Bundle Health and Safety Committee 9 October 2018

Agenda attachments

Agenda.docx

	Presentation - Personal Injury Claims - Robert Jenkins, NHS Wales SSWP - Legal and Risk
1	Part 1: Items for Action
1.1	Welcome and Introductions
1.2	Apologies for Absence
1.3	Declarations of Interest
1.4	Minutes of the Health and Safety Committee meeting held on the 10th July 2018 1.4 - Minutes of Meeting 10 July 2018.docx
1.5	Action Log Review 1.5 - Action Log.docx
1.6	Review of the Committee's Terms of Reference 1.6 - Terms of Reference.doc
2	Deliver Outcomes that Matter to People
3	Our Service Priorities
4	Sustainability
4.1	Corporate Risk Assurance Framework (CRAF)
4.2	Pedestrian Access Safety Strategy Update 4.2 - Pedestrian Access Strategy.docx
4.3	Fire Safety Annual Report 2017/18 4.3 - Fire Safety Annual Report.docx
4.4	Fire Safety Report 4.4 - Fire Safety Managment and Enforcement Report.docx
4.5	Enforcement Agencies Report 4.5- Enforcement Agency Correspondence Report.docx
4.6	Health and Safety Improvement Plan 4.6 - Health and Safety Improvement Plan.docx
4.6.1	Priority Improvement Plan 4.6.1 - Health and Safety Improvement Plan.docx
4.7	Updated Health and Safety Related Policies Schedule 4.7 - Policy Schedule.docx
5	Cultures and Values
6	Part 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE - Papers are available on the website
6.1	Work Programme 2018/19 6.1 - Work Programme 2018-19.docx
6.2	Regulatory Review - 1st April - 30th September 2018 6.2 - Regulatory and Review Body Tracking Report.docx
6.2.1	Tracking Report 6.2.1 - Regulatory Review and Tracking Report.xls
6.3	Lone Worker System Progress Report 6.3 - Lone Worker System Progress Report.docx
6.4	Environmental Health Inspection Report of Main Wards, Food Production and Restaurant Areas, UHL on 14th August 2018 6.4 - EHO Inspection UHL Report.doc
6.4.1	Management Action Plan 6.4.1 - EHO Inspection UHL Report.docx

6.5	Minutes from other Committees/sub Committees/Groups. Operational Health and Safety Group - May 2018. Fire Safety Group - May 2018. Water Safety Group - MAY 2018 6.5.- Minutes of Operational Health and Safety Group May 208.docx
6.5.1	Fire Safety Group -May 2018 6.5.1- Minutes of Fire Safety Group May 2018.docx
6.5.2	Water Safety Group - May 2018 6.5.2- Minutes of Water Safety Group May 2018.docx
6.6	Review of the Meeting and Items to be raised at the Board
6.7	To note the date, time and venue of the next meeting - 9.30am on Tuesday 22nd January 2019 in HQ, Corporate Meeting RM, UHW

Health and Safety Committee
9.30am on 9th October 2018
Corporate Meeting Room, Headquarters, University Hospital of Wales
AGENDA

PRESENTATION **Personal Injury Claims - Robert Jenkins, NHS Wales SSWP – Legal and Risk**		
PART 1: ITEMS FOR ACTION		
1.1	Welcome and Introductions	Oral *Chair*
1.2	Apologies for Absence	Oral *Chair*
1.3	Declarations of Interest	Oral *Chair*
1.4	Minutes of the Health and Safety Committee meeting held on 10 July 2018	*Chair*
1.5	Action Log Review	*Chair*
1.6	Review of the Committee's Terms of Reference	*Chair/Hospital Manager - UHL*
2. Deliver Outcomes that Matter to People		
3. Our Service Priorities		
4. Sustainability		
4.1	Corporate Risk Assurance Framework (CRAF)	*Oral - Director of Corporate Governance*
4.2	Pedestrian Access Safety Strategy Update	*Director of Capital, Estates and Facilities*
4.3	Fire Safety Annual Report 2017/18	*Director of Capital, Estates and Facilities*
4.4	Fire Safety Management and Compliance Report	*Director of Capital, Estates and Facilities*
4.5	Enforcement Agencies Report	*Head of Health and Safety*
4.6	Health and Safety Improvement Plan	*Head of Health and Safety*
4.6.1	Priority Improvement Plan	*Head of Health and Safety*
4.7	Updated Health and Safety Related Policies Schedule	*Hospital Manager - UHL*
5. Culture and Values		

6. PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE Papers are available on the Health Board website		
6.1	Work Programme 2018/19	*Hospital Manager - UHL*
6.2	Regulatory Review: 1st April – 30th September 2018	*Hospital Manager - UHL*
6.2.1	Tracking Report	*Hospital Manager - UHL*
6.3	Lone Worker System Progress Report	*Head of Health and Safety*
6.4	Environmental Health Inspection Report of Main Wards, Food Production and Restaurant Areas, University Hospital Llandough (UHL) on 14th August 2018	*Director of Capital, Estates and Facilities*
6.4.1	Management Action Plan	*Director of Capital, Estates and Facilities*
6.5	**Minutes from other Committees/sub-Committees/Groups** Operational Health and Safety Group – May 2018	*C Dalton* *G Walsh*
6.5.1	Fire Safety Group – May 2018	*C Dalton* *G Walsh*
6.5.2	Water Safety Group – May 2018	*C Dalton* *G Walsh*
6.6	Review of the Meeting and Items to be Raised at the Board	Oral *Chair*
6.7	To note the date, time and venue of the next meeting:- • 9.30am on Tuesday 22nd January 2019 in the Corporate Meeting Room, Headquarters, University Hospital of Wales.	

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am on 10 JULY 2018 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:	
Michael Imperato	**Independent Member – Legal (Chair)**
Akmal Hanuk	Independent Member - Local Community
Charles Janczewski	Independent Member (Vice Chair)
In attendance:	
Carl Ball	Case Manager/Personal Safety Adviser (for agenda item HSC: 18/145)
Charles Dalton	Head of Health and Safety
Martin Driscoll	Director of Workforce and OD
Stuart Egan	Health and Safety Staff Lead
Carol Evans	Assistant Director of Patient Safety and Quality
Emma Foley	Case Management Officer (for agenda item HSC: 18/145)
Abigail Harris	Director of Planning
Fiona Kinghorn	Deputy Director of Public Health
Jon McGarrigle	Head of Energy and Performance (representing Geoff Walsh)
Alun Morgan	Assistant Director of Therapies and Health Sciences (representing Fiona Jenkins)
Sian Rowlands	Head of Corporate Governance (representing Peter Welsh)
Apologies:	
Steve Allen	CHC Representative
Rachael Daniel	Health and Safety Adviser
Fiona Jenkins	Director of Therapies and Health Sciences
Peter Welsh	Director of Corporate Governance
Geoff Walsh	Director of Capital, Estates and Facilities
Observer:	
Holly Williams	Quality and Safety Facilitator – Specialist Services Clinical Board
Secretariat:	
Zoe Brooks	Health and Safety Senior Departmental Administrator

PART 1

HSC: 18/141 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

HSC: 18/142 DECLARATIONS OF INTEREST

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

HSC: 18/143 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 10th April 2018 were **APPROVED** and **ACCEPTED** as a true record.

