HEALTH AND SAFETY COMMITTEE

9.30am on Tuesday 10 April 2018
Corporate Meeting Room, Headquarters, UHW

CARING FOR PEOPLE
KEEPING PEOPLE WELL

Health and Safety Committee
9.30am on 10th April 2018
Corporate Meeting Room, Headquarters, University Hospital of Wales
AGENDA

PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral *Chair*
2	Apologies for Absence	Oral *Chair*
3	Declarations of Interest	Oral *Chair*
4	Minutes of the Health and Safety Committee meeting held on 23 January 2018	*Chair*
5	Action Log Review	*Chair*
Deliver Outcomes that Matter to People		
6	Mental Health Smoking Cessation 2017/18	*Head of Operations and Delivery – Mental Health Clinical Board*
7	Patient Manual Handling ProACT Equipment Audit Action Plan	*Director of Corporate Governance*
Our Service Priorities		
Sustainability		
8	Pedestrian Access Safety Strategy – paper presented to Management Executive Meeting	*Director of Capital, Estates and Facilities*
9	Fire Safety Report	*Director of Capital, Estates and Facilities*
10	Shared Services Fire Safety Audit of University Hospital Llandough – ***Deferred to Next Meeting***	*Director of Capital, Estates and Facilities*
11	Health and Safety Mandatory Training Requirements – ***Deferred to Next Meeting***	*Director of Workforce and OD*
12	Enforcement Agencies Correspondence Report	*Director of Corporate Governance*
13	Health and Safety Improvement Plan	*Director of Corporate Governance*

14	Control of Contractors in Non Estates Activities	*Director of Corporate Governance*
15	Management of Contractors and Job Registration Form	*Director of Capital, Estates and Facilities*
Culture and Values		

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE Papers are available on the Health Board website		
16	Work Programme 2018/19	*Director of Corporate Governance*
17	Regulatory and Review Body Tracking Report	*Director of Corporate Governance*
18	Lone Worker System Progress Report	*Director of Corporate Governance*
19	**Minutes from other Committees/sub-Committees/Groups** Operational Health and Safety Group – December 2017 Security and Personal Safety Strategy Group – December 2017	 *P Welsh* *P Welsh*
20	Updated Health and Safety Related Policies Schedule	*Director of Corporate Governance*
21	Review of the Meeting	Oral *Chair*
22	To note the date, time and venue of the next meeting:- • 9.30am on Tuesday 10th July 2018 in the Corporate Meeting Room, Headquarters, University Hospital of Wales.	

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UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am ON 23 JANUARY 2018 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Michael Imperato	**Independent Member – Legal (Chair)**
Charles Janczewski	Independent Member (Vice Chair)

In attendance:

Charles Dalton	Head of Health and Safety
Martin Driscoll	Director of Workforce and OD
Stuart Egan	Health and Safety Staff Lead
Abigail Harris	Director of Planning (from agenda item 18/010)
Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Deputy Director of Public Health
Catherine Salter	Staff Representative (RCN)
Geoff Walsh	Director of Capital, Estates and Facilities
Peter Welsh	Director of Corporate Governance

Apologies:

Steve Allen	CHC Representative
Carol Evans	Assistant Director of Patient Safety and Quality
Mike Turner	Cardiff University Representative

Observer:

Maria Battle	Chair

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 18/001 WELCOME AND INTRODUCTIONS

Mr Imperato welcomed Maria Battle, Chair to the meeting who was attending as an Observer.

Mr Imperato also informed the Committee it was Catherine Salter, Staff Representative (RCN) last meeting and thanked her for her contribution to the Committee and wished her well for the future.

HSC: 18/002 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.

HSC: 18/003 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 24th October 2017 were **APPROVED** and **ACCEPTED** as a true record, with the exception of some minor amendments:

- HSC: 17/088 – typo –'report'
- HSC: 17/088 – the staff representative (RCN) stated at the last meeting it was agreed that the action plan with timescales would be reinstated within the Fire Safety Annual Report and this was not reflected in the minutes.

  The Director of Capital, Estates and Facilities reiterated from the last meeting that this was not straightforward but for the next meeting he would provide details of completed and outstanding actions.

  ACTION – Mr G Walsh

- HSC: 17/092 – typo – 'had been made'
- HSC: 17/097 – should read a score of 4 had been awarded.

HSC: 18/004 UPDATED ACTION LOG

The Committee **RECEIVED** the Updated Action Log from the previous meeting. The following updates were provided:

- 17/058 – the Committee Chair stated a definitive timeframe was required for the implementation of the e-datix risk module. The Director of Corporate Governance added the review of the risk management process would be completed by the end of March 2018.

  ACTION – Mrs C Evans

- 17/061 – the Deputy Director of Public Health suggested the action log was reviewed to ensure actions were appropriately reflected and more specific.

The Independent Member (Vice Chair) requested the action log included timeframes for completion.

ACTION – Miss R Daniel

HSC: 18/005 PRESENTATION ON THE RESULTS OF THE ARJO PROACT 2017 SURVEY

Sara Thomas, National Solutions Manager for Arjo UK Limited thanked the Committee for inviting her to present to them. Ms Thomas informed the Committee the 1st survey was undertaken in June 2015, the 2nd in July 2017 and the 3rd would be undertaken in November/December 2018 to determine whether the time of year had an impact on the range of inpatient mobility levels.

Ms Thomas highlighted the key findings from the survey:

- 10% of equipment was now discontinued, it may still be working well but should a fault develop it could not be repaired as the parts were no longer available.
- 4% of equipment was well beyond its lifespan.
- 10% of equipment was just beyond its lifespan.
- In respect of equipment condition – 7% was in poor condition and 28% was in a satisfactory condition.
- In respect of washable slings – 54% were well beyond their lifespan and 7% was just beyond their lifespan.
- 55 hoists will require replacing during 2018.
- 266 slings will require replacing during 2018.

The Committee Chair thanked Ms Thomas for her presentation and stated there was obviously equipment needs for the next five years and queried how this was going to be addressed. The Head of Health and Safety stated a bid for the obsolete equipment would be made from Welsh Government monies as in the previous year. The Director of Capital, Estates and Facilities advised a bid should be submitted to the Capital Management Group as a matter of urgency in order for it to be considered but to be mindful there was real pressure on discretionary capital monies.

ACTION – Mr C Dalton

Mr Imperato requested an action plan be submitted to the next meeting. Mrs Battle, Chair also requested the action plan was shared with ward staff as there was a real concern regarding the lack of equipment and also the slow process in getting equipment repaired. Mr Dalton stated he would include a communication plan within the action plan. He also added one of actions would be to review the current maintenance regime.

ACTION – Mr C Dalton

The Deputy Director of Public Health queried whether Ruth Walker, Director of Nursing had seen the results of the survey, Mr Dalton advised Mrs Carol Evans, Assistant Director of Patient Safety and Quality had been made aware of the presentation.

The Director of Therapies and Health Sciences queried whether a similar survey had been undertaken in the Community, Ms Thomas advised the Manual Handling Advisers work very closely with the 2 Local Authorities but currently no survey of this type had been conducted.

The results of the Arjo Proact 2017 Survey had been **RECEIVED** and **CONSIDERED** by the Committee.

HSC: 18/006 PEDESTRAIN SAFETY STRATEGY

The Director of Capital, Estates and Facilities provided the Committee with an oral update as to the progress being made. Mr Walsh advised information in relation to pedestrian movement was limited within other Health Boards and following liaison with the Local Authority it had been decided to engage Consultants to look at this on behalf of the Health Board. An initial meeting had taken place with the Company who were in the process of developing a brief which should be available by the end of the week.

With regards to the accident that occurred on the Medical Physics Road, Mr Walsh advised that the footpath had been segregated from the road by means of a physical barrier.

The Health and Safety Staff Lead requested the mini roundabout outside the Emergency Unit was considered as part of the brief. Mr Egan also stated he was aware of plans to restrict access to the tunnels and suggested this was prioritised as it was being reported to him that relatives were often being directed through the tunnels by Emergency Unit staff. Mr Walsh advised some modifications were required to the lifts before access could be restricted.

The Independent Member (Vice Chair) queried whether the brief would just focus on University Hospital of Wales (UHW), Mr Walsh confirmed initially UHW and then University Hospital Llandough (UHL). The Director of Corporate Governance added significant improvement had already been made to pedestrian safety in UHL.

The Committee Chair stressed a written report must be provided to the next meeting in order for the Committee to be assured this was being progressed appropriately.

ACTION – Mr G Walsh

HSC: 18/007 FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT

The Director of Capital, Estates and Facilities informed the Committee there had been an increase in the fire training figures which was pleasing to note. Mr Walsh however added the fire evacuation drill arranged for August 2017 was unable to run despite all non clinical staff being available as no clinical staff were available on the day.

The Staff Representative (RCN) commented on the positive report and queried whether the training figures could be broken down by e-learning, tutor led etc. The Head of Health and Safety advised the Learning Education Department (LED) were now able to provide better training statistics and these would be included in future reports.

ACTION – Mr G Walsh/Mr C Dalton

The Independent Member (Vice Chair) stated he was not clear what the aim was; what was the target and why some Clinical Boards were were better than others. Mr Walsh advised the target was 85%.

The Director of Workforce and OD informed the Committee his department were reviewing the statutory and mandatory training requirements and a report on the health and safety elements would be brought to the next meeting.

ACTION – Mr M Driscoll

The Chair advised she would raise the thwarted fire evacuation drill with the Chief Operating Officer.

ACTION – Mrs M Battle

The Health and Safety Staff Lead raised concerns that non clinical areas undergo a 3 yearly fire inspection but this needed to be reviewed for high risk areas. Mr Walsh assured the Committee high risk non clinical areas were being appropriately inspected.

The report was **CONSIDERED** by the Committee in relation to the on-going work to meet the requirements of fire enforcement compliance.

ASSURANCE was provided by:

- Identified fire enforcement compliance and safety were being appropriately managed.

HSC: 18/008 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

The Director of Capital, Estates and Facilities provided the Committee with an oral update as to the status of the action plan following the shared services audit.

HSC: 18/009 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee one new event had occurred since the last meeting where a member of staff had been assaulted by a patient and was absent from work for more than 7 days. The Health and

Safety Executive (HSE) had requested information in relation to the violence and aggression risk assessment and the patient care plan, this has been provided to them and no further correspondence has ensued.

The Independent Member (Vice Chair) asked after the welfare of the member of staff and was informed they had now returned to work and offered support via the Case Management Team. The Committee Chair suggested the Case Management Team present to a future meeting the support mechanisms available to staff, this was **AGREED** and **SUPPORTED** by the Committee.

Action – Miss R Daniel

Mr Dalton stated the legionella event remained active as based on the information submitted to the Water Safety Group not all Clinical Boards were undertaking the flushing regime and therefore full assurance could not be given.

The report was **RECEIVED** and the Committee **AGREED** that appropriate actions were being pursued to address the issues raised.

ASSURANCE was provided by:

- The continued investigations, actions and monitoring referred to within the report.

HSC: 18/010 HEALTH AND SAFETY IMPROVEMENT PLAN - EXCEPTION REPORT

The Head of Health and Safety informed the Committee there were currently fifteen red areas on the plan that were being actively progressed.

In respect of 7.8 Control of Contractors, the Director of Capital, Estates and Facilities stressed he was only responsible for those Contractors employed by the Capital and Estates Department and could not be responsible for those outside of his remit. Mr Dalton added a working group was established in estates for contractor control and a similar group was required for non estates contractor control. The Director of Corporate Governance advised he would be happy to lead this, scope the extent of the problem and bring a progress report back to the next meeting.

ACTION – Mr P Welsh

The Director of Planning stated it was important everyone was clear on their responsibilities when engaging and managing contractors.

In respect of 1.4 Health and Safety Management Training, the Health and Safety Staff Lead advised it was evident when undertaking workplace inspections that some Managers were not aware of what was required of them particularly in the corporate departments where they do not have the same health and safety structure as Clinical Boards. Mr Welsh advised he would

discuss with Mr Egan outside of the meeting and a workplace inspection programme be developed.

ACTION – Mr P Welsh/Mr S Egan

The Safety Representative (RCN) queried the timeframe for implementing the manager's training, Mr Dalton advised the content could be completed within one month however delivering the training would be more difficult as the department had limited resources.

In respect of 5.6 Bariatric Patient Care, Mrs Salter suggested clarity was required on who was leading on this for the Health Board as it was not clear from various discussions she'd had, Mr Welsh would raise this with the Executive Directors.

ACTION – Mr P Welsh

In respect of 2.5 Violence and Aggression Training, Mrs Salter informed the Committee Security and Emergency Unit staff were not currently compliant. Mr Dalton stated security staff had received an appropriate level of training but in order for the full joint training to take place Emergency Unit staff have to be present as the training must be clinically led. Mrs Harris suggested that as the training requires commitment from the emergency unit the deadline needs to be reviewed as April was not realistic and suggested September would be more achievable.

ACTION – Mr C Dalton

The Independent Member (Vice Chair) stated the full improvement plan requires milestones to be included so that it becomes more of a meaningful document.

ACTION – Mr C Dalton

The exception report was **RECEIVED** and **CONSIDERED** by the Committee.

REASONABLE ASSURANCE was provided by:

- The demonstration of progress against each strategic area and highlighting further actions required within set timescales.

