Royal Papworth Hospital
NHS Foundation Trust

Agenda Item 4.iii

Report to:	Trust Board	Date: 06/11/2025
Report from:	Maura Screaton - Chief Nurse, Director of Infection Prevention and Control and Executive Lead for Health and Safety	
Report prepared by	Terri-Louise Smith – Health and Safety Risk Manager Louise Palmer – Deputy Director for Quality and Risk	
Principal Objective/ Strategy and Title	**Health and Safety Annual Report for the period of April 2024-March 2025.** To provide the Board of Directors with an annual report in respect to Health and Safety Legislation for 2024/2025 and to highlight key priorities that are underway for the Health and Safety Committee and its subgroups for 2025/26	
Regulatory Requirement	Regulatory Requirements – CQC (All CQC Domains) Health and Safety at Work Act 1974 Management of Health and Safety at Work Regulations 1999	
Equality Considerations	Equality has been considered. Where required if non-compliance occurs this will be highlighted in report.	
Key Risks	Non – compliance with regulatory standards monitored by the Health and Safety Executive CQC Domains	
For:	Approve, as recommended by the Quality and Risk Committee	

1. Executive Summary

The purpose of the report is to provide the Trust Board with a summary of principal activity and outcomes relating to the management of health and safety at work within Royal Papworth Hospital NHS Foundation Trust (RPH) during the financial year 2024/25. The report also highlights current key priorities for the Health & Safety Committee and its sub-groups that are underway for 2025/26.

The report summarises the prevailing legislative framework within which health & safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety management within the Trust.

Summary of performance for 2024/2025:

- During the financial year there have been 847 incidents that relate to Health and Safety. This represents a 5.8% decrease when compared to the previous financial year 2023/24, in which 888 incidents were reported. Over 98% of incidents reported were graded as near miss, no harm and low harm (n=830). The remaining 1.8% (15) were moderate harm (10 staff and 5 patients related).
- There were 13 RIDDORs reported throughout 2024/25, 4 more than that reported in 2023/24 (n=9), however this remained comparable to 2021/2022 and 2022/23 (n=11).
- There were 24 Moving and Handling Incidents reported in 2024/25, which represents a 27% decrease from 2023/24 (33).

- There were 3 incidents that were externally reported to the CQC in 2024/25 under the Ionising Radiation (Medical Exposure) Regulations (IRMER). This is an increase when compared to last year where only one incident was reported. All incidents were unrelated.
- There were 42 staff referred to Occupational Health for reported sharp injuries in 2024/25 which remains comparable with 2023/24 (n=45).

2. Introduction

This report provides analysis of standards of Health and Safety (H&S) management throughout the Trust from April 2024 to March 2025. The Health and Safety at Work Act 1974 (HASAWA), supported by the Management of Health and Safety at Work Regulations 1999 (MHSWR), provides a legislative framework to promote, stimulate and encourage excellent H&S at work standards. This takes place via delegated responsibility through the Chief Executive Officer to the Chief Nurse to implement systems that ensure Trust staff work in a safe and compliant manner to protect both themselves and other service users from significant or avoidable harm.

In particular, this legislation requires organisations to provide and maintain:

- A Health and Safety Policy
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substance
- A safe and secure working environment
- Safe and suitable plant, work equipment and systems of work that are without risks
- Suitable and sufficient Information, instruction, training, and supervision
- Adequate welfare facilities
- Clear emergency procedures
- Competent personnel to oversee H&S
- The conduction and documentation of suitable and sufficient risk assessments

As part of the Committee's oversight, H&S incidents or related matters experienced by the OCS (provider of Housekeeping/catering services) and Skanska teams (PFI Building Owner) are reported to the Trust on a monthly basis via the monthly report received from Project Co. This is a contractual requirement between the organisations. Any immediate issues are escalated to the Trust Estates and Facilities Team for information, communication, and escalation as required.

The Trust's Health & Safety Committee at Royal Papworth Hospital NHS Foundation Trust is Chaired by the Chief Nurse as Executive Lead. The Health and Safety Committee meets quarterly and reports into the Quality and Risk Committee, with escalation to the Trust Board.

The Health & Safety Committee is tasked with monitoring the development, implementation, audit and delivery of health and safety organisational management throughout the Trust. The committee has two formal sub-committees which report into H&S committee as listed below:

- Radiology Protection Committee
- Medical Gases Committee

Further key quarterly reports are also received from the following areas:

- Estates and Facilities Management (including fire and security updates)
- Moving and Handling (including incident review and training compliance)
- Occupational Health for Staff (including skin surveillance)
- Infection Prevention and Control for Staff and Patients - relating to H&S (including Fit testing)
- Health and Wellbeing from Workforce
- H&S Quality Report from Clinical Governance (for staff and patients) related to; incidents (including RIDDORS's), H&S risk assessments (open/closed in quarter), training of staff on

H&S related subjects. Overview of H&S representatives who have been nominated and their training compliance for all areas of the Trust (both at the hospital and other offsite facilities).

- Relevant updates from Project Co, Skanska and OCS from their link representatives for H&S related matters for the building and maintenance. This may be in person at committee meetings or via the Trust Estates reports as required. This information is received monthly, alongside any H&S issues to be raised by the Trust team, for governance purposes and to ensure oversight from a Risk Management perspective.

3. Health and Safety Training and Risk Management

The Health and Safety at Work etc. Act 1974 and Management of Health and Safety at Work Regulations 1999 places responsibilities on employers and employees with respect to H&S at work. For supervisors, this includes the responsibility to ensure staff are suitably monitored and supervised with respect to H&S.

The previous Risk Manager left the Trust during the 2024/2025 reporting period in April 2024 and at this time the title and scope of this role was updated. The new Health and Safety Risk Manager was appointed within the same month and commenced working for the Trust in July 2024. The current post holder has the Institute of Occupational Safety and Health (IOSH) membership and holds the NEBOSH Diploma in Occupational Health and Safety.

H&S legislation requires that all staff are provided with appropriate information, instruction, training, and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of all employees (including young people on work experience, volunteers, contractors/self-employed and Union Representatives). The level of education is based upon training needs analysis, job role, location and service need. The learning outcomes are supplemented by specific job and site training as necessary to ensure competence in safe working practices and compliance with legal requirements. Table 1 shows percentage compliance with training in the mandatory elements of Health and Safety at work for 2024/25.

	Apr 23 - Sept 23	Oct 23 - Mar 23	Apr 24 - Sep 24	Oct 24 - Mar 24
Fire Safety	88.47%	86.63%	85.80%	87.29%
Conflict Resolution	92.66%	92.06%	92.96%	93.24%
Health, Safety and Welfare	93.32%	93.52%	94.20%	94.13%
Infection Prevention and Control - Level 1	93.63%	93.65%	93.81%	92.83%
Infection Prevention and Control - Level 2	86.20%	84.85%	83.42%	84.92%

Table 1 – Compliance with Health and Safety mandatory training for each 6-month period

Compliance with Trust mandatory H&S training remains comparable to that reported in the previous financial year.

In addition to mandatory training provision for all staff the Trust nominated H&S representatives and managers received in house training provided by the previous Risk Manager. Previously, training was delivered on an ad hoc basis throughout the year and was divided into individual training sessions dependent on topic. This included separate sessions on H&S Rep Training, H&S Inspections, H&S Risk Assessment Training, Control of Substances Hazardous to Health (COSHH) and Display Screen Equipment (DSE).

Training is now scheduled to be delivered by the H&S Risk Manager with sessions commencing in July 2025 and all sessions will be combined and streamlined into a 1-day course. Topics covered by the session will include:

- What is a health and safety rep?
- How to conduct a H&S inspection

- DSE Assessments
- Basic Risk Assessment completion
- COSHH Assessments

This will be delivered in person and will include some scenario-based training. In addition to this a monthly drop-in session by the Health and Safety Risk Manager will provide additional support for role commencement and to further embed learning. Training levels will continue to be reported to the Health and Safety Committee on a quarterly basis to provide assurance on the provision of suitable and sufficient training provision across the Trust.

A review of nominated H&S Representatives and Managers was also undertaken to ensure that those previously listed as responsible staff remained correct. Alongside this a hospital mapping exercise was completed to ensure that all areas of the hospital have regular H&S inspections conducted. This review identified several areas that had previously not received regular inspection and, following allocation, assurance is now provided on their inclusion.

Amendments to the inspection timelines has occurred with all inspections now due to be conducted on an annual basis and within the same month of October as a Trust wide focus on Health and Safety. This will allow for strategic support for implementation and to enable teams to adequately plan and facilitate for H&S representatives and Managers to be provided with dedicated time for completion.

3.1 Risk Management in the Trust

Risks associated with Health and Safety at work are captured onto the Trust Datix® Risk Register, and these are located across the Health and Safety, Corporate, Board Assurance Framework (BAF) and Emergency Planning (EPRR) registers.

Risks relating to Health and Safety currently includes:

- **Biological hazards** relating to a risk of failure to protect patients from harm caused by hospital acquired infections (ID675 – BAF Risk – 16) remains with oversight from the Trust board. Improvement plans are in place in relation to compliance with IPC standards and a ventilation safety group oversees maintenance and monitoring of ventilation systems trust-wide. During 24/25 the risk of biological particles / fungal spores entering the RPH ventilation system from neighbouring building projects (ID 3703 – Corporate Risk – 12) was realised and current air handling systems are under review with consideration of air testing to mitigate against this risk.

- **Violence and aggression** remain a risk to staff due to the nature of the business with Physical and Psychological harm to staff from patients and others being reported as a high risk specifically within Critical Care (ID204 – Corporate Risk – 9). Current controls are adequately controlling the risk with incident numbers regularly monitored. The overall risk of assault, violence and threats is managed with a security team via contractor OCS on site (ID3622 – Corporate Risk – 8). Advanced training for these staff members in de-escalation techniques is currently being considered, and additional swipe card access has been installed to further mitigate the risk.

  Formulation of an abuse violence and aggression workstream has been developed to look objectively at staff survey results reporting increased levels of incivility within the Trust. This is discussed further in the report under section 7 in relation to reporting of these incidents.

- **Fire and evacuation** procedure risk includes the Trust wide evacuation strategy (ID3677 – EPRR – 12) which has been realised within the last financial year 24/25 and this links

directly to the previously identified risk associated with vertical evacuation procedures (ID3501 – EPRR – 8). A review and revision of evacuation plans are underway by the Fire Safety Manager with support from an external fire specialist to ensure compliance with the relevant legislation.

- **Staff injury from sharps** (ID1827 – Corporate Risk – 6) remains a residual risk due to the nature of the business. However, a rise in needlestick injuries across 24/25 when compared with 23/24 has prompted a review of safer sharps Trust wide as discussed further in section 6.1.

- **Moving and handling** risks relating to patients (ID928 – Corporate Risk – 8) and other inanimate loads (ID2881 – Corporate Risk – 8) continues to be mitigated against with the provision of Trust wide moving and handling training. To reduce the risk from patient moves, patient hoists are provided both fixed to the ceiling and as portable systems. These continue to be serviced in-line with Lifting Operations & Lifting Equipment Regulations 1998 (LOLER) by a competent person.

  The use of non-automated doors has been identified as a risk during 24/25 (ID3680 – Corporate Risk – 12). Work has been undertaken to automate high frequency used doors with consideration of delayed closing devices on other areas.

The complete Datix® register continues to have existing risks evaluated to ensure that their placement within each of these registers is accurate and appropriate. In particular it has been identified that some risks recorded onto the Health and Safety risk register may be corporate risks as opposed to formal risk assessments. Progression into this data cleansing is reported and overseen by the Health and Safety Committee to provide assurance and the Health and Safety Risk Manager is linking closing with the clinical teams to update this information appropriately.

The open Health and Safety risk assessments and risks are monitored by the Health and Safety Committee on a quarterly basis to aid overall compliance and assurance. As of time of reporting there are currently 150 open records and of these 27 (18%) are overdue for review. In comparison with 2023/2024 the total number of Health and Safety risk assessments/ Risks has reduced by 20 (170-150), and an 18% improvement in risk-review compliance was observed (36%-18%).

Key areas for improvement for Training and Health and Safety Risk Management for 2025/26

- To re-commence Trust wide Health and Safety Representative and Manager Training to allow for role completion.
- Continue to cleanse the Health and Safety Risk Assessment module of Datix® to establish any corporate risks and update these where appropriate.

