

## Health and Safety Management Annual Report 2025-26

**Public Board**  
**28 May 2026**

<b>Presented for:</b>	Assurance and Information
<b>Presented by:</b>	Hayley Lancaster, Head of Health and Safety
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<b>Previous Committees:</b>	Risk Management Committee, 2 April 2026

<b>Freedom of Information Act (FOIA) Exemption</b>	<input type="checkbox"/> <b>YES</b> (restricted from the FOIA) <input checked="" type="checkbox"/> <b>NO</b> (available to the public under the FOIA)
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<b>Link to Strategic Objective</b>	Support and develop our people
<b>Link to Provider Capability Assessment</b>	Governance, risk and regulatory
<b>Link to CQC Well-led Statement</b>	Governance, Management and Sustainability
<b>Regulatory Impact</b>	Regulation 17: Good governance

<b>Key points</b>	<b>Purpose</b>
1. This report provides assurance that the Trust has effective arrangements in place to manage operational health and safety risks, supported by proactive and reactive monitoring.	Assurance
2. Monitoring indicates that key incident risks remain stable, with no new or emerging trends and controls aligned to known risk areas.	Assurance
3. Development of a Trust-wide Health and Safety Strategy will strengthen strategic oversight and future risk management	Information

<b><u>Risk Appetite Framework</u></b>			
<b>Level 1 Risk</b>	<b>Level 2 Risks</b>	<b>(Risk Appetite Scale)</b>	<b>Impact</b>
Workforce Risk	Choose an item.	Choose an item	Choose an item.
Operational Risk	Health& Safety Risk - We will protect the health and wellbeing of our patients and workforce by delivering services in line with or in excess of minimum health & safety laws and guidelines.	Minimal	Moving Towards
Clinical Risk	Choose an item.	Choose an item	Choose an item.
Financial Risk	Choose an item.	Choose an item	Choose an item.

External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Towards
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## 1. Summary

This report presents the Annual Health and Safety Report for Leeds Teaching Hospitals NHS Trust, providing assurance on how operational health and safety risks are being managed across the Trust. The report was reviewed by the Risk Management Committee, which received assurance regarding the arrangements described within the report. The Board is asked to receive the report for assurance.

The report summarises the performance of the Trust's Health and Safety Management System over the previous year, drawing on both proactive monitoring, including the Health and Safety Controls Assurance Process and mandatory training compliance, and reactive monitoring of incidents, including Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reports.

It highlights key risk themes, external assurance and areas of ongoing development, including the introduction of a Trust-wide Health and Safety Strategy, and confirms that established governance arrangements support the identification, management and escalation of health and safety risks across the organisation.

## 2. Findings

### 2.1 Governance and Safety Management System

The Trust manages health and safety risks through an established Safety Management System aligned with the Health and Safety Policy and supporting procedural framework. These arrangements define the governance structures, roles and responsibilities required to identify, assess and control risks affecting staff, patients, visitors and others.

Health and safety performance and emerging risks are monitored through established governance routes, including the Risk Management Committee.

In addition, formal consultation with Trade Union Safety Representatives is undertaken through the Health and Safety Consultation Committee, providing a structured mechanism for workforce engagement and input, supported by regular engagement between the Health and Safety Team and the Chair of the Staff Side Safety Representatives.

In April 2026, Executive oversight arrangements for the Health and Safety portfolio will transfer from the Chief Medical Officer to the Director of Estates and Facilities as part of wider Executive portfolio realignment arrangements.

Further detail on how key health and safety risks are managed, including objectives, monitoring arrangements, governance forums and assurance routes, is set out in Appendix Four.

### 2.2 Reactive Monitoring

Reactive monitoring of RIDDOR reportable incidents provides an indicator of the effectiveness of the Trust's Health and Safety Management System.

Overall, incident levels have remained broadly stable across the reporting period, with no sustained upward trend. SPC analysis indicates variation remains within expected limits, suggesting that existing control measures are effective.

Slips, trips and falls and moving and handling continue to account for the largest proportion of incidents, with no new or emerging trends identified.

Ongoing monitoring through established governance arrangements ensures that any variation outside expected limits is identified and acted upon.