PART 2

HSC: 18/011 COMMITTEE WORK PROGRAMME FOR 2018/19

The Work Programme for 2018/19 was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/012 HEALTH AND SAFETY IMPROVEMENT PLAN (DETAILED)

The full Priority Improvement Plan was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/013 WASTE MANAGEMENT COMPLIANCE REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/014 ENVIRONMENTAL HEALTH REPORT OF AROMA UNITS, UNIVERSITY HOSPITAL OF WALES ON 17TH NOVEMBER 2017

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 4 had been awarded.

HSC: 18/015 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF SEPTEMBER 2017

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/116 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF SEPTEMBER 2017

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/117 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The schedule was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/118 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

No items are to be bought to the attention of the Board or other Committees.

HSC: 18/119 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 10th April 2018 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed .....

Date .....

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UP DATED ACTION LOG

NB: Following presentation to the Committee meeting in January 2018, those actions completed have been removed

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/032	25/04/17, 18/07/17, 24/10/17 & 23/01/18	Pedestrian Safety	Pedestrian Safety Strategy to be developed	Mr Charles Dalton/Mr Geoff Walsh	**COMPLETED** Agenda Item
HSC: 17/058	18/07/17, 24/10/17 & 23/01/18	CRAF - E-Datix Risk Module	To clarify the status of the e-datix risk module.	Mrs Carol Evans	**ACTION STILL UNDERWAY** Definitive response to be provided to April Committee meeting.
HSC; 17/061	18/07/17, 24/10/17 & 23/01/08	Fire Enforcement and Management	Feedback on trial of e-cigarettes in the Mental Health Clinical Board.	Mrs Fiona Kinghorn	**COMPLETED** Agenda Item - Mental Health Clinical Board presenting to Committee
HSC: 17/088	23/01/18	Fire Safety Annual Report	Action Plan to be re-instated with timescales	Mr Geoff Walsh	**COMPLETED** Agenda Item

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/090	24/10/17 & 23/01/18	Shared Services Fire Safety Audit of UHL	To remain on the agenda until all actions have been completed	Mr Geoff Walsh	**ACTION STILL UNDERWAY** Updated Action plan to be presented to July 2018 meeting.
HSC: 18/005	23/01/18	ProACT Equipment Audit	Bid to be submitted for discretionary capital to replace obsolete hoists.	Mr Charles Dalton	**COMPLETED** Funding received from WG and order submitted to replace 39 hoists.
HSC: 18/005	23/01/18	ProACT Equipment Audit	Action plan to be developed to address results of audit.	Mr Charles Dalton	**COMPLETED** Agenda Item
HSC: 18/007	23/01/18	Fire Enforcement and Management Compliance	Breakdown of training figures i.e. tutor led, e-learning	Mr Geoff Walsh/Mr Charles Dalton	**COMPLETED** Agenda Item
HSC: 18/007	23/01/18	Fire Enforcement and Management Compliance	A review of statutory and mandatory health and safety training to be considered at a future meeting.	Mr Martin Driscoll	**ACTION STILL UNDERWAY** Deferred to July 2018 meeting
HSC: 18/009	23/01/18	Enforcement Agencies Correspondence Report	Case Management to be invited to present to a future meeting.	Miss Rachael Daniel	**COMPLETED** Added to Work Programme for July 2018 meeting.
HSC: 18/010	23/01/18	Health and Safety Improvement Plan	Update on the management of non estates contractors.	Mr Peter Welsh	**COMPLETED** Agenda Item

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 18/010	23/01/18	Health and Safety Improvement Plan	Development of Workplace Inspection Programme for Corporate Departments	Mr Peter Welsh/Mr Stuart Egan	**COMPLETED**
HSC: 18/010	23/01/18	Health and Safety Improvement Plan	Obtain clarification on Executive Director Lead for bariatric care.	Mr Peter Welsh	Confirmation required
HSC: 18/010	23/01/18	Health and Safety Improvement Plan	Improvement Plan to include milestones.	Mr Charles Dalton	**ACTION STILL UNDERWAY** A full review of the improvement plan is being undertaken

MENTAL HEALTH **Smoking Cessation** **2017/18**
Name of Meeting : Health and Safety Committee **Date of Meeting:** 10/4/2018
Executive Lead: Mental Health Clinical Board Director & Director of Public Health
Author : Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: The immediate cost of NRT compared to requiring additional clinical staff to supervise smoking in ward gardens is still under review.
Quality, Safety, Patient Experience impact: Smoking impacts on the health and safety of patients, staff and visitors via the dangers of passive (second hand smoke) and risk of fire. Overall, a patient's experience of the health board is enhanced by no visible evidence of smoking (cigarette butt litter and smokers on site) and promotes the 'health promoting hospital'
Health and Care Standard Number: 1&63 Health promotion, protection and improvement
CRAF Reference Number: 1.2, 4.3
Equality and Health Impact Assessment Completed: N/A

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RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the contents of the paper and **SUPPORT** the ongoing pilot within the mental health clinical board.

Situation

Smoking is harmful to the health of people with mental health problems, particularly those with serious mental illness. Currently in patients are exempt from the smoking ban in all other health settings and public buildings, for seemingly no good reason allowing these risks to persist for repeated generations of people with mental health problems. Smoking legislation and policies do not prevent mental health patients from smoking in NHS premises, sitting outside the mainstream public health efforts for the remainder of the population, with most services allowing this inside and outside of mental health buildings. This can also be problematic for detained patients who are unable to leave the hospital or ward to obtain or use tobacco in designated garden no-smoking areas or outside the hospital premises. In such circumstances staff may escort patients to purchase or use tobacco. When the patient is not able to leave the ward staff may find themselves under

pressure to facilitate access to tobacco for example contacting relatives, coordinating other patient to run errands or purchasing tobacco on the patient's behalf.

For these reasons the MHCB, following 12 months of preparation banned smoking in all its settings in January 2018 being warned that there would be an increase in incidents of violence and aggression against staff and other patients.

This paper is a review of the situation after a couple of months of the pilot and the measures mental health services took to improve the success of this approach.

Background

Smoking is the leading cause of serious illness and avoidable death in Wales. People with a mental disorder are more likely to smoke than the general population (33% compared to 19%) and people diagnosed with schizophrenia or psychosis up to three times more likely (range 40%-75%) furthermore they are more likely to be heavy smokers (20 cigarettes a day)[1,2].

Smoking leads to approximately 10 years of life lost. Whilst having a mental illness leads to between 9 and 15 years of life lost. Both share increased risks of mortality through cardiovascular disease. The prevalence of smoking in the general population is reducing from 20% to 19% in 2013 it remains unchanged in people with mental illness. Furthermore many are on low incomes for which the expense of smoking can add to economic hardship. Smoking and its interactions with metabolism of drugs lead to higher medication regimes and increased treatment costs[3,4].

The high rate of smoking in people with mental illness is attributed to a number of reasons which include:

- Poor access to stop smoking services
- A culture within primary and secondary services that gives rise to very low referral rates to quit services based on beliefs that it will be harmful to quit or impossible to quit.
- People get some symptom relief from smoking.
- The presence of heavy smoking

When asked up to 50% of people in the general population say they would like to quit and the same figure is true of people with a serious mental illness. Quitting smoking is difficult with about one in five of the general population eventually succeeding success rates are about half that for those with schizophrenia. Strategies to support people with a mental illness to quit are identical to the general population but may need to be delivered intensely and over a longer period of time[5].

In considering the ethics of smoking the rights of smokers have significantly diminished in recent years. The balance now favours the individual and societal benefits of non-smoking against the rights of the individual smoker. The court of appeal has ruled that there is no right to smoke in psychiatric hospital settings on the basis of residency (July 2009). On basis of the right to a private life McCann v State Hospitals Board for Scotland (2013) overturned

the state hospital ban on smoking in the hospital and its grounds however the following year the decision was reversed by a higher court.

The rulings do not constitute a ban on the individual smoking instead where they may smoke and so detained patients can be prevented from smoking in and on hospital premises. It should be noted that applying the principle of least restrictive practices to detained patients who wish to smoke remains.

Professional and governmental guidance consider facilitating smoking as incompatible with providing a health service[3,6]. Therefore staff should not facilitate smoking but should consider the patient's wishes and their personal freedoms. A concern is that smoking bans lead to conflict, violence and aggression. There is anecdotal evidence to support this but also guidance on how to reduce its likelihood.

The MHCB concluded in light of these issues and the long term public health message to people with mental health problems, that there remain significant harms from smoking to the individual and those near them. Ethical, public and professional viewpoints support a position that on balance as a mental health service we should pilot a period of a smoking ban in mental health for 6 months starting the first week in January 2018 with a formal review of its impact every 8 weeks.

Assessment, Action Plan Timescales and Impact

Action	Lead	Outcome	Timescale
Phase 1: Preparation			
1.Draft an Implementation Plan for discussion at the next Mental Health Smoking Stakeholders Group	• Trina Nealon, Cardiff and Vale Public Health Team • Ian Wile, Mental Health Clinical Board	Implementation Plan produced	June 2017
2.Meeting to discuss Prescribing of NRT, storage and e-cigarettes – agreed Prescribing Pathway E-cigarettes to be permitted for use in the gardens due to the fire alarm activation on ward areas.	• Ian Wile • Pharmacy, UHB • Prescribing, PCIC • UHB Smoking Cessation Service	Prescribing pathway agreed and use of e-cigarettes agreed	August 2017
3.Discussion with Board member to negotiate reporting mechanisms	• Ian Wile	Reporting mechanisms agreed (to include any amendments)	May 2017
4. Mental Health Smoking Stakeholders Group Meeting to agree draft Implementation Action Plan (and/or amendments)	• Members of the Mental Health Smoking Stakeholders Group/Ian Wile	Implementation Plan agreed (to include any amendments)	July 2017
5. Data Collection – baseline data collection commencing 1st April 2017 to 30th June 2017, from all wards and units, on patient admission numbers, number of smokers, numbers of smokers opting to stop smoking and/or be provided with NRT, prescribing rates, no of smokers currently receiving smoking cessation support, no of ward based Smoking Cessation Champions (and numbers trained), no of smoking	• Mental Health Clinical Board • Trina Nealon, Cardiff and Vale Public Health Team	Baseline report produced	August – December 2017

related incidents/DATIX recording			
6. Baseline Report produced	• Trina Nealon, Cardiff and Vale Public Health Team	Baseline report produced to inform final evaluation of project	December 2017
7. Risk Assessment – to include an assessment of patient activity in the Clinical area and staffing levels to accommodate the change. To include proposal for additional staffing for early morning and an Occupational Therapist to visit ward to encourage activities (distraction from smoking)	• Ian Wile/Mental Health Clinical Board	Risk Assessment completed and actions as required undertaken	July 2017
8. Establish project Implementation group to meet fortnightly initially in 'Preparation' and early 'Implementation' stages of Action Plan and monthly during later pilot implementation stages	• Ian Wile/Mental Health Clinical Board	Established	July 2017
9. Development of clinical and operational pathway for smoking cessation from admission – including service user contract development, admission checklist and review of smoking status procedures, the use of e-cigarettes, medication, NRT prescribing via a PGD, smoking cessation support and weight management All NRT Products to be available to service users including disposable nicorettes to replace the habitual hand to mouth action dependency.	• Ian Wile/Mental Health Clinical Board • Trina Nealon Public Health • Pharmacy Department - MH	Pathway produced and agreed	July 2017
10.Promotion and awareness raising – to include preparation of staff and patients – smoking myth-busting, 'countdown' period for staff and SU education and support using social media, internal briefings and public health messages	• Ian Wile/Mental Health Clinical Board • Trina Nealon, Cardiff and Vale Public Health Team	All stakeholders aware of the pilot and prepared to implement the Plan	July/August 2017
11. Training identified and supply of smoking cessation support scoped/sourced and implemented and culture change support with consideration to additional staffing Training available online from the National Centre for Smoking Cessation and Training http://www.ncsct.co.uk/	• Ian Wile/Mental Health Clinical Board • Trina Nealon, Cardiff and Vale Public Health Team • UHB in-house Smoking Cessation Service	• Training completed • Staffing levels assessed and agreed	July/August 2017
12.Production of patient information resources (admission/discharge/visitors information) to include information sheet and/or posters, fliers	• Ian Wile/Mental Health Clinical Board • Communication Team, UHB	Awareness raising materials and resources produced, disseminated and/or displayed	August 2017
13.Re-designing/change of use of current smoking area to reflect no smoking on pilot ward areas – to include signage	• Ian Wile/Mental Health Clinical Board • UHB Estates	Designated smoking area 'repatriated' /temporarily removed	August 2017
14. Cordoning off of existing wall mounted cigarette lighters – to be permanently removed if pilot successful and No Smoking Policy to be changed	• Ian Wile, Mental Health Clinical Board	Wall mounted Cigarette lighters not used and removed if Policy is amended	August 2017/December/January 2018
Phase 2: Implementation			
15.Implement smoking ban across all UHB Mental Health Units (6 month from the first week in January 2018)	• Mental Health Clinical Board	No smoking permitted on all Mental Health pilot wards (to include outside areas)	January 2018

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Phase 3: Evaluation			
16. Data Collection – baseline data collection report (up to December 17), from all wards and units, on patient admission numbers, number of smokers, numbers of smokers opting to stop smoking and/or be provided with NRT, prescribing rates, no of smokers currently receiving smoking cessation support, no of ward based Smoking Cessation Champions (and numbers trained), no of smoking related incidents/DATIX recording	• Ian Wile/Mental Health Clinical Board • Trina Nealon, Cardiff and Vale Public Health Team • H&S Dept MH	Evaluation report to be completed	June 2018
17. Staff Feedback – survey and/or meeting to discuss experience and consideration of future options	• Ian Wile/Mental Health Clinical Board • Trina Nealon, Cardiff and Vale Public Health Team	Evaluation report to be completed following bi-monthly reviews with ward managers	April 2018 and June/July 2018
18. Draft Complete Evaluation Report	• Ian Wile/Mental Health Clinical Board • Trina Nealon, Cardiff and Vale Public Health Team	Evaluation report to be completed	April 2018 and June/July 2018
Phase 4 - Follow Up Action			
19. Arrange regular evaluation sessions with ward managers and the wider ward MDT to review the impact and adjust action plan accordingly (see below for initial evaluation	• See below	Initial evaluation completed with follow up recommendations for the pilot	March 2018
20. Re-drafting of UHB's No Smoking and Smoke Free Environment Policy to reflect changes (if required) which removes the exemption relating to mental health in-patients permitted to smoke in outside, designated areas	• Trina Nealon, Cardiff and Vale Public Health Team	Revised No Smoking and Smoke Free Environment Policy to include mental health in-patients	July 2018

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1st Review Meeting – 25th March 2018 at Hafan y Coed

Attendance: Chair –Ian Wile - Ward Managers from all specialist areas of the MHCB, Directorate Managers, Senior Nurses, Medical Staff and Pharmacy.

