S objectives and planning to achieve them**
Continual steer towards completing local and peer workplace inspections to identify and eliminate or reduce hazards and associated risks. **Amber risks causing concern / potential cross divisional risk this quarter.** • *MRC 30-Patients may be at a higher risk of falls when they are admitted or attend hospital*- Falls engagement session has been undertaken with second stage meeting 31st October. • *MRC 20-Potential exposure to violence and aggressive behaviour as part of working practice.* ○ Violence and aggression initiatives below around staff support through reflection sessions and de-brief and training provision around de-escalation. • MRC 1001-Nmab triage is undertaken by 5 different services across the week (oncology, haematology, AOT, rheumatology, renal) with pharmacy screening of prescriptions, delivery by renal day case and AOT and admin by AAU reception team.	Staff Support being offered. • Debriefs offered-excellent feedback from staff in OCE. • Use of psychological medicine support • Divisional/PSR visits to areas with high impact physical and psychological incidents noted. • Use of RMN's to help support challenging patients. • Template for Matrons/managers to use to send to staff signposting them to support etc. • Correct use of enhanced observations terminology to support staffing requests. • Body worn cameras within emergency departments with follow up survey completed this quarter advocating for their use and positive impact to support staff. Training. • Extra staff can now attend conflict resolution training who did not have the opportunity before • Breakaway/restraint training has taken place in high-risk areas such as OCE to help staff because of a challenging situation with a patient • Body camera training

• MRC 24-Risk of not having sufficient funds to support the sustainability/growth of MRC service. **Static risks causing concern.** • Patients coming to harm due to no inpatient podiatry service and non-compliance with NICE guideline 19.	• Staff actively encouraged to report all incidents including appropriate level of harm. Violence and aggression review meetings • Bi-weekly meeting based on incidents reported against staff in ED/EAU-JR. Attended by Matron, Trust security lead, community • safety practitioner, Clinical governance, and deputy divisional nurse. Letters are sent to individuals (patients, families etc) stating behaviour is unacceptable. Having Community safety practitioner allows for information to be shared with outside agencies such as TVP/SCAS/Turning point • CMU have weekly meetings to allow staff to have debrief after incidents. Review of incidents with Matron, safeguarding and medical team to review if further action is appropriate • Specialist medicine have a new meeting arranged for Friday 29th. This will be a focus group from each clinical unit in the directorate. • Sexual health has their own working group due to increase in verbal aggression to admin staff.

ISO 45001: 7. Support			
7.1 Resources	**7.2 Competence**	**7.3 Awareness** **7.4 Communication**	**7.5 Documented information**
Current H&S resource consideration include releasing staff to undertake wellbeing champion training and to undertake local H&S reviews. Investment into violence and aggression meetings and breakaway training.	MRC now has 24 trained H&S Champions. H&s Champions are competent to conduct workplace inspections and to support managers with H&S arrangements, including review and updating of	The MRC Divisional H&S group has good attendance from Directorates, OSM / Matrons who disseminate information to CSUs etc. Information shared within the Division via H&S teams channel including preparedness for ISO 45001 audit, radiation audit and violence and aggression data.	Use of MS Teams to retain Workplace Inspection checklists and meeting notes. Divisional Network drive stores risk assessments. All departments requested to review and update H&S risk assessments.

	risk assessments and safe systems of work.		

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**
Ongoing review of any relevant operational process controls below: a) the use of procedures and systems of work. b) ensuring the competence of workers. c) **establishing preventive or predictive maintenance and inspection programmes.** d)**specifications for the procurement of goods and services**- The ongoing disruption of supply chains of manufacturers and suppliers of cardiothoracic surgery disposable equipment. Suppliers report that this is due to a shortage of raw materials and short staffing levels. Delays at customs are also leading to delays in receiving supplies. e) **using ergonomic approaches when designing new, or modifying, workplaces, equipment**, CCU/Oak ward at the Horton have quoted for expansion works to increase bed stock. Remaining CMU wards are keen for refurbishment work to ensure that the environment is fit for purpose. Currently update of curtain poles to ensure ability to procure curtains and maintain patient dignity.	Division is supporting the clinical services with the completion and review of the Business Continuity Plans and delivery of the tabletop exercises following most recent industrial action. Significant improvement in compliance noted since standing agenda item monitoring within steering group.

CHECK		
ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**
The Division has continued to monitor emerging themes and risks and escalate to relevant	Division will support the H&S team with the completion of the health and safety audits.	To continue to review, monitor and maintain risk registers and

committees such as reducing violence and aggression group.	MRC has 5 trained ISO 45001 internal auditors. These auditors have trialled the use of 'local audits' developed by the Assurance team and have also completed internal audits of departments at the Churchill site; internal audits are planned for departments in the JR and other sites in the next reporting period.	appropriately archive once mitigations are in place.
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
Violence and aggression initiatives Staff Support being offered. • Debriefs offered-excellent feedback from staff in OCE. • Use of psychological medicine support • Divisional/PSR visits to areas with high impact physical and psychological incidents noted. • Use of RMN's to help support challenging patients. • Template for Matrons/managers to use to send to staff signposting them to support etc. • Correct use of enhanced observations terminology to support staffing requests. • Body worn cameras within emergency departments with follow up survey	Managers and Health and Safety Champions have completed Workplace Inspections of departments. These inspections have identified H&S hazards that have been addressed locally or escalated, for example to Estates helpdesk for building defects.	24/7 thrombectomy service has been recently established. Divisional falls engagement session with collaboration from health and safety, safeguarding team, falls practitioner and ward leads. Follow up session 31st October with area specific narrative around initiatives for improvement. Work is ongoing to monitor compliance and audit of radiation personal dosimetry in collaboration with head of imaging and non-ionising physics who will share the audit results and areas for improvement within health and safety meetings. This will include:

completed this quarter advocating for their use and positive impact to support staff. Training. • Extra staff can now attend conflict resolution training who did not have the opportunity before • Breakaway/restraint training has taken place in high-risk areas such as OCE to help staff because of a challenging situation with a patient. • Body camera training • Staff actively encouraged to report all incidents including appropriate level of harm. Violence and aggression review meetings across directorates. • Bi-weekly meeting based on incidents reported against staff in ED/EAU-JR. Attended by Matron, Trust security lead, community safety practitioner, Clinical governance, and deputy divisional nurse. Letters are sent to individuals (patients, families etc) stating behaviour is unacceptable. Having Community safety practitioner allows for information to be shared with outside agencies such as TVP/SCAS/Turning point. • CMU have weekly meetings to allow staff to have debrief after incidents. Review of incidents with Matron, safeguarding and		• Where badges have been unreturned • Where badges have been recorded as unused (different to actual compliance data) • Where badges have been recorded as late • Incurred costs from provider • Notification of any radiation investigations and report • Notification of any dose audits and report MRC have been trialling an enhanced observation tool across the CMU wards but are keen to get a more diverse working group to review how this can be implemented trust wide set up so a working group has been established.

medical team to review if further action is appropriate. • Specialist medicine have a new meeting arranged for Friday 29th. This will be a focus group from each clinical unit in the directorate. • Sexual Health has their own working group due to increase in verbal aggression to admin staff.		

6. Table 6: MRC - new and emerging risks and opportunities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
Violence and aggression- the division have seen an increase in prevalence over the last quarter. Impact on staff morale and wellbeing Visitor patient experience is compromised	• Invested in local debrief sessions and psychological support. • Extra staff can now attend conflict resolution training who did not have the opportunity before • Breakaway/restraint training has taken place in high-risk areas such as OCE to help staff because of a	Ongoing investment is required to release staff to undertake debrief, de-escalation and educational sessions	Evolving theme in both Ulysses data and staff survey results.	ongoing	Division	Increase in level of reporting. Positive feedback around staff wellbeing and support levels. Reduction in short term staff	

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
increase in short term sickness.	challenging situation with a patient. • Body camera training • Staff actively encouraged to report all incidents including appropriate level of harm. • Awareness of impact on admin staff as well as clinical staff.					sickness related to V&A incidents. Improvement over time within staff survey results from V&A from patients, family and public.	

NOTSSCaN Report

6.1. Submitted by Fiona Beveridge, Deputy Divisional Director of Nursing.

6.2. NOTSSCaN Executive Summary

6.2.1. Within NOTSSCaN, all H+S related incidents are reviewed and actioned on submission, with oversight from the Divisional H+S Steering Group. A review of H+S related risks forms part of the monthly Divisional Risk Register Review, with dissemination of mitigation and actions through the Steering Group and Divisional Assurance and Governance Committee. The Division champion the ethos of health and safety being the responsibility of all staff.

6.2.2. The Division actively support our Directorates in the completion and ongoing management of workplace risk assessments. This is currently one of two priorities, with the second being training of more H+S Champions. The use of CSU and Directorate risk registers, and the Ulysses reporting system, to escalate concerns is actively encouraged. This has allowed identification of specific themes, particularly in relation to violence and aggression.

6.3. NOTSSCaN report comments

6.3.1. Ongoing management of workplace risk assessments remains a Divisional priority and is a standing agenda item at H+S Steering Group. It is acknowledged that although the Division has a number of trained H+S Champions, more would be appropriate to the size of the Division.