4. Health and Safety Incident Reporting

All incidents (including H&S incidents) are reported on the RPH Datix® system. Table 2 outlines the number of health and safety incidents from April 2024 to March 2025 affecting staff, patients and others. During 24/25 financial year there have been 847 incidents that relate to Health and Safety, which depicts a 5.8% (n=49) decrease in the total number of incidents reported when compared to 23/24 financial year (n=888). The decrease of additional incidents was noted across all areas and no distinct themes were identified.

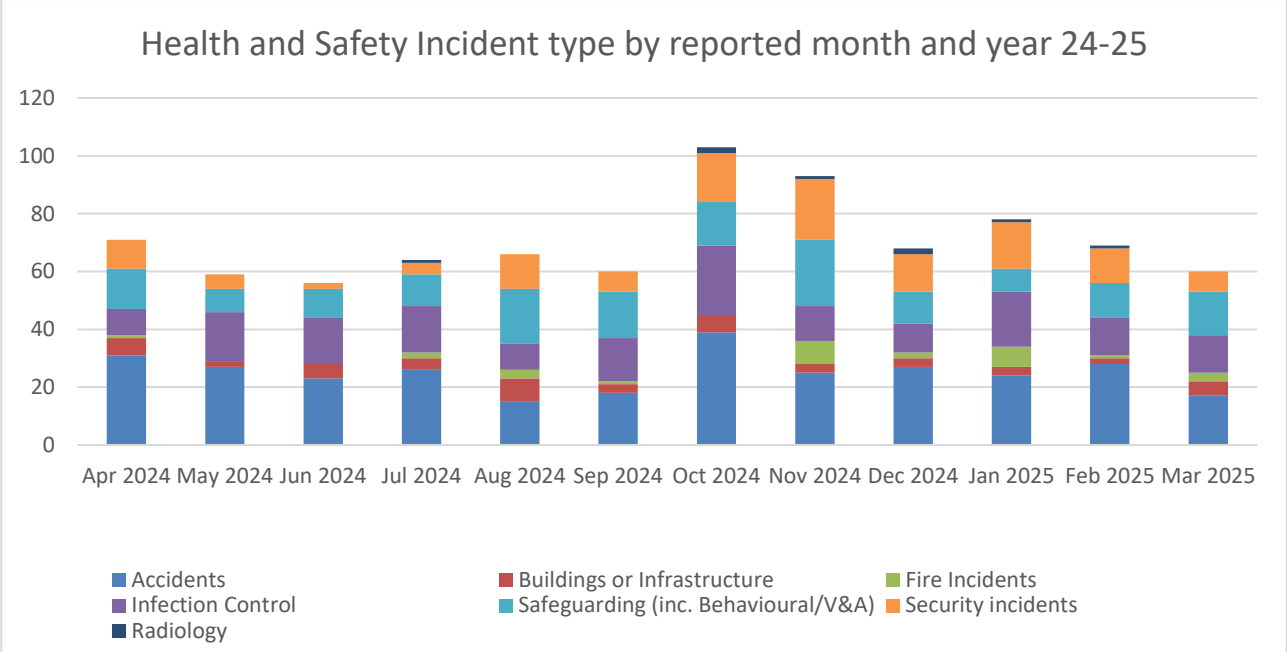
The majority of incidents were graded as near miss, no harm, low harm 98% (n=832). The remaining 1.8% (n=15) related to moderate harm (10 staff and 5 patients related). The harm levels of incidents are comparable to 23/24, where the majority were also graded as near miss, no/low harm (99%) with the remaining 1% relating to incidents of moderate harm. For the data period 2024/2025 there were no Health and Safety associated Serious Incidents reported.

Table 2- Total Health and Safety incidents reported from April 2024 to March 2025

All incident Types	Near Miss	No harm	Low harm	Moderate harm	Total
Accidents	16	103	168	13	300
Infection Control	3	96	72	2	173
Safeguarding (inc. Behavioural/V&A)	0	100	62	0	162
Security incidents	0	105	21	0	126
Buildings or Infrastructure	2	30	18	0	50
Fire Incidents	0	26	2	0	28
Radiology	0	4	4	0	8
Total	21	464	347	15	847

Data Extracted from Datix® 09/07/2025.

Graph 1 shows the Number and Type of incidents reported each month in the year 2024/25:



Data extracted from Datix® 09/07/2025

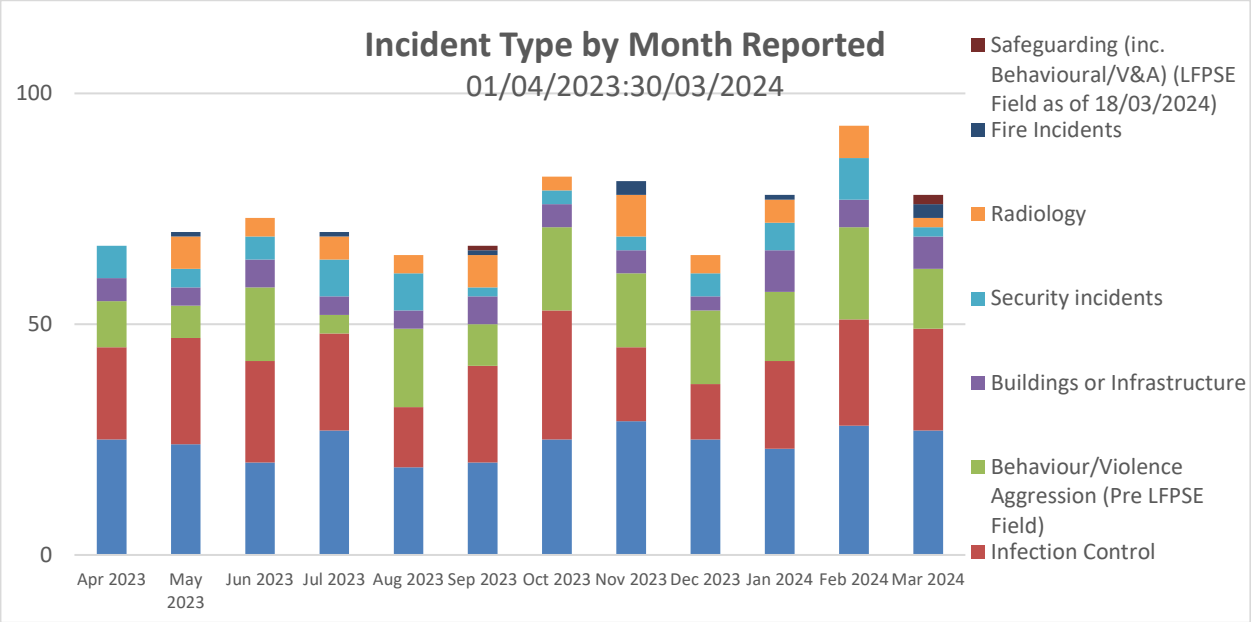
As seen in the data Table 2 and within graph 1 above the main three incident types reported for patients and staff were:

1) Accidents (n=300) – 35% of incidents reported in 2024/25
2) Infection Control (n=173) - 20% of incidents reported in 2024/25
3) Safeguarding (inc. Behavioural/V&A) (n=162) - 19% of incidents reported in 2024/25

The top three incident types (in addition to the less frequently reported incident types) remain comparable between 2023/24 and 2024/25, as shown in Graph 1 which depicts health and safety incidents reported in 24/25 (Accidents (292) = 33% of incidents reported in 2023/24/ Infection Control (240) = 27% of incidents reported in 2023/24/ Behaviour / Violence Aggression (164) = 19% of incidents reported in 2023/24).

The following additional categories reported in 24/25 had similar incidents numbers to that reported in 23/24: Buildings or infrastructure (50), Security Incidents (126), Radiology (8) and fire incidents (28).

Graph 2 shows the number and category of incidents reported each month in the year 2023/24:



Graph 2 Data extracted from Datix 16/08/2024

5. Accident Incidents for staff and other workforce working in the Trust

Table 3 depicts accidents by sub-categories for the Trust's Workforce (involving Staff / Contractor / Student / Volunteer). There were 85 accidents recorded in financial year 24/25 with 23 no harm incidents, 52 low harm incidents and 10 moderate harm events (all of which were RIDDOR reported).

Table 3 – Accident sub-categories – Staff, Contractor, Student (Apprentice) and Volunteers

Accident sub-categories - Staff / Contractor / Student / Volunteer	Near Miss	No harm	Low harm	Moderate harm	Total
Collision with fixtures/fittings/equipment	0	3	13	1	17
Slip/trip/fall - Witnessed	0	3	10	3	16
Slip/trip/fall - Unwitnessed	0	2	8	3	13
Other type of accident	0	4	8	0	12
Moving & handling - inanimate loads	0	1	5	2	8
Moving & handling - patients	0	2	4	1	7
Exposure to hazardous substance (inc. chemical, dust, asbestos)	0	4	0	0	4
Became unwell/first aid given to patient/visitor etc	0	1	1	0	2
Exposure to radiation (ionizing)	0	1	1	0	2
Road Traffic Accident	0	1	1	0	2
Exposure to radiation (electromagnetic)	0	1	0	0	1
Slip/trip/fall – carrying/lifting objects	0	0	1	0	1
Total	0	23	52	10	85

Data Extracted from Datix® 10/07/2025

To note, between table 3 (accidents incidents involving staff, contractors, students and volunteers) and table 4 (accidents involving patients and the public) there are 4 events more than the true incident total. This is due to 4 incidents where both staff and patients were affected and thus the information has been captured twice

Out of the staff, contractor, student and volunteers' accidents top 3 sub-categories were: Slip/trip/falls the highest number reported (n=30) and of these 6 were reported to HSE under RIDDOR; collision with fixtures and fittings (n=17) demonstrated 1 HSE RIDDOR reportable injury; and moving and handling incidents (n=15) in which 3 were reported to HSE via RIDDOR.

Accidents involving substances hazardous to health or ionising radiation were all graded as low or no harm, including Exposure to hazardous substance (inc. chemical, dust, asbestos)/ Exposure to radiation (electromagnetic)/ Exposure to radiation (ionising) in which there were a total of 7 incidents. These incidents report blood splashes/ radioactive pharmaceutical spillages/ inadequate handover to staff for patients with radioactive tests/ radioactive contamination of tunic bottoms / floor contaminated with radioisotope.

5.1 Accident Incidents for Patients and Public (visitors)

In relation to patients / visitors as seen in Table 4 below, 81% (176/218) of accidents related to slips / trips / falls across a variety of areas. For clarity this is the most commonly reported patient safety incident within healthcare and relates to an event where the person or a body part of the person comes to rest inadvertently on a surface lower than them. The majority of these incidents relate to clinical condition, patient frailty and age, medical deconditioning or medication interactions and do not relate directly to health and safety concerns. The current Datix reporting system at the Trust categorises slips / trips / falls under the accident category, however, work is underway in 2025 / 2026 to review this categorisation.

There were no public harm events and in total there were two patient moderate harm accidents, which related to patients that came to harm in our hospital from a fall in the ward environment.

1. WEB52133 – fractured neck of femur due to leg weakness post procedure. The review did not represent any health and safety concerns.
2. WEB52308 - left tibial plateau fracture due to a patient slipping on some soap whilst in the shower. The review did not represent any health and safety concerns.

Patient falls are not covered within the scope of this report as they are comprehensively reviewed within the Falls Prevention and Management Group with oversight from the Harm Free Care Panel and the Quality Risk Management Group.