Issue Raised	Action and Who Responsible
Service Users 'take up' of the opportunity to stop smoking is very low with the original aspiration of seeing a marked decline in smoker numbers being unrealistic – it was felt more realistic to plan this as a public health effort over a longer period of harm reduction	Continue to provide public health information via social media and internally to service users from all mental health sites, particularly prior to admission. Continue to promote the availability and access to smoking cessation
The restrictions around the use of e-cigs in the wards to be only used in the garden areas due to the risk of tripping smoke alarms no longer exists following the changing of the detectors. The restrictions on where ecigs can be used is reported to be causing additional challenges to people running the wards from day to day – with service users who require escorting into garden areas resorting to covertly smoking in their rooms. This poses a significant risk of fire.	Decided that the least risk was for there to be no restrictions of the use of e-cigarettes indoors following clarification with the fore officer that fire alarms are now not sensitive to smoke. Patients also will be allowed to re-charge e-cigarettes on the ward in areas permitted by staff – this is felt to be a reasonable step as there have been no fires reported as a result of recharging appliances compared to the risk of a fire through unauthorized smoking. TN to seek advice on safe

	products to recommend to patients
Use of Section 17 Leave has changed with the need for some service users to take leave to smoke off the ward areas rather than use leave for recovery purposes. Leave is currently being prescribed by MDTs sympathetic to the patients position. Consequently ward staff spending a lot of their time at the ward doors & patient's smoking in their rooms posing a fire risk.	IW and JT to discuss the issue of leave with the consultant body with the changes proposed for the use of e-cigs potentially reducing these problems
Access to E cigs – it remains a problem for detained patients to access e-cigarettes without time off wards and often little family support – this often falls to ward staff	Following a discussion with PH - IW to investigate the possibility of selling e-cigarettes on site
No-Smoking enforcement – problems remain at the main entrance of HYC as well outside aroma-coffee opposite. TN reported that an enforcement office will be on site in the near future for 1 day a week to challenge smoking and enforce fines for littering with smoking material – this will include staff who could face disciplinary action if found repeatedly smoking on the site.	IW and JT to establish when the enforcement officer is due to cover the site and investigate an SLA with domestic services to clean the front of HYC more frequently.
Prior to the ban, staff and others were understandably fearful of there being an increase in frustration with the policy and see an increase in V&A against staff and possibly other patients.	Jan – Mar 2017 V&A codes total 145 of which 3 include 'smoking related' in motivation field. Jan – 25 Mar 2018 V&A codes total 139 of which 18 include 'smoking related' in motivation field.
Ward culture – other than the issues raised above, the reduction in the 'smoking culture' on the wards and the often complex dynamics that brings where cigarettes are used as ward currency has reduced	Continue to monitor

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PATIENT MANUAL HANDLING PROACT EQUIPMENT AUDIT ACTION PLAN	
Name of Meeting : Health and Safety Committee	**Date of Meeting** 10/04/2018

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : £200k
Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The progress shown against the attached Action Plan.

The Committee is asked to:

- **NOTE** the content of this report and the actions taken to address the issues raised.

SITUATION

The Priority Action Plan brought to the Health and Safety Committee identified concerns that the Health Board may be failing to meet the Lifting Operation and Lifting Equipment Regulations requirement to ensure that there is suitable and sufficient patient handling equipment available.

To validate this risk a comprehensive patient handling equipment audit was undertaken in July 2017, looking at equipment status in comparison to patient requirements.

The Health and Safety Committee received a presentation on the ProACT audit of the status of manual handling equipment at the January 2018 meeting. The Committee requested that an action plan be submitted to address the findings.

BACKGROUND

The Lifting Operations and Lifting Equipment Regulations 1998 require the UHB to have 6 monthly inspections for lifting equipment at our premises. RSA is our 'competent person' who currently performs these inspections.

The Health Board priority action plan identified 2 areas related to patient handling, requiring attention.

LOLER regulations require the inspection and maintenance of all lifting equipment including hoists and slings. Slings have previously been internally inspected.

Restricted finance has resulted in aged hoisting stock.

The presentation covered a total of 1775 in-patients and identified an increase in the number of patients requiring hoisting equipment to meet their needs, since the previous audit in 2015. This has enhanced the demand on both staff and the importance of equipment.

The analysis identified that 10% (33) of the Health Board's equipment was obsolete, with a further 4% well beyond. It also identified that 7% of the equipment was in a poor condition.

The audit included the age and condition of washable slings and identified some 495 washable slings were well beyond the expected manufacturer life of 3 to 4 years.

It also identified as part of the audit all slings in poor condition and damaged be removed.

ASSESSMENT

It was highlighted that obsolete hoists were no longer suitable and as a result these hoists would not pass their next inspection date of June 2018 and as such would leave a significant risk to the management of handling patients.

It identified that there was some gaps against need which required addressing. It also justified a repeat of the programme at the end of 2018 to consider seasonal issues and validate the enhanced demand on hoists.

It recognised that there was a need for an effective maintenance programme to ensure that the loss of hoists for maintenance was minimised.

It also identified that the age and condition of re-usable slings presented a risk and should be addressed at local level.

It recognised that the changes in the design of bathrooms within the Health Board should consider the hygienic equipment to support the change of use from bathing to showering.

An action plan attached has been prepared and progressed during the period to implement the findings. Those items which require a continual management role will be included within the Priority Implementation Plan at both the Operational Health and Safety Group and the Health and Safety Committee.

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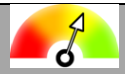
		ProACT audit Action Plan		Significant assurance 				
CRAF Ref	Ref	Area	Requirement	Action taken	Accountable Lead	Status/ Assurance	Priority	Time Scale
8.1.4	**1.1**	Monitoring	Repeat ProACT audit to assist monitoring of condition of equipment, ongoing and potential change in clinical need.	Arjo ProACT Assessment planned to be repeated in November/December 2018. In addition potential to add new scope of assessment such as related to Bariatric equipment provision	Head of Health and Safety	Action planned	Mod	December 2018
	1.2	Obsolete Equipment	Replacement of patient hoists which are **OBSOLETE** and in **POOR** condition. **x7 passive hoists/x1 active hoist** Replacement of patient hoists which are **OBSOLETE** with **NO SERVICE/INSPECTION SUPPORT. x25 passive hoists**	• Discretionary Capital Bid covering all obsolete hoists with no service/ inspection support prepared • Funding to replace all obsolete hoists secured • Hoists ordered	Head of Health and Safety Director of Therapies Head of Health and Safety	Completed	High	March 2018
	1.3	Replacement	Distribution of above hoisting equipment prior to inspection date	Commitment given from supplier to deliver all hoists ordered prior to inspection/ service date	Head of Health and Safety	Action planned	High	June 2018
	1.4	Equipment shortfall	Prioritise the areas **WITHOUT** patient hoists that have an identified patient population **NEEDING** equipment - **fill the 'gaps'**	Priority shortfall addressed through purchase of above new stock. Mechanisms of appropriate re-distribution of hoist to service needs being discussed with Ast Director of Therapies	Head of Health and Safety/ Ast Director of Therapies	Action being progressed	Mod	December 2018
	1.5	Equipment Maintenance	Renewal of planned maintenance contract required and review of response to equipment defects to minimise disruption	All obsolete hoisting stock planned to be replaced, this will reduce demand on urgent maintenance. Means of creating an equipment library to cover defect loss being examined	Head of Procurement/ Director of Estates/Ast Dir of Therapies	Status not confirmed	Mod	April 2018
	1.6	Slings	Continued **sling management** programme at Clinical Board level – using assessment information provided.	**This requirement has been submitted to the Operational Health and Safety Group for** this programme to be picked up at	Head of Health and Safety	Continued progressed action will be	High	June 2018

			Consideration of shift to use 'patient specific' slings for general use – **cost analysis** of patient specific slings versus washable slings based upon real time costs of quantities, laundering and costs of ownership (including LOLER inspections, labelling etc). Currently **x266 WELL BEYOND** expected service life.	Clinical Board level to ensure replacements as and when required As Above		monitored via the Operational Priority Improvement Plan		
	1.7	Hygiene Equipment	Continued evaluation and trials of appropriate hygiene solutions (Hygiene and Shower Chairs) at ward level in line with the bathroom refurbishment programme currently underway	10 carida shower chairs under evaluation. Information passed to Capital Planning re refurbishment programme	Head of Health and Safety	Action progressed	Mod	April 2018

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PEDESTRAIN ACCESS SAFETY STRATEGY	
Name of Meeting: Management Executive Meeting	**Date of Meeting:**

Executive Lead : Director of Planning
Author : Director of Capital Estates and Facilities 02920 743761
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Health and Safety" elements of the Health Board's Strategy.
Financial impact : The cost of the study will be £24k + VAT.
Quality, Safety, Patient Experience impact : Not Applicable
Health and Care Standard Number: 2.1 Managing Risk and Promoting Health and Safety
CRAF Reference Number: 3.3 CRAF Reference Number Objective 6 – (Resources - All the UHB's resources: money, staff, estates and equipment are maximized to deliver the best possible care). Objective - 6.4 Plan, resource and implement safe and adequate estate.
Equality and Health Impact Assessment Completed: Not Applicable at this stage
ASSURANCE AND RECOMMENDATION The Board is asked to: • **NOTE** the content of the paper • **APPROVAL** is sought to proceed with the development of a Pedestrian Access Strategy for the UHW site.

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SITUATION

Cardiff and Vale University Health Board recognises its responsibility for the management of Pedestrian safety throughout its portfolio of properties.

University Hospital of Wales (UHW) has seen significant increases in Clinical activity during the last 10 years which has resulted in dramatic increases in traffic and pedestrian volumes at this site. Other premises have also had notable increases in activity.

The UHB has undertaken a number of traffic management studies at UHW to identify traffic movements and profiles and has implemented infrastructure changes to reduce traffic congestion, improve Health and Safety and reduce vehicle emissions.

The UHB is also promoting and encouraging patients, visitors and staff to adopt where appropriate sustainable and active travel methods to attend UHB premises e.g. cycling and walking etc.

As UHW has significant volumes of pedestrians who need to traverse the site there is a need to develop a Pedestrian Access strategy. This need is also reinforced as there has been a pedestrian incident at UHW.

This paper summarises the development of this strategy including the methodology adopted, timescales and costs.

BACKGROUND

Traffic and Transport Management

UHW has observed significant increases in activity due to historic and current rationalization programs where services have transferred to this site but also associated with natural growth and changing models of Healthcare.

UHW has four vehicle entrances/exits and a range of pedestrian access points and is flanked by a range of busy road networks serving Cardiff city and surrounding districts.

The UHB's Transport and Travel Team have been developing a range of promotional and infrastructure measures to encourage patients, visitors and staff to consider alternative methods to travel to the UHB, to reduce traffic congestion, improve Health and Safety and curb vehicle emissions.

These actions and proposals are summarised below:

- Traffic Management infrastructure changes at UHW have resulted in reduced traffic volumes. Benefits include reduced traffic congestion and carbon emissions and Improved Health and Safety.
- A Park and Ride scheme based at the A48M Pentwyn junction has been implemented for patients, visitors and staff further reducing traffic volumes at UHW.
- A series of Traffic Roadshows and events promoting Sustainable Travel options including walking, cycling, park and ride, car sharing and public transport.
- A Sustainable Travel Bus Hub is being planned and developed for the UHW site.
- An integrated UHB Travel Plan is being developed and an external consultant has been appointed to undertake and develop this strategy.

Pedestrian Incident

There has been an incident at UHW whereby a pedestrian had an incident involving a vehicle and the pedestrian suffered a broken leg. This has highlighted and prioritized the need for a formalised Pedestrian Access strategy for UHW to be developed and implemented.