6.3.2. Recent industrial action, and power outages on the NOC site, have allowed facilitation of several business continuity plans to be tested, however there is scope for increased compliance in both updating and testing plans. The Division continue to actively support this.

6.3.3. Encouragement in actively reporting violence and aggression incidents has aided in identifying areas of concern. Review of the themes has allowed the correct support to be provided, particularly in respect of breakaway/de-escalation training opportunities.

6.4. Table 7: NOTSSCaN Division achievements

PLAN
ISO 45001: 4. Context of the organisation

4.1 Understanding the organization and its context	4.2 Understanding the needs and expectations of workers and other interested parties	4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)	4.4 OH&S management system
Not applicable in this reporting period.			

ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles responsibilities and authorities**	**5.4 Consultation and participation of workers**
Divisional H+S Committee was set up in 2022 with senior presence from all Directorates and has continued with this structure. Senior representation was deemed necessary so as to allow strength in decision making and challenge where required.	N/A	Divisional Steering Group has until recently been co-chaired by Div Head of Finance (Div H+S Lead) and DDDoN. Following departure of Div Head of Finance from the Trust, the Div structure is being reviewed, however DDDoN will assume lead role in the interim.	All staff are welcomed to attend Steering Group, particularly H+S Champions.

ISO 45001: 6. Planning	
6.1 Actions to address risks and opportunities	**6.2 OH&S objectives and planning to achieve them**
1. Review and reduction of environmental risks is a Divisional priority with the cohort of patients seen in some of our clinical areas. This is particularly relevant in Neurosciences and in CHOX, where both the clinical and/or psychological elements of their presentation can increase the risk of self-harm, absconding, and also aggression towards staff. The Division welcome the ongoing support of OUH Psychological Medicine, and the collaborative working relationships with CAMHS and our partners in Oxford Health to support these challenges.	Senior Divisional support where incidents of violence and aggression have been reported, including: - face to face conversation, including PSR visits - Support from Psych Med - OH referrals where indicated - use of behaviour contracts where appropriate - continued support for Security Services - sign posting to Trust Education leads to access the behaviour management training currently provided to Bank BNA's, with the intention to roll out to substantive team members A formal checking procedure is being implemented by Radiology, dosimeters will be issued where staff request them, OH referrals

2. The Division currently has a focus on falls reduction and is undertaking a trial of hot debrief following all falls in Neurosciences and Specialist Surgery until the end of October. Following the discovery of breaches in a number of lead aprons used in WW Theatres, extensive support and actions has been taken, with active support from Medical Physics and Radiology.	will be made where indicated/requested. A safety message is also being produced in respect of all PPE, with both Trust and staff responsibilities in undertaking checks.

ISO 45001: 7. Support				
7.1 Resources	**7.2 Competence**	**7.3 Awareness**	**7.4 Communication**	**7.5 Documented information**
The Division has a number of H+S Champions across all Directorates however the number could be improved commensurate to the size of the Division Consideration is being given to creating a Violence and Aggression Lead, to act as a link/support to all teams.	A number of staff have completed training as Health and Safety Champions and managers continue to complete the Managing Health and Safety course as required.	The Divisional H&S group is attended by representatives from Directorates who share information within the Division and via H&S teams channel.		H+S documents are stored/shared via MS Teams channel and Divisional SharePoint.

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**
A business case to replace old, difficult to clean incubators on NNU has been approved. This replacement programme will be invaluable in the ongoing work on managing infection outbreaks in the unit.	Directorates continue to be encouraged to complete testing of business continuity planning.

CHECK
ISO 45001: 9. Performance evaluation

9.1 Monitoring, measurement, analysis and performance evaluation	9.2 Internal audit	9.3 Management review
N/A in this reporting period.	Although not included in the recent ISO 45001 audit on the Churchill site, a walk round and “mock” audit, using ISO structure was completed on Blenheim ward. This was a useful exercise which highlighted some opportunities to improve compliance with PAT testing and safe use of kitchen appliances in staff rest areas. This audit also showed areas of outstanding practice, particularly with fire plans.	N/A in this reporting period.
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
Estates issues on PCC continue to be the biggest environmental risk in the Division. Support from CNO, Director of Estates and Head of H+S has been very helpful in the proactive management of “quick fixes” – identification of alternative storage space, solutions for IT equipment management for example.	Review of incidents to identify themes and trends, with shared learning across all Directorates vis Steering Group.	Monthly Risk Register review.

6.5. Table 8: NOTSSCaN - new and emerging risks and opportunities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
Risk assessment currently being completed at Div level in respect of violence and aggression towards staff. The outcomes, timescale for completion etc will be populated once Risk Register is complete.							

SuWON report

6.6. Submitted by Ali Cornall, Divisional Director of Nursing; Dominic Balchin, Divisional Business and Project Manager; and Jane Kilbey, Advanced Clinical Governance Risk Practitioner.

6.7. SuWON Executive Summary

6.7.1. In Quarter Two the SuWON Division continued to see a large increase in the reported incidences associated with estates relating to sewage leaks, blocks and flooding. These incidents have predominantly been in the Women's Centre (including outpatients and the ward), Sobell House Hospice and Gastroenterology. These incidents have been raised at the Trust Estates Compliance Meeting and subsequently escalated to the Trust Director of Estates.

6.7.2. The clinical services are working with the relevant corporate OUH Teams to monitor, manage and mitigate where possible and appropriate.

6.8. SuWON report comments

6.8.1. The SuWON Division continue to emphasise the importance of robust risk assessment, escalation, and action planning. The Division continues to monitor estates / health & safety related risks through the Divisions monthly H&S Meeting and ensure H&S is reported ward to board. Given the estate's compliance issues the Division has widened the membership of the Divisional Health & Safety Meeting to include representatives from OUH Estates and the PFI to provide support on prioritisation and facilitate resolution.

6.9. Table 9: SuWON Division achievements

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	**4.2 Understanding the needs and expectations of workers and other interested parties**	**4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)**	**4.4 OH&S management system**
The Division continues to focus on achieving full compliance with Business Continuity Planning, across the services. This is a standing item at the Divisional Health and Safety Group to confirm assurance and share learning with two outstanding areas to address fully.	The SuWON Divisional H&S Group has become the forum for escalation of estates H&S related issues alongside significant issues of concern corporately such as Entonox and Dosimetry. This is underpinning reporting to the Trust Risk Committee, Trust Health & Safety Meeting, Capital Management Group and Trust Estates Compliance. Hence the Division has widened the membership of the Divisional Health & Safety Meeting to include representatives from OUH Estates and the PFI.	N/A in this reporting period.	In Quarter 3, the Division anticipates the completion of the fire and health and safety audits across the division along with the ensuing action plans which will become a focus for future meetings.
ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles responsibilities and authorities**	**5.4 Consultation and participation of workers**
The Divisional leads for Health and Safety continue to maintain oversight of H&S matters in the	N/A	The Maternity Directorate commissioned the services of an Occupational Hygienist in July to undertake a review of Entonox use across all OUH Maternity Services. The	The Divisional H&S group meets monthly and continues to provide an

Divisional and to lead on continued improvement of health and safety arrangements, supported by directorate H&S leads (OSMs and matrons) who share information throughout the division.		report issued in late September made the following recommendations. • Amendments to the existing Entonox SOP. • Additional SOPs that would be considered as necessary. • The upgrading / replacement of equipment used in each location. • Consideration of additional equipment/services that would be considered necessary. • Provide a report covering methodology assessment, and recommendations for Entonox testing The Maternity Directorate will be reporting progress against these recommendations via the Divisional Health & Safety Meeting.	effective forum for involving workers from management and non-managerial roles in the health and safety arrangements for the Division.

ISO 45001: 6. Planning	
6.1 Actions to address risks and opportunities	**6.2 OH&S objectives and planning to achieve them**
Entonox The SuWON Division has asked for all services using Entonox to commission Cairns Technology to undertake a baseline measurement of Entonox within their areas to establish if levels fall within the WEL guidelines. **Dosimetry** The Trust H&S Committee have escalated concerns regarding the local compliance with personal monitoring of radiation levels. The services were provided with a data extract showing compliance in key areas with a target agreed at 98%. The plan is to review this data every 6 months with services feeding back to improve the quality of the data.	The Division has reviewed H&S incidents as part of Divisional H&S meetings, and the DDoN has requested all department leads to ensure that responses to incidents include comments for how to prevent future recurrences. The DDoN requested all directorates to identify any local initiatives that have been developed within the Division that will support a Trust strategic objective (to reduce incidents by 10% year on year).
ISO 45001: 7. Support	

7.1 Resources	7.2 Competence	7.3 Awareness	7.4 Communication	7.5 Documented information
No update in this reporting period.	Staff from across the Division have completed training as H&S champions and managers have completed the Managing Health and Safety training when required.	Abuse violence and harassment has continued to be closely monitored and learning shared across the Division. An escalation pathway has been established to provide timely enhanced observation and provision of specialist mental health staff to support.		All H&S documentation has been retained in the Divisional MS teams channel, providing better access for all.