Table 4 – Accident Sub-categories – Patient and public (Visitors)

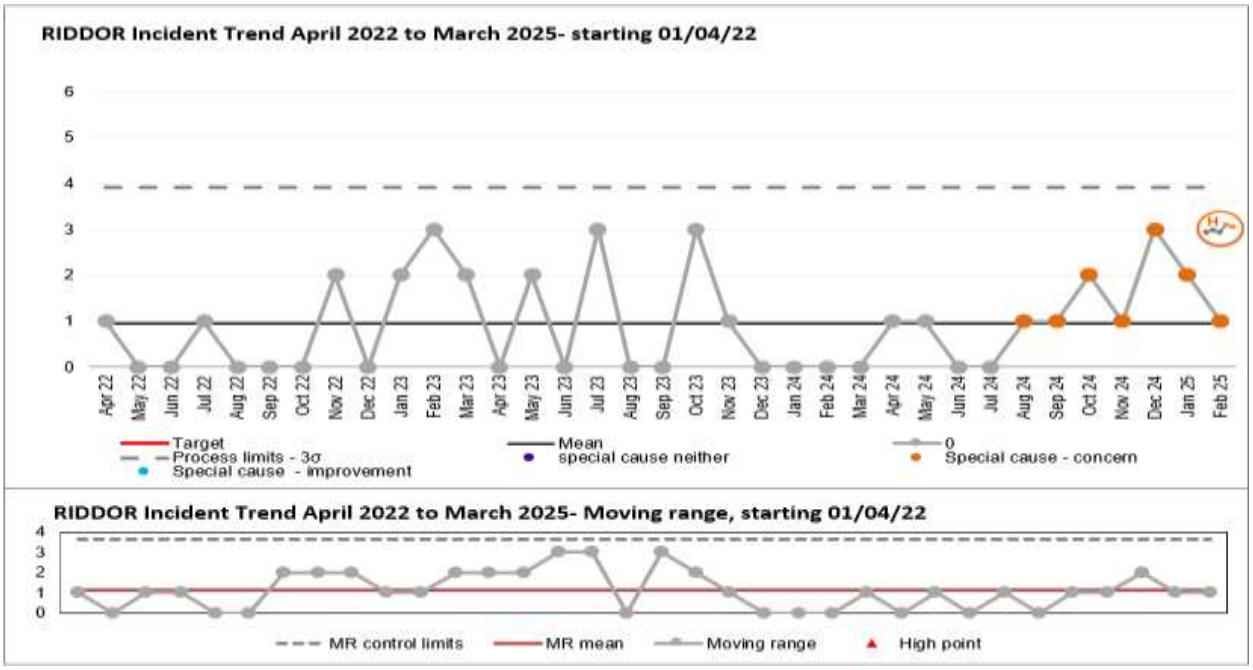
Accident Sub-categories – Patient and public (Visitors)	Near Miss	No harm	Low harm	Moderate harm	Total
Slip/trip/fall - Unwitnessed	4	47	76	2	129
Slip/trip/fall - Witnessed	1	15	16	0	32
Other type of accident	1	6	10	0	17
Patient lowered to the floor (near miss)	9	5	1	0	15
Moving & handling - patients	2	7	4	0	13
Collision with fixtures/fittings/equipment	0	0	6	0	6
Became unwell/first aid given to patient/visitor etc	0	1	2	0	3
Contact with hot or cold sources	0	1	1	0	2
Exposure to radiation (ionizing)	0	0	1	0	1
Total	17	82	117	2	218

Data Extracted from Datix® 10/07/2025

Reporting of Injuries Diseases & Dangerous Occurrences Regulations (RIDDOR)

RIDDOR legislation requires all accidents and incidents occurring on site or in relation to work activities, that result in an over 7-day absence from work to be reported online to the HSE via the designated reporting platform. In addition to reporting all incidents and injuries to staff at RPH, RIDDOR legislation requires employers, and other people in charge of work premises to report and keep records of all: work-related fatalities, work-related accidents resulting in certain specified injuries (reportable injuries), diagnosed cases of certain industrial diseases and certain dangerous occurrences (incidents with the potential to cause significant harm). The purpose of the regulations is to inform the relevant enforcing authority that a work-related accident or incident has happened. This includes the Health and Safety Executive and local authority to respond to ensure compliance with health and safety law.

Graph 3 - shows Total RIDDOR reportable incidents by month for the past 3 years.



Data extracted from Datix® 14/07/2025.

Within the financial year (2024/25), the Trust reported 13 RIDDOR reportable incidents compared to 9 in the previous financial year (2023/24). Although this increased by 4 from 2023/24 it remains comparable to figures reported in 2021/22 and 2022/23 (n=11). Of these 13 RIDDOR incidents, 10 were reported due to injuries from work which resulted in sickness absence of over 7 days. The remaining 3 incidents were reported as dangerous occurrences, as they related to the release of biological incidents due to the involvement of dirty needlestick injury with patients with a known Blood Bourne Virus (HIV and Hepatitis C).

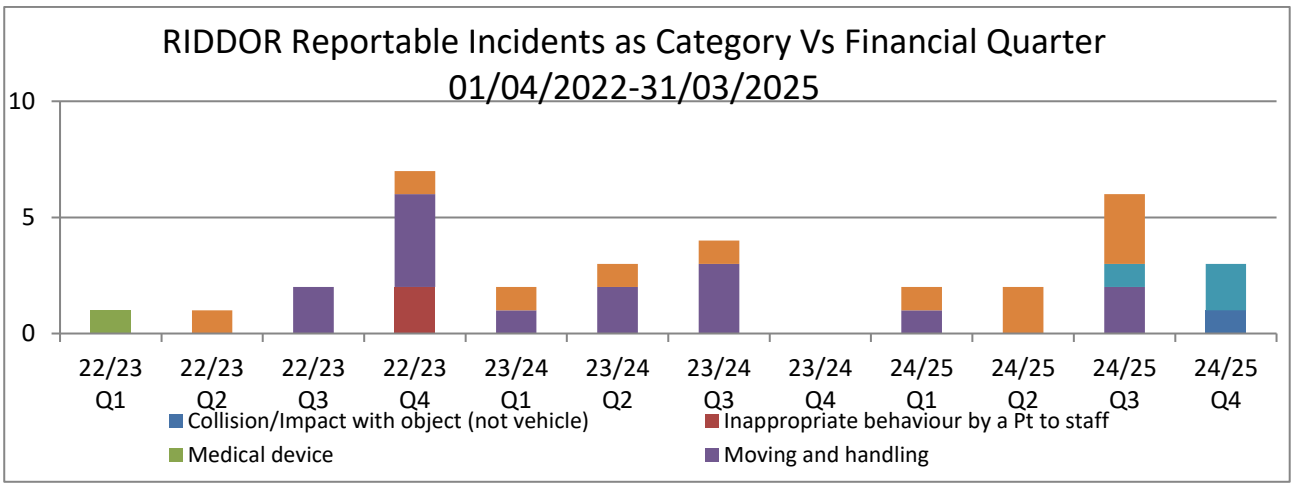
Graph 3 above shows a statistical process chart of RIDDOR reportable incidents by month over the last three financial years. The graph depicts a relatively small number of events in any given month, with over 50% of months over the 3-year period having no RIDDOR reportable events. Whilst the chart suggests a statistically significant run of RIDDOR reportable incidents between August 2024 and February 2025 (as highlighted by the orange dots) this special cause variation is likely due to the low numbers reported, as relatively small changes may appear significant proportionate to the low total number of events.

Table 5 - Shows the RIDDOR reported incidents in the financial year 2024/25, by directorate.

	Cardiology	Cath Labs	Estates	Surgical	Theatres, Critical Care and Anaesthesia	Total	% Total RIDDORS
Collision/Impact with object (not vehicle)	0	0	0	0	1	1	8%
Moving and handling	1	0	0	1	1	3	23%
Sharps	1	0	0	0	2	3	23%
Slip, Trip or Fall	0	1	1	3	1	6	46%
Total	2	1	1	4	5	13	100%

Data extracted from Datix® 10/07/2025

Graph 4 - shows RIDDOR reportable incidents reported by financial quarter and category for the past three years (01/04/2022-31/03/2025).



Data extracted from Datix® 14/07/2024.

Table 5 and Graph 4 above demonstrate that the most common RIDDOR reportable injury in the past financial year related to slips, trips and falls (46% 6/13) which demonstrates a change from 2023/24 where moving and handling incidents were the most common (67% 6/9). Of these incidents, 5 were reportable due to related absence from work for over 7 days. The final incident was a specified reportable injury as a broken wrist (WEB 53806) but also resulted in incapacitation from work for over 1 week.

Four of the reportable injuries reported over the year occurred on 5 North Surgical ward with three of these relating to slips and trips. One related to tripping over a foot stool which has now been removed from use, one due to a slip on a urine spillage from a broken catheter and one from a patient sliding sheet. All incidents had a full investigation carried out and were discussed at the Safety Incident Executive Review Panel (SIERP) with any trust wide learning raised.

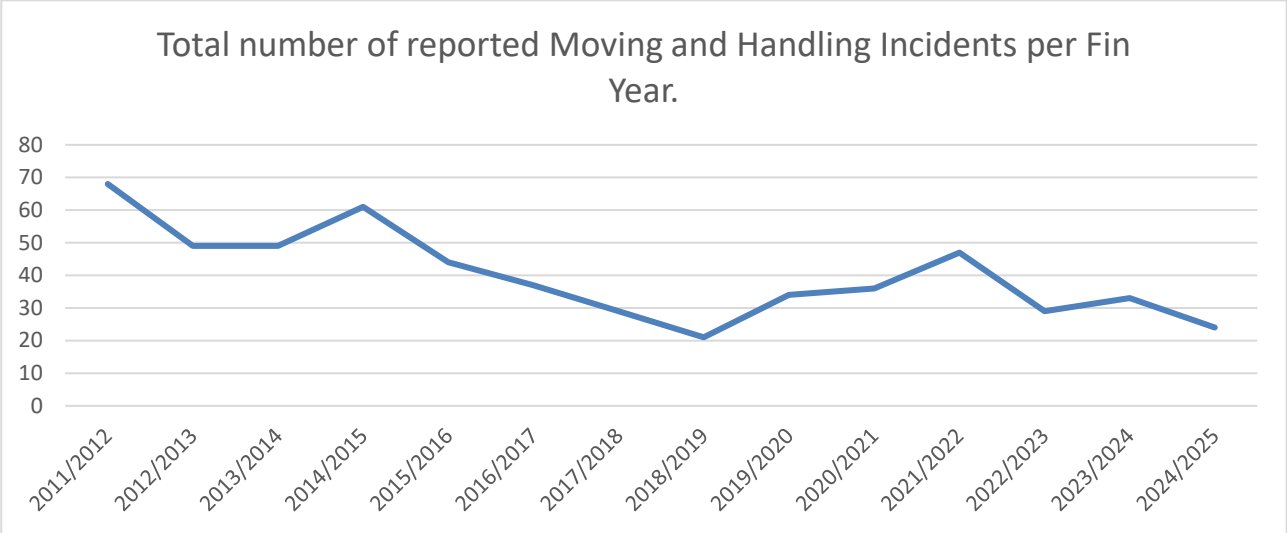
Key Areas for improvement for RIDDOR reportable incidents for 2025/26

- The Trust will continue to monitor the types and themes of RIDDOR reportable incidents
- Further education on work-place assessments will form part of the Health and Safety Representatives and Mangers training to support mitigations against hazards and risks in departments across the Trust

5.3 Moving and Handing

The total number of reported Moving and Handling Incidents (including patients, visitors, staff, contractor, student (apprentice) and volunteers) has decreased by 27% this year from 33 reported in 2023/24 to 24 reported in 2024/25. Out of these incidents, 3 were staff RIDDOR reportable incidents as displayed above. Graph 5 shows the trend of moving and handling total incident by year from 2011/12 to 2024/2025.

Graph 5 - Total number of reported Moving and Handling Incidents per financial year.



Critical Care (CCA) has achieved a significant reduction in the number of reported incidents from 16 in 2023/24 to 2 in the previous 12 months. Level 5 North and South has shown an increase in the number of incidents reported from a total of 8 across both areas in 2023/24 to 10 in 2024/25. One of the RIDDOR reportable injuries occurred on 5 North and related to an accident in which a staff member trapped their hand between a piece of equipment and a door (WEB54397).

Of all incidents reported from across the Trust 50% of these (n=12) related to a staff member incident and the other 50% to a patient safety incident. When considering common themes and trends moving and handling of patients remained the highest category reported demonstrating 33% of all incidents (n=8). This is a recognised risk within the healthcare sector due to the frequency of the task performed in addition to the nature of the moving and the load involved.

Non-automated doors were reported to have caused incidents three times across the course of the year and this links in with the previously discussed risk ID 3680 and the lack of automated doors. As stated above a number of these doors have now been updated to have automatic fixings with slow closers being considered on further doors across the Trust.

5.4 Moving and handling Training

Mandatory training has been successfully conducted across 2024 and a permanent training space has been established on Level 3. This has allowed for a patient room to be simulated that can remain permanently present with no interference with clinical care.