Pedestrian Access Strategy

Due to the background detailed above, there is the need for the UHB to develop and implement a Pedestrian Access Strategy for UHW. An external consultancy with the necessary expertise and experience is to be appointed to complete this exercise.

The objectives of the study are to:

- Identify the current pedestrian access arrangements, suitability and areas of risk and opportunity.
- Develop proposals for the implementation of a Pedestrian Access strategy.
- Action plan and next steps

The study will include the assessment of current pedestrian activity and pedestrian infrastructure and access arrangements. From these findings recommendations will then be formulated to improve access points, pedestrian routes and associated signage/information.

ASSESSMENT AND ASSURANCE

The development of the pedestrian access strategy will include the following stages:

Stage 1

- Site visits and investigations.
- Modelling of information.
- Consultation with stakeholders.
- Interim report of findings.

Stage 2

- Development of pedestrian access options.
- Preferred option selected and outline design developed.
- Development of supporting requirements including wayfinding and signage.
- A complimentary set of traffic management measures will support the pedestrian access proposals.
- Final presentation and report .

The estimated costs of the study will be £24k + VAT and will be completed in a timescale of 6-8 weeks. The study will commence in late March 2018 with completion scheduled for May 2018.

Approval is therefore sought to proceed with the development of a Pedestrian Access Strategy for the UHW site.

FIRE SAFETY REPORT	
Name of Meeting : Health and Safety Committee	**Date of Meeting** 10/04/2018

Executive Lead : Director of Planning
Author : Senior Fire Safety Advisor 02920 742292
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: The report is strategic with direct cost being identified as required.
Quality, Safety, Patient Experience impact: The fire safety action plan will improve fire safety and reduce the fire risk.
Health and Care Standard Number 2.1
CRAF Reference Number 6.4.5
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Providing additional information to the issues identified in the Annual Fire Safety Report to demonstrate they are being appropriately managed.

The Health and Safety Committee is asked:

- to **CONSIDER** the report

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SITUATION

This paper provides an update on the relevant fire safety issues

Key issues:

- Fire Risk Assessments
- Fire Training
- Fire Warden Training
- Compartmentation
- Fire and Smoke Dampers

BACKGROUND

Cardiff & Vale University Health Board is committed to ensuring the protection from fire and explosion, so far as is reasonably practicable, of its employees and persons other than employees (e.g. patients, members of the public, contractors, visitors etc.) who use the Health Board's premises, or may be affected by its activities.

ASSESSMENT AND ASSURANCE

1.0 Fire Risk Assessments

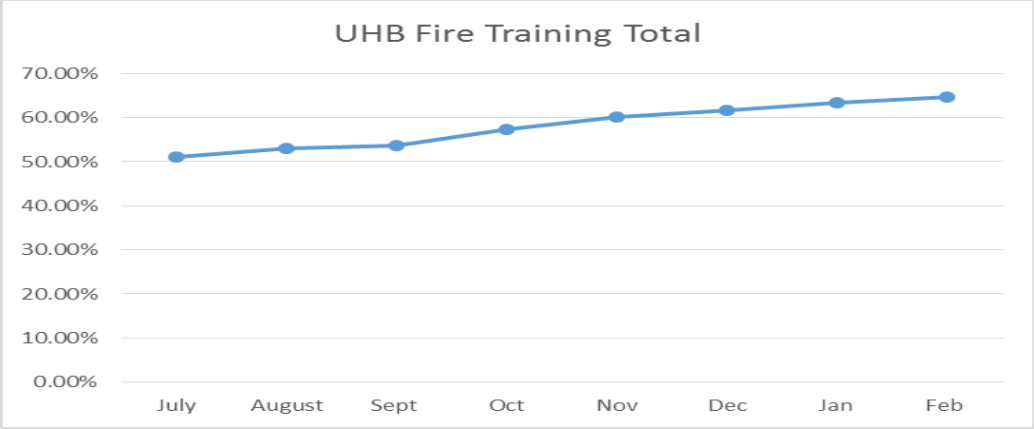
We have 400 current risk assessments across the Health Board.
The findings of the risk assessments are divided into three areas of responsibility: Management, Estates and Compliance, each sector has a data base, from which progress is monitored.

A meeting of the Deputy Fire Safety Managers is now held quarterly. Progress on remedial actions in both the fire risk assessments and the Fire Service Audits are monitored.

2.0 Fire Training

Fire Training (1 year refresher) data as at the 28th February 2018.

Clinical Boards	July - %	August %	Sept %	Oct %	Nov %	Dec %	Jan %	Feb %
Children & Women	51.75%	54.51%	56.09%	59.11%	64.23%	67.02%	69.83%	72.02%
Capital, Estates & Facilities	46.32%	46.61%	47.57%	52.08%	56.34%	58.88%	61.22%	62.25%
CD&T	67.91%	71.53%	72.72%	74.61%	73.05%	72.18%	72.22%	71.93%
Corporate	54.32%	57.04%	58.88%	63.24%	67.69%	68.82%	70.51%	74.78%
Dental	69.89%	69.57%	75.14%	80.00%	78.27%	79.93%	82.47%	79.30%
Medicine	37.23%	38.45%	39.29%	44.41%	52.63%	55.87%	61.22%	63.61%
Mental Health	50.63%	51.33%	52.48%	54.96%	54.75%	54.53%	56.01%	58.97%
PCIC	50.62%	52.37%	54.06%	61.72%	64.81%	64.97%	64.48%	66.82%
Specialist Services	50.44%	52.56%	48.26%	52.55%	55.07%	55.20%	56.99%	57.85%
Surgical Services	41.24%	42.74%	43.35%	46.13%	48.90%	51.29%	51.79%	52.45%
UHB Total	**51.08%**	**52.99%**	**53.64%**	**57.39%**	**60.16%**	**61.55%**	**63.37%**	**64.70%**



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For many years the fire training compliance figures have constantly been around 50% whilst the Health Board target is to achieve 85%. As can be seen from the above table, since July 2017 there has been a steady increase in compliance and currently stands at 64.7%.

It has been confirmed that the Electronic Staff Record data system records fire training differentiating between Tutor led or Electronic courses. This information will be evaluated against assessments made by the Senior Fire Adviser of those staff requiring each type and will be considered at the next Fire Safety Group Meeting.

Action Plan:
Undertake a review of training against role function i.e. those staff that are clinical based requiring tutor led courses and those who may achieve compliance through E learning.

An additional 17 courses are to be run throughout May and a similar number in November. We are providing cascade training via the Nurse Practitioners in addition to regular drop in classes with the aim to achieve 85% by December 2018.

3.0 Fire Warden Training

Fire wardens are the focal point for fire safety issues for local staff. The local fire wardens report fire safety issues to their line manager who in turn report to their management. The aim is to have fire wardens in all areas and we run courses monthly to help to achieve this. It is disappointing that while the courses are fully booked substantial delegates fail to turn up on the day with no notice.

Action Plan:
To obtain permission to charge the Directorates for failed attendance, this has been trialed for other courses and has proved to be effective.

4.0 Compartmentation

The fire strategy involves restricting a fire to a limited area by fire resisting construction and fire and smoke dampers in order for any patients to be safely moved horizontally to a safe location. Over a period of time the structural fire compartmentation has been compromised by passing cables, pipes and other services through fire compartment walls and ceilings and not completing the required fire stopping to these penetrations.

Action Plan

A prioritized action plan is in place to survey and repair damaged fire barriers. The risk factors are sleeping risk and dependant or highly dependent patients which increase with the height above ground.
Areas recently completed include the following:

- All A , B and C wards at the Heath
- Women's Hospital

- Main theatres at Llandough
- Day surgery at Llandough

The next phase to be completed in 2018 will be the Link Blocks and Theatres at the Heath. It is estimated to complete the works over a 5 year period at an estimated cost of £500,000.

The newer buildings and refurbished areas have been completed to current standards and do not pose a risk.

5.0 Fire and Smoke Dampers

Fire and smoke dampers are required to stop the spread of smoke via the ventilation ductwork running through the buildings. Due to their age the majority does not comply with current standards and due to lack of maintenance over many years it cannot be confirmed they will operate effectively. We did not have accurate plans of where these dampers are located.

A risk identified in the surveys is that approximately 20% of dampers are totally inaccessible due to service pipes and cables fitted around the inspection hatches.

Action Plan:

- We have now completed a survey to identify the location of all dampers.
- A contractor has been appointed to inspect and service all dampers and report all defects.
- All areas being refurbished to be fitted with dampers conforming to current standards.
- Where possible new hatches are being installed but in some ducts this is not possible.

    - Dampers identified in the initial survey 2857
    - Dampers tested to date 2115
    - Passed 78%
    - Failed 3% with remedial work now in progress
    - No access available 19%. Where no access is available where possible inspection hatches will be cut into the duct work; however we have to accept that due to the constriction around the dampers by other services it will not be possible to inspect a percentage of these.

It is estimated all the inspections and repairs, where possible will be completed within 12 months

ENFORCEMENT AGENCIES REPORT
Name of Meeting: Health and Safety Committee **Date of Meeting:** 10/04/2018

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact : Potential fiscal costs relating to breaches of statutory obligation
Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The continued investigation, actions and monitoring referred to within the report

The Health and Safety Committee is asked to:

- **AGREE** that appropriate actions are being pursued to address the issues raised
- **NOTE** the content of this report

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SITUATION

As appropriate the Health and Safety Committee is briefed about action taken in response to correspondence from the Health and Safety Executive (HSE)

During the period there were three additional issues raised by the Health and Safety Executive (HSE) relating to:-

a) a reported examination of a boiler at Rookwood, resulting in a potential danger under the Pressure System Safety Regulations 2000.
b) concerns raised about enhanced risks as a result of a lift (No26) being out of service for an extended time due to asbestos requirements.
c) concerns raised following an asbestos inspection carried out by the HSE Inspector on a specialist contractor working on the X-ray Department in University Hospital of Wales.

This report updates the Committee on progress for each event.

BACKGROUND

If the HSE Inspector is of the opinion that a contravention of one or more statutory provisions has occurred they may issue Improvement Notices, Prohibition Notices or criminal proceedings.

The above may affect the Health Board's reputation and have significant financial implications.

ASSESSMENT

Road Traffic Accident at UHW

As previously reported an incident occurred when a Contractor's van was reversing out of the old Emergency Admissions Road and struck a member of staff walking to the Medical Physics building, fracturing her right elbow and nose.

The investigation report was submitted to the HSE. The HSE confirmed that the planned remedial actions were suitable and have closed their investigation. However they did consider the Health Board should review our pedestrian strategy for similar public/vehicle risks in other areas.

The remedial actions and the pedestrian strategy has progressed with an external consultant approached to advise on the strategy, this being the subject of a separate agenda item.

Hydrotherapy Pool

The HSE visited Rookwood Hydrotherapy Pool on 19th September 2016 to establish appropriate regulations were being applied.

A Working Group of Therapies, Estates and the Health and Safety Department has continued to actively pursue the required actions to close out HSE involvement.

Contractor Fall

The HSE initiated an investigation following a fall from height of a contractor engaged to clean the windows on the Women's Unit on the 22nd September 2016. Regular update reports have been submitted to the Committee on their correspondence.

The HSE wrote to the Health Board on the 17th December 2017 stating that they had now completed their investigation and offered the Health Board the opportunity make a formal submission by 14th February 2018 prior to the HSE making any decision in relation to any further action.

Legal advice was sought and a formal submission made. We are awaiting the HSE to review and respond, although it is understood that due to their demands they have yet to consider the submission.

New Event - reported examination of a boiler at Rookwood Hospital

The HSE received an examination report from British Engineering Services on the 9th November 2017. This required immediate attention; equipment that is subject to defect should be removed from service under regulation 9 of the Pressure System Safety Regulations 2000.

The HSE Inspector required the Health Board to confirm that the boiler was not in use or had been repaired. Confirmation was given that the boiler was not back in action and a new boiler was installed. There has been no further correspondence and item closed.

New Event - enhanced risks as a result of lift (No26) being out of service for an extended time due to asbestos requirements

The HSE wrote to the Health Board outlining that a concern had been raised to them by a third party in relation to the enhanced risks to manual handling and accumulation of material causing fire and falls risk due the lifts being out of action.

The Health Board responded that:-

- The breakdown of the lift (number 26) was reported on 19/5/17. The lift required a new part and was repaired on the 11/7/17 but due to asbestos in the plant room it required a further six weeks to clear the asbestos before commissioning the lift. The same lift then broke down on the 19/1/18 and was subsequently repaired and the lift is now functioning.

  The 2nd lift is currently awaiting safety repairs and requires a lift insurance inspection before it is put back into service which is currently in hand.

  A risk assessment was completed for the movement of specimens and solvents – risk rating 9 (moderate risk) and reviewed on the 23/1/18. The containers used to move the tissue were suitable and met UN3373 standards for the packing and transport of biological diagnostic specimens category B. Trolleys used to transport solvents were assessed as part of the risk assessment for the amended process.

- The department is subject to regular annual health and safety inspections in conjunction with staff safety representatives and there had also been a recent fire safety inspection. The department was aware of some accumulating waste which was waiting for the lift to be working before it could be moved and this has now been removed. The Manager had visited the areas concerned and confirmed there were no trip hazards or restriction to access/egress.