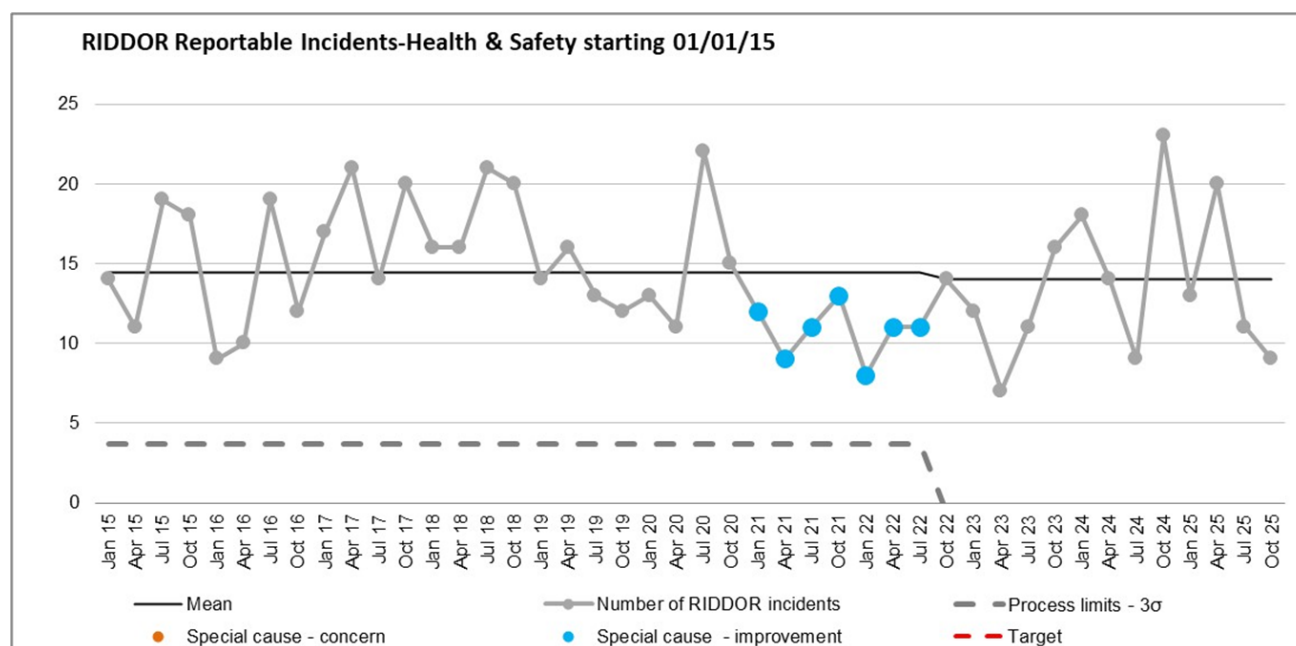


Figure 1: Staff RIDDOR reports are presented by financial quarter on a Statistical Process Control (SPC) chart, displaying data from January 2015 to December 2025.

RIDDOR reportable incidents remain an important indicator of significant harm and are monitored alongside SPC analysis to identify trends over time. A detailed breakdown of incident types is provided in Appendix One.

## 2.3 Key Incident Themes

The Trust continues to monitor key incident risks, focusing on those that contribute most significantly to staff harm. In a healthcare setting, effective management is reflected in stable levels of serious incidents, a clear understanding of contributory factors, and control measures aligned to these risks.

Overall, incident levels remain broadly consistent with those reported in the previous six-monthly update, with no new or emerging trends identified.

### Slips, Trips and Falls

Slips, trips and falls remain one of the most frequently reported incident types, representing 10 incidents (25%) of all RIDDOR reports in Q1-Q3 2025/26. Analysis identifies consistent contributory factors, including environmental conditions such as spillages and obstructions, alongside behavioural factors such as rushing.

Actions continue to focus on strengthening housekeeping standards, spill management and risk control in high footfall areas, ensuring interventions remain targeted and proportionate.

### **Moving and Handling**

Moving and handling incidents account for a significant proportion of RIDDOR reportable injuries, representing 11 incidents (28%) of all RIDDOR reports in Q1-Q3 2025/26, reflecting the inherent risks associated with patient care.

Incidents are subject to structured review, enabling learning to be applied at both local and organisational level. Ongoing investment in equipment and staff training supports safe systems of work and risk reduction.

### **Violence and Aggression**

Violence and aggression towards staff remains a recognised risk, particularly within high acuity and public facing areas, representing 5 incidents (13%) of all RIDDOR reports in Q1-Q3 2025/26, and remains a key area of focus within the Trust.

While RIDDOR data reflects the most serious incidents, this risk is more widely represented across broader incident reporting. Staff involved in incidents are supported through established processes, including the Violence Prevention and Reduction team and specialist-led review where appropriate, supporting a consistent approach to support, investigation and organisational learning.

### **Other Incident Types**

Other incident categories, including needlestick injuries and contact with objects, continue to be monitored through established governance arrangements, with no emerging trends identified.

Overall, the Trust demonstrates a consistent understanding of its key risks, with control measures aligned to known contributory factors and oversight maintained through established governance processes.

## **2.4 External and Independent Assurance**

External and independent assurance provides validation of the Trust's health and safety management arrangements and supports confidence in the effectiveness of its systems and controls.

### **RoSPA Achievement Award**

The Trust has achieved the RoSPA President's Award, recognising ten consecutive Gold Awards within the RoSPA Health and Safety Achievement Awards. This provides independent assurance of the maturity, consistency and effectiveness of the Trust's health and safety management system.

### **Health and Safety Executive (HSE)**

Regulatory oversight is provided by the Health and Safety Executive. In September 2025, a proactive inspection of the Centre for Laboratory Medicine Category 3 laboratories assessed compliance with statutory requirements for work involving hazardous biological agents.

The inspection identified four areas requiring improvement to meet minimum legal standards. Two actions have been completed within required timescales. The remaining actions relate to strengthening maintenance, monitoring and competency arrangements for safety critical systems, with agreed completion dates in October 2026.

Progress is monitored through established governance arrangements, including specialist oversight and technical assurance.

This inspection has provided constructive external challenge and strengthened arrangements within high-risk laboratory environments.

A summary of historical HSE enforcement action is provided in Appendix Two.

## **2.5 Active Monitoring**

The Health and Safety Controls Assurance process provides a key mechanism for assessing compliance with the Trust's Safety Management System and identifying areas for improvement.