Table 6 demonstrates the moving and handling training compliance for level 1 and level 2 by month over the last year 2024/25. There is a slight variation in month, but this has not reached the Trust target of 95% for both L1 and L2.

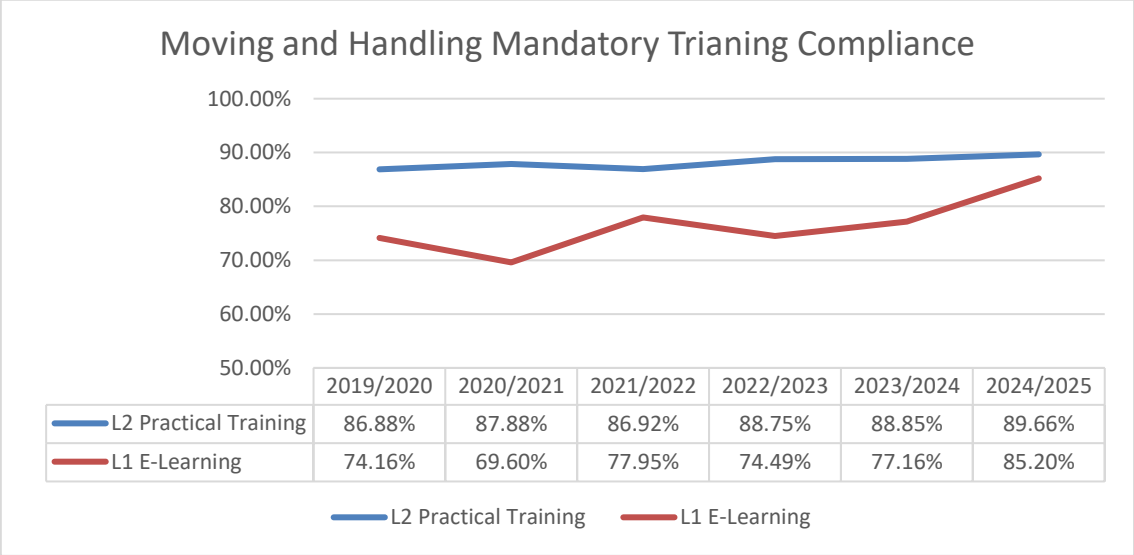
Table 6 - Moving and handling training compliance for 2024/25

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Average Yearly Compliance
L1	89.25%	90.14%	89.13%	88.39%	90.23%	90.21%	90.45%	90.30%	89.91%	89.71%	89.62%	88.56%	89.66%
L2	80.10%	80.80%	84.72%	85.24%	85.89%	85.54%	86.62%	86.21%	87.34%	86.61%	87.09%	86.18%	85.20%

When considering training compliance over the previous six years there has been a small increase in average yearly compliance of Level 1 E-Learning training from 87% to 90%. Level 2 Practical Training has seen a significant increase in training compliance from 74% 2019/20 to 85% in 2024/25.

Of the 706 available training spaces for Level 2 Practical Training only 70% of the training spaces were utilised successfully. Spaces that were not utilised included 142 non-filled spaces, 74 spaces where staff did not attend and 39 late cancellations; however, this was offset slightly by 49 members of staff attending on an ad hoc basis without having pre-booked.

Graph 6 - Shows the moving and handling training compliance for level 1/2 over the last 6 years.



Following a Moving and Handling training needs analysis, medic only mandatory drop ins are now an established part of the training planning. During 2024/25 an additional 17 medical staff have been trained and the Level 2 (Medic specific) Moving and Handling compliance has improved considerably from 59% in the previous year to 70% this year.

Key Areas for improvement for manual handing for 2025/26

- Due to increasing numbers experienced across the Trust a bariatric patient handling study day is due to take place July 2025.
- Continue to strengthen the work-based instructor programme to increase ability to train staff across the Trust and further increase training compliance across all staff groups.

6. Infection Prevention and Control Incidents

The Control of Substances Hazardous to Health (COSHH) (2002) covers micro-organisms and is defined as any micro-organism, cell culture, prion or human endoparasite whether genetically modified which may cause infection, allergy, toxicity or otherwise create a hazard to human health. Incidents relating to infection control may lead to exposure to biological hazards and therefore are overseen by both the Infection Prevention Control Committee and Health and Safety Committee. Particular attention is paid to sharps injuries, fit-testing and skin surveillance for staff as discussed further within the report.

Table 7 – IPC Incidents by Severity for the year 2023/24

	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
Near Miss	0	0	1	0	1	0	1	0	0	0	0	0	3
No harm	5	10	9	11	6	12	14	5	6	7	6	5	96
Low harm	4	7	6	5	2	2	9	7	2	11	7	8	72
Moderate harm	0	0	0	0	0	1	0	0	0	1	0	0	2
Total	9	17	16	16	9	15	24	12	8	19	13	13	173

Data extracted from Datix® 11/07/2025.

As shown in table 8 a total of 173 infection control incidents were reported during 2024/25 including near-miss (3), no harm (96), low harm (70) and moderate harm (4) incidents. This demonstrates a significant reduction from that recorded in 2023/24 (n=240). All IPC incidents have been broken down further into sub-categories in table 9.

Table 8 – IPC incidents by sub-categories for 2024/25

IPC incidents by sub-category	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
Other healthcare associated infection incident	4	6	2	5	1	4	9	1	1	4	2	0	39
Contact with sharps – dirty needlestick	0	2	3	0	0	1	4	4	1	4	4	5	28
Cleaning/hygiene processes not followed	1	2	1	5	1	5	2	0	2	2	1	1	23
Contact with potentially infectious materials – blood/bodily fluids	0	2	0	1	0	2	1	0	2	2	5	1	16
Isolation process for infected patients not followed	0	0	1	1	1	1	3	1	2	4	0	1	15
Safe injections/sharps disposal not followed	0	2	2	0	1	1	1	0	0	0	0	1	8
Device, product, medication, fluid associated infections	0	0	3	1	1	0	1	0	0	1	0	0	7
Infection source – C diff. positive result	3	1	0	1	1	0	0	1	0	0	0	0	7
Contact with sharps – clean needlestick	0	1	0	0	1	0	0	1	1	0	0	2	6
Infection source – cross infection	0	0	0	1	2	0	0	2	1	0	0	0	6
Infection source - Surgical wound/site infection	0	0	2	1	0	0	0	0	0	0	1	1	5
Indwelling Device	1	1	0	0	0	0	2	0	0	0	0	0	4
Infectious outbreak – Ward closed	0	0	0	0	0	1	0	1	0	1	0	0	3
Infection diagnosis delay	0	0	1	0	0	0	1	0	0	0	0	0	2
Infection diagnosis failure	0	0	0	0	0	0	0	1	0	0	0	1	2
Hand hygiene procedure not followed	0	0	1	0	0	0	0	0	0	0	0	0	1
Sterilisation procedure not followed	0	0	0	0	0	0	0	0	0	1	0	0	1
Total	9	17	16	16	9	15	24	12	10	19	13	13	173

The most frequently reported categories included:

1. Other healthcare associated infection incident (n=39),
2. Dirty needlestick injuries (n=28),
3. Cleaning/hygiene process not followed (n=23)
4. Contact with potentially infections materials – blood/bodily fluids (n=16).

Whilst dirty needlesticks and cleaning/hygiene remained a key theme between 2023/24 and 2024/25 the total reported events related to these themes had decreased between financial years. Sharps injuries are discussed further below in section 6.1

6.1 Sharps safety

Measures to avoid occupational exposure to blood borne viruses including prevention of sharps injuries must include the safe handling and disposal of sharps. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, known herein as the Sharps Regulations 2013, provides legal obligations relating to the use of Sharps. This legislation is further supported with guidance from the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance. This includes avoiding unnecessary use of sharps (Reg5(1)(a)), and the provision and use of safer sharps with protection mechanisms where reasonably practicable to do so (Reg5(1)(b)),

The COSHH Regulations require systems for the safe disposal of contaminated waste, and this is supplemented by the Sharp Regulations 2013 that require easy access to secure containers with appropriate instructions for safe sharps disposal (Reg5(1(d)).

The Sharps Regulations 2013 Regulation 8 states that an employee injured by a sharps instrument has a duty to report this as soon as practicable including if the injury occurs outside of normal working hours. The Trust policy DN180 Needlestick Sharp and Splash Incidents involving blood or body fluids contains information on steps that should be taken following a Sharps injury. This policy is currently under review as it has been recognised that a flow chart of information on steps to be taken, including reporting both onto the Datix incident system and to OH are not always undertaken following an incident.

During Q4 of 2024/2025 a new process has been established to provide a report to the OH department to ensure that all needlestick injuries reported via the Datix incident system have also been reported to OH. This will aid assurance that staff that have sustained Sharps injuries are followed up by the OH department for any further support required and to allow for the further review and analysis of these incidents to occur. Regulation 7(1) of the Sharps Regulations also states that a record of sharps injury must be kept with the circumstances and cause of the incident in addition to any actions required to prevent further incidents.

The main data for RPH sharps injuries has been captured through Occupational Health (OH) via staff referral numbers. The Quarterly and annual Data for the data period 2024/25 is included in Table 9 below.

Table 9 - sharp injury data is captured through Occupational Health via referral by Year/Quarter

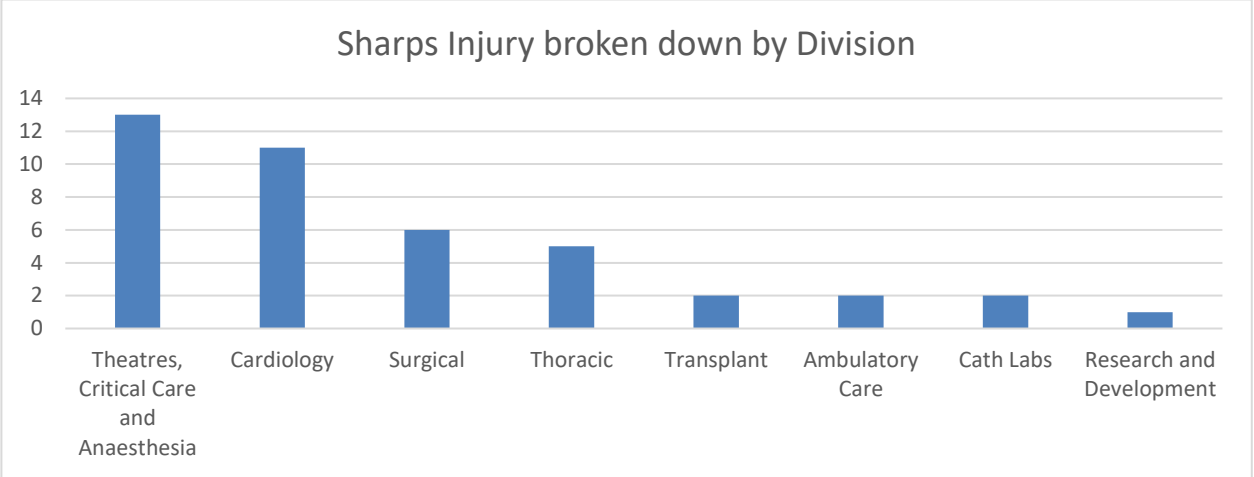
Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2021/22	9	8	11	22	52
2022/23	10	5	10	12	37

2023/24	14	8	9	14	45
2024/25	8	6	12	16	42

Data provided by OH 07/07/2025.

There were 42 referrals to OH received in total across 2024/2025 representing a slight decrease when compared to 2023/24 when 45 incidents were reported. Maintenance of similar numbers of reported needlestick injuries are felt to be related to the improved documentation on sharps, splash and needlestick injuries (SSNI) which was incorporated late 2022/23 and has been maintained throughout both financial years.

Graph 7 – Sharps injuries broken down by Division for 2024/25



Data provided by OH 07/07/2025.

Graph 7 above depicts that Theatres, Critical Care and Anaesthesia and Cardiology had the most sharps injuries (57.14%). This is as expected due to the significant use of sharps within these areas, many of which cannot be replaced with safer sharps alternatives due to the nature of their use.

In Table 10 below, the distribution of sharps injuries across the staff groups is recorded. The nursing discipline reported the highest numbers of both needlestick/sharp injuries (n=22) and splash / spray of blood / bodily fluid incidents (n=5), representing 64% of all OH exposure referrals. Once again this is as would be expected due to the nature of the tasks that nurses are required to undertake in addition to the higher staff numbers within this group.