- In respect of the general maintenance/servicing of lifts this is undertaken as part of an All Wales Contract. The company carries out monthly inspections of every lift which includes general maintenance and there is also a call out service for breakdowns. There is also an annual insurance inspection of every lift which is carried out by the Insurance Company contracted by the Health Board.

The HSE has responded and no further action is to be taken and the item closed.

<u>New Item - asbestos inspection carried out by the HSE Inspector on a specialist contractor working on the X-ray Department in UHW</u>

On 22nd March 2018 the HSE wrote to the Health Board following an inspection it had undertaken of a licenced asbestos contractor who was working on UHW, their location was on the outer windows of the x-ray corridor. This work was planned to be done as some windows were going to be replaced.

The Inspector requested the Health Board investigate whether better arrangements could have been made so contractors were not having to carry tools and waste materials long distances, and to justify that this was the only access route available for the contractors, as it introduced a lot of manual handling issues and risks if asbestos bags ripped .

Essentially the contractors had to go up over another building and through a 'plant room' which had very much reduced head room, then onto the roof of an x-ray building. It was a hundred metre walk up onto the top of a roof through a plant room which had very restricted head room at one area. The asbestos workers would have to do this carrying all their gear and waste.

In the same area a roofing contractor was also working as they were over roofing the x- ray and had to use the similar access.

A response was prepared outlining that the extended route was required to ensure that the disruption to the x-ray service was minimised and no services cancelled.

HEALTH AND SAFETY PRIORITY IMPROVEMENT PLAN 2017/18
Name of Meeting: Health & Safety Committee **Date of Meeting:** 10/04/2018

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety 02920 743751
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact : The report is strategic with direct cost being identified as required
Quality, Safety, Patient Experience impact: The Priority Improvement Plan covers patient health and safety, with specific reference to the patient environment and falls.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4,6.4.7,6.4.5,6.4.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- Demonstrating progress against each strategic area and highlighting further actions required within set timescales.

RECOMMENDATION

The Health and Safety Committee is asked to:

- **CONSIDER** the on-going work to meet the requirements of the Priority Improvement Plan

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SITUATION

The Health Board has initiated a Health and Safety Priority (Improvement) Action Plan to monitor its progress on key health and safety strategic areas. This plan has been reviewed during the period to reflect planned changes to the Corporate Framework and builds upon the previously considered 2016/17 plan. The revision includes a review of the title considering that a Priority Improvement Plan is more relevant than a simple Action Plan.

The Priority Improvement Plan is the Health Board's strategic approach to tackling significant health and safety risks and has proved successful at reducing risks and progressing on the basis of real risks and practical solutions. This can be demonstrated by both the number of completed action areas

(green) and the reduction in incidents as demonstrated in the previously submitted Annual Report.

BACKGROUND

The Health and Safety Department has been working to integrate the plan with the Corporate Risk Assurance Framework ensuring that the risks identified within the Priority Improvement Plan are being appropriately addressed and monitored such that strategically health and safety is progressing.

The Priority Improvement Plan will continue to be monitored at each of the Operational Health and Safety Group meetings and progress reported at each Health and Safety Committee meeting. It is also considered that each Clinical Board will in turn produce its own Priority Improvement Plan based on the eight strategic areas.

An identified enhancement will aim to ensure that the status of milestones within the core strategic area will be evaluated in addition to the status of each of the identified actions. However the plan continues with the eight strategic areas.

The prioritised approach continues to identify the eight strategic areas, these being:

(1) Structural and Health and Safety Management (including incident reporting)
(2) Violence and Aggression Management
(3) Manual Handling
(4) Health Issues
(5) Environment Safety and Health and Safety Patient Issues
(6) Fire Safety Management
(7) Health and Safety Estates Management
(8) Sharps Safety

ASSESSMENT

Milestones
Key Milestone Actions Progressed During Period

1 Structural and Health and Safety Management				
Milestone	**Actions**	**Assurance**	**Lead**	**Completion**
Meet the health and safety legal requirements with regard to contractor control	Submission given to HSE detailing the actions taken in regard to the Contractor incident was justified and meeting its legal requirements	Legal advice sort	Director of Corporate Governance	Dec 2018
	Enhanced contractor control within Estates department including monitoring and permit	Report submitted to Committee	Director of Capital, Estates and Facilities	April 2018

	system Creation of contractor control group for non - estates work Business Appointment of Corporate Adviser to support same standard as implemented within Estates		Director of Corporate Governance	Feb 2018 April 2018 July 2018
2. Violence and Aggression				
Milestone	**Actions**	**Assurance**	**Lead**	**Completion**
1 Progress the review and implementation of the Memorandum of Understanding between NHS, Police and CPS	Case management team actively involved in launching new agreement, endorsed by Welsh Government with a planned date of November 2018	Working group including all interested parties. Cardiff and Vale used as exemplar of practice with 400 successful prosecutions under the original MOU	Director of Corporate Governance	Dec 2018
2 Staff at risk in the community have effective lone worker protection	Implement and monitor the lone worker system devices	Progress report submitted to Committee	Head of Health and Safety	Completed
3. Manual Handling				
Milestone	**Actions**	**Assurance**	**Lead**	**Completion**
1.Suitable and sufficient hoisting equipment available to staff	Implement findings of ProACT audit	Report submitted including action plan	Director of Therapies/ Director of Corporate Governance	December 2018
2 Meeting the Requirements of LOLER Regulations	UHB Procedure for the inspection of patient hoist slings was approved at the Operational Health and Safety Group and circulated for implementation	Monitored at local level and as part of the manual handling audit in November 2017	Head of Health and Safety	Completed Feb 2018
7. Health and Safety Estates Management				
Milestone	**Actions**	**Assurance**	**Lead**	**Completion**
Development of a pedestrian strategy for the	Consultants appointed to prepare outline plan. Prioritised pedestrian	Report to Committee	Director of Capital, Estates and	April 2018

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2 major health board sites in relation to their traffic risks.	safety in tunnels being pursued by Estates Department		Facilities	

CONTROL OF CONTRACTORS IN NON ESTATES ACTIVITIES
Name of Meeting: Health and Safety Committee **Date of Meeting:** 10/04/2018

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact : Direct cost of £30K to mitigate against the potential fiscal costs relating to breaches of statutory obligation in the estimate amount of £500K- £5 million
Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- The continued investigation, actions and monitoring referred to within the report.

The Health and Safety Committee is asked to:

- **AGREE** that appropriate actions are being pursued to address the issues raised
- **NOTE** the content of this report.

SITUATION

The January meeting of the Committee recieved a report on possible Health and Safety Executive (HSE) action following its investigation into the Contractor fall at UHW.

The Health and Safety Committee noted at the January meeting the need to ensure that the continued enhanced contractor control regime implemented within the Capital, Estates and Facilities Service Board were being adopted across all Health Board Departments that were utilising contractors.

Those departments effected have implemented a hold on their work which falls within this remit, this places considerable restraint on their ability to meet their commitments.

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This report further updates the developments and progress since the January Committee Meeting.

BACKGROUND

The Health and Safety Executive Inspector had completed his investigation into the fall from height of a Contractor on the 22nd September 2016, whilst working on the windows of the Women's Services Unit at UHW.

They wrote to the Health Board stating that they have identified a number of possible breaches and required us to provide a written submission, which the HSE will take into account prior to making a decision of further action.

The Health and Safety Committee have been kept updated on the progress with both the HSE investigation and remedial actions implemented as a result of this event.

The Health Board has implemented a Contractor Control Policy, which mandates that all Contractors require onsite management. This includes contractor briefings, risk assessments, method statements and review and validation of work against asbestos regulations, buried services and local supervision.

Estates manage the largest percentage of contractors; however contractors are employed outside of the estates function in areas such as IT, telecommunications and procurement that require similar arrangements.

ASSESSMENT

The Health Board has submitted a robust defense outlining its existing controls to the required legal standard in this event and its overall safety performance. However it is recognised that should an incident occur or the HSE identify a gap outside of the estates management of contractors, there would be no defense and immediate likelihood of prosecution in the order of £1.3M, based off the companies turn over.

The submission also outlined the considerable progress made both prior to and post the event in contractor control. The submission was made within the required timeframe of the 14th February 2018. The HSE has confirmed that due to their existing workload they have yet to fully evaluate the submission.

Consistant with the concerns raised at the January meeting, the Director of Corporate Governance formed a Corporate Contractor Group to underpin the progress made within the Estates Department and ensure the standards introduced were consistant across all areas that utilise contractors.

The meeting identified that the demand on the existing Safety and Asbestos Team within the Estates Department was fully utilised with very limited ability to respond to, or to a portion of the appropriate priority to non estates based contractor work.

Although the Director of Capital, Estates and Facilities has co-operated as much as possible and committed to support a number of the key priority IM&T project work, some planned work has had to be postponed and meeting their future requirements will be restricted under current arrangements. It is understood that one of the planned projects alone would require over 300 asbestos assessments as well as the related review of method statements, risk assessments and contractor briefing.

However, failure to fully implement the requirement of the Contractor Control Policy will leave the Health Board very vulnerable to prosecution with no defense and considerable reputational loss and financial risk.

Subsequently after consultation and agreement of the Head of IM&T, Head of Health and Safety and the Director of Capital, Estates and Facilities, a business case is being submitted to the Management Executive Meeting to support the appointment of an additional competent adviser to underpin the standard within the organisation.

The proposal is to appoint an Adviser within the Corporate Health and Safety team, this will be merged with an existing vacancy resource within the department's budget to allow the role to become a fulltime post which is necessary to give the required response.

THE MANAGEMENT OF CONTRACTORS and JOB REGISTRATION FORM	
Name of Meeting : Health and Safety Committee	**Date of Meeting** 10/04/2018

Executive Lead : Director of Planning
Author : Estates Health, Safety & Asbestos Manager
Caring for People, Keeping People Well: This report underpins the Health Board's Sustainability avoiding harm waste and variation**.**
Financial impact :
Quality, Safety, Patient Experience impact :
Health and Care Standard Number :
CRAF Reference Number:
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Monthly reports on contractor control to the Capital planning & estates Health and safety meeting.
- The introduction and use of the Job Registration Form (JRF)
- Ongoing monitoring and interaction with Capital Compliance and Estates employed contractors across the University Health Board (UHB) estate.
- Monitoring by both the UHB Supervising Officers and estates H&S personnel
- Periodic analysis of contractor control
- Supervising Officers awareness of their roles and responsibilities in accordance with the *Control of Contractors Policy. Reference Number: UHB 163 Version Number:2* and appendices 1-9 plus supporting documentation
- Enhanced site induction
- Further enhanced Permit to Work systems

The Health and Safety Committee is asked to:

- **AGREE** in this format the ongoing monitoring/ management of contractors across the UHB estate

SITUATION

Following a request from the Health and safety committee, a previous report was submitted in July 2017 regarding trend analysis of contractor control safety breaches**.**

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Further enhancements continue to be made to the contractor control this paper summarises current actions and future plans.

Enhancements to the contractor control system include the introduction of the Job Registration Form (JRF) across the UHB estate. The Job Registration form is essentially a checklist which documents the exchange of information between the health board supervising officer and the contractor manager. This ensures the requirements of the contractor control policy are consistently applied

This report also summarises further enhancements implemented and provides an update on the ongoing monitoring and management of estates employed contractors across the UHB.

BACKGROUND

Following a serious incident during September 2016 where a contractor undertaking window cleaning, fell from a redundant gantry, the subsequent HSE investigation highlighted deficiencies in the UHB Contractor Control System.

The subsequent enhanced management and control of contractors which includes the implementation of the JRF across the UHB estate is in direct response to these deficiencies.

The *Control of Contractors Policy V: 2* precedes the incident. After trialing the JRF firstly within the estates dept. the first entry included on the JRF database was made on December 1st 2017.

Management of Contractors

The Capital Planning and Estates department aligns its control strategy for the management and control of its contractors with that of, the Cardiff and Vale University Health Board *Control of Contractors Policy V: 2*

The management of contractors at UHB sites originates before the contractor attends site to commence works. Guidance for this is provided within the Control *of Contractors Policy V: 2*

In the first instance suitable contractors are identified.

During the tender stage the UHB supervising officer ensures that contractors meet the H&S criteria required by the UHB, this is achieved by providing the contractor with the Pre-Qualification Questionnaire – *Control of Contractors Health and safety Questionnaire 1* which is returned and audited accordingly.

During the tender monitoring stage the following questions are asked –

- Is the tender price un-expectantly low?

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- Has adequate provision been made for the management of health and safety?
- How does the contractor propose to manage health and safety at the UHB, particularly high risk activities?
- Does the contractor have the infrastructure to manage health and safety effectively?

At contract award, all relevant health and safety information, risk assessments, method statements and on site procedures should be provided.

Contractors are advised that there is a mandatory requirement to ensure that they have attended the UHB contractor's induction prior to the commencement of any works.

The monitoring of contractors on site is carried out by the project supervising officer supported by the Capital Planning and Estates H&S team. Site visits are carried out by both the supervising officer and the Estates H&S team and are recorded on the *Guidance for Monitoring Contractors* document and collated on the Contractor Control Monitoring Database.

On contract completion the supervising officer will check the work area for compliance as part of the contract performance review.