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**
The Division is undertaking a review of the estates considering the Self-Harm by fall from height risk assessment. This will be addressed via the Divisional Health and Safety Group – planned walk around of all areas by services including access to roof spaces by ladder or door, window compliance. The corporate Risk will be then added to Divisional Risk Register with additional information.	Whilst compliance has improved during the reporting period, directorates continue to be encouraged to complete testing of business continuity planning. This remains a standing agenda item for monthly Divisional H&S Group meetings.

CHECK		
ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**
The ISO 45001 audit at the Churchill site (July ’23) included a number of SuWON departments, all of which demonstrated robust health and safety arrangements.	The Divisional Business & Project Manager along with the Maternity OSM undertook an ISO / H&S inspection of the Maternity Led Units in the summer.	applicable in this reporting period.

There were no non-conformities raised against the Division.	The Divisional Advanced CRGP undertook a number of inspections including Gastroenterology and Gynaecology. Key consistent issues have been identified and fed back to each service and escalated through the divisional health and safety group.	
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
Estates Arising from the H&S inspections it became evident that remedial estates works were being closed by the Estates Helpdesk without the issue being fully resolved. This was flagged with the intention of improving communication between estates and the clinical areas.	**Entonox** The SuWON Divisional Business & Projects Manager continues to lead the Maternity Delivery Suite Nitrous Oxide & Ventilation Task and Finish Project group. The Entonox Central Destruction Unit and AGSS is planned to be operational January 2024.	The Division will continue to work with the Estates team to improve responses to H&S inspections.

6.10. Table 10: SuWON - new and emerging risks and opportunities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
Violence & Aggression – The division continue to report of violence and aggression particularly within Gastroenterology and continuing in the RTU, Gynae and Surgery Directorates. Reported via Ulysses – to Board via Clinical Governance Committee and Health and Safety Committee.	Training of staff to manage physical and verbal abuse to protect themselves and other/ de-escalate situations. Aim to empower staff to manage situations and protect others on periphery of situation. Clear escalation pathways to: • Staffing - enhanced observation, mental health staff • Expert support from Security • Escalation of Zero Tolerance Policy • Use of Body cams. Management of physical/ psychological wellbeing of staff members – Implemented Staff debriefs – exploring use of Schwartz Rounds.	Yes	Commonly the services experience a cluster of incidents related to a single patient/ visitor which requires activity related to all measurable outcomes. In the event of a single event local action may require that the outcome measure/ action is tailored to	Underway – December 2023	Matrons will co-ordinate action plans	Ulysses completed – emerging themes / cohorts of incidents escalated to Divisional Nurse and reviewed. Local Action plans monitored through Divisional H&S Group	

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
	Medical management plans for patients where there are underlying causes. Care planning for individual cases. Local SOPs for teams who work as isolated workers.		focus on specific aspects of management of the situation.				

Fire Safety Report

6.11. Submitted by Russell Adlam, Trust Fire Safety Manager (FSM).

6.12. Fire Safety - Executive Summary

6.12.1. The FST have continued to deliver the fire risk assessment programme and reviews across the Trust. The implementation of the 2023/24 Capital Plan includes projects to address priority locations and is having a positive risk reduction.

6.13. Fire Safety report comments

6.13.1. The Fire Safety Team (FST) have continued to support a number of key capital projects including the fire remedial works at the Horton Medical Block and John Radcliffe Blocks 9 and 6. The FST continue to be engaged in planning for the new proposed JR2 Block 9 Helipad and new Theatre building and have been in early discussions with the project managers and designers to gain assurance of design specification and strategy in accordance with HTM 05 suite of documents.

6.14. Table 11: Fire Safety Team (FST) achievements

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	**4.2 Understanding the needs and expectations of workers and other interested parties**	**4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)**	**4.4 OH&S management system**
The FST team has continued to align fire safety strategy and planning with the Trust's assessment and prioritisation of fire safety risks and the plans and funding to address these.	The Trust FST have been working with the Trust PFI Contracts Team to replicate the successful model of the JR PFI Collaborative Fire Safety Group across the other PFI sites at the Churchill and NOC. The group is an open forum for safety discussions to take place prior to contractual meetings.	N/A in this reporting period.	The FST has continued to maintain and, where required, to improve, fire safety processes required by the OHSMS, particularly to ensure departmental fire safety risk assessment are in place and up to date.
ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles, responsibilities and authorities**	**5.4 Consultation and participation of workers**
The Fire Safety Manager has continued to lead the direction of fire safety planning and actions to address issues during the reporting period. In the absence of an appointed external Authorising Engineer (Fire), the FSM has been able to utilise the expertise of the team's Senior fire Safety Advisor.	N/A in this reporting period.	The Fire Safety Manager is working with Deputy Director of Capital and the Procurement team to appoint a new Authorising Engineer (Fire) as the external independent expert to support the Trust under Health Technical Memorandum (HTM) 05.	The FST has continued to provide advice and support to teams across the Trust, often in situ in departments, where the fire safety measures can be discussed with staff and workers' insights and operational issues are incorporated to fire safety measures such as emergency procedures.
ISO 45001: 6. Planning			

6.1 Actions to address risks and opportunities.	6.2 OH&S objectives and planning to achieve them
Upon completion of fire risk assessments those risks that do require escalation continue to be escalated via the relevant Risk Register/s.	The departmental fire safety audit is now live on Ulysses. Departments are required to complete the audit on the 12-month expiration date of their old paper version. This change enables the digital data to be used to support Divisions in line of sight and in maintaining compliance for fire safety.

ISO 45001: 7. Support			
7.1 Resources	**7.2 Competence**	**7.3 Awareness** **7.4 Communication**	**7.5 Documented information**
The Fire Safety Manager is progressing the employment status from NHSP to a OUH contract for the Senior Fire Safety Advisor. The post holder provides an essential resource for the FST, and a level of expertise not commonly found within a Trust fire advisor role.	The FST has continued to provide training for Fire Incident Coordinators and Fire Marshals and has supported the ongoing provision of the Core Skills Fire Safety course required for all new starters and as refresher training for existing staff.	The FST has attended a wide variety of meetings and provided information by a variety of other means to ensure relevant staff are aware of fire safety requirements, updates and risks and to provide suitable communications about these.	Fire safety Policies and Procedures, as well as guidance documentation has been migrated to the new SharePoint Fire safety Intranet site.

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**
The FST has conducted fire safety inspections of external and internal areas of the Trust, to monitor that operational controls are effective. Where hazards or nonconformities have been noted, these have been addressed with the relevant parties, including with Estates and Facilities teams for infrastructure such as fire hydrants.	The FST has continued to liaise with all relevant parties, including Oxfordshire Fire and Rescue Service (OFRS) to develop, implement and practice emergency preparedness and response measures. The FST has supported the Estates and Facilities team for a review of fire hydrants at the Horton, Churchill and JR sites.

CHECK		
ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**
The FST has routinely monitored fire safety risks to ensure, so far as possible, that suitable mitigation are in place and that plans to eliminate or further reduce these risks are in place. The FST has evaluated the performance of current fire safety measures, including the accuracy of reporting to the Trust from external contractors (e.g., for location and functionality of fire hydrants) – this work is ongoing and updates will follow in future reporting.	The departmental fire safety audit is now live on Ulysses. Departments are required to complete the audit on the 12-month expiration date of their old paper version. This change enables the digital data to be used to support Divisions in line of sight and in maintaining compliance for fire safety.	N/A in this reporting period.
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
The FST has reviewed and improved the Fire Safety Intranet site. The new SharePoint site supports improved user experience, easier access to information and enables the site to be updated quickly with current news and links to external sites of interest.	The FST conducted planned evacuation testing in the NOC Theatres and identified deficiencies in the response to alarm activations by the PFI Security desk. Supported by the Director for PFI Service Delivery, a digital system and process improvement has been agreed to be installed to eliminate the risk. Immediate mitigations were implemented and remain in place until completion of the works.	N/A in this reporting period.

6.15. Table 12: Fire Safety Team - new and emerging risks and opportunities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
The FST identified and are working with the Trust Estates team to ensure several fire hydrants on the CH and JR sites are returned to operational use after external reports highlighted the deficiencies.	All designated fire hydrants on OUH site must be working to their intended specification and maintained as such.	Yes.	The provision of fire hydrants allows attending fire crews to access water on OUH premises in a fire. The lack of access could delay or prevent crews ability to tackle a fire.	1 month.	Retained Estates.	Record of successful testing for all OUH managed fire hydrants.	TBC.

Fit Test Team Report

6.16. Submitted by Phil Salisbury, Senior Project Manager (SPM), Fit Testing.

6.17. Fit Testing - Executive Summary

6.17.1. The current situation for Fit Testing is addressed in this report to include an update to the current situation regarding Department of Health and Social Care (DHSC) resilience principles for Fit Testing (there should be at least two masks for each staff member requiring FFP3 standard masks, and mask(s) to be retested every two years).

6.17.2. The FFT team has worked in collaboration with the Infection, Prevention and Control Team following the Trust being granted High Consequence Infectious Disease (Airborne) status.