HSC: 18/144 UPDATED ACTION LOG

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

- HSC: 17/058 – the Assistant Director of Patient Safety and Quality informed the Committee that a scoping exercise was due to commence imminently with the work plan being developed over the coming months.

- HSC: 18/132 – the Head of Health and Safety informed the Committee that a newly appointed Health and Safety Adviser would commence on the 23rd July 2018. Part of their role would be to manage Contractors for non estates activities and the Adviser would work closely with the Estates Department to ensure there was a uniform approach and the same standards were being adhered to.

HSC: 18/145 STAFF STORY – PERSONAL SAFETY/CASE MANAGEMENT SUPPORT

Mr Imperato welcomed Mr Carl Ball, Case Manager/Personal Safety Adviser and Mrs Emma Foley, Case Management Officer to the meeting and informed the Committee their presentation would be in relation to personal safety and case management support available to staff.

Mr Ball explained the purpose of the presentation was to highlight the role of the Case Management Team and advised of the four main areas managed by the team; these being:

- Case Management
- Lone Working
- Violence and Aggression Passport Scheme
- Proactive and reactive work in relation to criminal sanctions

Mr Ball briefed the Committee the Case Manager role was introduced by the Health Board in 2009 and since that time all Health Boards/Trusts in Wales now have an equivalent.

Mr Ball highlighted during 2017 there were 334 physical assaults on staff and 504 verbal assaults which resulted in 20 lost time events. In respect of these reported incidents the Case Management Team would assist with the following:

- Meet with staff to offer immediate protection and reassurance.
- Attend court with staff to support them through the process.
- Act as the single point of contact with South Wales Police.
- Send warning letters to patients and visitors regarding their behaviour.
- Support staff that are experiencing domestic abuse.

Mrs Foley then provided the Committee with an overview of the lone worker system. In 2011 the Health Board were issued with devices from Welsh Government to allocate to staff to protect them from risks associated with lone working. These devices had very low usage compliance by staff and two years ago the Health Board researched alternative devices. As a result a new device (Skyguard) was introduced and 638 devices were issued to staff, usage has now improved and is running at around 73%. Mrs Foley stated usage of these devices was regularly monitored and monthly reports were sent to Managers.

Mrs Foley also provided the Committee with details of two cases that demonstrated good use of the devices where escalations had been closed out safely.

To summarise, the presentation highlighted:

- issues relating to violence and aggression.
- the benefits of the Case Management Team and their role.
- the help and support available to staff who witness or who are victims of violence and aggression.

Mr Imperato thanked Mr Ball and Mrs Foley for their comprehensive presentation and invited comments from members.

The Director of Workforce and OD queried the training compliance figure of 728%. The Head of Health and Safety clarified this was set against the Training Needs Analysis (TNA) completed by Managers. 728% demonstrates that more staff completed the e-learning module than were required to do so.

The Independent Member – Local Community queried whether there was many staff on staff incidents. Mr Ball advised any incidents of this nature were referred to Human Resources to investigate.

Mr Hanuk also queried whether many incidents of violence against patients by staff were reported. Mr Dalton advised the Case Management Team is contacted in these circumstances and patients are signposted to the Concerns Department for formal investigation. The Assistant Director of Patient Safety and Quality added these incidents would also be covered by the All Wales Protection Against Vulnerable Adults Policy.

The Deputy Director of Public Health queried the review period for violent warning markers. Mrs Foley advised review periods were set at 3, 6 or 12 months and a decision is then made as to whether the violent warning marker is to be removed or not.

The Committee thanked Mr Ball and Mrs Foley for their presentation, they then left the meeting.

HSC: 18/146 REVIEW OF THE COMMITTEE'S TERMS OF REFERENCE

It was noted the Terms of Reference would be reviewed at the October meeting and would take into account recent organisational changes.

HSC: 18/147 CORPORATE RISK ASSURANCE FRAMEWORK (CRAF)

The Head of Corporate Governance updated the Committee on the current status of the Corporate Risk Assurance Framework (CRAF). Mrs Rowlands reported meetings had taken place to review the current processes and she was working closely with the Health and Safety Department. A further meeting was taking place on the 12th July to look at better planning and how best to take risks forward.

Mrs Rowlands stated new documentation had been established and was being piloted in some areas.

The Independent Member – Local Community queried the timescales for completing this review. Mrs Rowlands advised further details should be finalised at the meeting on the 12th July with the aim to roll out during the next few weeks. An update would be provided to the next meeting.

ACTION – Mrs S Rowlands

The Committee **NOTED** the current status and progress made in relation to the review of the Corporate Risk Assurance Framework (CRAF).

HSC: 18/148 HEALTH AND SAFETY 2017/18 ANNUAL REPORT

The Head of Health and Safety presented the 2017/18 Annual Report to the Committee and highlighted the key points:

- The Health and Safety Committee and its sub- groups have continued to meet on its responsibilities.

- The Health and Safety Executive have been very active in visiting the Health Board taking up significant departmental resource. Although the Health Board has not received any Enforcement Actions during the year, the HSE has continued to pursue the investigation into the contractor fall, this required the Health Board to take formal legal advice. The HSE has made no decision as to whether legal action is warranted.

- Personal injury claims are proportionately higher than other Health Boards at 22% of All Wales claims whilst employing 16% of healthcare staff.

- The number of RIDDOR events has remained constant over the previous years, with little change in either by injury type or clinical board performance.

- Staff reported incidents show that violence and aggression accounts for 52% of all events. During the year, there was a significant increase by 30% in contact injuries.

- Mandatory training of health and safety has significantly improved, with 4 clinical boards achieving the 85% target.

- Conversely tutor led training compliance for both manual handling and violence and aggression has reduced, although a review of the requirement is being progressed.

- The introduction of fees for failing to attend tutor led health and safety training has proved successful in significantly reducing the level of failure to attend on the day.

- The number of prosecutions and other police inventions improved during the period with an 8 year average of 1 conviction a week and a further 2 per week other actions. The Health Board is working closely with the Police, Crown Prosecution Service and Shared Services Legal to improve the Memorandum of Understanding between all parties.

- The lone worker devices continue to be highly valued by staff with average usage being at 73% and devices being in great demand.

- Following the completion of a Manual Handling Proact Audit, the age and quality of patient hoists has significantly improved with 60 new hoists purchased at the commencement of the year and a further 39 ordered ensuring that all obsolete hoists will be replaced.