In addition to the pre-existing control of contractor's strategy further procedures and arrangements have been put in place, the most significant of these being, to allocate an additional resource in the form of a Capital Planning and Estates H&S officer to undertake contractor monitoring across the UHB sites. On site contractor monitoring involves both interacting with and where necessary challenging contractors where non conformances are evident.

The Capital Planning and Estates H&S team engage with contractors at their place of work in support of the supervising officers, the schedule of site visits is determined by the level of risk associated with the project works.

It is essential to ensure a proactive approach to H&S by the contractor and foster a decent working relationship between the contractor and the health board.

The Capital Planning and Estates H&S team reports periodically on procedural and significant breaches to the monthly Capital planning & estates safety meeting. An example of this reporting procedure is shown in the Control of Contractors Analysis Graph presented later within this paper. As part of the UHB interaction with on-site contractors the UHB also reports on good practices that are evident during site visits.

Job Registration Form

It was identified that there was a requirement to introduce the JRF as a means to enhance the UHB control of contractors. The JRF must be

completed for all contractor estates activities across UHB sites, to include both project works and service contracts. The JRF in principle now replaces Appendix 1 of the *Control of Contractors Policy V: 2* for Capital Planning and Estates works.

The JRF is completed in conjunction with the contractor and includes the following –
Plant and Work Details, Confirmation as to whether RAMS have been received, confirmation that contractors have completed induction training, Site Hazards, Contractor Workgroup Hazards, Safety Precautions Required, the Agreed Usage of Services, Asbestos Information, Permits, Certificates and Documentation plus Authorising Signatures.

There is an exception, an example of which are, work areas that are not under the direct control of the UHB, a case in point being the new MRI building currently under construction, this is classed as a F10 reportable project and therefor under the control of others, in this case Kier Construction.

ASSESSMENT

Management of Contractors

The monitoring and management of contractors is carried out from both practical and administrative perspectives. Between 04th January 2017 and 13th March 2018 there were 1008 approaches made, the monthly average of approaches, have increased, since the full time contractor control post was implemented.

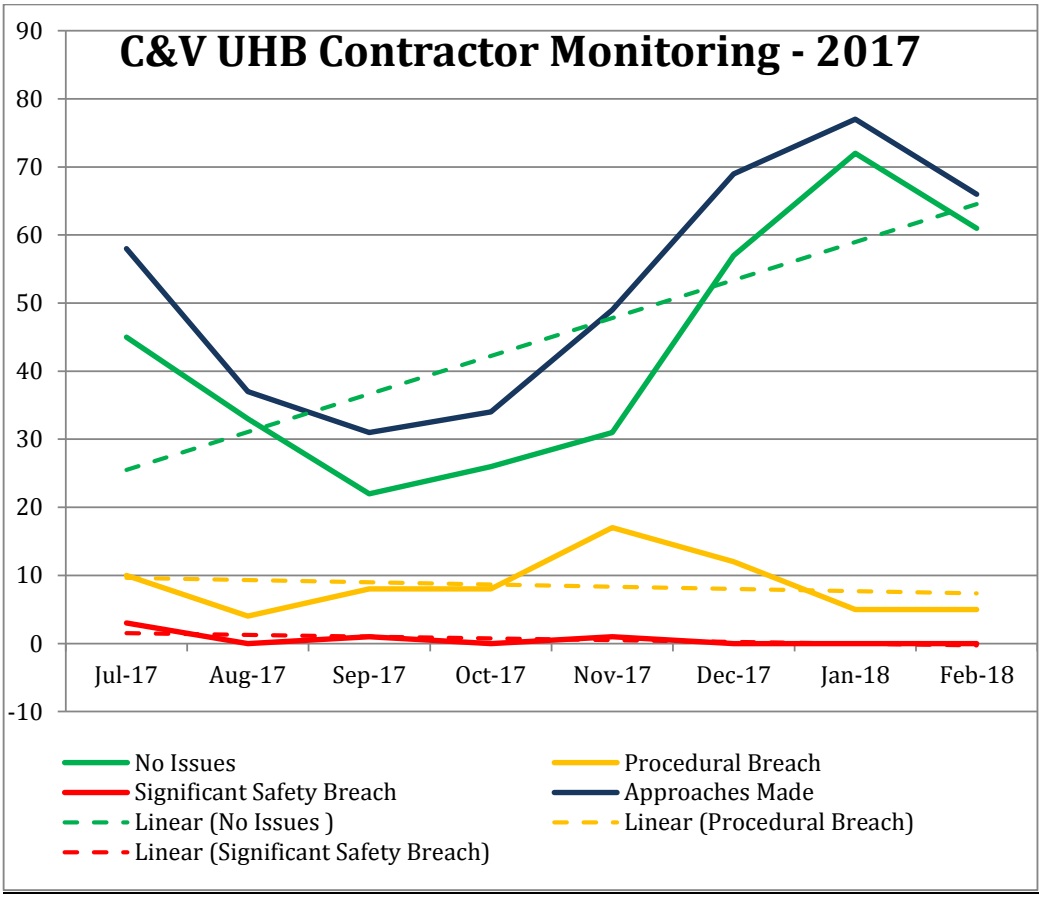
Thirty three approaches made during this period, were deemed as significant and resulted in the work being suspended and referred to a senior manager. Significant breaches are defined as those that have an imminent risk with the potential to culminate in a serious injury e.g. working at height with no edge or fall protection in place.

During the same period there were one hundred and sixty six procedural breaches recorded, resulting in verbal warnings given and or work being suspended until the issue was resolved by the project supervising officer.

The total number of significant and procedural breaches amount to < 20% of the total number of approaches made during this fourteen month period.

Taking these figures into consideration the trend is one of relative compliance. That said, there is room for further improvement. As the analysis graph below highlights, it is apparent that the number of significant breaches have declined during the last three recorded months, with none being recorded during that period.

February 2018 Control of Contractors Analysis Graph



To further improve upon the current trend the Capital Planning and Estates H&S team are carrying out a program of refresher training for supervising officers in the management and control of contractors, the training covers the following subjects -

- *Control of Contractors Policy V: 2* and its appendices 1 through to 9
- *Guidance for monitoring contractors* document
- *Control of Contractors – A Quick guide*
- *Job Registration Form*
- *Hot Work Permit* (new format)

The training is being rolled out throughout the Capital Planning and Estates dept. it is envisaged that this training will further bolster our current contractor monitoring and management protocols leading to an increase in contractor H & S performance.

In addition to the in-house activities regarding contractor management and monitoring, it is being assessed as to whether contractors working at the UHB should hold the Construction Skills Certification Scheme (CSCS) cards.

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Initially it has been suggested that this would be a requirement for contractors engaged in higher risk work activities across the estate.

The CSCS cards provide proof that an individual's competency has been evaluated. Holding a CSCS card will clearly indicate the ability of the worker from a H&S perspective. The CSCS card is only available to those workers who have applied for the card and have successfully passed the Construction Industry Training Board Health Safety and Environment Test.

Job Registration Form

The JRF was trialed initially during November 2017 within the Estates dept. at UHW. Following its successful trial, the JRF was rolled out across the UHB. Between December 1st 2017 and 15th March 2018 there has been six hundred and sixty eight entries onto the JRF database.

The JRF is included as a subject in the current round of refresher training being provided for the supervising officers. Following the delivery of the refresher and JRF training it is envisaged that the monthly average number of JRF submissions will increase. Plus in addition to the quantity of submissions it is also envisaged that the quality and collation of the supporting documentation found within the respective JRF Evidence Folders will also improve.

The implementation of the JRF provides ongoing assurance towards combatting the deficiencies that were highlighted regarding contractor management and control, identified by the enforcing authorities.

Recommendation

Management of Contractors

The management and monitoring of contractors onsite and through the desk top exercises continues to work well and it is recommended that these methods should continue in its present format.

Following on from the current round of training and refresher training for supervising officers it would be beneficial that a specific audit program for ensuring that Capital Planning, Facilities & Estates staff are fully implementing all aspects of the *Control of Contractors policy V2*. is implemented.

It would be a positive development, in the first instance, to introduce a requirement for contractors engaged in high risk activities across the UHB estate to hold cards accredited to the CSCS or their equivalent.

Although already widespread within the construction industry it is apparent that not all contract companies engaged by the UHB subscribe to this scheme.

It is not a legislative requirement for contractors to hold a CSCS card or its equivalent, although, by requesting that contractors engaged in high risk activities across the UHB estate hold CSCS cards, this would provide a further measure of assurance as to their H&S performance.

Capital Planning and Estates site inductions, are mandatory for all personnel working on behalf of the Capital Planning and Estates dept. Currently inductions are delivered in a number of ways and at various locations e.g. standard H&S dept. delivery (Mondays/ Thursdays at 08:00 or by arrangement), departmental, via email and at varying locations across the estate (delivered by estates supervisors).

It would be sensible if all inductions were carried out by the H&S team where practical. This would provide assurance that inductions are standardised and are delivered in a manner that ensures that in addition to attending the standard presentation, that all contractors are made aware of the risks and hazards that can be associated with working across the UHB estate, for example Working at Height, Working on or near to Asbestos, Road Traffic Accidents.

This standardisation would also allow for early interaction with the contractor by the H&S Team, ensuring that the contractor was fully conversant with the safe working procedures for the site and that any questions that they were to raise could be answered in a manner that was concise and unambiguous.

Following the implementation of the revised Working at Height Permit, the UHB Capital Planning and Estates, Hot Work Permit has been recently revised and the revised version implemented within the Capital Planning dept. This permit will be rolled out shortly to the Estates dept.
It is recommended that following on from the successful implementation of both of these permits that the current Permit to Dig will be reviewed along with that of Confined Spaces permit. The revised permits could then be trialed and implemented accordingly.

Job Registration Form

On completion of the ongoing training and refresher training for supervising officers it would be useful that a specific audit program for the JRF were to be implemented. The JRF is one component of the overall JRF procedure. In addition to the actual JRF, the JRF supporting Evidence Folder encompasses copies of the Permit to Works and any supporting documentation associated with the task and should be audited and incorporated within the *Control of Contractors policy V2*

HEALTH AND SAFETY COMMITTEE WORK PROGRAMME 2018 - 2019

Meeting Date / Agenda Item	**January 2018**	**April 2018**	**July 2018**	**October 2018**	**January 2019**
Presentation/Staff Story	Arjo Proact Survey Findings	Mental Health CB – Trail of No Smoking	Case Management/Personal Safety Support		
Review of Committee's Term of Reference			√		
Priority Improvement Plan – **CRAF No's: 8.1.4, 6.4.7, 6.4.5, 6.4.4**	√	√	√	√	√
Policy Schedule **- CRAF No: 8.2.3**	√	√	√	√	√
Fire Enforcement Report – **CRAF No: 6.4.5**	√	√	√	√	√
Environmental Health Inspection Report – **CRAF No: 8.1**	√	√	√	√	√
Corporate Risk Assurance Framework Exceptions Report – **CRAF No: N/A**	√	√	√	√	√
Health & Safety Annual Report and presentation - **CRAF No's: 8.1.4, 6.4.7, 6.4.5, 6.4.4**			√		
Regulatory and Review Body Tracking Report – **CRAF No: 8.1**		√		√	

Meeting Date / Agenda Item	January 2018	April 2018	July 2018	October 2018	January 2019
Enforcement Agencies Report – **CRAF No: 8.1.4**	√	√	√	√	√
Pedestrian Safety Strategy – **CRAF No: 8.1.4**	√	√			
Review of Statutory and Mandatory Health and Safety Training – **CRAF No**:			√		
Review of Fire Safety Policy - **CRAF No: 8.2.3**			√		
Review of Latex Allergy Policy - **CRAF No: 8.2.3**				√	
Review of Environmental Policy - **CRAF No: 8.2.3**				√	
Review of Closed Circuit Television (CCTV) Policy – **CRAF No: 8.2.3**				√	
Review of Security Services Policy **– CRAF No: 8.2.3**					√
Waste Management Compliance Report – **CRAF No: 8.1.1**	√		√		√
Fire Annual Report - **CRAF No: 6.4.5**			√		
Healthcare Standards – **CRAF No: 5.16**					
Public Health Targets – Smoking - **CRAF No: 1.2.1**			√		

Meeting Date / Agenda Item	January 2018	April 2018	July 2018	October 2018	January 2019
Internal Audit Reports with Health & Safety Inference – **CRAF No: 8.1**					
Lone Worker Devices Report – **CRAF No: 9.2**		√		√	
Health and Safety Management Audit – **CRAF Nos: 8.1.4, 6.4.7, 6.4.5, 6.4.4**					
Shared Services Fire Audit – UHL – **CRAF No: 6.4.5**	√		√		
Contractor Control – **CRAF No: 8.1.14**		√			

REGULATORY AND REVIEW BODIES TRACKING REPORT 1ST APRIL 2017 – 31ST MARCH 2018
Name of Meeting : Health and Safety Committee **Date of Meeting** 10/04/2018

Executive Lead : Director of Corporate Governance
Author : Health and Safety Adviser 46433
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : Not applicable
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number Governance, Leadership and Accountability Standard
CRAF Reference Number 8.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The action taken as detailed in the report and the continual monitoring of inspections/visits undertaken by the Health and Safety Executive, South Wales Fire and Rescue Service and Local Authorities by the Health and Safety Committee and relevant Sub-Committees.