6.17.3. Data to support the resilience principles are available at Appendix A.

6.18. Fit Test report comments

6.18.1. The Fit Testing team had their technician return from maternity leave, but with a change from full time to a part time basis only. Efforts continue to increase the percentage of staff on two or more FFP3 masks in line with the DHSC resilience principles.

6.18.2. 50% of staff that have had a Fit Test are certified to two or more masks and efforts continue to bring in those who require recertification as well as continuing to fit test new starters.

6.18.3. The Team have been working closely with Infection Prevention and Control (IP&C). With the Trust granted High Consequence Infectious Disease (Airborne) status, the Trust could see an increase in patients with transferrable respiratory diseases. Areas identified by IP&C Team where there will be a need to have up to date fit testing to ensure staff remain as safe as possible at work, include the Emergency Department, John Warin Ward and Oxford Critical Care. The Fit Test Team Senior Project Manager (SPM) has worked with these areas to monitor compliance and to assist with increasing compliance. The FFT diary is fully booked for the next four weeks (October 2023) at all sites in consequence.

6.19. Table 13: Fit Test Team achievements

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	**4.2 Understanding the needs and expectations of workers and other interested parties**	**4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)**	**4.4 OH&S management system**
Fit Testing continues across the Trust. The SPM has continued to work with The OxSCA and My Learning Hub (MLH) teams to ensure Fit Testing records become more readily available. It is hoped that in next quarter there will be new courses available re Fit Testing that	The SPM liaised with medical staffing re new doctors starting and their requirements for Fit Testing. The Fit Testing team assisted some new doctors to get appointments that were struggling to book via the appointment booking website.	NA in this reporting period.	NA in this reporting period.

will be available to managers to review and comment on.	The SPM has been liaising with Mitie about the need for their night and weekend shift workers to get fit tested. A plan to action this next quarter is in negotiation.		
ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles, responsibilities and authorities**	**5.4 Consultation and participation of workers**
The Head of Health Safety continues to provide leadership for the FFT team to ensure the team's role and function within the Trust is maintained and to support the team to share expertise accumulated within the team, for example to collaborate and provide guidance to national and local external networks and internal collaborations with IP&C.	NA in this reporting period.	NA in this reporting period.	The FFT worked in conjunction with the OxSCA team regarding their new audit and involved them in discussion surrounding the correct questions regarding Fit Testing that should be included within the audit.
ISO 45001: 6. Planning			
6.1 Actions to address risks and opportunities		**6.2 OH&S objectives and planning to achieve them**	
As well as supporting high priority areas across the Trust, the Team has continued to assist departments with increasing their Fit Test compliance. An example of these areas is Laburnum as well as Neuro Red and Green. Compliance in these areas has increased.		No updates in this reporting period.	
ISO 45001: 7. Support			
7.1 Resources	**7.2 Competence**	**7.3 Awareness & 7.4 Communication**	**7.5 Documented information**

The Head of Health Safety has ensured that staffing is kept at a suitable level and supported the team by ensuring funding is available to keep all equipment configured and working to the correct standard.	One Fit Tester and the SPM are British Safety Industry Federation (BSIF) accredited Fit Testers with the other Fit Tester looking to be accredited soon. All the team are up to date with their core skills and role specific tasks on MLH	As a result of the communication between IP&C, the Fit Testing SPM and Ward Managers the appointments diary is fully booked, and the SPM is looking at offering dedicated days for key areas such as ED and OCC to be held in their own space. Communication with ward managers has increased so that they are reminded that those wearing FFP3 masks should be successfully tested to two masks and be retested every two years. Communication with Mitie and other agencies continues to raise awareness of the need for fit testing.	No significant updates to FFT documentation within this reporting period.

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**
Operation planning has focused on ensuring that staff members requiring FFP3 standard masks, have been tested to at least two masks and are retested every two years. and encouraging areas to engage in this and send their teams for retesting when required. As part of that, adding questions to OxSCA audits has increased the visibility of fit testing and has resulted in more staff members returning for retesting.	No updates in this reporting period.

CHECK		
ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**

Data is supplied to MLH so that performance against the DHSC resilience principles can be observed to see that improvements are being made. Currently the compliance (Two masks – Two Years) with the resilience principle of staff being Fit Tested to two or more masks stands at 50%.	Fit Testing questions now appear in the COSHH element of the annual H&S Audit. Fit Testing questions also appear on the OxSCA Audit. Both audits are in progress, so no outcomes or data are currently available but updates to follow in future reporting.	Not applicable in this reporting period
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
No updates in this reporting period.		

6.20. Fit Test Team - new and emerging risks and opportunities

6.20.1. There are no new or emergent risks to report for this period.

Infection, Prevention and Control (IP&C) Report

6.21. Submitted by Lisa Butcher, Lead Nurse and Manager IP&C.

6.22. IP&C - Executive Summary

6.22.1. The number of sewage leaks / events across the organisation, particularly In the Women's Centre, is becoming increasingly concerning from a staff and patients' perspective.

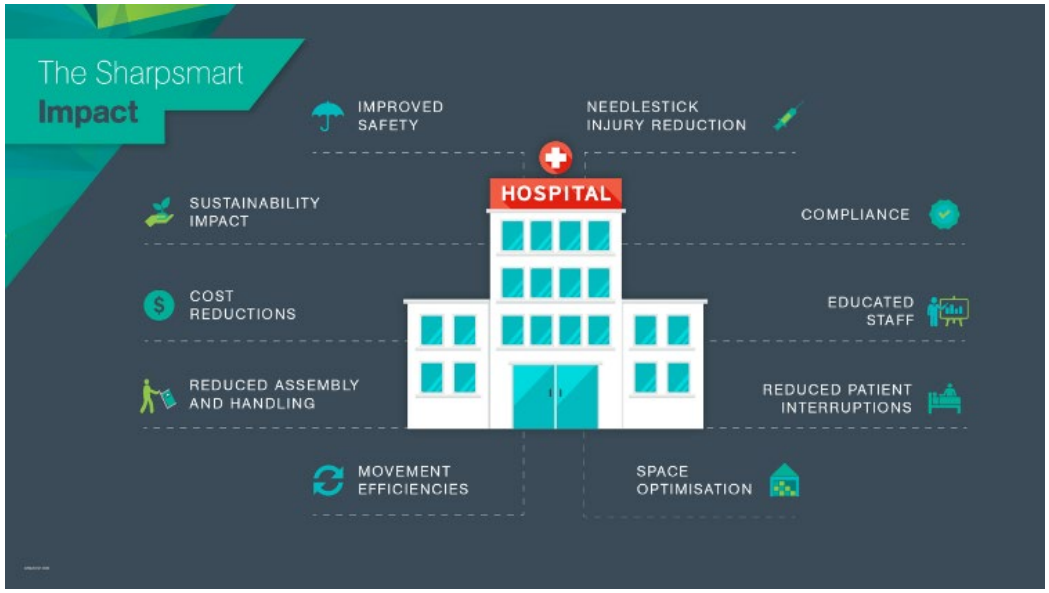
6.22.2. Sharp safety- A number of sharps injuries occur during disposal. IPC are working with key stakeholders to initially launch 'Sharpsmart' at the Horton General Hospital. Sharpsmart has evidence to demonstrate reduction of sharps injuries compared to our current disposal method. The sharps audit has been updated on the Ulysses system to (a) review sharp safety practice (b) consider environmental matters such as lighting, container placement, based on the RCN guidance.

6.23. IP&C report comments

6.23.1. It is not clear what the extent of the problem is but anecdotally appears to be an increase in the number of events of sewage related issues. Ulysses has been interrogated and reports 32 incidents, 16 of which have been reported by gynaecology over last 12 months. It is evident that not all incidents are entered onto Ulyssess. Senior nursing staff report that staff are afraid and anxious about working in an environment where sewage leaks are now a regularly event. From a patient safety perspective, clinical areas have been taken out of action impacted on ability to treat patients.

6.23.2. Estates are working to identify the extent of the issue and what mitigation can be taken to in the first instance reduce the risk of incidents in the short term and secondly what works will be required to ensure that waste systems are able fit for purpose.

6.23.3. A site visit of the Horton General Hospital with key stake holders (procurement, estates, clinical team and IPC) was conducted to assess feasibility and clinical engagement. Reasons for the proposed switch are for sustainability, safety and reduction in spend on sharps disposal. A paper is being prepared to present the case for moving to a reusable sharps (and pharmaceuticals) disposal method. The sharps audit has been updated on the Ulysses system to (a) review sharp safety practice (b) considers environmental matters such as lighting, container placement, based on the RCN guidance.



6.23.4. The water safety engineering works are at the Churchill are now completed and there is a period of surveillance in progress which includes monitoring temperatures for compliance. Point of use filters (POUF) remain in place. Once there is confirmation that the temperatures are compliant then a new legionella sampling programme will be agreed. It is unlikely that the POUF will be removed until the end of next year.

6.23.5. The OUH has been granted High Consequence Infectious Disease (Airborne) status. A specialist nurse will be appointed who will be responsible for training programmes. IPC/H&S are working collaboratively in this project.