The 2025 process achieved high levels of engagement, with a self-assessed compliance rate of 96%. Validation is undertaken through a combination of sampling by the Health and Safety Team and Specialist Advisors, using both random and risk-based approaches. Final validated outcomes will be reported in March 2026. A breakdown of self-assessed compliance scores by CSU and Corporate Department is provided in Appendix Three.

Each participating area receives a validation summary to support local understanding of performance. Where gaps or areas for improvement are identified, targeted action plans are developed and managed through local governance arrangements. This approach supports proportionate assurance, ensuring areas of higher risk or lower compliance receive greater scrutiny while maintaining oversight of overall performance.

A summary of risk-specific objectives, key activities, performance monitoring and governance arrangements across the Trust's principal health and safety risk areas is provided in Appendix Four. This supports transparency of how risks are managed and provides a clear line of sight from operational activity through to assurance.

Mandatory Health, Safety and Welfare training compliance remains strong at 92%, providing assurance that staff have access to the knowledge and skills required to work safely.

## **2.6 Strategic Development and Future Direction**

Following feedback from the Trust Board development session in June 2025, an opportunity was identified to strengthen the strategic approach to staff health and safety. While the existing Safety Management System provides a structured framework for managing risk and monitoring compliance, it does not currently include a single overarching strategy defining long-term ambition, priorities and measures of success.

In response, development of a Trust-wide Health and Safety Strategy has commenced, with initial focus on establishing baseline performance measures and identifying data to support a more structured approach to improvement.

Initial indicators include Accident Frequency Rate (AFR), staff safety training activity, and incident investigation and close-out timeliness. AFR is benchmarked against Health and Safety Executive data for both the healthcare sector and all industries.

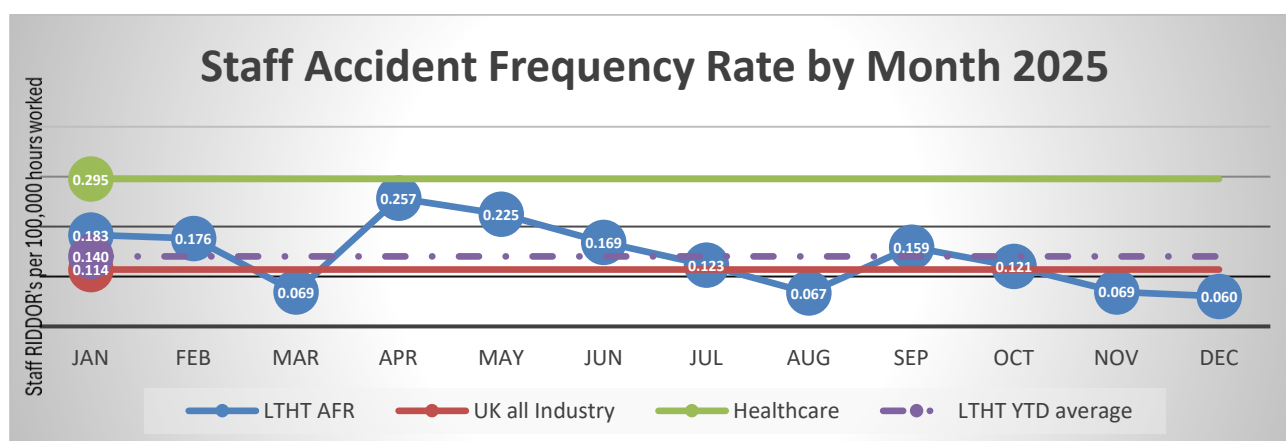


Figure 2: AFR benchmarked against Healthcare and All Industry

The Trust's AFR remains below the healthcare sector average and broadly aligned with national trends, providing assurance that overall incident frequency is being effectively managed.

A staff safety climate survey is planned for Spring 2026 to provide insight into staff perceptions of risk, reporting culture and the effectiveness of existing control measures, informing future priorities.

Work-related stress and psychological risk continue to be a national priority, with the Health and Safety Executive promoting the Management Standards. The Trust continues to apply this approach, with a recent review of the stress risk assessment process and refreshed supporting guidance to strengthen its application in practice. Health and wellbeing conversations are also being piloted to support earlier, proactive engagement. This remains a shared workforce risk, with ongoing work to strengthen consistency and organisational insight.

Overall, the evidence from both proactive and reactive monitoring provides assurance that the Trust's arrangements for managing operational health and safety risks remain established and effective, with clear governance routes in place to identify and escalate emerging risks where required.

### 3. Quality and Performance Implications

This report provides assurance on the management of quality or performance implications and their mitigation and control mechanisms.

### 4. Financial Implications

There are no financial implications outlined within this paper.

### 5. Risk

The content of this report reflects the Trust's existing operational health and safety risk profile and does not propose any change to the current risk appetite.

Operational health and safety risks are managed within established governance and control frameworks and are considered to be within the defined risk appetite and aligned with the Trust's approach to managing operational risk within defined tolerance levels.

Key risks, including slips, trips and falls, moving and handling, violence and aggression, and staff wellbeing, are recognised, actively managed and subject to ongoing oversight through established governance arrangements. No new or emerging legal or regulatory risks are identified through this report.