- COSHH compliance remains at 62% with some areas as low as 30%. Environmental monitoring has continued on a prioritised basis.

- A mental health ligature audit was completed and the findings implemented.

- Mental Health Clinical Board introduced a complete ban on smoking both within its grounds and ward areas.

- A project to improve bariatric patient care has been initiated.

- Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period.

- Estates continue to enhance contractor control and implementing the same standards for contractors working in other areas is being pursued.

- Needle stick and sharp incidents slightly increased during the period but is still significantly lower than previous to implementing the safer sharps programme. The number of needle stick claims remain lower than the All Wales average.

The Chair thanked Mr Dalton for his comprehensive presentation and invited comments from the members.

The Independent Member (Vice Chair) thanked Mr Dalton for his report and stated that it demonstrated the complexity of heath and safety within such a large organisation. He welcomed the structure of reporting and responsibility and that the report highlighted the clinical board's commitment towards health and safety issues.

Mr Janczewski commended the report and Mr Dalton's plans to include any problematic areas into the Priority Implementation Plan as this will aid lessons learnt.

Mr Dalton stated benchmarking against this document was important and the findings will be fed into sub groups such as the Operational Health and Safety Group.

Mr Imperato raised concerns in relation to COSHH compliance and stated further work should be undertaken to improve this. Mr Dalton advised the annual report was to be presented to the August meeting of the Operational Health and Safety Group and this would be highlighted to the Clinical Boards.

ACTION – Mr C Dalton

The Deputy Director of Public Health highlighted the document refers to the Health Board achieving re-validation of Gold in the Corporate Health

Standard, however Platinum was also retained during the period and suggested the report be amended to reflect this.

ACTION – Mr C Dalton

Mr Imperato queried why stress was linked with RSI in relation to personal injury claims. Mr Dalton stated these figures were provided by the NWSSP Legal & Risk Services and would contact them for clarification. He also added he would invite Andrew Hynes, Solicitor for Legal & Risk Services to attend a future meeting to give a presentation on personal injury claims.

ACTION – Mr C Dalton

The Director of Planning thanked Mr Dalton and his team for their work. She asked that page 24 in relation to Policy Lead be changed from herself to Mr Walsh, Director of Capital, Estates and Facilities.

ACTION – Miss R Daniel

Mr Dalton informed the Committee the Management of Stress and Mental Health Wellbeing Policy had been reviewed with final amendments being made and would be brought to the October meeting for approval.

The Director of Workforce and OD re-iterated the importance of the annual report and how it allows the Health Board to reflect on where it is in respect of health and safety. Mr Driscoll did feel the report had a lot of actions in respect of violence and aggression and manual handling and very few in respect of slips, trips and falls which was the biggest cause of incidents and more attention should be given on taking this forward.

Mr Dalton clarified the annual report focuses on staff incidents in which slips, trips and falls were small in comparison to patient falls.

It was noted the annual report would be presented to the Board for information.

The annual report was **RECEIVED** and **NOTED** by the Committee.

ASSURANCE was provided by:

- Health and safety aspects being appropriately monitored and progressed as detailed within the report

HSC: 18/149 PEDESTRAIN ACCESS SAFETY STRATEGY

The Head of Performance and Energy firstly apologised to the Committee for the length of time it had taken to complete the survey. Mr McGarrigle added concerns had been raised around the lack of urgency being shown by the consultancy, however the survey had now been completed and the findings and recommendations shared with the Health Board.

Mr McGarrigle informed the Committee a meeting with stakeholders was planned for the 25th July 2018 to take the findings forward and a plan to be developed.

The Director of Planning stated there was no budget for this work and there would need to be a reprioritisation of monies for remedial works identified.

The updated position was **NOTED** by the Committee.

HSC: 18/150 FIRE SAFETY REPORT

The Head of Performance and Energy informed the Committee fire inspections undertaken had highlighted concerns in relation to fire dampers and compartmentation, however there was a rolling programme of remedial work being carried out on a priority basis.

The Independent Member – Local Community queried whether the Health Board had assurance that none of our properties contained any cladding. The Head of Health and Safety confirmed a risk assessment of all buildings had been carried out in line with the Welsh Government request and no cladding of those levels was present.

The Director of Planning reported unwanted fire signals remain a concern and was regularly discussed at All Wales meetings as Cardiff and Vale remain one of the highest reporting Health Boards in Wales. It was noted these figures were due to Cardiff and Vale being the largest Health Board and therefore have more fire detectors present, however many of these detectors were old and contributed to the number of false alarms. Mrs Harris stated this further investigation and actions taken to improve the situation.

ACTION – Mr G Walsh

The report was **CONSIDERED** and **NOTED** 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: 18/151 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

The Head of Health and Safety informed the Committee an in-depth audit was carried out in November 2016 of University Hospital Llandough (UHL), the findings were considered and monitored by the Fire Safety Group.

The Chair noted this was an on-going report and assurance had been given for actions completed to date.

The report was **CONSIDERED** and **NOTED** by the Committee.

ASSURANCE was provided by:

- Identified fire safety issues in the Shared Services Audit are being appropriately managed.

HSC: 18/152 PROPOSAL FOR STATUTORY AND MANDATORY TRAINING

The Director of Workforce and OD informed the Committee mandatory training had been high on the Health Board's agenda for the past few months due to performance not being at the level set by the Health Board. As part of a review the Mandatory Training Steering Group had been looking at the modules in relation to roles. To support this piece of work a training needs analysis (TNA) would be developed to identify specific staff groups and their training requirements, this would be illustrated through the individual's Electronic Staff Record (ESR) allowing for effective monitoring and management.

The Chair queried whether the completion date of July 2018 in the document was correct. Mr Driscoll clarified that a plan is to be in place by July 2018, however due to the extensive piece of work required no timescale can be committed to at this stage.

Mr Imperato requested the Committee **AGREE** the recommendations subject to the amendment of the completion date, this was **AGREED** by the Committee.

HSC: 18/153 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Heath and Safety informed the Committee many of the items raised in the document had been discussed as part of the Annual Report.

Mr Dalton updated the Committee in relation to the concerns raised as part of an asbestos inspection that contractors were taking an extended route and whether better arrangements could be made. Mr Dalton advised following a site visit by HSE Inspectors to walk the route undertaken by the contractors it was concluded that the best available route had been taken and this concern was now closed.

Mr Dalton also informed the Committee of a new additional issue raised by the HSE in relation to concerns raised following their audit of the Public Health Laboratories at University Hospital of Wales (UHW) and University Hospital Llandough (UHL). The Inspector had raised a number of concerns in relation to the lack of containment of the level 3 laboratory at UHL and lack of communication/co-operation between the Health Board and PHW. The Health Board has given a commitment to put in place an improved communication plan with PHW which will be formalised. The HSE has agreed that an

Improvement Notice would not be justified in this instance, but the Health Board will receive a letter holding us to the formal agreed plan.