6.24. IP&C - new and emergent risks and opportunities

6.24.1. There are no new or emergent risks to report for this period.

PFI Contracts Team Report

6.25. Submitted by Cleo Hadfield, PFI Contracts Compliance Manager.

6.26. PFI Contracts Team - Executive Summary

6.26.1. The PFI team is currently working on improving the H&S management systems and information reporting. They are in touch with the Facilities Management (FM) Providers to achieve the best results. However, there are still challenges with G4S Churchill in obtaining sufficient investigation reports for Ulysses incidents raised, which is affecting the quality of information and data to support various investigation reports. The PFI team is working collaboratively with all parties to resolve this.

6.26.2. The NOC SIRI (327920) issue, which has been ongoing since the generator malfunction caused by a power outage in June, is still being addressed. An action plan is being developed and put into action to enhance communication and resilience throughout the OUH, including all PFI's.

6.27. Table 14: PFI Contracts Team – achievements

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	**4.2 Understanding the needs and expectations of workers and other interested parties**	**4.3 Determining the scope of the Occupational Health & Safety**	**4.4 OH&S management system**

		Management System (OHSMS)	
In this period, the Churchill PFI H&S group meetings have been reviewed, and the ToR refreshed to match those across the OUH.	The PFI team has actively engaged with the FM Provider to adopt the Health & Safety Champion Model to encourage their staff to take ownership of their areas.	N/A in this reporting period.	The H&S Management system has continued to be developed in line with the requirements of ISO 45001. Including engagement with the Churchill and John Radcliffe PFI FM providers in preparation for audits in 2023/24.

ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles, responsibilities and authorities**	**5.4 Consultation and participation of workers**
Minimum quarterly meetings and monthly tours of the PFI H&S Groups have commenced a formal collaboration process with PFI Contracts for H&S matters.	No updates in this reporting period.		The PFI H&S Group for the NOC is being re-evaluated. TOR is to be amended and agreed upon to guarantee discussions around the H&S at Work Act and staff welfare is a priority.

ISO 45001: 6. Planning	
6.1 Actions to address risks and opportunities	**6.2 OH&S objectives and planning to achieve them**
The PFI team have planned to include a regular review of the Risk Register in their meetings, ensuring risks remain relevant and working through the action plans.	Planned improvements to the H&S Management systems across the PFI Contracts to include extra assurance, particularly around evidence of internal audits and site-specific risks.

ISO 45001: 7. Support				
7.1 Resources	**7.2 Competence**	**7.3 Awareness**	**7.4 Communication**	**7.5 Documented information**

No updates in this reporting period.			A Standard operating procedure has been developed for internal review; to provide access to the OUH Trust Ulysses platform by the third-party PFI Facilities Management (FM). Allowing the opportunity to identify, respond to, manage, and learn from incidents reported. Providing transparency and accurate reporting of H&S throughout the OUH Trust.	While access to the Ulysses system remains in discussion around the solution, the PFI team are logging all PFI-reported incidents on the system on their behalf to provide transparent reporting. There were 56 reported in the last quarter.
DO				
ISO 45001: 8. Operation				
8.1 Operational planning and control			**8.2 Emergency preparedness and response**	
The PFI Partners have successfully encouraged their staff to report hazards and near misses during their workday to prevent accidents. This has resulted in an increase of reported hazards in the quarter, with a total of 612 across the three sites.			An action is currently being developed by the NOC SIRI to review all PFI BCPs and escalation processes to ensure they are linked with the Trust's, as well as creating joint trigger points for operational and clinical impacts.	
CHECK				
ISO 45001: 9. Performance evaluation				
9.1 Monitoring, measurement, analysis and performance evaluation		**9.2 Internal audit**		**9.3 Management review**
The Health and Safety reports, action trackers, and Duty Holder Matrix documents are regularly reviewed for compliance. Any items requiring escalation or resolution are discussed in quarterly PFI H&S Groups.		When the BCPs have been reviewed amended and reissued, the PFI team will request details per Service of tested plans throughout the year to		No updates in this reporting period.

	understand compliance and lessons learnt.	
ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
updates in this reporting period.		

6.28. PFI Contracts Team - new and emergent risks and opportunities

6.28.1. There are no new or emergent risks to report for this period.

Radiation Protection Committee Report

6.29. Submitted by Helen Amatiello, Head of Imaging and Non-Ionising Physics.

6.30. Radiation Protection Committee - Executive Summary

6.30.1. Radiation Protection Committee met on 27th April 2023, in the interim key issues have arisen.

6.30.2. Successful Environment Agency inspection with no non-compliances.

6.30.3. Revised HSE IRR17 Consent process from 2nd October 2023 for high-risk radiation practices. Trust must be ‘inspection ready’.

6.30.4. Use of ISO 45001 project established Divisional Health and Saaty committee structure to engage improved compliance with radiation dosimeter wearing.

6.31. Radiation Protection Committee report comments

6.31.1. RPC met on the 27th April and 10th October 2023, chaired by Rustam Rea, deputy CMO. Meetings are outside the reporting period of 1st July to 30th September 2023, however there are key points to note in the interim.

6.31.2. There was a successful Environment Agency routine inspection on 1st and 2nd August 2023. The inspectors reviewed JR and Ch facilities, inventories and monitoring records, security and the management system for radioactive sources, training records

and appointments, testing compliance with the issued Permits under which the Trust is permitted to operate services involving radioactive sources.

6.31.3. No non-compliances were found but the inspectorate made minor recommendations and observations regarding the wear and tear of facilities that will require closure by the Trust.

6.31.4. Risks surrounding radiation dosimeter compliance and culture have been previously raised. Sought engagement from Divisional Health and Safety committees to involve managers/leadership in the assurance process for their individual directorates/departments. If successful, then this should significantly improve compliance gaps. Also highlights positive outcome from ISO 45001 project in the setting up of these sub-committees to allow this escalation.

6.32. Table 15: Radiation Protection Committee – achievements

PLAN			
ISO 45001: 4. Context of the organisation			
4.1 Understanding the organization and its context	**4.2 Understanding the needs and expectations of workers and other interested parties**	**4.3 Determining the scope of the Occupational Health & Safety Management System (OHSMS)**	**4.4 OH&S management system**
No updates in this reporting period.			

ISO 45001: 5. Leadership and worker participation			
5.1 Leadership and commitment	**5.2 OH&S policy**	**5.3 Organizational roles, responsibilities and authorities**	**5.4 Consultation and participation of workers**
Significant theme relating to use and compliance of wearing PPE identified.	Divisions (MRC, SUWON, CSS) must ensure management responsibility of IRR17 Classified workers are effective. Health records must be maintained with	No updates in this reporting period.	

1. Wearing of physical PPE: compliance improved since last report 2. Finger dosimeter stall review following communications with HSE: Data in analysis pending report, but initial analysis shows that Trust can remove use of finger stalls for some staff groups with supporting control processes in place. 3. Overall, Trust- wide badge wear compliance: IRR17 requires the Trust to demonstrate that staff radiation doses are below the legal limit. Some staff groups have radiation badges issued to record their radiation doses where indicated. Classified staff must wear radiation badges. The trend of badge wear compliance issues continues without resolution. Several	timely attendance of staff at Appointed Doctor medicals at the Centre for Occupational Health. Advice being sought on most effective and compliant digital method to store data.	

avenues have been explored in the past to increase compliance and have not been achievable or have had little quantifiable improvement of compliance. Compliance and audit reports are now being shared with Divisional H&S meetings for managerial oversight and action.		

ISO 45001: 6. Planning	
6.1 Actions to address risks and opportunities	**6.2 OH&S objectives and planning to achieve them**
IRR1IRR17 consent safety assessment The HSE are requiring Consent holder for higher risk radiation work to reapply for consent under a different more robust process from 2nd October 2023. Risk to service should departments not pass the scheme and awarded revised Consent to practice (Services affected: external beam radiotherapy, HDR therapies, radio pharmacy, Diagnostic and therapeutic nuclear medicine). Action plan in place being led by Trust Radiation Protection Advisers but affected departments must work to assure necessary compliance against IRR17. Significant risk to the Trust as failure of process would risk immediate service suspension pending document resubmission. Funding required for cost of application being circa £5000 *per service*, to be paid when safety assessment application made. Service managers made aware of this funding requirement. HSE will invite Trusts to submit Sas over next 5 years. Trust should be 'inspection ready'	No update in this reporting period

ISO 45001: 7. Support				
7.1 Resources	**7.2 Competence**	**7.3 Awareness**	**7.4 Communication**	**7.5 Documented information**
Statutory advisory teams are significantly under resourced and are operating at levels below the nationally defined standard to be able to properly support the Trust. The risk from Imaging Physics and radioisotope Physics resourcing remains on the Risk register. Dangerous Goods Safety Adviser (DGSA) risk now resolved. The provision of Radiation Protection support to Radiotherapy is not properly resourced which is exacerbated by parallel service expansions. Support will be required to ensure that Classified worker training is made essential to role under Core Skills policy.	No updates in this reporting period.			