## **6. Communication and Involvement**

The Health and Safety reports provided to the Risk Management Committee and quarterly updates from Specialist Advisors are shared at the Health & Safety Consultation Committee and Trust Consultation and Negotiating Committee.

## **7. Improving Health Equity Impact on Equality & Health Inequalities**

The governance arrangements detailed throughout the report anonymise incident data to allow for unbiased trend analysis and learning. Terms of Reference for each governance group will consider their anticipated Health Equity impact. This report does not negatively impact our staff living in our most deprived communities or experiencing poverty.

## **8. Publication Under Freedom of Information Act**

This paper has been made available under the Freedom of Information Act 2000.

## **9. Recommendation**

Trust Board are asked to receive the annual Health and Safety report, for assurance.

## **10. Supporting Information**

The following appendices are provided to support the information presented within this report:

**Appendix One:** Figure 3: Staff RIDDOR reports by financial quarter, January 2016 to December 2025, and Table 1: Total number of staff RIDDOR reports by incident type, Q1 2024 to Q3 2025

**Appendix Two:** Summary of Health and Safety Executive (HSE) enforcement action

**Appendix Three:** Breakdown of Health and Safety Controls Assurance self-assessed compliance scores by Clinical Service Unit and Corporate Department

**Appendix Four:** Summary of risk-specific objectives, activities, performance monitoring and governance arrangements across key health and safety risk areas

Hayley Lancaster  
Head of Health and Safety  
March 2026

## Appendix One

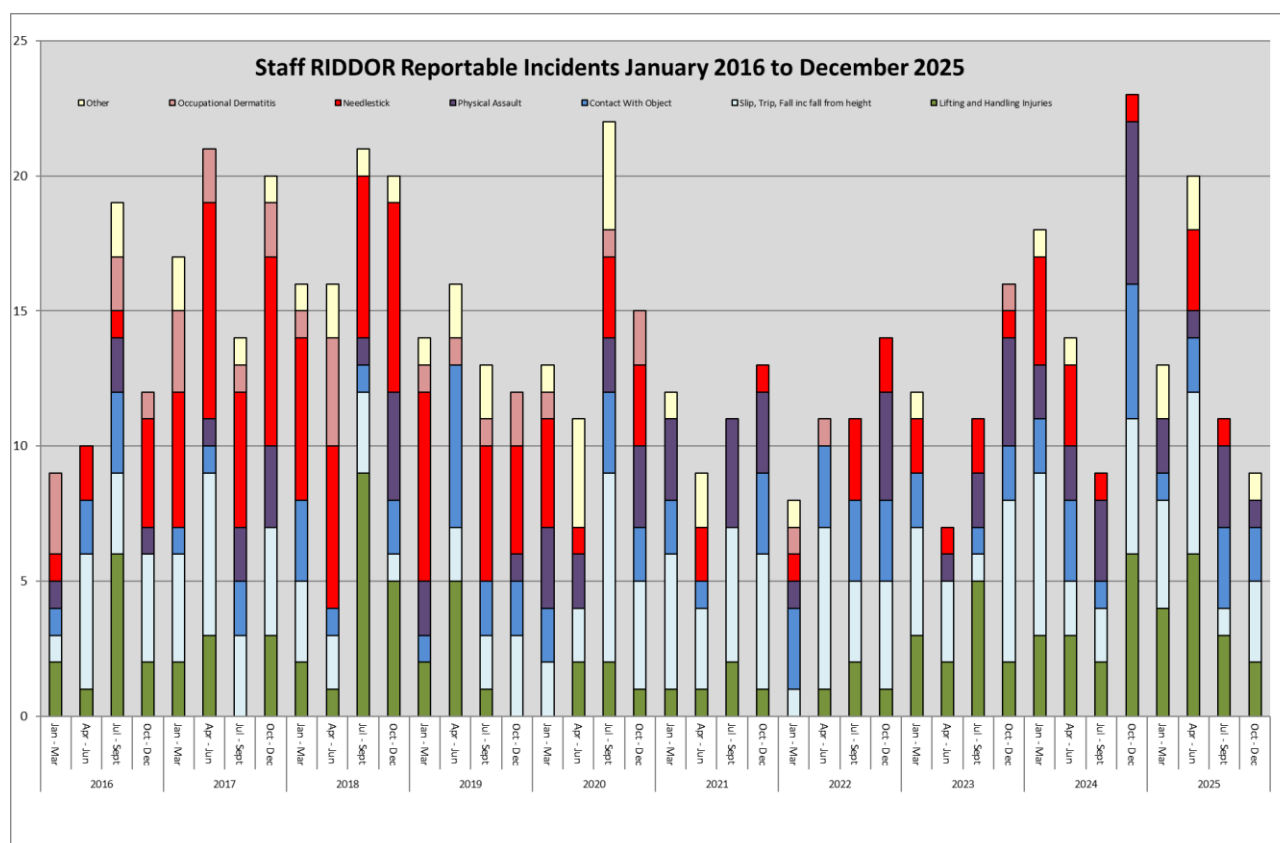


Figure 3: Staff RIDDOR reports are presented by financial quarter, indicating incident type from January 2016 to December 2025.