The Committee is asked to:

- **NOTE** the Regulatory and Inspections Visits Tracking Report

SITUATION

This report is presented to the Committee to track that relevant Board Committees are receiving reports and information regarding inspections undertaken by the various inspection/review bodies as a key source of assurance. The report provides information for the period 1 April 2017 and 31 March 2018 and includes:-

a) new inspections undertaken during the period as recorded in the post log or notified by Clinical Boards
b) formal reports received during the period. Some reports are received a number of months after the actual inspection.

BACKGROUND

The statutory obligations of the University Health Board (the UHB) are wide ranging and complex; the UHB must comply with general law as well as NHS specific legislation. The majority of regulatory visits monitored by the Health and Safety Committee fall into the following categories:

- Food hygiene inspections undertaken by the Local Authorities;
- Inspections undertaken by the Health and Safety Executive;
- Fire Safety inspections undertaken by South Wales Fire and Rescue Service.

ASSESSMENT

The attached report provides evidence that each category of review is assigned to the Health and Safety Committee. It contains a summary of 19 inspections, regulatory visits or correspondence received which all took place during the period.

Fire Service Informal Notices

These are reported to and monitored by the Fire Safety Group which then provides assurances to the Health and Safety Committee.

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Regulatory and Review Bodies Tracking Report - Reports Received and Inspections/Visits Undertaken - 1 April 2017 - 31 March 2018															
2																
3	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 10th April 2018 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
4	**Health and Safety Executive**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety*** **Theme 3: Effective Care *Standard 3.5 Record Keeping***							
5	1 November 2017	1 November 2017	Boiler - Rookwood Hospital	Capital, Estates and Facilities	Examination report from British Engineering Services which required immediate attention.	Equipment that is subject to defect should be removed from service under regulation 9 of the Pressure System Safety Regulations 2000.	Confirmation given that the boiler was not back in action and a new boiler installed.	Director of Capital, Estates & Facilities	Completed	No further action being pursued by HSE	Complete	Health and Safety - Michael Imperato	Operational Health and Safety Group	10 April 2018	Not applicable	
6	1 January 2018	1 January 2018	Hafan Y Coed Adult Mental Health Unit UHL	Mental Health	HSE following up a RIDDOR report where a member of staff was assaulted	The patient on PICU was displaying a continued violent manner towards staff.	Response to HSE included patient care plan and violence and aggression assessment	Head of Operations and Delivery - Mental Health Clinical Board	Completed	No response received from HSE to date		Health and Safety - Michael Imperato	Operational Health and Safety Group	23 January 2018	Not applicable	
7	21 February 2018	21 February 21018	Histopathology Laboratory - UHW	CD&T Clinical Board	Concern raised directly with HSE	(1) All lifts around Histopathology Department are broken meaning all transport of human tissue, solvents and general laboratory equipment are being carried outside as well as on stairs and in unsuitable containers/trolleys. (2) Dept is full of items boxes etc causing trip hazards and blocking walkways.	Concerns investigated by Clinical Board and response sent to HSE detailing all actions taken whilst lift was out of order including manual handling risk assessment. Containers met UN3373 standards. Dept visited and no accumulating waste at that time.	Clinical Board Director of Quality, Safety and Patient Experience	Completed	No further action being pursued by HSE	Complete	Health and Safety - Michael Imperato	Operational Health and Safety Group	10 April 2018	Not applicable	
8	22 March 2018	22 March 2018	X-ray Department, UHW	Capital, Estates and Facilities	HSE inspection of a licenced asbestos contractor.	HSE requested the HB investigate whether better arrangements could have been made so contractors were not having to carry tools and waste materials long distances.	A response was prepared outlining that the extended route was required to ensure that the disruption to the x-ray service was minimised and no services cancelled.	Director of Capital, Estates and Facilities	Response sent to HSE	Awaiting response from HSE	Ongoing	Health and Safety - Michael Imperato		10 April 2018	Not applicable	

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
3	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 10th April 2018 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
9	**South Wales Fire and Rescue**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety***							
10	9 December 2016	27 January 2015	Whitchurch Hospital	Executive Clinical Board	Enforcement notice numbered EN56/14	Failed to comply with requirements of safety order. Schedule of works required included.	All staff scheduled to vacate Whitchurch premises May/June 2017	Director of Planning	EN02 - Enforcement notice approval of extension	Visit planned by Fire Service 04/10/17 to confirm premises have been vacated	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	24 January 2017 18 July 2017 24 October 2017 10 April 2018	27July 2017 04 October 2017	Yes
11	3 May 2017	27 April 2017	Ward B6 & C6 UHW	Surgery Clinical Board Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2 x Management	2 x management actions dismissed by Fire Officer	Director of Planning	IN02: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x Management - dismissed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	18 July 2017 24 October 2017 10 April 2018		No
12	14 June 2017	8 June 2017	Hafan Y Coed Adult Mental Health Unit UHL	Mental Health	Audit of Fire Safety Arrangements	Failure to comply with the Regulatory Reform (Fire Safety) 2005	written confirmation received 4th October 2017 - enforcement complied.	Director of Planning	Enforcement Notice EN20/17 - 60 days from date of issue	12 Point Action Plan developed	complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	18 July 2017 24 October 2017 10 April 2018	60 days from date of notice	Yes
13	20 July 2017	12 July 2017	Llanishen Clinic (upper) CF14 5DB	Primary, Community Intermediate Care	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x Management 1x Estates 3 x Compliance		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 x management - completed 1 x estates - completed 3 x compliance - completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	24 October 2017 10 April 2018		Yes
14	20 July 2017	12 July 2017	Llanishen Clinic (lower) CF14 5DB	Primary, Community Intermediate Care	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x compliance 1 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 x compliance - completed 1 x Management - completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	24 October 2017 10 April 2018		Yes
15	6 December 2017	27 November 2017	24 Taff Embankment Cardiff CF11 7BE	Primary, Community Intermediate Care	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x Management	Fire Officer confirmed staff not employed by Cardiff & Vale NHS - IN01 revoked	Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 x management - completed	Complete	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	10 April 2018		Yes
16	3 January 2018	12 December 2017	Phoenix Centre 34 Wordsworth Avenue Cardiff CF24 3FR	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x Compliance		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 x compliance - completed	Complete	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	10 April 2018		Yes

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3	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 10th April 2018 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Comp lete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
17	21 February 2018	15 February 2018	Laboratories/ Teaching /Offices Link Block 5 UHW	Clinical Diagnostics & Therapeutics	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x management 2 x estates	Fire compartmentation is being carried out on a priority bases. Dampers replaced during major refurbishment.	Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x estates - ongoing 1 x management - ongoing for number of years	On-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	10 April 2018		Yes
18	21 March 2018	12 March 2018	Ward A3 UHW	Surgery Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2 x estates	Fire compartmentation is being carried out on a priority bases. Dampers replaced during major refurbishment.	Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x estates - ongoing	On-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	10 April 2018		Yes
19	**Environmental Health - Cardiff and Vale County Councils**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety***							
20	21 June 2017	20 June 2017	Aroma Outlet, UHL	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed	Complete	Health and Safety Committee - Martyn Waygood		18 July 2017		
21	13 July 2017	14 July 2017	Rookwood Hospital	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed	Complete	Health and Safety Committee - Michael Imperator		24 October 2017		
22	12 September 2017	21 September 2017	Central Food Production Unit, UHW	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed	Complete	Health and Safety Committee - Michael Imperator		24 October 2017		
23	14 September 2017	19 September 2017	Ward Based Catering, UHW	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed	Complete	Health and Safety Committee - Michael Imperator		24 October 2017		
24	14 September 2017	20 September 2017	Aroma Units, UHW	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 4 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed	Complete	Health and Safety Committee - Michael Imperator		24 October 2017		
25	17 November 2017	21 November 2017	Aroma Units, UHW	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 4 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed	Complete	Health and Safety Committee - Michael Imperator		23 January 2018		

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LONE WORKER SYSTEM PROGRESS REPORT
Name of Meeting : Health & Safety Committee **Date of Meeting** 10/04/2018

Board Lead : Director of Corporate Governance
Author : Head of Health and Safety
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Culture" elements of the Health Board's Strategy.
Financial impact: The current budget for the lone worker system is **£80,000 approximate.**
Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients.
Health and Care Standard Number: 2.1 **CRAF Reference Number:** 9.2
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The continued high demand and usage of the devices
- Monitoring undertaken at both local and corporate level

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the report

SITUATION

The Health Board decided to replace the Reliance Lone Worker devices with an updated contract. This process includes rationalisation of the new Guardian devices to reflect its greater flexibility of the device and system.

The Committee considered a report on the updated contract at the July 2017 meeting. This report updates the Committee on the progress made since.

BACKGROUND

The lone worker device is a system for calling for assistance; it is monitored 24/7 and recorded when justified.

The devices are issued to those staff in the community that are at risk, unless management has confirmed that suitable alternative mechanisms have been introduced to support staff.

The Health Board recognises that there is a risk of injury to NHS staff working in the community from members of the public which are increased due to their remoteness. The Committee previously noted and supported that an important control measure in managing this risk is that relevant NHS staff are issued with a Lone Worker Alert System.

Some concern was raised in relation to the poor usage for these devices which was shown to be at around 20% of the previous system and the need to monitor the usage of the new devices to ensure its improved usage was sustained.

ASSESSMENT

The devices are issued to those staff in the community that are at risk unless management has confirmed that suitable alternative mechanisms have been introduced to support staff.

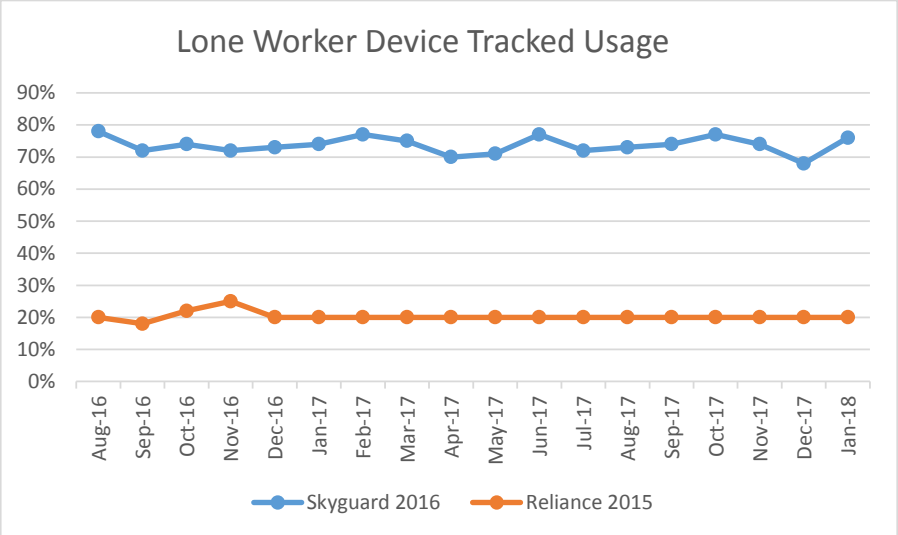
A lone worker device with access to a 24hr staffed Alarm Receiving Centre (ARC) with direct line access to the Emergency Services offers a level of lone worker protection that cannot be delivered in house.

A mobile phone, notebook device or paper based system could not offer the same level of protection offered by a lone worker device.

By issuing staff mobile and discreet personal safety alarms it provides increased protection and increases the confidence and safety of the user knowing that they can call for help at the touch of a button.

The utilisation and feedback from staff users are clearly highlighting that the new contracted devices are much valued and demand continues to grow.

The graph below shows the continued usage of month on month.



As can be seen from the above graph the overall percentage compliance shows that the current system is valued by the staff users with an average usage of 74% measured against device activity and movement. This has sustained the significant improvement over the previous contract which had a low usage average of 20%.

The success of the current system and devices has resulted in an increase of demand. All 638 devices have now been allocated to staff. Departments are asked to look at their current device allocation and consider reallocating unused devices or the possibility of sharing devices where logistically possible.

The allocation of devices has also been extended to victims of Domestic Abuse.

The Health and Safety Department has worked with Clinical Board Management and device users of mechanisms to improve the system within the financial restraints of the budget.

The success of the system is resulting in a greater demand from areas wishing to return to using the devices. This cannot be achieved within the current budget. Clinical Boards have been advised that further devices are available if local funding can be found.

Managers receive monthly usage reports and progress is also monitored at the Personal Safety and Security Strategy Group.

The Operational Health and Safety Group continues to monitor usage by Clinical Board and Sub Group.

MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9.30AM on MONDAY 4th DECEMBER 2017 – CORPORATE MEETING ROOM - UHW

Present:

Peter Welsh- Chair	Director of Corporate Governance
Charles Dalton	Head of Health and Safety
Rachael Daniel	Health and Safety Adviser
Rachael Sykes	Health and Safety Adviser
Jon McGarrigle	Estates Services
Nicola Bevan	Occupational Health
Stuart Egan	Staff Representative
Ann Baldwin	Paeds Physiotherapist

Clinical/Service Board Representatives

Ian Wile	Mental Health
Rhys Davies	Primary, Community and Intermediate Care
Rowena Griffiths	Dental Services

In Attendance:

Apologies:

Caroline Murch	Environmental Health and Safety Adviser
Catherine Salter	Staff Representative
Claire Wade	Surgery
Emma Stone	Dental
Heather Gater	Women and Children
Frank Barrett	Senior Fire Adviser
Karen Lewis	Claims Manager
Tina Bayliss	Surgery Services
Sue Morgan	Primary, Community and Intermediate Care

OHSG: 41/17 Minutes of the Meeting held September 2017

The minutes of the meeting held on the 4th September 2017 were accepted as a true record with the exception of item 33/17 – amendment to reflect the Priority Action Plan 4.5 be of a high priority area. It was noted that the action had been completed; however the minutes did not reflect this request.