DO	
ISO 45001: 8. Operation	
8.1 Operational planning and control	**8.2 Emergency preparedness and response**

Classified Worker: The Centre for Occupational Health and Radiation Protection Advisers training modules to ensure adequate training in place so responsibilities understood by staff and managers. Classified Worker medicals have been actively appointed by Centre for Occupational Health with evidence of poor attendance from some staff groups. Staff cannot work in areas requiring classified workers if their medical has lapsed. Issues at recruitment also identified where communication to Centre for Occupational Health of intention to employ classified workers not being made. RPAs and Centre for Occupational Health identified need to role-based training of Classified workers and managers to ensure their regulatory responsibilities and are clear. Will seek support of Trust to assign this training as role-based under Core Skills Policy. Divisions (SUWON, CSS, MRC) must ensure that health records are held for Classified workers.	No updates in this reporting period.

CHECK		
ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**
CSS Division must check compliance with PPE for staff working with unsealed sources at JR and Churchill sites. Divisions to assure badge wear compliance via Divisional Health and Safety committee framework.	No updates in this reporting period.	
ACT		
ISO 45001: 10. Improvement		

10.1 General	10.2 Incident, nonconformity and corrective action	10.3 Continual improvement
Divisions must ensure that personal radiation dosimeters are worn and returned as specified and communicated to Divisional H&S meetings. Divisions must ensure that PPE is worn as directed for Classified workers at risk of high radiation doses from accidental splash or needle stick injury.		Radiation Protection Advisers and Centre for Occupational Health to collaborate on project to develop role-based training for classified workers and managers.

6.33. Table 16: Radiation Protection Committee - new and emergent risks and opportunities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
Active closure of EA inspectorate recommendations and observations regarding the wear and tear of facilities.	Closure of actions	May require capital support	EA will follow up these recommendations at next planned inspection (Summer 2024). They will expect closure. If not closed, they will	6-months	Nuclear cardiology (MRC) and Radiology (CSS)	Full closure of recommendations in action plan	Active closure of EA inspectorate recommendations and observations regarding the wear and tear of facilities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
			be considered non-compliances.				

Security Report

6.34. Submitted by Rachel Collins, Trust Security Manager.

6.35. Security Team - Executive Summary

6.35.1. The Security report provides an update on incidents attended by Security year to date in 2023/24 detailing Quarter 2 and highlights trends or issues of particular concern.

6.35.2. The number of Security Officers on duty are not sufficient to deal with the number of incidents and act as a pro-active service. This can result in a delay in response times to incidents.

6.36. Security Team report comments

6.36.1. Year to date 2023/24 Security Officers have attended 849 incidents of physical aggression, verbal abuse, people removed from site, absconding patients, and theft across the Trust, which is a 14% increase over the same period last year.

6.36.2. During Quarter 2 Security Teams attended 405 incidents in those categories of which 329 (or 81%) were to deal with some form of unacceptable behaviour or aggression, which is an 18% increase over quarter 2 last year. A further 63 incidents were due to patients who had absconded from their ward and there were 18 reported thefts. In addition to these figures Officers

have also attended 194 incidents where patients were attempting to abscond but lacked the capacity to be allowed to leave the hospital; and were called proactively on 242 occasions where staff feared that a situation may develop into an aggressive incident.

6.36.3. In October 2021 the Trust's Security Manager investigated and reported to the Police a case of a former Trainee Anaesthetist who had been returning to the JR and fraudulently gained access into various drug rooms to steal CDs claiming to still be a doctor here. The Security Manager has pursued this case for just under 2 years, liaising with the Police and providing statements, CCTV and access to records, and the former employee has finally appeared in court, pleading guilty to 7 charges. He is due in Crown Court for sentencing in November 2023.

6.37. Table 17: Security Team – achievements

ISO 45001: 6. Planning	
6.1 Actions to address risks and opportunities	**6.2 OH&S objectives and planning to achieve them**
There was a break into the Gas Store at the Horton resulting in the theft of 7 Nitrous Oxide Cylinders. Although the security of the store was robust, extreme measures were used to gain entry. CCTV footage has been handed to the Police in which the vehicle used and one of the offenders were identifiable. Further reviews have been conducted on the gas stores on the other sites, however the planned removal of all Nitrous Oxide cylinders would be the best option. Security Teams are working proactively on both mobile patrols and using CCTV to try and address spikes in both bicycle and moped thefts on the Headington sites. A number of thefts have been disrupted, but the gangs carrying out the thefts have been persistent. Security are working closely with the Police, providing CCTV, sending out communications and advice to staff to try and combat the crimes.	No updates in this reporting period.

ISO 45001: 7. Support				
7.1 Resources	**7.2 Competence**	**7.3 Awareness**	**7.4 Communication**	**7.5 Documented information**

The Managing Violence, Aggression and Abuse Procedures are currently under review. It is planned to re-name them as Violence Aggression and Abuse Reduction and Management Procedures to reflect aims to reduce such incidents. The procedures include a more robust escalation in available warning letters that can be send to perpetrators of unacceptable behaviour.	All the Security Officers working within the OUH have now received physical intervention training that is accredited as compliant with the Restraint Reduction Network Guidance requirements. The security Manager has continued to attend staff training and away days to talk about staff safety, dealing with aggression, the role of and how to use Security, and the importance of reporting V&A incidents in order to be able to deal with perpetrators more robustly under the Violence, Aggression and Abuse Procedures. NB – these are information and discussion groups and are not a substitute for conflict management training.	No updates in this reporting period.		

CHECK		
ISO 45001: 9. Performance evaluation		
9.1 Monitoring, measurement, analysis and performance evaluation	**9.2 Internal audit**	**9.3 Management review**
The number of Security Officers on duty are not sufficient to deal with the number of incidents and act as a pro-active service. This can result in a delay in	No updates in this reporting period.	

response times to incidents, particularly when there is more than one incident happening simultaneously, increased staff vulnerability and a perception of reduced staff safety. There are currently 4 Officers and a CCTV Operator at the JR, two Officers at the HGH and one Officer at the CH under the main Security Contract. There is one Officer at the NOC under the PFI. The security Manager made a recommendation to increase the JR complement by to six Officers. This was not approved, and there is no current business case going through, however the Security Manager have been asked to update the recommendation paper.	

ACT		
ISO 45001: 10. Improvement		
10.1 General	**10.2 Incident, nonconformity and corrective action**	**10.3 Continual improvement**
No updates in this reporting period.	The Security Manager has contacted all the staff affected by incidents of non-medical related violence and aggression to check on their welfare and to offer support if they want it. This quarter the Security Manager sent 18 warning letters and issued 5 acceptable behavioural agreements to individuals who have acted in an unacceptable way towards Trust staff.	No updates in this reporting period.

6.38. Security Team - new and emergent risks and opportunities

6.38.1. The numbers of Security Officers present a risk as described in the report above at Para. 9.1.

Centre for Occupational Health and Wellbeing (COHWB) Report

6.39. Submitted by Dr Alina Morhan MD MFOM, Lead Consultant Occupational Physician, Centre for Occupational Health and Wellbeing.

6.40. Centre for Occupational Health and Wellbeing - Executive Summary

6.40.1. Control of Substances Hazardous to Health (COSHH) Regulations 2002: HCW Winter Flu Vaccination Campaign is currently underway. HCW's are able to receive influenza and covid 19 vaccination via 250 peer vaccinators and scheduled outreach across the 4 hospital sites. The campaign runs 25th September to 31st December 23.

6.40.2. The Sharps Safety Group has been reconvened to monitor compliance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

6.40.3. Ionising Radiation Regulations 2017 - IRR medical surveillance is underway. Due to the increased numbers eligible we have made improvements to the operational aspects of this programme for this year.

6.41. Centre of Occupational Health and Wellbeing Team report comments

6.41.1. The report focuses on compliance with regulatory framework and on current winter vaccination campaign. The related items are addressed in the risk table below.

6.42. Table 18: Centre of Occupational Health and Wellbeing - new and emergent risks and opportunities

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
Control of Substances Hazardous to Health (COSHH) Regulations 2002:							

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
1. Winter Staff Vaccination Campaign - HCW Influenza and COVID-19 vaccination	% frontline staff with patient contact vaccinated	Yes	Risk of transmission of seasonal flu/COVID-19 virus to vulnerable patient groups and HCW.	As per national schedule	250 peer vaccinators and scheduled outreach clinics across the 4 hospital sites.	CQUIN standard: 80% See Appendix B: Winter vaccination update Appendix B:	
2. Work related COVID –19 Infection	% work related COVID-19 infections in HCW/less sickness absence related to COVID-19	Yes	Risk of HCW and then possible onwards patient infection due to work related exposure to COVID-19	On-going	COHWB continue to update COVID-19 risk assessments guidance and screen for high risk cases with advice to the individual and the manager.	Winter vaccination update for current figures: ~25% flu ~15% COVID	
3. Health and Safety (Sharp Instruments in	Number of contamination incidents	Yes	Incidence levels remain broadly the same year on	On-going	COHWB Report to Sharps Safety Group (reconvened by	No work related COVID-19	

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
Healthcare) Regulations 2013 (Contamination incidents)			year with some hotspot areas identified i.e. SUWON have seen a significant increase in NSI during the last 6 months.		COHWB May 23) and Infection Control Committee	infections in HCW	
4. Health Surveillance for Respiratory Hazards	100% relevant staff engaged in respiratory health surveillance	Yes	Work related respiratory disease not detected. Failure of organisation to meet legal duties	On-going	COHWB/managers/exposed staff	Decrease in number of contamination incidents See **Appendix C:**	