Cause of RIDDOR	2024 / 2025				2025 / 2026			Total
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Slip, Trip, Fall	2	2	5	4	6	1	3	23
Moving & Handling	3	2	6	4	6	3	2	26
Contact With Object	3	1	5	1	2	3	2	17
Needlestick (Dangerous Occurrence)	3	1	1	0	3	1	0	9
Needlestick (Occupational Disease)	0	0	0	0	0	0	0	0
Dermatitis (Occupational Disease)	0	0	0	0	0	0	0	0
Physical Assault	2	3	6	2	1	3	1	18
Other	1	0	0	2	2	0	1	6
<b>Total</b>	<b>14</b>	<b>9</b>	<b>23</b>	<b>13</b>	<b>20</b>	<b>11</b>	<b>9</b>	<b>99</b>

Table 1: Total number of staff RIDDOR reports by incident type from Q1 2024 – Q3 2025.



**Appendix Two**

<b>Year</b>	<b>HSE Improvement Notice/ Notice of Contravention (NoC) Summary</b>
<b>2006</b>	Skin Health Surveillance not in place
<b>2009</b>	Control of Biological Agents - No patient self-phlebotomy procedure
<b>2011</b>	Risk of Falls - fatal fall of a patient from a window (Chancellor Wing)
<b>2012</b>	Radiation Safety - lack of a contingency plan if a CT scan fails to complete
<b>2019</b>	Occupational Disease (Dermatitis) - lack of a risk assessment for 'wet working'
<b>2023</b>	Radiation Safety – NoC re staff dosimetry

*Table 2: A summary of HSE enforcement action.*

### Appendix Three

Breakdown of Health and Safety Controls Assurance self-assessed compliance scores by Clinical Service Unit and Corporate Department.

CSU/Business Unit	Standards										Score
	1 H&S Governance	2 Fire Safety	3 Security & Conflict Resolution	4 MSD Prevention	5 COSHH	6 Safe Use of Sharps	7 Ionising Radiation	8 Laser Safety	9 Ligature Anchor Point Assessment	10 Work Related Stress	
Abdominal Medicine and Surgery	89	99	99	100	98	100			100	94	96
Adult Critical Care	94	100	100	100	100	100			100	100	99
Adult Therapies	96	98	100	100	100	100			100	100	99
Cardio-Respiratory	96	98	100	100	99	100	78	97	100	100	98
Centre for Neurosciences	81	98	100	100	100	100			100	100	94
Chapel Allerton	99	100	85	100	100	100		100	100	89	94
Chief Nurse CSU	95	99	97	100	100	100				83	97
Chief Operating Officer's Team	85	85	88		100					100	86
Children's	84	96	90	91	99	93		95	88	96	90
Communications	100	100	100								100
Estates & Facilities	98	100	99	100	98		100			100	99
Executive Support	80	100	100								93
Digital Information Technology	99	97	100	100	100						99
Finance	93	100	100							50	96
Head & Neck	84	98	100	100	95	100		100		100	95
Human Resources	94	97	100	100	100	100				100	97
Leeds Dental Institute	99	100	100	100	99	100	100		50	100	99
Medical Directorate	100	100	100	100	87	100					99
MMPS	96	100	100	100	100	100	100			100	99
Oncology	93	97	97	100	95	100	86	100	100	100	96
Outpatients	97	97	100	100	97	100		100	100	100	99
Pathology	93	99	100	100	96	100	100			100	98
Planning & Capital Estates	100	100	100								100
Radiology	97	96	100	100	99	100	97	97	100	100	99
Research & Innovation	97	99	99	100	97	100				100	98
Specialty & Integrated Medicine	92	98	100	100	100	100			100	100	98
Theatres & Anaesthesia	99	98	97	100	99	100	86	98	100	100	98
Trauma & Related Services	91	97	88	100	93	100			88	63	90
Urgent Care	92	96	96	100	97	100			79	100	94
Women's	76	94	92	100	96	100			100	100	93
CSU's Completing Standard:	30	30	30	25	26	23	8	8	16	25	
Average Score:	93	98	98	100	98	100	93	98	94	95	96
Lowest Score:	76	85	85	91	87	93	78	95	50	50	86
Highest Score:	100	100	100	100	100	100	100	100	100	100	100

Trust Compliance with Health & Safety Controls:

96 %

RAG Rating	
	95 - 100
	60 - 94
	0 - 59

**Appendix Four - Summary of risk-specific objectives, activities, performance monitoring and governance arrangements.**

Risk and Lead	Objective	Key Activities	Performance Monitoring	Governance Forum	Assurance Route
<b>Prevention of Non-Clinical Slips Trips and Falls</b> (Head of Health & Safety)	<b>Objective 1</b>  Completion of the annual Health & Safety Controls Assurance process, Health & Safety General Risk Assessment and Quarterly Workplace Inspections.	LTHT H&S Controls Assurance Process:  Compliance with Standard 1.1 (General Risk Assessment) i.e., The ward/Department has completed a General Health and Safety Risk Assessment within the last 2 years.  Compliance with Standard 1.2 (Quarterly Workplace Inspections) i.e., At least 4 completed Workplace Inspections will be completed every year.  Compliance with Standard 1.5 (Slip, Trip and Falls) i.e., The Slips, Trips and Falls section of the Health & Safety Controls Assurance Checklist will be completed every year.	Current assurance data is based on 2025 self-assessment.  Following the completion of the current Controls Assurance cycle a review and analysis (validation) is underway.  Local Action Plans will be developed for at least 25% of each CSU/CD, H&S team undertaking desk top assessments to validate the data, in addition to the H&S Gemba visits taking place throughout the year. This will be completed before the next cycle of the Controls Assurance which is anticipated to commence in August 2026.	Health & Safety Consultation Committee	Risk Management Committee
	<b>Objective 2</b>  All internal and external common circulation areas within LTHT premises are inspected by the Estates Department (at least annually).	Estates team co-ordinate a programme of planned, preventative inspections to main hospital and peripheral sites at LTHT to identify defects which present slip, trip or fall hazards. This is carried out at least annually and includes external and internal common circulation areas used by	A documented process for the 'Circulation Areas Condition Report' is used across all LTHT.	Health & Safety Consultation Committee	Risk Management Committee