Table 10 – Sharps injuries broken down by staff group in 2024/25

Professional discipline	Needlestick/sharp	Splash/Spray of Blood/Body Fluid	Grand Total
Health Care worker	**4**	**2**	**6**
Doctor	**5**	**4**	**9**
Nurse	**22**	**5**	**27**
Grand Total	**31**	**11**	**42**

When a needle stick injury occurs, normal process involves the completion of a Datix® Incident report followed by a review by the OH service for their needlestick injury, as detailed in Policy DN180 Needlestick Sharp and Splash Incidents. By providing a monthly report to OH for triangulation and confirmation of reporting there were equal numbers of sharps injuries reported through both OH (n=42) and Datix (n=42). Through this process the Trust 11 sharps injuries were reported as no harm, 29 as low harm and 2 were reported as moderate harm.

A quality improvement programme has been developed during 2024/25 to consider any themes and trends in relation to sharps injuries and the management of safer sharps across the Trust. OH are currently leading on a focussed review of these and will report into H&S committee meetings in 2025/26. Wider members of the clinical teams involved within this programme have been requested to review their local risk assessments in relation to safer sharps and whether any procedures can be updated to utilise this technology.

In addition to this, a rise in the number of sharps injuries reported within the theatre environment has prompted a review of standard procedures for the handling of equipment. It is noted that these procedures have a significant number of different sharps risks that do not fall under the category of needlestick and there are no safer sharps alternatives for these pieces of equipment. A change in practice has been introduced to minimise the likelihood that the handling of these devices will result in staff injury.

6.2 Face Fit testing

The Trust's face fit testing procedures are successfully aligned with the Health and Safety Executive (HSE) guidance as outlined in INDG 479: *"Guidance on Respiratory Protective Equipment (RPE) Fit Testing".* All fit testers have been trained by Full Support Healthcare personnel who are Fit2Fit accredited by the British Safety Industry Federation (on behalf of the HSE).

Fit testing compliance is tracked using the Electronic Staff Record (ESR) and this is overseen by the Trust's fit testing team. These levels are then monitored via the Infection Prevention and Control Committee (IPCC) and the Health and Safety Committee with a regular report of compliance levels presented.

The Trust continues to request staff are fit tested to at least one face mask (which is mandatory) and encourages fit testing to two masks or a hood (which is recommended). The IPCC has set a minimum compliance threshold of 80% for testing to one mask to ensure operational resilience. For the year 2024/25, compliance for fit testing to one mask decreased slightly to 76%, compared with 78% in 2023/24. It is recognised that this reduction may be attributed to both increased staff numbers requiring testing associated with a temporary reduction in service capacity.

Table 11 demonstrates Fit Test compliance with fit mask testing to both 1 and 2 masks

Number of Staff requiring fit testing	Number of staff that have in date fit testing to the current stock (1 mask)	% of staff that have in date fit testing to the current stock (1 mask)	Number of staff that have in date fit testing to the current stock (2+ masks / hood)	% of staff that have in date fit testing to the current stock (2+ masks / hood)
2049	**1548**	**75.55%**	**1259**	**61.44%**

TABLE 11: Data provided by ESR staff data. Correct as of 31/03/2025

The medical staff group continues to demonstrate the lowest levels of compliance, consistently falling below the 80% threshold.

An additional 200 clinical staff members required fit testing during 2024/25, placing further pressure on service capacity. A temporary reduction in service provision occurred between December 2024 and February 2025 due to the loss of a full-time fit tester. The service resumed full operation in February 2025 following the appointment of a new fit tester, with availability restored from Monday–Friday.

Non-attendance at pre-booked fit testing appointments remains a persistent challenge. Contributing factors include clinical shift cover, staff illness, and failure to attend due to oversight. Work is ongoing with clinical teams to support attendance and improve scheduling flexibility.

6.3 Staff Skin Surveillance

The Control of Substances Hazardous to Health Regulations (COSHH) 2002, supported by the Management of Health and Safety at Work Regulations (MHSWR) 1999, require skin surveillance to be undertaken for those members of staff that are exposed to potentially harmful chemicals or skin irritants on a regular basis.

Staff skin surveillance is an area which is overseen in the Trust by Workforce and Occupational Health. Previously, regular reviews of staff hands were carried out during the winter vaccination clinics before the Covid pandemic by a competent person. This involved the review and assessment of frontline staff hands by the vaccinator and allowed for a high-level inspection of individual skin status. It was, however, realised that as vaccination levels across the Trust often only cover approximately 50% of staff being vaccinated, this was not sufficient as a catch all.

During 2024/25 a task and finish group was formed to establish a robust system to capture frontline staff with completion of their physical hand examinations by a competent person. The group considered several different approaches but the most appropriate related to its addition into the Trust annual appraisal process.

This has now been incorporated into the new appraisal paperwork and should be completed by any manager conducting an appraisal on a staff member that is involved in wet work. A training package has been developed to ensure that the managers conducting these assessments have received suitable and sufficient training and any questions or queries are to be followed up with the OH team.

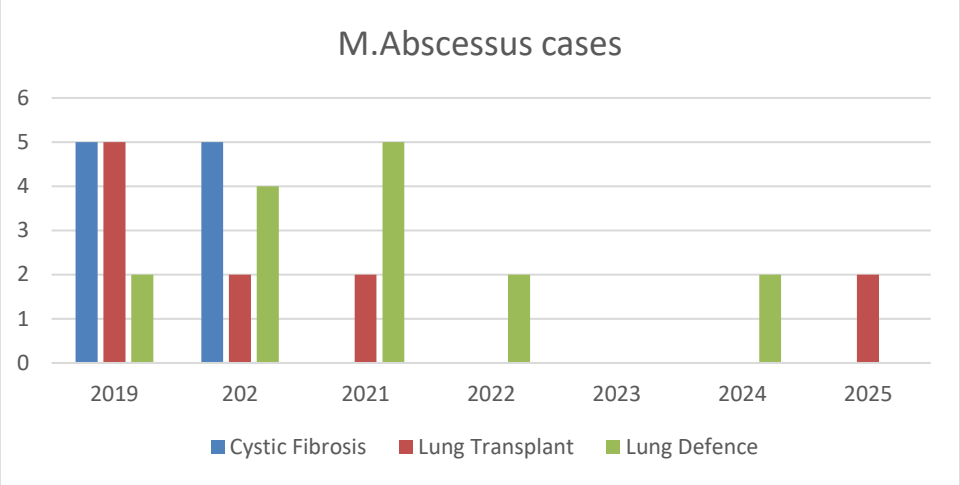
An internal electronic form is currently being developed to hold the data from these assessments and to allow for feedback to OH as currently the electronic systems used between RPH and the OH department are not compatible. In addition to this, OH will continue to send questionnaires to all staff across the Trust asking for feedback on their current skin condition. Further updates and monitoring of this progress will be updated to the H&S Committee throughout the year with escalations as required to the Quality and Risk Committee.

6.4 Hospital Acquired potential *Mycobacterium abscessus* (M abscessus)

M abscessus is a rare infection which can prove problematic for individuals that are immunosuppressed or suffer from specific underlying respiratory conditions. Following routine water testing in 2019 and identification of M abscessus (related to the strain identified in the water) in 2 lung transplant patients RPH declared an outbreak. A subsequent investigation was undertaken which led to several water safety measures being implemented. Since this time, the Trust Water Safety Group, overseen by the IPCC, have regularly reviewed safety measures in respect to their effectiveness.

Prevalence and current position: A total of 67 patients have had a confirmed diagnosis of M abscessus since the hospital relocated to the Biomedical campus in 2019. Of these cases 38 have been confirmed as being related to the outbreak strain via genetic sequencing provided by the UK Health Security Agency (UKHSA). The profile of positive cases annually is shown in graph 8. It is worth noting that two cases were linked to laboratory sample contamination and therefore have been omitted from the data displayed.

Graph 8 number of annual positive M Abscessus cases linked to the outbreak since 2019



Since implementing enhanced water safety controls and engineering interventions, the Trust has significantly reduced the incidence of new *M. abscessus* infections. In 2024/25, 3 out of 7 new cases were linked to the original outbreak cluster, demonstrating ongoing improvement but continued need for vigilance.

The M abscessus Steering Group, established in January 2021, continued to meet regularly during 2024/25. The group includes representation from IPC, Estates and Facilities, Clinical and Research, Governance, Communications, and Clinical and Research teams. Regular updates are provided to the Executive Oversight Committee, which also includes external stakeholders including UKHSA, the Care Quality Commission (CQC) and NHS England (NHSE). This governance structure ensures that mitigation measures remain robust and that learning continues to inform both operational and strategic responses.

Key areas for improvement for all IPC related H&S Issues:

Sharps:

- Clinical teams are reviewing departmental risk assessments in relation to safer sharps and this will be reported into H&S committee for monitoring and assurance
- OH are currently reviewing themes and trends in relation to an increase in sharps injuries across the 2nd half of 2024/2025

Fit Testing:

- Improve compliance Among Medical Staff Groups: targeted actions will focus on raising compliance rates among medical teams, where performance has consistently remained below 80%
- Increase attendance at Fit Testing appointments: measures such as reminder systems, increased appointment flexibility, and departmental support for protected time will be introduced to reduce non-attendance
- Strengthen service resilience: additional fit testers will be identified and trained to provide service continuity during periods of staff absence or increased demand
- Restore and exceed 80%: focused efforts will aim to recover and surpass the Trust's 80% target, ensuring baseline operational safety and preparedness
- Expand dual mask or hood testing coverage: increasing the proportion of staff fit tested to two masks or a hood remains a priority to improve flexibility during equipment shortages or fit failures
- Enhance fit tester training and retention: ongoing training and CPD opportunities will support skill retention and service sustainability

Skin Surveillance:

- Embedding of newly implemented process around skin surveillance and monitoring through the annual appraisal process

7. Behaviour / Violence Aggression

The Health and Safety Executive defines work-related violence as "*Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work*" [1] This can include verbal abuse or threats, including face to face, online and via telephone and physical attacks.

Under the Health and Safety at Work Act etc 1974 the Trust is required to mitigate situations arising from poor behaviours, violence and aggression between staff members but also between patients and visitors in order to keep all persons within the Trust safe. This includes, where appropriate, providing patients with safe healthcare premises when vulnerable or suicidal however it is recognised that as a Trust there is currently no provision, as we do not hold a licence to detain patients under the Mental Health act, but a process is in place to accept patients under section 17 of the Mental Health Act for specialised treatment if required (Risk ID 3783).

Incidents relating to poor behaviour, violence and aggression was the third most reported in 2024/25. A detailed breakdown of these incidents by category and division is detailed in Table 13 below. In the financial year 2024/25 there were a total of 162 incidents, and all were graded as no harm/low harm incidents. This compares to 166 reported in 2023/24 showing a minimal decrease in total numbers.

Table 12 contains a breakdown of these incidents as a category of the incident reported and the Division in which it occurred. It is worth noting that the total number of incidents reported here shows 186 (24 higher than the total number of incidents reported). This is because incidents that are reported with multiple affected parties are captured under each of these categories. There are a total of 17 incidents captured in this way.