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: 18/154 HEALTH AND SAFETY IMPROVEMENT PLAN

The Head of Health and Safety informed the Committee the Improvement Plan was being reviewed in line with the development of the CRAF and findings from the annual report.

The Assistant Director of Patient Safety and Quality queried the reason for limited assurance for the patient environment. Mr Dalton clarified this was due to issues relating to legionella at that time.

The improvement plan 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.

HSC: 18/155 HEALTH AND SAFETY ISSUES RELATING TO MEDICAL RECORDS STORAGE

The Health and Safety Staff Lead raised concerns in relation to the on-going issues around the storage of medical records. Mr Egan informed the Committee he visited these areas on a monthly basis and has previously escalated these concerns to the Board. It was also noted additional storage had been made available however this capacity was diminishing. Mr Egan added other Health Boards/Trusts had successfully implemented an electronic system and queried why this had not been progressed by Cardiff and Vale. Mr Egan stressed this issue was causing problems in relation to missing records, staff injuries and a fire risk.

The Head of Corporate Governance considered this would benefit from being progressed via the CRAF risk escalation process and offered her assistance to Mr Egan.

The Deputy Director of Public Health considered the document was not clear and had no scope, she suggested further work was required before it could be signed off. The Head of Health and Safety stated there was no strategic

approach in place which was being highlighted by Mr Egan, the issue was being progressed at a local level but higher level involvement was required.

The Chair agreed this was a concern and should be escalated higher. The Committee **AGREED** the best way forward was through the risk register to the Board.

ACTION – Mrs S Rowlands/Mr S Egan

The paper was **NOTED** by the Committee

LIMITED ASSURANCE was provided by:

- Actions being taken to address the issues raised.

HSC: 18/156 FIRE SAFETY POLICY

The Head of Health and Safety informed the Committee amendments made to the Policy were in relation to managerial changes and policy format.

The Fire Safety Policy was **RECEIVED** and **APPROVED** by the Committee.

HSC: 18/157 ASBESTOS MANAGEMENT POLICY

The Head of Performance and Energy informed the Committee amendments made to the Policy were in relation to its format.

The Head of Corporate Governance stated the Policy was longer than expected under the new policy format. Mrs Rowlands also considered the policy needed a few amendments as the policy refers to other documents however this is not reflected on the front sheet.

ACTION – Mr J McGarrigle/Mr G Walsh

The Asbestos Management Policy was **RECEIVED** and **APPROVED** by the Committee subject to the minor amendments discussed.

PART 2

HSC: 18/158 COMMITTEE WORK PROGRAMME FOR 2018/19

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

HSC: 18/159 PROGRESSING SMOKING CESSATION IN THE CARDIFF AND VALE POPULATION

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

HSC: 18/160 WASTE COMPLIANCE REPORT

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

HSC: 18/161 ENVIRONMENTAL HEALTH INSPECTION REPORT OF HAFAN Y COED, UNIVERSITY HOSPITAL LLANDOUGH ON 9TH FEBRUARY 2018

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 5 had been achieved.

HSC: 18/162 ENVIRONMENTAL HEALTH INSPECTION REPORT OF BARRY HOSPITAL ON 15TH MARCH 2018

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

HSC: 18/163 ENVIRONMENTAL HEALTH INSPECTION REPORT OF CENTRAL FOOD PRODUCTION UNIT ON 14TH MARCH 2018

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 5 had been achieved.

HSC: 18/164 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF FEBRUARY 2018

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

HSC: 18/165 FIRE SAFETY GROUP MINUTES OF JANUARY 2018

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

HSC: 18/166 WATER SAFETY GROUP MINUTES OF FEBRUARY 2018

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

HSC: 18/167 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

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

HSC: 18/168 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

Mr Imperato thanked everyone for their contributions.

HSC: 18/169 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 9th October 2018 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed .....

Date .....

UP DATED ACTION LOG

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

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 18/147	10/07/18	CRAF	To provide an update on the roll out of the revised CRAF.	Mrs Sian Rowlands	**ACTION STILL UNDERWAY** Update on timescales to be provided to the October meeting
HSC: 18/148	10/07/18	Health and Safety Annual Report	Annual Report to be presented to the Operational Health and Safety Group meeting in August and to specifically highlight COSHH compliance.	Mr Charles Dalton	**COMPLETED**
HSC: 18/148	10/07/18	Health and Safety Annual Report	Report amended to reflect platinum was achieved in the Corporate Health Standard prior to submitting to Board.	Mr Charles Dalton	**COMPLETED**
HSC: 18/148	10/07/18	Health and Safety Annual Report	Shared Services – Legal and Risk to be invited to a future meeting.	Mr Charles Dalton	**COMPLETED**

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 18/148	10/07/18	Health and Safety Annual Report	Policy Leads to be amended to reflect current practice.	Miss Rachael Daniel	**COMPLETED**
HSC: 18/148	10/07/18	Fire Safety Report	The number of false alarms requires further investigation and action.	Mr Geoff Walsh	**COMPLETED** Meeting took place on 6th September 2018, update to be provided to the Committee.
HSC: 18/155	10/07/18	Health and Safety Issues Relating to Medical Records Storage	To be escalated to the Board through the risk register process.	Mrs Sian Rowlands/Mr Stuart Egan	**COMPLETED** Presented to September Board meeting.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Health and Safety Committee

Terms of Reference and Operating Arrangements

Health and Safety Committee

Terms of Reference and Operating Arrangements

1. INTRODUCTION

1.1 The Cardiff and Vale University Health Board (UHB) Standing Orders provide that: "The Board may and, where directed by the Welsh Government must, appoint Committees or sub Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a committee to be known as the Health and Safety Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The organisation has a statutory obligation by virtue of the Health and Safety at Work Act 1974 to establish and maintain a Health and Safety Committee:

- "Section 2 sub section 7 : "it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed".

2. PURPOSE

2.1 The purpose of the Health and Safety Committee ("the Committee") is to:

Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place to ensure organisational wide compliance of the UHB Health and Safety Policy, approve and monitor delivery against the Health and Safety Priority Improvement Plan and ensure compliance with the relevant Standards for Health Services in Wales.

This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how, its Health and Safety management may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon the adequacy of assurance arrangements and processes for the provision of an effective Health and Safety function encompassing:

- Staff Health and Safety
- Premises Health and Safety
- Violence and Aggression (inc. Lone Working and Security Strategy)
- Fire Safety
- Risk Assessment
- Manual Handling
- Health, Welfare, Hazard Substances, Safety Environment
- Patient Health and Safety – Patient Falls, Patient Manual Handling
- Staff healthy lifestyle/health promotion activities
- Staff health and well-being

3.2 The Committee will support the Board with regard to its responsibilities for Health and Safety:

- approve and monitor implementation of the Annual Health and Safety Priority Improvement Plan;
- review the comprehensiveness of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non clinical;
- the consideration and approval of policies as determined by the Board.