		staff, patients, visitors, members of the public and contractors.			
COSHH (COSHH Advisor)	<b>Objective 1</b>  Support the Health and Safety team in the delivery of the Health and Safety Controls Assurance for standard 5	To promote understanding of and compliance with COSHH within LTHT <ul style="list-style-type: none"> <li>• Complete validations and make improvements to COSHH leaning burst as per common feedback provided/ "issues" identified.</li> <li>• Continue to offer targeted COSHH support to CSU H&amp;S representatives.</li> <li>• Attend some H&amp;S Controls assurance drop-in sessions to offer COSHH support/ advice.</li> </ul> Provide up to date information for staff: <ul style="list-style-type: none"> <li>• Ensure Inventory is up-to-date</li> <li>• Ensure users are aware of Workplace Exposure Limits (WELs) and where to find information.</li> <li>• Ensure risk assessments templates available and example risk assessment templates on the intranet are up-to-date.</li> </ul>	Health and Safety Controls Assurance published with updated standard.  COSHH queries answered as they arise.  Information and guidance for the COSHH standard can be used  Risk assessments completed with the correct information about controls in place justifying why monitoring is not required.  Updated inventory live on intranet	COSHH Steering Group  Health and Safety Consultation Committee	Executive assurance for COSHH is being aligned with Medicines Management and Pharmacy Services, with reporting through the annual paper to the Quality Assurance Committee.
	<b>Objective 2</b>  Ensure that COSHH risk assessment template and	To work towards updating risk assessment template to make it more user friendly.  Update inventory with substances commonly added to additional	Updated inventory and COSHH risk assessment template are completed before next H&S controls assurance season starts.	COSHH Steering Group	Executive assurance for COSHH is being aligned with Medicines Management and Pharmacy Services,

	inventory are updated.	<p>'items not added' table and carry out a review of the substances on the main body of the inventory.</p> <p>Update example risk assessment templates available on the intranet.</p> <p>Ensure users are aware of when exposure monitoring is required for substances with WELs or whether a justification for monitoring is sufficient. Provide advice to departments when completing validations.</p>	<p>Communicate update of COSHH inventory and risk assessment template.</p> <p>Communicate COSHH learning burst updates via trust wide communications.</p>	Health and Safety Consultation Committee	with reporting through the annual paper to the Quality Assurance Committee.
	<p><b>Objective 3</b></p> <p>Ensure trust exposure monitoring schedule is carried out of substances thought LTHT.</p>	<p>Ensure ward/ department exposure monitoring is carried out as per schedule, and results are shared with department leads and COSHH steering group.</p> <p>Escalate WEL failures to appropriate groups and ensure datix's are raised by the ward/departments. Ensure re-monitoring is carried out where appropriate once the appropriate control measures/ mitigating factors have been put into place. Continue to offer COSHH support to the departments with WEL failures.</p>	Exposure monitoring results communicated to	<p>COSHH Steering Group</p> <p>Ward/ departments forums</p>	Executive assurance for COSHH is being aligned with Medicines Management and Pharmacy Services, with reporting through the annual paper to the Quality Assurance Committee.
	<p><b>Objective 4</b></p> <p>Improve the management of the assurance with relation to trust Local Exhaust Ventilations (LEV's).</p>	<p>To update COSHH LEV asset register of the LEV's that have uploaded a compliant service record during the H&amp;S Controls assurance process.</p> <p>To highlight to Estates and Facilities Management which LEV's from the asset register have not</p>	The results from the H&S controls assurance will demonstrate that all LEV's as per asset register have been serviced and maintained.	<p>COSHH Steering Group</p> <p>Health and Safety Consultation Committee</p>	Executive assurance for COSHH is being aligned with Medicines Management and Pharmacy Services governance arrangements, with reporting through the

		<p>been serviced or have uploaded a non-complaint service record.</p> <p>Departments which have LEV's that do not have a compliant service record uploaded to be offered to be added to Estates LEV service contracts or decommissioned if not in use.</p>			<p>annual paper to the Quality Assurance Committee.</p>
<p><b>Asbestos</b> (Snr Asbestos Manager)</p>	<p><b>Objective 1</b></p> <p>Continue to re-assess all high-risk Asbestos areas.</p>	<p>This work is an ongoing rolling task where necessary Asbestos removal works are to take place to make areas safe. Any remaining high-risk areas will be assessed over the course of 2026 in order of risk.</p>	<p>Target to achieve 100% of all high-risk items to be reassessed on an annual basis with all recommendations undertaken or mitigations put in place.</p> <p>Continue with a robust audit programme of all works undertaken to the Trust estate to ensure the standards that are expected are met.</p> <p>Annual asbestos reinspection programme undertaken to monitor condition of asbestos materials as per HSG 264 Regulation 4. Data is audited when returned by Acorn to ensure all necessary actions are reviewed and actioned where required.</p>	<p>Health and Safety Consultation Committee</p> <p>Building Safety Group (Asbestos Sub-Group)</p>	<p>Safe, Effective, Efficient, Quality, Assurance (SEEQA) Group</p> <p>NHSE Premises Assurance Model (PAM).</p>