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
5. Skin health surveillance programme	100% relevant staff engaged in skin health surveillance	Yes	under COSHH 2002. Risk of occupational skin disease not being detected, leading to staff ill health. Failure of organisation to meet legal duties under COSHH 2002. Paper outlining recommendations for a suitable system of skin health surveillance presented to H&S Committee and to CWiLT. As per	On-going	Further work is being undertaken to identify roles and responsibilities of the programme e.g., competent persons and line managers.	**Staff Exposures to Body fluids and Infectious Diseases – Bi- Annual Report April 2023 to September 2023** or bi-annual report No cases of work related respiratory disease No cases of work aggravated skin disease	

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
			HSE guidance involves introduction of a system of skin health checks at appraisal by a competent person				
Ionising Radiation Regulations 2017 Statutory medicals for classified workers working with Ionising radiation	100% classified workers engaged in health surveillance	Yes	Statutory requirement/legal compliance and potential harm to health for HCW exposed to Ionising Radiation at work. The 2023 medical surveillance for IRR is running well. Improvement required re-	Before starting classified role and then on a yearly basis	COHWB/managers/classified workers	100% compliance with statutory medicals	

New and emerging risks Please highlight cells below to show risk level: Low / medium / high	Measurable outcome	Is this achievable?	How is this relevant?	Timescale for completion	Who needs to carry out the actions?	What evidence / success criteria is required?	Action completed and evidenced (date and details)
			training for classified workers re – radiation work, manager awareness re – waiting for medical assessment for new classified workers prior to starting classified work and storing health records.				

7. Recommendations

7.1. The Trust Board is asked to note the contents of the report.

8. Appendices

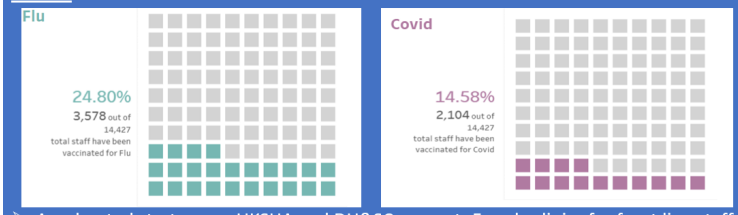
Appendix A: Fit Testing Figures for Q2 2023

MLH Figures		
Mask Pass Rates	8835+, 9330+, F31000, FSM18, HX-3, Force 8 & 10	
Total passes on MLH	**6,832**	**100%**
Individuals with 1 pass	3,432	50%
Individuals with 2+ pass	3,400	50%
No. of Masks Staff have currently passed fit test on	**FFP3 (disposable) & Force 8/10 (reusable)**	**FFP3 Only**
1	3,432	3,159
2	1,872	1,635
3	1,167	1,064
4	356	331
5	5	0
Grand Total	**6,832**	**6,189**

Appendix B: Winter vaccination update

Winter Vaccination progress to date

Staff



- Accelerated start as per UKSHA and DH&SC request- 5 early clinics for front line staff
- Dedicated vaccination clinics offering flu and covid, bookable, delivered by winter vaccine team, on **all sites** (including satellite units and Katherine House)
- Over 100 ward-based vaccinators offering flu, and a further 20-30 completing training.
- Saturday clinics well received and fully booked- over 120 slots.
- Dedicated clinics offered to OUFT partners- G4S, Mitie to ensure all groups have a chance to access vaccination
- Progress to date is achieved in 18 days from formal launch on the 2.10.2023
- Plan to deliver more covid on all sites, through hub and spoke model- making accessible but ensuring maximal use of each vial

Patients

Vaccination of patients accelerated as per request

Hepatology

60 patients received vaccination via OP and gastro day case

Funding secured to offer vaccination on the 'bus' ensuring that patients who are difficult to engage will be offered.

In-Patients

Robust scrutiny of long stay patients and vaccination offered to patients over 21 days, where appropriate

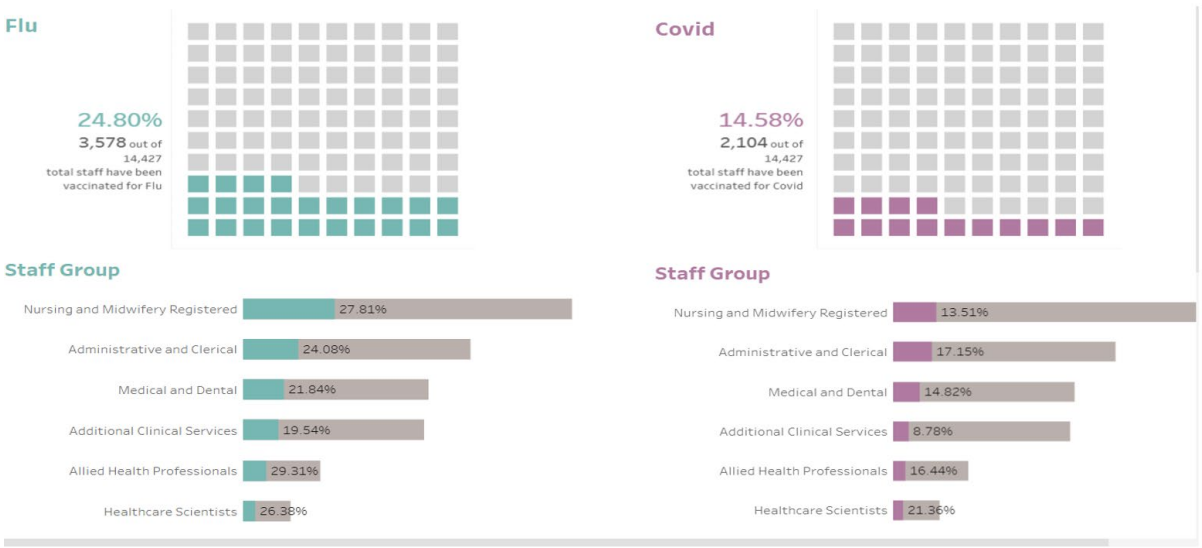
Renal

250- 300 dialysis patients have identified they would take up vaccination of flu and covid during a dialysis visit and vaccination started this week

Maternity

Pregnant women offered covid and flu as part of visit for a scan. 28 have taken up flu and 34 covid

Break down per staff group



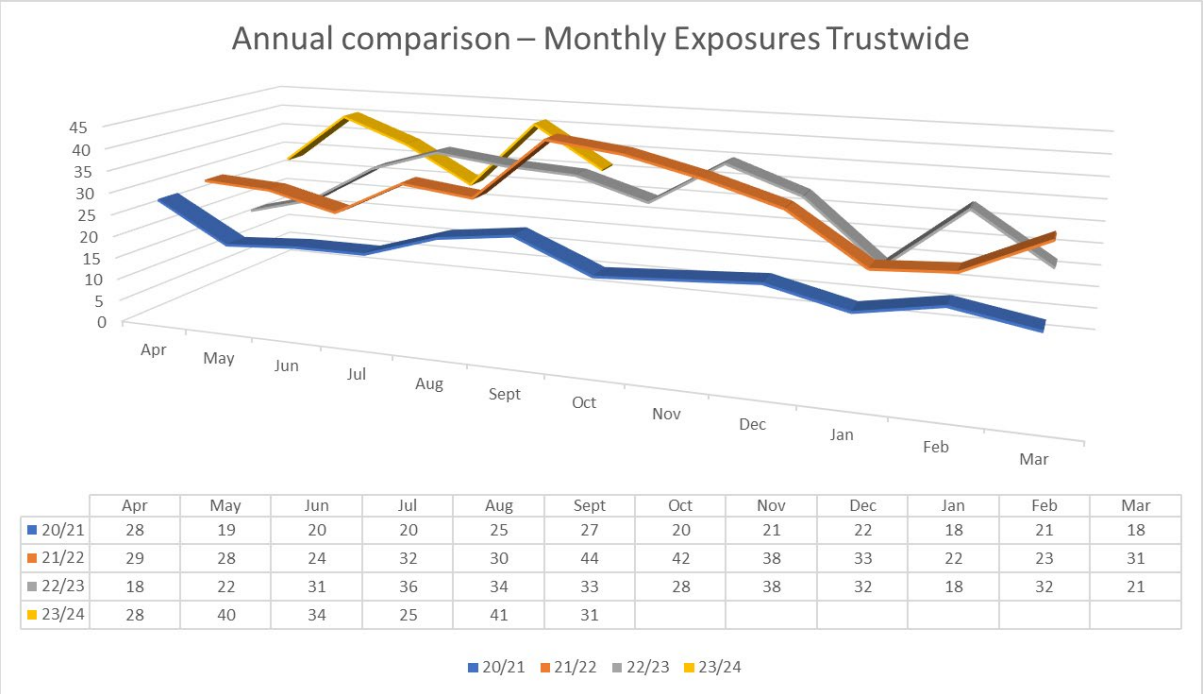
Appendix C: Staff Exposures to Body fluids and Infectious Diseases – Bi- Annual Report April 2023 to September 2023

8.1. Introduction

8.1.1. During the reporting period (1st April 23 to 30th September 2023) there were a total of 199 exposures (189 during same period 2022/23) reported to the COHWB.