3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- objectives set out in the Health and Safety Priority Improvement Plan are on target for delivery in line with agreed timescales;
- standards are set and monitored in accordance with the relevant Standards for Health Services in Wales
- proactive and reactive Health and Safety plans are in place across the UHB
- policy development and implementation is actively pursued and reviewed
- where appropriate and proportionate, health and safety incident and ill health events are investigated and action taken to mitigate the risk of future harm
- reports and audits from enforcing agencies and internal sources are considered and acted upon

- workforce, health, security and safety issues are effectively managed and monitored via relevant operational groups
- employee health and wellbeing activities are in place in line with the UHB commitment to be a public health practicing organisation and corporate health standards
- employee health and safety competence and participation is promoted
- decisions are based upon valid, accurate, complete and timely data and information

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.6 The Chair of the Health and Safety Committee shall have reasonable access to Executive Directors and other relevant senior staff.

3.7 The Head of Health and Safety shall have unrestricted access to the chair of the Health and Safety Committee

Sub Committees

3.8 The Committee may, subject to the approval of the UHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.9 There are no formal Sub-Committees of the Health and Safety Committee but the Committee will receive copies of the minutes of the Operational Health and Safety Group, Fire Safety Group, Security and Personal Safety Strategy Group and the Water Safety Group as part of its assurance framework.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) Members, comprising:

Chair	Independent member of the Board.
Vice Chair	Independent member of the Board.
Members	A minimum of 1 other Independent member of the Board

Attendees

4.2 The following officers to be in attendance:

- Senior Manager Lead
- Director of Corporate Governance
- Director of Workforce and Organisational Development
- Director of Public Health
- Director of Therapies and Health Sciences
- Director of Planning
- Head of Health and Safety
- Director of Capital, Estates and Facilities
- Assistant Director of Patient Safety and Quality
- Chair of Staff Health and Safety Group plus 2 other staff health and safety representatives
- Director, OSHEU, Cardiff University
- Community Health Council representative

Other Directors or nominated deputies should attend from time to time as required by the Committee Chair.

4.3 By invitation:

The Committee Chair may extend invitations to appropriate persons to attend Committee meetings as required from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration at each meeting.

Secretariat

4.4 Secretary: as determined by the Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Assembly Government.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair.

Support to Committee Members

4.7 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of development for committee members in conjunction with the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two Independent Members.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year and otherwise as the Chair of the Committee deems necessary – consistent with the UHB's annual plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may require any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of an annual report;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example, AGM, or to community partners and other stakeholders, where this is considered appropriate, for example, where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- **Quorum**

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed on a biennial basis by the Committee with reference to the Board.

PEDESTRIAN ACCESS STRATEGY
Name of Meeting: Health and Safety Committee **Date of Meeting:** 9/10/2018
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 £26k + 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 Health and Safety Committee is asked to: • **NOTE** the content of the paper and the update to the Pedestrian Access strategy.

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.

Capital Estates and Facilities engaged consultancy ARUP to progress a pedestrian access strategy focusing at UHW. This paper provides a progress update for the study and next steps and actions.

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

ARUP were appointed to undertake and develop a Pedestrian Access Strategy including additional advice and support for pedestrian safety in the tunneled areas at UHW.

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 development of the pedestrian access strategy includes 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 options selected and outline designs 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 timescale for the study was a completion date of May 2018, however there were performance and quality concerns with the works undertaken by ARUP. A series of meeting and discussions were held with ARUP who agreed to address the issues and complete the project to the satisfaction of the UHB.

ASSESSMENT AND ASSURANCE

Progress Update

The following activities have been completed:

- Site surveys, investigations and modeling of data and information
- Application and completion of WG Walking Route Audit Tool for UHW
- Collation of findings
- Stakeholder Engagement Workshop
- Development of Recommendations including costs and prioritization
- Preparation of interim reports and final draft report

The final draft report is being submitted during WC 24/9/18 for final review and will be followed by a final presentation of the findings.

Provided that the draft final report meets the expectations and standards expected, then the Pedestrian access strategy document will be distributed and an implementation action plan developed for approval in October/November 2018.

Pedestrian Access Findings and Themes

There are a range of pedestrian access findings and opportunities identified for improvement, including the following:

- Additional pedestrian crossing points required.
- Poor pedestrian continuity in certain areas and discontinuation of footways.
- Informal routes developed via pedestrians through grassed areas.
- Certain Pedestrian routes are not continuous and pedestrians have to negotiate stairs/ramps and some footways are narrow and have obstructions.
- Signage needs to be improved

Recommendations are being formulated to address the findings including a program of next steps. The action plan for implementation will be developed in October/November 2018.

ANNUAL FIRE SAFETY REPORT

Executive Lead : Director of Planning
Author : Senior Fire Safety Adviser 02920 742292
Complying with Fire Safety: 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 completion of all remedial actions detailed in the Enforcement Notices and Informal Notices as a result of Fire Service Audits will improve patient, visitor and staff fire safety. Fire risk within the UHB, further enforcements and potential prosecution for non compliance will also be reduced. 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 Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

- That issue identified in the fire risk assessments and the audits carried out by the Fire Authority and NHS Wales Shared Services Partnership - Specialist Estates Services are being appropriately managed.

The Health and Safety Committee is asked:

- to **CONSIDER** the on-going work to meet the requirements of fire Regulatory Reform (Fire Safety) Order 2005

SITUATION

Fire Safety Management is a key statutory compliance priority for Cardiff and Vale University Health Board (UHB). Fire Safety management in Healthcare is a complex and challenging discipline as there are a number of risks which need to be identified, prioritised and mitigated.

The UHB approach to Fire Safety includes a number of key elements including:

- Fire Safety Policy and procedures
- Fire Safety Group and supporting/reporting sub groups
- Fire Safety Manager and Deputy Fire Safety Managers
- Fire Safety Advisors and Fire Wardens
- Maintenance of Estate and Fire Safety equipment and plant

- Capital Investment in Fire Safety precautions and systems
- Training of all Staff
- Liaison with South Wales Fire Service
- Providing advise on fire safety on new developments

This paper provides an update on the UHB's progress and action plans relating to fire issues and also lists the key priorities for 2017/18.

BACKGROUND

The UHB is committed to ensuring the protection from fire and explosion, so far as is reasonably practicable, of its patient's staff and visitors. The UHB has developed and implemented a Fire Safety Policy and Procedures to satisfy these requirements which have the following principle objectives:

- Minimise the incidents of fire and all unwarranted fire signals throughout all properties used by Cardiff & Vale University Health Board.

- Minimise the impact from fire on life, safety, delivery of service, the environment and property.

Due to the diverse range and quantity and complexity of buildings throughout the UHB Estate there will be bespoke challenges which need to be addressed.