	<p><b>Objective 2</b></p> <p>Delivery of bespoke training plan for all Estates and Capital Staff</p>	<p>Continue the roll out and delivery of the bespoke training programme for members of Estates staff alongside Acorn. Classroom based training with an overview of specific areas of concern within the Trust, what processes apply to specific roles and what info staff can expect to receive for particular tasks.</p>	<p>Target to achieve 100% of relevant Estates and Facilities to undertake asbestos training on an annual basis. Reported monthly to Senior Leadership Team.</p> <p>A PowerPoint presentation was devised in 2025 that included the Trust's own ACMs to make the training as relevant to all staff as possibly. This is to be reviewed again within 2026 to capture any new ACM's that have been found across the Trust within the previous year. This training also is to aide with receiving feedback from staff on what they feel helps them deliver their works safely and helps instil a safety culture from the Senior team down to the works delivered on site. This feedback loop helps with continual improvements to the service.</p>	<p>Building Safety Group (Asbestos Sub-Group)</p>	<p>Safe, Effective, Efficient, Quality, Assurance (SEEQA) Group</p> <p>NHSE Premises Assurance Model (PAM).</p>
	<p><b>Objective 3</b></p>	<p>Ensure an improvement in usage and take up of the Alphatracker system via QR codes from Estates operatives now that the system is</p>	<p>Monitoring of access to the Alphatracker system is to be undertaken to ensure an improve</p>	<p>Building Safety Group (Asbestos Sub-Group)</p>	<p>Safe, Effective, Efficient, Quality, Assurance (SEEQA) Group</p>

	Improved usage of Alphatracker and QR codes	up and running and the operatives have been informed of how to use the system via their PDA's.	uptake in use of the system is taking place. Audits to be undertaken alongside general RESET audits to ensure data is being accessed and used.  Inclusion of QR code information and login details is now included in each round of asbestos awareness training that is to be provided by Acorn. Login numbers to be monitored throughout the year to enable feedback to Estates Managers		NHSE Premises Assurance Model (PAM).
<b>Prevention of Inoculation Incidents</b>  (Senior Nurse IPC)	<b>Objective 1</b>  Ensure that the use of sharp safety devices in LTHT is in line with current legislation.	Bring any new legislation to the quarterly (Inoculation and Incident Safer Sharp Group) IISSG meeting.	Quarterly minutes from IISSG meeting.	Inoculation and Incident Safer Sharp Group	IPC Sub-Committee
	<b>Objective 2</b>  Ensure that clinical areas have introduced sharp safety devices into practice unless it creates a patient safety concern to do so.	Procurement reviews all new sharp safety devices available, and introduce these into practice with training for staff.  Where patient safety is compromised by use of safe sharp devices an assessment is carried out and an Exemption Form completed appropriately.  The clinical area reviews annually whether new appropriate devices	The exemption form is required as evidence within the annual Health and Safety Controls Assurance process.  All exemptions are reviewed by the IISSG for sign off.	Inoculation and Incident Safer Sharp Group	IPC Sub-Committee



		are available and if not submit a new exemption form.			
	<b>Objective 3</b>  Ensure that during any supply disruptions for standard or sharp safety devices that alternative products are sought and reviewed.	Procurement review any supply issues and seek the most appropriate alternative devices during a potential shortage. They ensure that information pertaining to these devices and any training is shared with the CSU's.	Record to be made at the IISG meetings of any alternative devices and the Trust wide communication that has been shared.	Inoculation and Incident Safer Sharp Group	IPC Sub-Committee
	<b>Objective 4</b>  To ensure RIDDOR reportable high-risk injuries are investigated via RCA.  Lower risk sharps injuries are investigated by clinical areas via Datix.	Ensure that datix forms and RCA documents are reviewed and available for clinical teams to use. Ensure that investigations are completed by the clinical area with assistance from H&S as required, in a timely manner. RCAs will be signed off by either the CSU CD or HoN.	Attendance at relevant CSU IPC or QSAG meetings (H&S representative &/or IPN &/or Microbiologist) & presentation / discussion of relevant findings & actions etc.	Inoculation and Incident Safer Sharp Group	IPC Sub-Committee
	<b>Objective 5</b>  To ensure any lessons learned from sharps injury investigation are shared with the wider staff group to increase awareness and reduce risk of injury	Inoculation Incidents and Safer Sharps Group (IISG) work with Datix and Occupational Health teams to review risk of sharps and inoculation injuries in various clinical areas. The IISG members input into Trust-wide Lessons Learned Group and develop relevant material and communications to share Trust-wide or to defined staff groups.	Trust-wide sharing of 'Lessons Learned' from outcomes of incidents via the Lessons Learned bulletin/Quality and Safety Matters	Inoculation and Incident Safer Sharp Group	IPC Sub-Committee