Table 12 - Behaviour / Violence Aggression broken down by category

Category of Incident	CARDIOLOGY DIVISION	CLINICAL ADMIN TEAM	ESTATES TEAM	NURSING CORPORATE	SURGERY TRANSPLANT ANAESTHETICS DIVISION	THORACIC/ AMBULATORY CARE DIVISION	WORKFORCE DIVISION	Total
Patient Affected Incidents								
Inappropriate behaviour by a Pt to a Pt	1	0	0	0	0	0	0	1
Inappropriate behaviour by a staff to a Pt	3	0	0	0	4	2	0	9
Inappropriate behaviour by a Pt to staff	5	0	0	0	8	2	0	15
Inappropriate behaviour by staff to staff	0	0	0	0	3	0	0	3
Missing Person/Absconded	2	0	0	0	1	3	0	6
Other behavioural issue	4	0	0	0	2	2	0	8
Self-harming behaviour	0	0	0	0	2	1	0	3

Category of Incident	CARDIOLOGY DIVISION	CLINICAL ADMIN TEAM	ESTATES TEAM	NURSING CORPORATE	SURGERY TRANSPLANT ANAESTHETICS DIVISION	THORACIC/ AMBULATORY CARE DIVISION	WORKFORCE DIVISION	Total
Use/possession of prohibited goods	1	0	0	0	2	1	0	4
Staff (Workforce) Affected Incidents								
Inappropriate behaviour by a Pt to a Pt	1	0	0	0	0	0	0	1
Inappropriate behaviour by a Pt to staff	12	3	0	1	22	14	0	52
Inappropriate behaviour by a staff to a Pt	1	0	0	0	1	0	0	2
Inappropriate behaviour by staff to staff	4	1	2	12	21	4	0	44
Inappropriate behaviour by visitor to staff	3	0	0	3	2	4	0	12
Other behavioural issue	0	0	1	1	3	0	0	5
Missing Person / Absconded	0	0	1	0	0	0	0	1
Other Incidents (Including Organisational, Visitor / Member of the Public, Contractor, Student / Apprentice, Volunteer)								
Inappropriate behaviour by a Pt to staff	1	0	0	0	1	1	0	3
Inappropriate behaviour by a staff to a Pt	0	0	0	1	0	0	0	1
Inappropriate behaviour by staff to staff	1	0	3	0	0	1	0	5
Inappropriate behaviour by visitor to staff	0	1	1	0	0	3	0	5
Other behavioural issue	0	0	1	1	4	0	0	6
TOTAL	39	5	9	19	76	38	0	186

Table 12: Data extracted from Datix® 14/07/2025.

Poor behaviour, violence and aggression can present in many forms e.g. racial, physical verbal, and managing these events can be facilitated by multidisciplinary teams e.g. safeguarding and clinicians using clinical interventions. It is recognised that the implications of physical assault can have a direct impact on staff wellbeing, sickness absence and retention levels.

The two highest areas reported in year were inappropriate behaviour by a patient to staff and inappropriate behaviour by staff to staff. These have been broken down further into their sub-categories against the divisions and are detailed below in Tables 12 and 13.

Table 13 - Patient to Staff Incidents by Subcategory and Division

	CARDIOLOGY DIVISION	CLINICAL ADMINISTRATION	NURSING CORPORATE	SURGERY TRANSPLANT ANAESTHETICS DIVISION	THORACIC / AMBULATORY CARE DIVISION	Total
by patient to staff – physical	7	0	0	15	0	22
by patient to staff – psychological/bullying	0	0	0	0	3	3
by patient to staff - racial	1	0	0	0	1	2
by patient to staff – sexual	1	0	0	0	2	3
by patient to staff – verbal	6	3	1	7	9	26
by patient to staff on CCA due to delirium (CCA MM)	0	0	0	4	0	4
Total	15	3	1	26	15	60

Table 13: Data extracted from Datix® 14/07/2024.

The most reported type of incidents were verbal incidents from patient to staff (Table 13). All the incidents have been reviewed and appropriate investigations have taken place. There has been a small increase in the number of verbal incidents reported from 22 in 2023/24 to 26 in 2024/25, however, the numbers remain comparable.

Patient to staff physical incidents reported has shown a larger increase in numbers of 10 from 12 in 2023/24 to 22 in 2024/25. These increases have remained within Cardiology and Surgery Transplant and Anaesthetics (STA) with the latter showing the greatest increase (7 in 23/24 to 15 in 24/25). These patients are often the most agitated and volatile due to the effects of surgery and drug administration. It is recognised that an increased age and poor physical health can also be a contributory factor to developing delirium and confusion post-operatively and both are risk factors widely present across the Trust due to the nature of the service.

Table 14 - Staff to Staff Incidents by Subcategory and Division

	CARDIOLOGY DIVISION	CLINICAL ADMINISTRATION	FINANCE DIVISION	NURSING CORPORATE	SURGERY TRANSPLANT ANAESTHETICS DIVISION	THORACIC / AMBULATORY CARE DIVISION	Total
staff to staff - bullying	1	0	0	3	5	0	9
staff to staff – physical	0	0	1	0	0	0	1
staff to staff – psychological/ emotional	1	0	0	2	0	0	3
staff to staff – sexual	0	0	0	1	0	0	1
staff to staff – verbal	2	1	2	5	17	4	31
Total	4	1	3	11	22	4	45

Table 14: Data extracted from Datix® 14/07/2025.

The highest reported staff to staff sub-category (Table 15) remains verbal incidents with 31 incidents occurring (2023/24 29). Previously 79% of these incidents reported occurred within STA

(23/29), however, during 2024/25 incidents have been more widespread across the Trust with only 55% falling into STA (17/31).

Of the 11 incidents being recorded as occurring under the Nursing Corporate Division 8 of these occurred within the wider Trust however, are captured within the Clinical Governance and Risk department as the incidents are of a sensitive nature.

During 2024/2025 the formation of an abuse violence and aggression workstream was developed to evaluate several areas including public health standard approaches, online NHS England resources, training and ensuring implementation of the updated NHS Violence Protection Reduction Standard. This comes as a result of a nationwide result showing that one in four people completing the 2023 NHS Staff Survey had experienced at least one incident of harassment, bullying or abuse from patients or other members of the public within the previous year. At RPH this figure from the 2024 staff survey showed that 17.6% of staff had experienced at least one of these incidents and so was slightly below the nationally reported average.

The group are also considering the methods of reporting of abuse violence and aggression throughout the Trust. Currently this is via the Datix® Incident reporting system or within the annual staff survey. The development of an anonymous reporting system for incidents is being developed for launch in the summer of 2025 to allow staff to report incidents and experiences that may be considered to be too sensitive for the traditional incident reporting. This will allow staff to escalate issues in a supportive manner and to be supported by the Freedom to Speak Up Guardian as required. Triangulation of all methods of reporting is being considered to ensure that figures are not duplicated across the platforms for reporting.

Key areas for improvement for Behaviour/Violence and Aggression Incidents

- Currently an active workstream is in place that is reviewing and scoping the improvement of reporting of these incident types and how mitigations against these risks can be implemented. This is a joint workstream with workforce with regular updates to be provided via the H&S and workforce committee throughout 2025/26.

8. Radiation protection

Radiation protection Committee, compliance with IRMER

The Committee continued to meet in 2024/25 following its relaunch in 2022 and work continues to improve reporting for feeding directly into the Health & Safety Committee. Actions are monitored monthly via the Radiology Business Unit meeting.

Radiation protection update training is currently delivered in the Radiology and Cath Labs (cardiology team) teams for radiographers and is provided by Radiation Protection Advisors (RPAs) at EARRPS (East Anglian Regional Radiation Protection Service). This training is recorded on MAPS to allow easy review of who requires training. All Radiation Protection Supervisors (RPSs) are up to date with their EARRPS mandatory training and work is ongoing with EARRPS to create an e-learning package that can be added to Learnzone to streamline access to these updates.

The dose management system (Opemrem) continues to be well utilised and has been used to update the dose reference levels (DRLs) and provide assurance that doses to staff are as low as reasonably practical. In 2025/26 plans are underway to setup an optimisation group to continue with this work.

It has been identified that there are a number of policies and procedures that are due for review late 2025 and the majority of these are owned by Diagnostic Radiology and cross both specialities (Radiology and Cath Labs/Cardiology).

8.1 Radiation protection incidents and number IRMER reportable

All radiation protection incidents are reported through the Datix® reporting system. For ease of reporting all radiology incidents are overseen the Radiation Protection Committee reporting which feeds into the H&S committee on a quarterly basis.

Ionising Radiations Regulations 2017 (IRR17), made under the Health and Safety at Work etc Act 1974 and administered by the Health and Safety Executive (HSE), provides regulations that govern the general safety aspects for all types of ionising radiation usage and are principally concerned with minimising radiation doses to staff and members of the public. To ensure that these regulations are adhered to all incidents (Table 16) are reviewed by the Health and Safety committee. A particular focus falls on those where there has been an unintended dose (for patients and staff), as detailed in DN006 Ionising Radiation Safety Policy, and those relating to high radiation exposure due to prolonged Cath Lab procedures, as detailed in DN878 Skin Dose Policy.

Table 15 - All Radiology incidents reported in year

	Near Miss	No Harm	Low Harm	Moderate Harm	Severe Harm	Total
Radiology - Investigation incorrect	0	4	2	0	0	6
Radiology - Investigation insufficient/incomplete	0	0	2	0	0	2
Radiology - investigation not performed/delayed	0	5	2	0	0	7
Total	6	9	6	0	0	15

All incidents were graded as no/or low harm incidents.

There were three incidents which met the CQC reporting threshold during 2024/2025:

- WEB 53100 – Incident date 31/07/2024 – Prior to the scan occurring the patient's cannula had extravasated and the scan was required to be repeated. In an effort to reduce the level of contrast being exposed to the radiographer amended the technique in order to produce accurate images whilst using a lower level of contrast.
- WEB 53129 – Incident date 07/08/2024 – Two patients presented with the same name. The incorrect patient received a CT scan as they were awaiting only an Echocardiogram.
- WEB 54657 – Incident date 05/11/2024 – An incorrect protocol was assigned to the patient due to the wrong referral being attached to the event. The scan required repeating.

All three incidents have had full root cause analysis investigations completed with the development of robust action plans. This has included steps such as making the patient aware of the incident, speaking directly with staff about the incident, providing refresher training for the department as a whole and discussion at Radiology teaching sessions. Were required, process changes have been considered and implemented.

9. Estate Facilities

Hard and soft facilities management services are provided and managed for the Trust by external contractors, Skanska and OCS respectively.

Health Technical Memoranda (HTM) gives comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. Estates and Facilities are responsible for the health and safety related HTM below:

- Fire Safety (HTM 05)
- Water safety (HTM 04)
- Electrical Safety (HTM 06)
- Temperature and Ventilation (HTM 03)

All HTM have sub-groups with the appropriate Authorising Engineer and work plans to support safe working practices and management of risk. Estates and Facilities manage other health and safety risks on behalf of the Trust such as:

- Workplace Transport
- Control of Noise
- Contractors and Sub-contractors
- Asbestos
- Security and Violence.

9.1 Trust Reported Buildings or Infrastructure Incidents

At RPH the building is primarily maintained by Skanska however, incidents are regularly recorded on the Datix® Incident module in order for the Trust to also monitor issues experienced.

A total of 50 incidents were reported onto the Datix® system during 2024 / 2025 that were categorised as relating to buildings and infrastructure and all were reported as near-miss, no or low harm incidents. These incidents are reported as occurring either at the Royal Papworth Hospital site or at the office location of Kingfisher House in Huntingdon. Due to the low numbers at the office location this data has not been further separated for this report however, following a review no specific themes and trends have been identified.

Incidents related to heating and ventilation (inc overheating) continued to be an issue in 2024/25 making up 20% of total incidents in this category (n=10). Elevated temperatures in the rehabilitation gym, relating to risk ID 2233, continued to prove problematic during 24/25 however the number of instances of elevated temperatures had reduced when compared to the previous year. Ongoing works is now required as the surrounding office areas are experiencing uncomfortably low temperatures as a result of the previous works.

There were two incidents reported that related to the failure of lifts or pulley systems in the Trust. As per the Lifting Operations and Lifting Equipment Regulations 1998 all lifting equipment across the Trust is serviced using a contractor to provide a competent person every 12 months. This includes all lifts across the Trust. Incident WEB 52950 reported that a member of staff was trapped in the lift during a routine fire alarm testing for over 30 minutes. Lifts are designed to become out of service and automatically park at level 1 or the ground floor following activation of the fire alarm. The lifts were fully reviewed following this incident and no further issues have been reported. The further incident WEB 52627 did not relate specifically to failure of the system but instead due to a lack of available space for all equipment to be transported. This occurred during closure of the tunnel between the hospital building and neighbouring Addenbrookes hospital for essential maintenance works to be carried out.

A further incident relating to potential electric shock was reported by a staff member using a desk located in the Heart and Lung Research Institute (HLRI) (WEB 55328). A desk with integrated sockets was being used when the staff reported the incident and upon further inspection the cables to the desk appeared to be damaged. The equipment had recently been PAT tested and had passed all testing, however, upon a retest was found to fail. All desks of this type were reviewed as due process and any that were found to have any damage were immediately removed from use. The staff member did not report any ill effects as a result of the incident and no further reports have been received in relation to this.