The principle fire safety legislation applicable to all the Health Board's premises is the Regulatory Reform (Fire Safety) Order 2005 enforced by the Local Fire Authority. To be compliant with this legislation a Fire Risk Assessment must be completed for every building. Fire safety advisers are continually reviewing and updating the assessments and it is a mandatory requirement that an annual audit is completed.

The UHB has Fire advisors located across the major geographic sectors of the UHB supported by Fire Wardens and they also interface with the Fire Safety manager and Deputy Fire Safety manager.

South Wales Fire Service (SWFS) undertake regular audits of a representative sample of UHB departments and buildings and these visits will generally result in one of the following notices:

1) **INO1 or IN02 Informal Notice:** Remedial actions will be noted during the SWFS audit and will need to be addressed. Within 12 months the Fire Service will re-visit the area to ensure all actions are complete. Failure to complete all the high risk actions will result in an Enforcement notice.

2) **Enforcement Notice:** Where remedial actions are noted during the visit which will result in the Fire risk exceeding a certain level, an Enforcement notice is served. This will require the UHB to complete the

remedial actions within a specified timescale otherwise further action will result.

ASSESSMENT

1.0 FIRE RISK ASSESSMENTS

The principle fire safety legislation applicable to all the Health Board's premises is the Regulatory Reform (Fire Safety) Order 2005 enforced by the Local Fire Authority. To be compliant with this legislation a Fire Risk Assessment must be completed for every building and the Fire Safety Advisers are continually reviewing and updating the assessments. There are currently 442 risk assessment reports.

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.

During the period, September 2017 and August 2018 a total of 572 managerial actions were identified, 85 of which were risk rated at 5 or below, 487 therefore were of higher risk. The 4 most common failings relate to training compliance, doors wedged open, storage in corridors, obstructions in fire routes and electrical appliance fire risks including portable equipment.

2.0 ENFORCEMENT NOTICES

There was one Enforcement Notice in force for Hafan Y Coed, for failing to effectively control smoking on the premises. The Enforcement Notice was withdrawn on 4th October 2017. Since the notice was withdrawn we have recorded 9 fire incidents at Hafan Y Coed.

As we have received two Enforcement Notices previously the Health Board could be liable to prosecution as technically SWFS cannot give a further Enforcement Notice for the same issue.

3.0 AUDITS

Regular fire audits are carried out by SWFS during the twelve month period the Fire Service has carried out 13 audits resulting in Informal Notices. The reports are sent to the local management and their Deputy Fire Safety Managers, Estates and Capital Planning to address the issues they are responsible for and are monitored at the Fire Safety meetings

4.0 UNWANTED FIRE SIGNALS

The occurrence of an unwanted fire signal (UwFS) is detrimental to the operation of any healthcare establishment. Such instances lead to disruption of service and patient care, increased costs and unnecessary risk to those required to respond to the alarm raised. Whilst it is impossible to eliminate all UwFS these figures must be reduced.

The Welsh Government has tasked SWFS with reducing false alarms, in turn SWFS are concerned by the number of alarms we generate, in particular at UHW. They have already reduced the response to alarms between the hours of 08.00 and 18.00 from 3 appliances to a single pump for investigation purposes only, unless it can be confirmed there is a fire.

The UHB have been advised by SWFS they may not respond in future at all to alarm activation unless we confirm there is a fire.

The Fire Safety Advisers investigate every false alarm and do what they can to prevent the event being repeated. As 70% of the alarms are the result of human activity it is very difficult to prevent.

Comparison of fire incidents and UwFS on a site-by-site basis
Between 20/09/2017 and 20/09/2018 inclusive

449 incidents found.

Site	Fire	UwFS
15 - 17 Park Road, 15 - 17 Park Road	0	3
34 Wordsworth Avenue, Roath	0	1
5 - 11 Park Road, 5 - 11 Park Road	0	2
Amy Evans CMHT, Holton Road	0	3
Barry Hospital, Colcot Road	0	5
CRI - West Wing, Glossop Terrace/Road	0	1
Cardiff & Vale Therapy Centre, Splot Road	0	1
Cardiff Royal Infirmary, Newport Road	0	14
Dental Hospital (University Hospital of Wales), Heath Park	1	8
Global Link, Dunleavy Drive	0	1
Hafan Y Coed, Llandough Hospital	9	27
Lansdowne Hospital (Remainder), Sanatorium Road	0	2
Llandough Hospital, Penlan Road	2	67
Riverside Health Centre, Wellington Street	0	1
Rookwood Hospital, Fairwater Road	1	11
St David's Hospital (Cardiff), Cowbridge Road East	0	5
Unit B5, West Point Industrial Estate	0	1
University Hospital of Wales, Heath Park	4	268
Whitchurch Hospital, Park Road	0	10
Whitchurch Lodge, Park Road	0	1

Cause of alarm signal

UwFS incidents
between 20/09/2017 and 20/09/2018 inclusive
All sites

Item	Value	%
Accidental damage	44	10.2%
Alarm activated by patient or public	29	6.7%
Cooking fumes	19	4.4%
Good intent	24	5.6%
Insects	15	3.5%
Malicious	10	2.3%
Management procedures not complied with/building not used correctly	14	3.2%
Other environmental effect	92	21.3%
Smoking	15	3.5%
Sprinkler alarm - water pressure	2	0.5%
System fault/design	55	12.7%
System procedures not complied with	14	3.2%
Unknown	99	22.9%
Grand total	**432**	**-**

There have been 17 reportable fires in the last 12 months. The main issue has been in Mental Health accounting for 9 fires 8 of which related to smoking materials and their ignition source.

There has been a dramatic increase in fires resulting from discarded smoking materials and ignition sources for smoking in Hafan Y Coed. The increase is the result in the removal of the smoking shelters and the banning of smoking on the premises. The smoking ban and the resulting fires could result in the Health Board being the subject of further action including the potential of prosecution.

5.0 FIRE TRAINING

The fire training figures from last August have recorded consecutive increases until July where there has been a slight dip, due to the holiday period. Although the figures have improved we have not achieved the Health Board's target of 85% compliance.

Managers report the problem of releasing staff to complete the fire training is an ongoing problem.

CLINICAL BOARD	HEAD COUNT	PERCENTAGE
Children's & Women's	2085	73.86
Capital Estates & Facilities	1253	65.84
CD & T	2374	69.76
Corporate	786	73.28
Dental	568	82.22
Medicine	1799	67.48
Mental Health	1422	65.40

PCIC	909	68.98
Special Services	1817	63.29
Surgical	1973	58.03
Total	**14986**	**67.60**

The training figures above relate to a rolling 12 month period, the fire safety e-learning package, classroom, locality based & Fire Warden training . All fire safety training records are recorded on the staff personal records Electronic Staff Records (ESR) database. LED collates all statistical information in relation to Fire Training and notifies the figures to this department. It can be seen that 67.60% of staff received fire training in the previous 12 month period ending 31st August 18.