OHSG: 42/17 Action Log

Item 31/17:- The meeting was updated on the status and importance of confirming a fire with the Fire Service. It was explained that the Fire Service during office hours would only send a single appliance, unless a fire is confirmed.

Item 35/17:- The Group was informed that a paper was being submitted to the Security & Personal Safety Strategy Group and that the safety of pedestrians in tunnels was a part of the overall pedestrian safety strategy. The Director of Estates will be shortly convening a Group to progress this issue.

Item 38/17.4:- The representative for Mental Health Mr I Wile outlined that smoking ban was being progressed and that it was due to commence the first week in January, however this had been deferred a little to allow for nurses to have the ability to prescribe nicotine therapies.

OHSG: 43/17 Feedback from Health and Safety Committee

The report of the Health and Safety Committee was received and noted by the Group.

The Health and Safety Adviser – Ms R Daniel gave an overview of this report, highlighting items that were raised at the meeting.

OHSG: 44/17 Pro-Act Audit findings

An apology was received from the presenter of the Pro-Act Audit. A presentation was handed out to all members with regards to the findings.

It was highlighted that the report identified both hoisting and sling status, by area and it was agreed that the details be circulated to each of the Clinical Boards for action.

The report also identified that the age of the stock had improved relevant to the significant purchase, however there was still some 33 hoists in poor condition and old, this highlighted the importance of the review of the maintenance contract.

It was also noted that the report highlighted the change in demographics of the mobility of patients, with more persons needing hoisting assistance since its previous audit in 2015.

It was confirmed that another Pro-act audit will be completed in 2018, during winter period as it is presumed that hoisting demand will be even greater.

The findings will be taken to the Health and Safety Committee and will form part of an Action Plan, towards further improvements.

OHSG: 45/17 Enforcement Agencies Correspondence Report

The report was received and noted by the Group.

The Head of Health and Safety informed the Group that an additional item had been added during the period in relation to an assault on a member of staff by a patient in mental health. It was noted that an investigation had been

undertaken and issues identified. It was reported that the Health and Safety Executive (HSE) had been given further information and the Health Board is awaiting their response.

Three other items remain active, in that the HSE are still investigating (i.e. Contractor Control) or the HSE have closed the issue, however the Health Board are yet to complete agreed actions.

OHSG: 46/17 Fire Safety Management and Enforcement Report

The Fire Safety report was submitted in the absence of the Senior Fire Adviser and considered by the Group.

OHSG: 47/17 Health and Safety Priority Action Plan

The Report was received and noted by the Group.

It was highlighted that there had been a change to the format, to include overall strategy status.

It was reported that the Priority Action Plan was being reviewed in calibration with the review of the Corporate Risk Assurance framework (Risk Register).

OHSG: 48/17 PI Claims Report

Item deferred to next meeting, due to absence of representation.

OHSG: 49/17 Staff Group Inspections - Medical Records

Concerns were raised in relation to Medical Records with regards to both fire and Health and safety risks associated with these areas.

It is understood that these concerns have been raised with both the Chair and Chief Executive, with the view that until the issue with duration of storage is resolved, this problem will continue.

The Chair of the meeting outlined that this had been raised at Board level and that action is being taken to speed through policy on record storage.

OHSG: 50/17 Lone Worker

The Head of Health and Safety presented a report that identified the consistent high performance of the Lone Worker device at 77% compliant for the period.

It was however highlighted that additional devices were being requested and that these related to areas where compliance was rated at around 50%. It was considered that until this percentage could be resolved, an enhanced number of devices could not be justified i.e. the area should be looking to share or transfer the devices which are latent.

OHSG: 51/17 Clinical/ Service Board Feedback

PCIC- Concerns at Whitchurch
PCIC representative raised concerns in relation to the security of the Locality Office at Whitchurch, with lighting and lack of security presence.

It was agreed that this would be an agenda item at the Security & Personal Safety Strategy Group, however it was understood that the lack of lighting had been resolved.

Storage at UHL
The Chair raised concerns around storage and dumping of equipment at Llandough, in the area which is planned for development for Rookwood re-location.

It was noted that there was a considerable quantity of beds and other equipment. He informed the meeting that a group had been formed, with the aim to resolve the risks associated with both excess equipment and the security of these parts of the building.

OHSG: 52/17 Policies and Procedures

Handling of Cytotoxics During Pregnancy Procedure - out for consultation. The Group were asked to send any comments to Sarah Rowlands, Clinical Nurse Specialist Haematology by Friday 5th January 2018.

OHSG: 53/17 DATE AND TIME OF NEXT MEETING
28th February 2018 – Corporate Meeting Room HQ UHW – 9:30AM

MINUTES OF THE SECURITY & PERSONAL SAFETY STRATEGY GROUP HELD AT 9:30AM 7th DECEMBER 2017 IN THE MANUAL HANDLING UNIT, DENBIGH HOUSE, UHW

Present:	Charles Dalton	Head of Health and Safety **(Chair)**
	Carl Ball	Personal Safety Manager
	Catherine Salter	RCN Representative
	Catherine Lang	Case Management Officer
	Jane Maddison	Therapy manager
	PC Tom Haigh	South Wales Police
	Raymond Cockayne	Assistant Security Manager
	Peter Cockburn	Head of Commercial Services
	Julie Madoc-Smart	South Wales Police
Apologies:	Peter Welsh	Director of Corporate Governance
	Damien Winston	Security Manager
	Emma Foley	Case Manager Officer
	Wayne Parsons	Emergency Unit
	Rowena Griffiths	Dental Nurse Manager
	Eleri Crudgington	Assistant Locality Manager
	Steven Meek	Cardiff University
	Zoe Brooks	Health and Safety

17/33 Minutes of the last meeting

The minutes of the Security and Personal Safety Strategy Group held in September 2017 were **APPROVED** and **ACCEPTED** as a true record.

17/34 Action Log

Developing a Protocol for Security Specialling for long Periods
It was noted that the Head of Security is progressing a protocol regarding justification and extended cover for security presence.

Presentation on Security/Staff Interventions.
It was reported that this item had been completed.

17/35 Priority Action Plan/ Risk Register

The Priority Action Plan was discussed. It was agreed that this would be reviewed to enhance current status.

17/36 VCRS Weapons Guidance

It was noted that the guidance had been previously circulated. The Personal Safety Manager advised that the document was aimed at assisting staff, when they observe weapons within patient's dwellings.

It was considered that the document was very useful; however the Personal Safety Manager asked that any comments be sent to him by the first week of January.

17/37 Pedestrian Safety Tunnels

The Head of Commercial Services raised concerns in relation to pedestrian safety in tunnels and also deliveries immediately adjacent to the tunnels, close to the Concourse area.

It was reported that a number of accidents had occurred in the Tunnels and that there was a need for greater controls for the use of service rather than convenience. It was identified that access to the Tunnels via the lifts was now, in most cases not TDSI controlled as they were damaged without repair. This allowed risk of patients accidently wandering and/or malicious acts of theft or terrorism.

It was highlighted that an Estates based Group were looking at a phased approach of reviewing zones and introducing greater access controls.

It was considered that a project team approach was relevant, with a Project Lead; this proposal will be taken forward to the Health and Safety Committee and included on both the Priority Action Plan and Risk Register. **Action CD**

17/38 Llandough storage Concerns

The Chair raised concerns that a recent inspection at Llandough in the area allocated for the development of the Rookwood Hospital re-location, had identified that there was serious dumping of equipment with significant quantity of mattresses and beds and other disused equipment.

He also reported that these areas had also been subject to patients being found wandering and therefore there was both a security risk that required access control and personal safety risk associated with the lack of control of storage.

A Group had been formed, Chaired by the Hospital Manager to introduce enhanced controls.

17/39 Security feedback

The Head of Commercial Services reported that they were progressing discussions to enhance security/Co-operations and Service at St David's Hospital and Cardiff Royal Infirmary.

17/40 V&A Training – Compliance

The Personal Safety Manager highlighted that compliance levels was better than the previous years, however not at the Health Boards targeted level.

He noted that the level of compliance showed enhanced performance within the e-learning module and would need to validate that this was the appropriate competence.

Concerns were again raised by the Group about the accuracy of the ESR and tutor led statistics.

17/41 Case Management

The Personal Safety Manager reported on the number of active cases that had been pursued. He commented that the lower level identified in the previous periods statistics, were related to communication problems associated with data protection; which has since been resolved.

He outlined that there was a plans for the review of the MOU for which there was a workshop, led by the Chief Executive of Wales on the 8th December 2017.

It was agreed feedback from this workshop will be brought to the next meeting. **Action CB**

17/42 Lone worker

The compliance report was submitted and considered by the Group.

It highlighted the high level of overall compliance of 77%. The Chair outlined that some requests were coming forward for additional devices, however these were from areas where compliance was much lower at around 50% and therefore greater utilisation/sharing or transfer of the device was needed, prior to being able to make a case to the Board.

17/43 Search of Patients/Persons and belongings Policy/Procedure

This Policy/Procedure was open for discussion. It identified that the existing document was out of date and only related to Mental Health.

It was considered by the Group that the searching of Patients/Persons and belongings should be a Health Board wide policy, that was relevant to all areas in particularly security.

It was therefore agreed that the Head of Security would review the document and submit to the next meeting for progressing. **Action DW**

17/44 Police Partnership

The Police reported that they were working in partnership with Security for a campaign relating to cyclists, titled (Be bright, Be seen). This is in relation to risk of cyclists not having appropriate lights and high visibility clothing in the current darkness hours.

17/45 Local Feedback

No reported feedback.

17/46 Date and Time of Next Meeting

14th March 2018 – Manual Handling Department, Denbigh House UHW – 9.30AM

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE
Management of Stress & Mental Health Wellbeing in the Workplace	UHB 071	Employee Wellbeing	July 2014 (2nd review)	July 2014	July 2017
Management of Asbestos	UHB 072	Director of Planning	July 2014 (2nd review)	July 2014	July 2017
Fire Safety	UHB 022	Director of Planning	July 2015 (2nd review)	July 2015	July 2018
Latex Allergy	UHB 127	Health and Safety Adviser	October 2015 (2nd review)	October 2015	October 2018
Environmental	UHB 143	Director of Planning	October 2015 (2nd review)	October 2015	October 2018
Closed Circuit Television (CCTV)	UHB 303	Head of Health and Safety	October 2015	October 2015	October 2018
Security Services	UHB 037	Head of Health and Safety	January 2016 (2nd review)	January 2016	January 2019
Contractor Control	UHB 163	Director of Planning	July 2016 (3rd review)	July 2016	July 2019

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE
Health & Safety	UHB 021	Head of Health and Safety	July 2016	November 2016 (Board approval)	November 2019
Safe Working with Electricity	UHB 208	Director of Planning	October 2013 (3rd review)	January 2017	January 2020
Management of Violence & Aggression	UHB 035	Personal Safety Adviser	January 2014 (3rd review)	April 2017	April 2020
Lone Worker	UHB 034	Health and Safety Adviser	January 2014 (3rd review)	April 2017	April 2020
Minimal Manual Handling	UHB 036	Manual Handling Advisers	January 2014 (2nd review)	April 2017	April 2020
Waste Management	UHB 038	Patient Experience Manager	January 2014 (2nd review)	April 2017	April 2020
Water Safety (previously Control of Legionella)	UHB 091	Estate Asset Manager	April 2017	April 2017	April 2020
First Aid at Work	UHB 093	Head of Health and Safety	July 2017 (3rd review)	July 2017	July 2020
Sharps Management Policy	UHB 269	Head of Health and Safety	July 2017 (2nd review)	July 2017	July 2020
Incident, Hazard and Near Miss Reporting	UHB 138	Head of Health & Safety	July 2017 - previously Quality & Safety (2nd review)	July 2017	July 2020

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	APPROVING COMMITTEE	APPROVAL DATE	REVIEW DATE
Safe Use of Ionising Radiation	UHB 031	Superintendent Radiographer	Quality, Safety & Experience	December 2016	December 2019
Safety Notices & Important Documents	UHB 069	Head of Corporate Risk & Governance	Quality, Safety & Experience	December 2017	December 2020
No Smoking and Smoke Free Environment	UHB 073	Head of Health Promotion	UHB Board	July 2016	July 2019
Occupational Health	UHB 103	Business Manager, Workforce & OD	Workforce & OD	March 2012	March 2015
Mandatory Training	UHB 080	Learning Education & Development Manager	Workforce & OD	June 2013	June 2016
Risk Management	UHB 023	Head of Corporate Risk & Governance	Audit	July 2013	July 2016
Working Time	UHB 168	Business Manager, Workforce & OD/Unison	People, Performance & Delivery	July 2014	July 2017
Domestic Abuse, Violence against Women & Sexual Violence	UHB 167	Senior HR Policy & Compliance Officer	People, Performance & Delivery	March 2015	March 2018