8.1.2. The following report identifies the numbers of exposures during this period for each division. It also shows the numbers from the same period last year in brackets as a comparison.

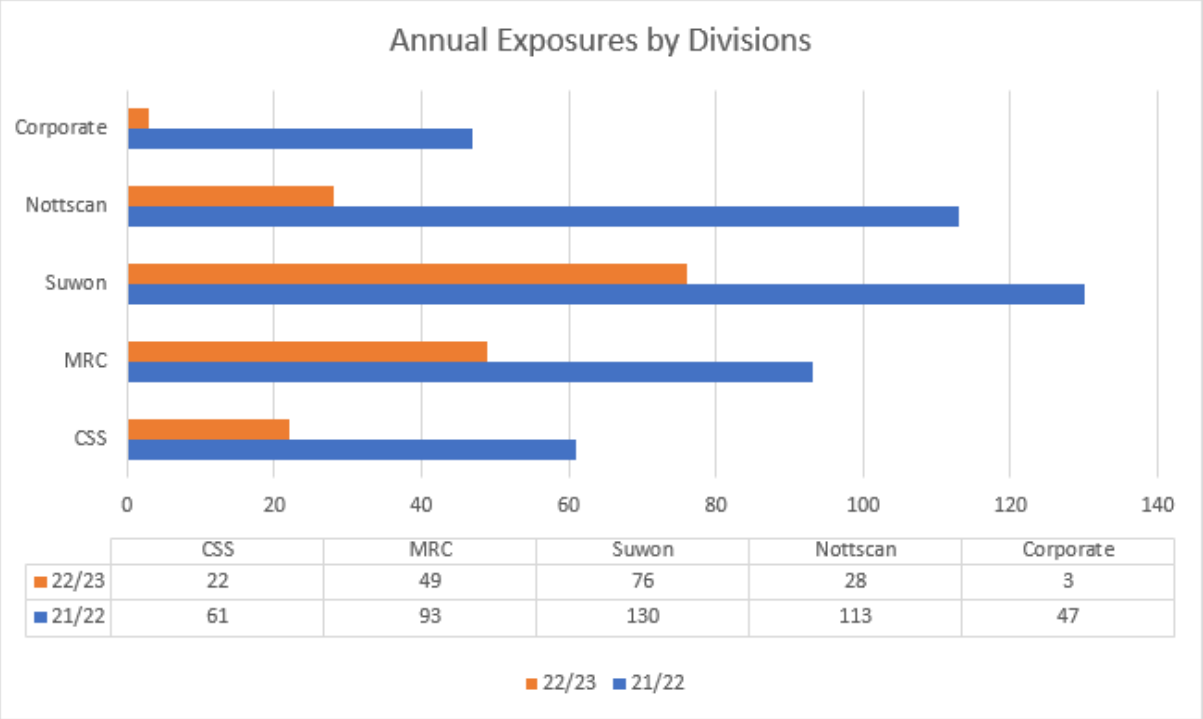
8.2. Figure 1 shows the total number of exposures reported to the COHWB as an annual comparison over the past 3.5 years. Overall, the number of exposures seem slightly higher (199) across the Trust to the comparable months in the previous reporting period (April 22 to September 22) (177). Averaging around 33(29) injuries per month.



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
20/21	28	19	20	20	25	27	20	21	22	18	21	18
21/22	29	28	24	32	30	44	42	38	33	22	23	31
22/23	18	22	31	36	34	33	28	38	32	18	32	21
23/24	28	40	34	25	41	31						

Figure 1- Monthly Exposure comparison by annual basis from 2020-2023

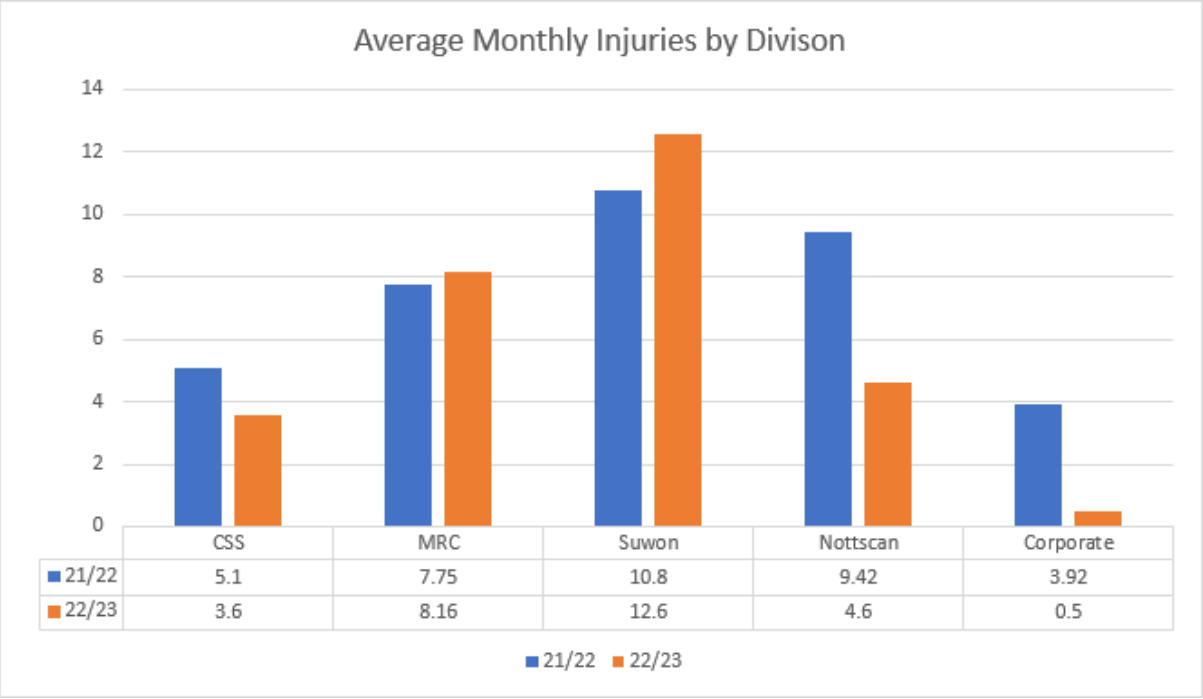
8.3. Figure 2 Shows the total numbers of exposures by division by year over the past two years. It consistently demonstrates an overall increase in all divisions, while notably, the largest surge consistently appears in Suwon and NOTSSCaN.



	CSS	MRC	Suwon	Nottscan	Corporate
22/23	22	49	76	28	3
21/22	61	93	130	113	47

Figure 2 - Yearly total numbers of exposures by division

8.4. Figure 3. The average number when the totals for the divisions were collectively combined ranged from 3 to 7 incidents per division per month, with the noticeable exception being Suwon that averaged 12 per month.



	CSS	MRC	Suwon	Nottscan	Corporate
21/22	5.1	7.75	10.8	9.42	3.92
22/23	3.6	8.16	12.6	4.6	0.5

Figure 3- Monthly Exposures to contaminated instruments and needles by Division

8.5. Figure 4. Table demonstrates a breakdown of number of Staff by group showing current April - September 2023 in comparison to same period

2022 numbers by Division. Nurses and Midwives have maintained as the highest numbers of exposures across the Trust during this period.

Period	Nurses and Midwives	Doctors	Healthcare Support Staff	Allied Health Practitioners	Other
Current	65	55	28	13	19
Previous	61	57	24	9	46

8.6. Type of Instrument Used

8.6.1. Incidents involving both hollow bore needles (e.g., insulin needles, butterflies, vacutainer, and cannulas) have increased from 55 to 93, whereas in the previous period, they were similar at 41 (55).

8.6.2. Re-sheathing incidents for insulin needles, among the hollow bore needle cases, have remained at 19.

8.6.3. Splash incidents have slightly decreased to 24 in this reporting period.

8.7. Timing of injury

8.7.1. Out of the 174 incidents reported most incidents occur during medical procedures (99 incidents) and after procedures (52 incidents) and during disposal (20 incidents). These safety concerns will be investigated further during Sharp Safety Action Group and within Divisional Meetings.

Time of Injury	Incidents
During disposal	20
During procedure	99
Before procedure	3
After procedure	52

8.8. Incidents with Confirmed Positive Exposure

8.8.1. There was a total of 8 (10) exposures to patients who tested positive for one of the blood-borne diseases: HIV = 0 and Hepatitis C = 7, Hepatitis B = 1 during this reporting period.

8.8.2. Of the 7 known Hepatitis C source patients, 6 were found not to have detectable viral loads. All recipients have had follow up appointments with the COHWB at appropriate intervals.

8.8.3. Regarding possible Hep B exposure, follow up and management of exposure which included vaccination was advised under the guidance from Microbiology Team.

8.8.4. No seroconversion has been reported. Results B

8.8.5. Other exposure incidents include a reverse Needlestick injury reported and managed as per Trust protocol.