In addition to the 10,130 staff trained in the 12 month period we have also provided training for approximately 1000 University and other organizations working on our sites.

Mandatory fire training sessions at UHW & UHL conducted by Fire Safety Advisors are organized by LED, with information in relation to venues, dates and times being available on the intranet.

The Health Board has recently purchased an electronic extinguisher training kit. The system has been used successfully on the fire wardens' course and we will be advertising extinguisher training for staff.

6.0 FIRE EVACAUTION EXERCISES

Fire exercises have been carried out in the following locations:

- Ward B4 at UHW
- Special Care Baby Unit at UHW
- Alas Treforest
- Global Link x 2 (1 announced and 1 unannounced).

It is intended to carry out more practical fire evacuation exercises to test procedures. This type of event is very difficult to organize owing to staff shortages and suitable venues to hold the event. It is appreciated that patient care cannot be compromised to carry out this training and it will be implemented in a sensitive manner.

7.0 VERTICAL FIRE EVACUATION

The provision of equipment for implementing vertical evacuation of patients in the event of a fire emergency have been introduced in ward areas where there is a possibility of vertical evacuation down stairs. Equipment is provided & will greatly reduce the manual handling risks associated with vertical evacuation, and facilitate a more effective and speedy evacuation procedure.

Continuation training on the evacuation equipment has not been carried out and staff are not confident in using this equipment. The lack of training could

cause a considerable delay if it was ever essential to evacuate vertically in the event of an emergency.

8.0 COMPARTMENTATION

The fire strategy involves restricting a fire to a limited area by fire resisting construction so that patients can 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 carrying out the required fire stopping to these penetrations.

We have a rolling program of remedial work which is being carried out on a priority risk basis and have recently completed works in the Women's Hospital and work is now to commence in Barry Hospital.

Extensive issues with the compartmentation at St David's Hospital have finally be addressed with the associated costs borne by the PFI Company.

9.0 FIRE POLICY AND PROCEDURES

The Cardiff & Vale Health Board Fire Safety Policy and Procedures have been updated and approved in July 2018 and are available to view on the health Boards Intranet.

10.0 APPOINTMENT OF DEPUTY FIRE MANAGERS

Each directorate has now nominated a Deputy Fire Safety Manager to be responsible for fire safety in their directorate.

11.0 ANNUAL FIRE AUDIT

The annual fire audit for the Welsh Government has been completed and submitted on the web based on-line reporting system administered by NHS Wales Shared Services Partnership - Specialist Estates Services.

12.0 STORAGE IN CORRIDORS

Due to limitation on storage facilities the problem of storage in main corridors has increased and is a cause of concern this has been recorded in both the Health Boards Fire Risk Assessment and in SWFS Audits.

13.0 PROJECT REVIEW

During the last year the Fire Safety Advisers have completed technical reviews and reports for numerous major and minor projects undertaken in the Health Board. In this connection there are continuing developments for the MRI Unit, Obstetrics and major ward refurbishments at UHW and the Rookwood replacement at UHL.

FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT
Name of Meeting: Health and Safety Committee **Date of Meeting**: 09/10/2018

Executive Lead : Director of Planning
Author : Head of Health and Safety – 02920 743751/Senior Fire Safety Adviser 02920 742292
Complying 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 completion of all remedial actions detailed in the Enforcement Notices and Informal Notices as a result of Fire Service Audits will improve patient, visitor and staff fire safety. Fire risk within the UHB, further enforcements and potential prosecution for non compliance will also be reduced. 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 Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

- that identified fire enforcement compliance and safety are being appropriately managed.

The Health and Safety Committee is asked:

- to **CONSIDER** the on-going work to meet the requirements of fire enforcement compliance

SITUATION

The Health Board has a statutory obligation to protect persons from the risk of fire. The South Wales Fire Service (SWFS) monitors and enforces compliance to the Regulatory Reform (Fire Safety) Order 2005 (RRO).

Following the Fire Service audits they issue either an Enforcement Notice for serious breaches in the legislation or an IN02 Notice when they consider the Health Board have not fully complied with the RRO but the issues are not so serious to warrant enforcement.

BACKGROUND

The South Wales Fire Service undertakes a program of visits to mainly inpatient areas on Hospital Sites. The audit results in the Fire Service reporting to the Health Board on failure to comply with Regulatory Reform (Fire Safety) Order 2005 and may also result in Enforcement Actions.

This report provides the current status of the Enforcement Notices and IN02's in respect of progress.

ASSESSMENT

There are currently no Fire Enforcement Notices in force.

SWFS continue to carry out regular audits on our sites the following areas have been visited since the last report:

Wards B 4 and Brecknock House at the Heath, the ground and first floor of CRI and West 6, East 8 and the Rehabilitation Unit at Llandough.

There are 3 recurring items noted in the fire audits relate to fire compartmentation and fire dampers which do not comply with current standards.

We have planned program of fire compartmentation works, just completed, the Women's Hospital and work is to commence on Barry Hospital

The majority of our fire dampers do not comply with current standard. It has been agreed with the Fire Authority that we would have a phased program of replacements as we refurbish areas. In addition to the refurbishment scheme a Company has been contracted to identify and service all existing dampers.

The third issue of storage in corridors needs to be addressed by the Health Board as problem is increasing.

FIRE TRAINING FIGURES

CLINICAL BOARD	HEAD COUNT	PERCENTAGE
Children's & Women's	2085	73.86
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ENFORCEMENT AGENCIES REPORT
Name of Meeting: Health & Safety Committee **Date of Meeting:** 9th October 2018

Executive Lead : Senior Manager - UHL
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

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 was one additional issues raised by the Health and Safety Executive (HSE) relating to:-

a) Concerns raised following HSE Audit of the Public Health Laboratories at UHW & UHL

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 safety strategy have progressed as reported by the Director of Capital, Estates and Facilities at the April Health and Safety Committee meeting and is on the agenda for this meeting.

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 Group on their correspondence.

Legal advice was sought and a formal submission made on the 14th February 2018. We are still awaiting the HSE to review and respond.

Inspection of Public Health Laboratories at UHW & UHL

The HSE inspected the Public Health Laboratories (PHW) at both UHW and UHL at the beginning of May. The Health Board has a service agreement for the maintenance of the Laboratory and the pressure vessels (autoclaves).

The inspector had raised a number of concerns in relation to the lack of containment of the level 3 laboratory at UHL and lack of communication/co-operation between the Health Board and PHW and was minded to issue an **Improvement Notice** against both organisations.

The Health Board gave a commitment to put in place an improved communication plan with PHW which was formalised.

The HSE subsequently issued PHW with an Improvement Notice, but accepted that we had met its remit providing the agreed plan was implemented.

A meeting with Public Health and the Estates Department has taken place during the period.