<p><b>Prevention of Musculoskeletal Disorders</b></p> <p>(Director Of Business Development)</p>	<p><b>Objective 1</b></p> <p>Maintain the number of Musculoskeletal Health Champions, until such time as the numbers can be increased.</p> <p>These Champions support local staff and managers to prioritise musculoskeletal health &amp; wellbeing and decrease risk.</p>	<p>Champions will be supported digitally and personally as necessary to continue undertaking their important role.</p>	<p>The number of Musculoskeletal Health Champions will be maintained so far as is reasonably practicable as Champions are lost through natural wastage.</p>	<p>Workforce Management Group</p>	<p>People Committee</p>
<p><b>Ionising and Non-Ionising Radiation</b></p> <p>(Lead Clinical Scientist and Principal Clinical Scientist)</p>	<p><b>Objective 1</b></p> <p>To support LTHT in demonstrating that work with Ionising and Non-Ionising Radiation is carried out in a safe and effective manner and in accordance with the requirements of the relevant legislation.</p>	<p>Undertake a review of the personnel monitoring requirements for LTHT staff working with ionising radiation to ensure that all LTHT staff are appropriately monitored and to provide assurance that radiation doses are restricted to levels which are as low as reasonably practicable.</p> <p>Ensure that the correct PPE has been provided and complies with the latest guidance</p> <p>Ensure that the designation of all LTHT staff is correct particularly those working with unsealed radioactive sources</p> <p>Ensure that the Trust is aware of and is prepared for the changes in the HSE's requirements with regard to granting consents</p>	<p>Review completed with recommended actions</p> <p>Ensure that all radiation risk assessments are up to date for staff working with unsealed radioactive sources particularly with respect to foreseeable accident scenarios and if on the basis of these assessments staff are required to be designated as classified radiation workers ensure that steps are taken to classify these staff. In addition, ensure that regular rehearsals of contingency arrangements for foreseeable accident scenarios are regularly rehearsed.</p>	<p>Radiation Governance Group</p>	<p>Quality and Safety Assurance Group</p>

		<p>Specialist advisers (RPA's, RWA, LPA, MRSE and DGSA) to undertake compliance audits.</p> <p>This will be based on areas identified as part of the annual controls assurance exercise</p>	<p>Report on new requirements submitted to the Radiation Governance Group.</p> <p>Specialist Advisor reports produced identifying level of compliance with legislation including areas of non-compliance and recommendations for improvement.</p>		
	<p><b>Objective 2</b></p> <p>Assess the requirements and support for Ionising and Non-Ionising Radiation Safety Training programmes including delivery where appropriate.</p>	<p>Identify which staff groups require priority training in Ionising and Non-Ionising Radiation Safety. Where appropriate and if resources allow, with the support of Organisational Learning, develop and deliver appropriate levels of training to relevant Trust staff.</p>	<p>Training materials developed and delivered.</p> <p>With support from Organisation Learning, where appropriate and manageable ensure the training undertaken is appropriately recorded to allow audit of compliance.</p>	Radiation Governance Group	Quality and Safety Assurance Group
<p><b>Work Related Stress</b></p> <p>(Director of Business Development)</p>	<p><b>Objective 1</b></p> <p>Raise awareness of the Stress Risk Assessment process.</p>	<p>Increased communications.</p>	<p>Increase in Stress Risk Assessment usage.</p> <p>Reduction in mental health sickness absence.</p>	Workforce Management Group	People Committee
<p><b>Violence &amp; Aggression</b></p> <p>(Associate Director - Estates, Fire and Security)</p>	<p><b>Objective 1</b></p>	<p>Carry out thematic reviews of Conflict Resolution (CR) related DATIX incidents. Visit the victims and offer support to staff that have been subject to incidents. Underpinning this will be the re-</p>	<p>Review DATIX process.</p> <p>Provide one central address for reporting incidents so initial investigations are consistent. Provide a</p>	Workforce Management Group	<p>Board</p> <p>People and Culture Committee</p>

		assertion of 'report to support and work without fear.'	website with signposting to resources.  Provide additional training capacity within existing whole time equivalent staff. LTHT will demonstrate that support is offered to those staff involved in CR incidents and staff will be reassured that their safety is a priority.		
	<b>Objective 2</b>	Conflict Resolution Risk Assessments across the trust will also be reviewed.	Implement and deliver a plan supported by an action tracker of findings	Workforce Management Group	Board  People and Culture Committee
<b>Fire Safety</b>  (Specialist Fire Safety Officer)	<b>Objective 1</b>	Review the fire safety management across LTHT; this includes delivery of fire training, PPM, fire safety advice information, requirements of the new Building Safety Act and changes to HTM Fire code	Provide reports detailing any changes required.  Agree gap analysis plan.	Infrastructure Committee	Risk Management Committee  Safe, Effective, Efficient, Quality, Assurance (SEEQA) Group
	<b>Objective 2</b>	Continue with implementation of fire risk assessment, incorporating all changes to HTM and Fire Safety Order requirements	Review all fire risk assessment to bring them in line with the new HTM with Primary and Secondary FRA's and ensure information within is suitable and sufficient.	Infrastructure Committee	Risk Management Committee  Safe, Effective, Efficient, Quality, Assurance (SEEQA) Group