Further incidents related to broken locks and doors awaiting repair, extended fire alarms and obstructions caused by incorrect storage of equipment (Table 16) were reported across the year but there were no significant themes or trends identified. It is worth noting that an update to categories was conducted in April 2024 and therefore some of last year's categories were no longer reported on.

Table 16

	Near Miss	No harm	Low harm	Total
Other Environmental Issue	2	14	5	21
Heating and ventilation (inc overheating)	0	6	4	10
Buildings access and carparking issues	0	3	5	8
Loss of power	0	1	2	3
Failure of lifts or pulley systems	0	2	0	2
Failure of non-medical electrical equipment	0	1	1	2
Loss of Utilities/water supply	0	1	0	1
Poor ventilation (heating, air conditioning)	0	1	0	1
Unhygienic environmental conditions	0	1	0	1
Waste Management (hospital) Issues	0	0	1	1
Total	2	30	18	50

Data extracted from Datix® 14/08/2025.

Staff accommodation is provided at Waterbeach located 8.7miles northeast of the main hospital site. During 2024/2025 a tenants' meeting has been established and is supported by the Freedom to Speak Up Guardian to share comments, queries and concerns, improvement and sustainability. This forms part of reducing abuse violence and aggression between residents and a further process review is underway to ensure that all building users are supported.

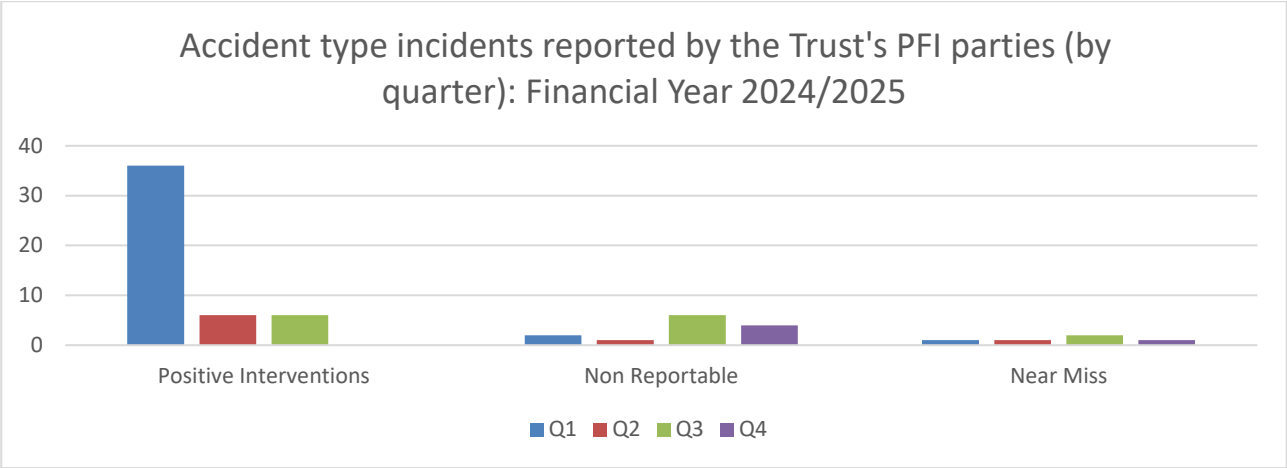
In addition to this to ensure safe access and egress to the hospital site, particularly for those people without access to vehicular transport, the provision of a shuttle bus service between the main site and the accommodation is provided. This runs on a designated schedule with only two incidents reported that related to the bus not arrived during the year. This is regularly monitored for issues requiring escalation.

9.1 Health and Safety incidents experienced by the OCS and Skanska

Health and Safety incidents experienced by the OCS and Skanska Teams are reported to the Trust Estates team monthly via the monthly report received from Project Co. This is a contractual requirement between the organisations. Any immediate issues are communicated to the Trust Estates and Facilities Team for information and escalation as required.

The severity of incidents reported differs from that used by the Trust Datix® system. Positive interventions involve action prior to any issues being reported. Non-reportable incidents are those that have occurred but are not reportable to the HSE under the RIDDOR Regulations. The graph below shows a summary of accident reporting by type and how this is recorded across the year.

Graph 9 - Accident type incidents reported by the Trust's PFI parties (by quarter): Financial Year 2024/2025



Total incidents and positive interventions experienced by the provider service saw a substantial decrease from 86 in 2023/24 to 66 in 2024/25, with over 80% not resulting in any harm (near-miss / positive intervention). This overall reduction aligns with personnel improvements and the implementation of additional technological security solutions. Positive interventions included cases such as the movement of fire extinguishers out of direct sunlight to prevent overheating and ensuring that cages / pallets were removed from access routes to prevent blocking. During Q1 of 2024/25 there was a significant number of positive interventions when compared to later quarters.

This occurred due to a dedicated Trust wide review led by the Skanska team being implemented to identify, record and rectify any areas of concern.

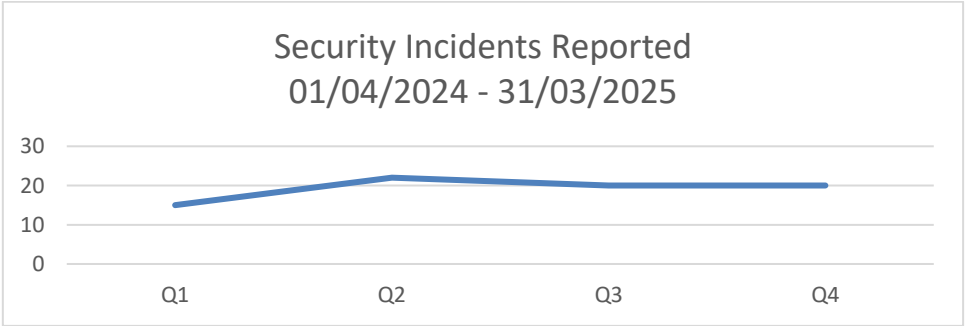
Hot coffee that was spilt over an OCS employee in Costa was reported internally as a Dangerous Occurrence (Inc. Rpt. 42323) however, injuries that were sustained did not meet the threshold for external HSE reporting. There were no RIDDOR reportable incidents from OCS or Skanska staff that occurred during the financial year 2024/25.

As a result of several slips relating to spillages and wet floors refresher training has been provided to ensure that the correct signage is displayed and spills are cleaned up promptly following identification.

9.3 Security incidents

A total of 78 security related incidents were reported by the soft FM provider OCS within the financial year 2024/2025 representing an increase of 16 incidents than that reported in 2023/2024 (n=62). The number of incidents remained consistent across all four quarters.

Graph 10 - Security Incidents Reported in Fin Year 2024/2025



The Trust's Security Services are provided by our Soft Facilities Management Provider OCS via a hands-off, presence only. Assistance with de-escalation and talk down is provided as and when required. As the result of findings from a security risk assessment conducted during 2024/2025 the Trust is currently reviewing Security Services under the PFI Contract based on outputs and deliverability.

A Security intranet page is available and during 2024/2025 this has been updated to include Security Awareness points with clear direction of the services provided by the OCS Security team clarified. Security continues to be monitored via risk assessments, internal and external audits and associated actions recorded onto a live Security Action Plan. Additionally, the CBC Security Group continues to review the impacts of The Terrorism (Protection of Premises) Bill 'Martyns Law' which is currently being led by the EPRR Lead for RPH.

Of the incidents reported there were several that related to false fire alarm activations, patients reported as absconded and observations of abusive or aggressive patients / visitors in which a member of the security team attended.

There has been significant investment in CCTV across the Trust with additional camera placements in response to incidents reported in previous financial years including thefts from the Trust Bike Store. Further to this there has been Trustwide installation of further Access Controlled doors in response to reports of tailgating from unauthorised individuals. The effectiveness of these measures will continue to be monitored, and any further incidents appropriately escalated.

A Conflict Resolution Training pilot was delivered across July, August and September 2024. Feedback from staff was mixed including concerns that too much information was delivered in one day and the levels of staff were too mixed. Responses are under review to update further sessions that have been scheduled for May and June 2025. In addition to this, official Restrain and Reduction Network (RRN) training is to be provided in October 2025 to support staff in reducing the use of restrictive practices for conflict resolution. This will provide a recognised teaching qualification and enable the Trust to deliver in-house training that can be tailored to suit Trust needs.

9.4 Fire safety

During 24/25 fire training for all staff continued to be delivered via an e-learning package. As of March 2025 fire safety training 86.26% compliance meaning 1886 members of staff out of 2186 had successfully completed the competency. During the first quarter of 2025/26 compliance with Trust Fire Safety Training has increased to over 91% in-line with Trust Mandatory Training Compliance. During the reporting period the training schedule for Fire Safety e-Learning has been reduced from annually to bi-annually. This is in line with updates to the Core Skills Training Framework (CSTF) and brings the Trust in line with standardised statutory and mandatory training. Further work remains underway to introduce co-ordinated evacuation training into high-risk areas including the introduction of practical and theoretical fire extinguisher use.

A Fire Authorising Engineer has now been appointed within the Trust. They will aid to provide support and technical advice to the Trust and to support the fire safety estates manager with general fire management. They have conducted an initial Trustwide assessment to identify areas requiring improvement and to aid prioritisation of these tasks.

The Trust has unofficial Fire Wardens at the ward and departmental level who play a vital role in fire safety. It is a legal responsibility of the Trust to provide Fire Wardens and the Fire Response Team with adequate training (either via e-learning, video or in person) on how to fulfil their role, how to use fire extinguishers, evacuation plans etc. This is outlined in both the RRO (Regulatory Reform (Fire Safety) Order 2005 and HTM 05-03 Operational Provisions Part A: Training that it is a legal requirement of healthcare providers to provide training.

At least one person, per area, who is trained in the use of fire extinguishers, should be on duty at any given time, to ensure that if a fire occurred, someone is on hand who can use one, should it be necessary and safe to do so to prevent fire from spreading further. Fire prevention is paramount to containing a fire as quickly as possible before it escalates into a major incident and re-enforces the need for allocated staff to be trained.

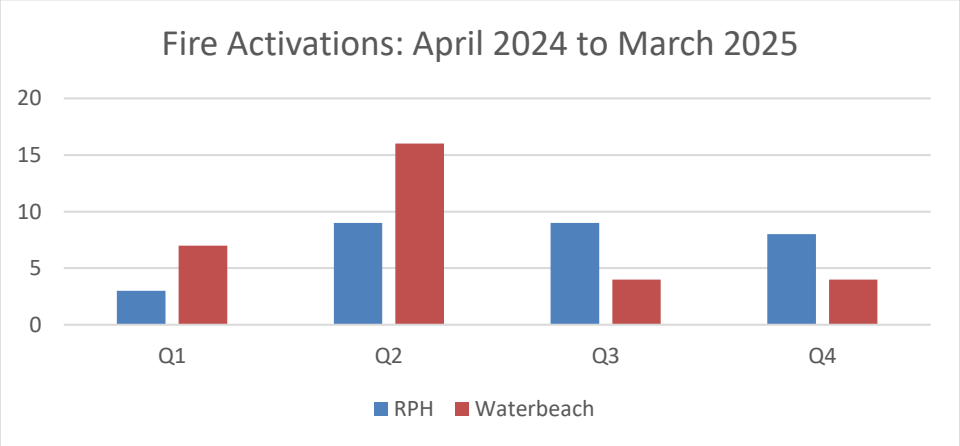
Training that is under development during 2025/26 will include:

- Understanding the importance of their role in fire safety
- Regular checks of the fire extinguishers
- Good housekeeping to minimise risk of a fire occurring
- Minimising risk should a fire occur
- Evacuation aids.

The Fire Safety Manager along with Estates and Facilities has conducted a Training Needs Analysis which has been signed off by the Matrons and Clinical Leads and will be used to identify those requiring training. During training development, a Fire Intranet Page will be provided as a reference guide and online guidance tool. Incident response training is scheduled to commence during the first quarter of 2025/26

Fire activations across the hospital and Waterbeach sites are highlighted in Graph 11 below, with fluctuations in activation numbers for the main hospital and Waterbeach sites. Example causes of fire alarm activations in both areas are as is listed below:

Graph 11 - Fire Activations: April 2024 to March 2025



Waterbeach

- Burnt toast
- Deodorant being sprayed
- Fire Alarm System fault
- Smoke from cooking
- Smoke detector head replacement
- Vaping in bedroom

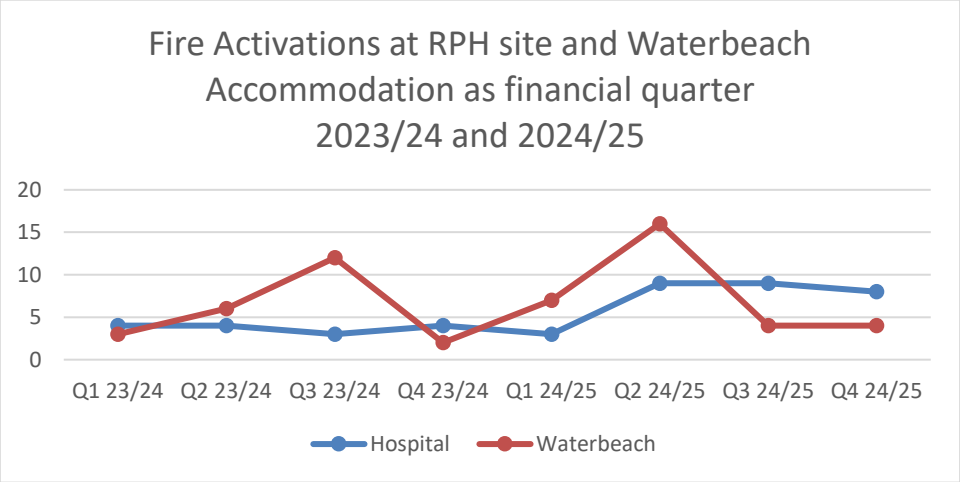
Royal Papworth Hospital Site

- Accidental pushing of call point instead of exit button
- Accidental catching of button
- Faulty equipment
- Technician laptop activated interface via the combined heat and power panel

An increased number of activations at the Waterbeach site were seen in Q2 of 2024/25 in-which 38% of these incidents (n=6) related to two faulty smoke detector heads. These were replaced and subsequent quarterly fire activation numbers reduced to normal levels.

Following on from identification of the risk relating to the sleep pods located on the hot floor (ID3558) these pods were removed entirely from the organisation as their safety could not be guaranteed for use.

Graph 12 - Fire Activation Alarms for 2023/24 and 2024/25 as financial quarters



Key Areas for Improvement for Fire Safety

- Work between the fire safety manager, moving and handling specialist and EPRR lead continue to review, trial and recommend vertical fire evacuation equipment and plan for training and management of this equipment
- Practical fire extinguisher training. Theoretical training being developed.
- Review call point activations to identify possibility of a protective cover or to move its position to a more appropriate area
- Provide greater 'Fire Safety' communications to Waterbeach residents and add this information onto the welcome pack

10. Medical Gases Committee

The medical gas committee meets three times per year. The membership is as recommended in the Medical Gases Health Technical Memorandum 02-01 and includes the Chief Pharmacist (chair), authorised person, authorised engineer as well as representatives from education, Skanska and OCS. The medical gas committee oversees the policies and procedures surrounding medical gas pipelines and cylinders within RPH (excluding the Heart Lung Research Institute).

A business continuity plan for piped oxygen has been written and was approved at the March 2025 meeting. It has been submitted to the emergency planning committee for approval. Minor amendments were made to DN323 (medical gas policy) and DN111 (ordering of oxygen) in year to reflect up to date practice.

Skanska have undertaken a health and safety inspection of the medical gas store and have provided the committee with a copy of the Authorised Engineer report 2024. There were no outstanding actions identified.

The Department of Health released a Nitrous Oxide toolkit for Trusts to support a decrease in usage where appropriate. RPH does not have a piped nitrous oxide system, therefore is compliant with much of the toolkit by default. There have been further reductions in usage however with the decision taken by STA to no longer use Entonox for pain relief and new anaesthetic machines in theatres that no longer require a nitrous oxide cylinder for calibration.

Compliance with training
92% of the matrons have completed Designated Nursing Officer (DNO) training and DNO cover is available across all divisions. Additional training for new starters and as refresher training for those whose training is expiring was arranged for June.

At the end of March 2025 medical gas mandatory training compliance was 69%. On discussion with the education team it is felt that the difference in platform (medical gas training is hosted on Learnzone rather than on ESR) was one contributing factor for the low compliance rates. A review of all staff groups who are required to undertake the training has taken place to ensure the correct baseline. All remaining staff members who are non-compliant have been contacted and reminded how to access the training.

Incident reporting
There have been only 5 incidents categorised as being related to medical gases in the year. Medical gas incidents are rare, however there are limitations with the current reporting system that contribute to some incidents not being corrected identified and therefore not picked up on reporting.

A data search using keys words in Datix® identified a total of 23. With such small numbers of incidents thematic analysis is limited. There were 4 incidents that were related to the medical gas cylinders on resus or transfer trolleys being missing or empty and 3 reports of patients not being connected properly to their oxygen.

Storage and maintenance of medical gases and equipment
The replacement of the O rings that began in 2023/4 is still ongoing. It took time to reach an agreement on how quality control of the works would be carried out. This is now resolved, and a detailed work plan is in place with an aim to complete all works by the end of the year. Pendant hoses are also being replaced, with critical care having the most fitted. This work is ongoing alongside that of the O rings and aims to be completed by September 2025.

Risks in relation to medical gases
As of March 2025, there are 4 risks related to medical gases on the risk register. Of these 3 are moderate risks and have been on the risk register for 4-5 years with mitigations. The 4th is a new risk, related to the O ring works and is a low risk.

11. Trust wide improvement plan for Health and Safety Governance:

In March 2023 a gap analysis was completed against the Workplace Health and Safety Standards as described by the Health Safety and Wellbeing Partnership Group (Revised July 2013). This review highlighted key areas for improvement which formed the work plan for the Health and Safety committee for the following two years.

Appendix 1 shows a summary of the key legislation identified from these Standards and the gaps that were identified at the time of the exercise. The improvements and strengthening that has occurred as a result of this exercise are listed and all actions have now been addressed. A further review of the newly commenced Health and Safety Rep and Manager Training programme will be included in the 2025/26 report to complete the action surrounding training for these individuals.

12. Health and Safety Committee Objectives 2025/26

For 2025/26 the objectives of the Health and Safety Committee will continue to update on the key areas that were identified as a part of the Gap Analysis performed in 2023. This will include identified themes and trends from the Annual Report. As a result, the key areas of focus for 2025/26 agreed objectives will include:

1). Implementation of Health and Safety Inspections

Following identification as an area requiring improvement the implementation of Trust wide Health and Safety Inspections is a key focus for the year. This review has led to inspections now being undertaken:

- Annually for all areas Trustwide to allow for improved monitoring of compliance. This will be undertaken across all departments in one month (November) as a safety drive across the Trust. This will be via a Microsoft Forms approach to allow for data to be easily collated with trends and themes easily identified.

2). Health and Safety Representative and Manager Training

The continuation of training in line with the training needs analysis is key to ensuring that all staff have the necessary tools and skills when it comes to managing health and safety whilst at work. This includes how to conduct a Helath and Safety Inspection in addition to DSH and COSHh training. During 2025/2026 the target is to have delivered this bespoke training to over 50% of those specified to receive this.

3). Reporting of Behaviour / Violence and Aggression

The establishment of a robust system for the reporting of all behaviour / Violence and Aggression incidents is a key objective of the upcoming year. It has been identified via multiple routes, including the staff survey, that these incidents are an area of concern for the Trust and a system for combining Datix incidents, those reported through the Freedom to Speak up Guardian and the WorkInConfidence (Trust Anonymous Reporting System) is under development. Once established this will feed into the quarterly Health and Safety Committee meetings as a recurring agenda item with identified themes and trends identified for committee oversight.

4). Fire Safety

Improvement of fire safety across the Trust in the following financial year will remain a key project and continue to build on the progress made during 2024/2025. Processes for vertical evacuation will be established, involving a multi-disciplinary approach to the sourcing of appropriate equipment in addition to providing staff with suitable and sufficient training in how to use this equipment. Further training of key individuals to co-ordinate a vertical evacuation response will be cemented and progress of this will be followed through the quarterly reports provided to the Health and Safety Committee via the Fire Safety Group.

In addition to this the development of Trust wide theoretical and practical fire extinguisher training will provide staff with the skills and knowledge to be able to potentially extinguish small fires if they arise.

13. Recommendations – Trust Board is asked to note:

- Activity in respect to Health and Safety at work at RPH for period 2024/25. The key areas of improvement completed and strengthened from the Health and Safety Committee and subgroups oversight.
- The Health and Safety Committee Objectives 2025/26.
- Approve this report, as recommended by the Quality and Risk Committee.

Appendix 1

Improvement plan for Health & Safety Governance that had identified gaps as of 2023 with updates completed in 2025

Legislation	Compliance measure	Identified Gap March 2023	Improvements update 2024/25:
Health and Safety at Work Act 1974	RPH Health and Safety Management policy Subject matter experts in place to provide compliance advise. Health and Safety committee held 4 times a year as per ToR	Roles and responsibilities clarification from ward to Board Review governance and ToR Poor attendance and lack of quoracy at times.	Health and Safety committee now held 4 times a year. Updated ToR in place. All Roles and responsibilities are now clarification from ward to Board. Sub-committees to H&S are now Radiation protection and Medical Gases Attendance to Committee has improved and is monitored. **Completed**
Management of Health & Safety at Work Regulations 1999	Annual H&S Audit programme Annual H&S Work plan Training for Risk Management and RSPH Level 3 for Divisions	Re-establish robust identification of and monitoring of workplace audit programme Perform training needs analysis for identified Health and Safety reps.	Training Needs Analysis completed for H&S reps and managers. Training schedule established from July 2025 to take place monthly to cover all individuals that hold responsibilities within their areas **Partially completed with further review require as part of annual report 2025/2026**
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)	Identification of incidents that meet threshold for RIDDOR reporting. Investigations and learning shared with Health and Safety Committee	Evidence of dissemination of wider learning	RIDDOR processes in place and reduction in number of RIDDOR's reported. Shared learning in place through H&S Committee, QRMG and with workplace Reps as part of training **Completed**
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977	Terms of reference have been reviewed for the H&S Committee RPH. H&S Policy has been updated H&S Trade union H&S Reps in place and attendance at H and S committee. Reports on Audits, Action Plan progress, KPIs and Risk Register Acts as consultative committee for H&S policies.	Lack of trade union H&S representation and attendance at Health and Safety Committee	Trade union H&S reps are invited to attend H&S Committee Meetings as other non-unionised Reps are. **Completed**
		Incomplete oversight of ward and department H and S reps and training.	Training Needs analysis completed for H&S reps and re-established of training was in place in 2023/24. New programme to start in Oct 24. This is monitored through H&S Committee now. **Completed**
		Inconsistent audit plan for Health and Safety, including follow up and closure of action plans	Internal BDO Audit to be completed 2025. Feedback to feed into H&S Committee following report production. **Completed**
Control of Substances Hazardous to Health 2002 Electricity at Work Regulations 1989 Workplace (Health Safety & Welfare) Regulations 1992	Regulations are monitored by the RPH Health and Safety Committee and managed through meetings of the specialist groups. Authorising Engineers are in place to advise on subject matters.	Review reporting as part of Trust Health and Safety Committee review	There is more robust reporting now in place to the H&S Committee. Reporting through Project Co to estates and project Co are also a core member of the H&S group now. Authorising Engineers are in place to advise on subject matters. **Completed**

Legislation	Compliance measure	Identified Gap March 2023	Improvements update 2024/25:
Provision and Use of Work Equipment Regulations 1998 Personal Protective Equipment at Work Regulations 1992	Health and Safety advisors attend the subject matter groups to monitor compliance. Reporting through Project Co and Estates and Facilities.		Reporting structure now clearly in place through estates reporting. **Completed**
Ionising Radiations Regulations 2017 (IRR17) The Ionising Radiation (Medical Exposures) Regulations 2017	Regulations are monitored through the Radiology Business Unit (monthly), Radiation Protection Committee (quarterly), the Trust Health & Safety Committee (quarterly) and the Quality & Risk Management Group (monthly) Medical Physics experts available to advise on the detail when required	Embed governance processes following recent CQC review	Embed IR(ME)R governance processes now in place following the CQC review. IR(ME)R action plan completed Regular reporting is now in place to H&S Committee on a quarterly basis. Good robust working relations with East Anglian Regional Radiation Protection Service (EARRPS). **Completed**