New Item - HSE concern over and an unreported RIDDOR

The HSE contacted the Health Board following direct contact made to them by an employee who had fallen on site enquiring why the event had not been reported under the RIDDOR regulations.

The Adviser explained the circumstances relating to both the event and the reasons as to why it was not reportable under the RIDDOR regulations. The HSE accepted the Health Board had acted correctly. **Item closed**

HEALTH AND SAFETY PRIORITY IMPROVEMENT PLAN 2018/19
Name of Meeting: Health & Safety Committee **Date of Meeting:** 09/10/2018
Executive Lead : Hospital Manager - UHL
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 Action 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 milestone and 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

SITUATION

The Health Board has initiated a Health and Safety Priority (Improvement) 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 2017/18 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 the status of each milestone and the number of completed action areas (green) shown with the assessment paragraph and the 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 produced its own Priority Improvement Plan based on the eight strategic areas.

The report has been reviewed to reflect the finding of the 2017/18 Annual Health and Safety Report, consistent with the commitment given at the July Meeting.

The Plan has been amended to reflect the status of milestones within each of the core strategic areas which is 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
(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

	Total no of Milestones	Green	Amber	Red	Total Actions	Green	Amber	Red	Overall Strategy Status
Health and Safety Policy Management and Organisational Arrangement	8	0	6	2	16	2	9	5	Reasonable assurance
Violence and Aggression (inc Lone worker)	3	2	1	0	10	6	3	1	Substantial assurance
Manual Handling	9	2	4	3	12	3	6	3	Reasonable assurance
Health Issues	8	1	5	2	16	2	9	5	Reasonable assurance
Patient and Environment Health and Safety	8	0	5	3	15	5	5	5	Limited assurance
Fire Safety Management	6	1	3	2	9	1	6	2	Reasonable assurance
Estate Health and Safety Management	9	2	6	1	17	9	6	2	Reasonable assurance
Sharp Safety	1	0	1	0	1	0	1	0	Reasonable assurance
Total	52	8	31	13	96	28	45	23	

As can be seen the Plan has been reviewed following the Annual Report, as a result there is a larger quantity of Red and Amber areas for Improvement.

The plan identifies 52 milestones within the 8 strategic areas and 92 actions for improvement.

These will be progressed in conjunction with the reviewed Corporate Risk Assessment Framework, which plans to more easily demonstrate the level of progress made.

Appendix 1 contains details of each of the Identified requirements.

The most significant changes include plans to enhance progress in 4 keys areas and the facilitate this the Health and Safety Department allocated an adviser to co-ordinate progress .These being

1 Health Aspects – Co-ordinator Adviser R Daniel
- Stress Reactive and Pro-active approaches
- Hazardous Substances assessment & Controls
- Muscular Skeletal Disorders
- Display Screen Equipment
- Health Environmental effects (Space, Lighting, Welfare etc)
- Hand Arm Vibration
- Menopausal Effects

2 Risk Assessment and Control improvement Co-ordinator Adviser R Sykes
- Management of Assessment processes
- Monitoring Control measures implementation
- Working within the CRAF and E Datix
- Support mechanisms for manager.

3 H&S Competence Co-ordinator Adviser J Davies
- Effective H&S Training whilst minimizing staff disruption
- Managers H&S Training
- Validating effectiveness
- Post Training support inc of Handbook
- Monitoring compliance
- Best means of Communication

4 Compliance & Priority Improvements - Co-ordinator Adviser C Murch
- Maintaining a H&S legislation register
- Gap Analysis of any compliance shortfall
- Review of approaches in similar organizations
- Review of Priority Improvement plan for greater assurance of subjectivity
- Monitoring progress at local level

The above will require co-operation from specialists, from other departments and Staff Group within the Health Board and outside groups; if it is to be successful. The Co-coordinators will need to work with these specialists to maximize the benefit.

Priority Improvement Plan **Appendix 1**

1. Health & Safety Management

CRAF	REF	Area of Improvement	Milestone	M/stone Status	Actions Requirement	Progress/Assurance	Action Status	Lead	Date Due
	1.1	**Health and Safety Policies**	Comprehensive range of H&S Policies covering all legislative requirements	Amber	Gap analysis of policies by reviewing policies and procedures of other health boards	Project lead identified within the H&S team, to complete analysis.	Amber	Head of Health and Safety	Apr 19
					Develop register of safety legislation to provide gap analysis and ensure any changes or new legislation incorporated into policies and procedures	Register of legislation utilised, Project lead reviewing findings using Barbour information system ensure any changes or new legislation incorporated into policies and procedures	Amber	Head of Health and Safety	Apr 19
			H&S Policies are appropriately reviewed and communicated to all relevant staff	Amber	Ensure link to all current H&S policies & procedures of H&S web page.	Departmental review of H&S polices undertaken, Reviewed at each H&S Committee and approved policies add to web	Green	Director of Governance	
					Status of related H&S Policies approved by other committee requires progress through relevant committees	Those policies outside of review period identified	Amber	Director of Governance	Jan 19
	1.2	**Risk Assessments**	H&S Risk Assessments are included with CRAF register	Amber	Implement new CRAF format	CRAF Pilot project of Dental & capital planning & estates progressed. rollout of revised risk register approach being progressed.	Amber	Director of Governance/Head of Risk Governance	Apr 19
					Review H&S items on clinical / service boards risk register and ensure high risk H&S items included on priority action plan	Being progressed jointly with above	Amber	Head of Health and Safety	Apr 19
			Managers maintain a suitable and sufficient Risk Assessments	Red	Utilise E Datix System to monitor progress of controls identified within Risk assessments	Plans to develop E Datix agreed	Red	Director of Governance/Head of Risk Governance	Apr 19
					Identify some common high risk activities and produce some generic risk assessment pro-forma for local use	Project co-ordinator identified with H&S to progress risk assessment status and control measures for H&S issues.	Amber	Head of Health and Safety	Jun 19
	1.3	**Managers Safety Course**	Managers competency in their H&S role is enhanced	Red	Allocate H&S resource to develop training package	Role identified in new appointed H&S Adviser. Course being devised.	Amber	Head of Health and Safety	Jan 19
					Offering of course to all mangers	As above	Red	Head of Health and Safety	Jan 19
					Accompanying training materials to support course and attendees in their role.	As above	Red	Head of Health and Safety	Jan 19

					Monitoring and support of H&S management improvements post course.	As above	Red	Head of Health and Safety	Jan 19
	1.4	**Mandatory Training Compliance**	Review of mandatory training to maximise effectiveness	Amber	Review of mandatory training to maximise effectiveness through appropriate frequency review and assessment of training needs.	Paper submitted to the H&S Committee, further progressed with training plans during period.	Amber	Director of WOD	Jan 19
			Mandatory training compliance - Health Board 85% target		Monitoring of mandatory training compliance - Health Board 85% target	Annual report showed success improvement in mandatory training compliance. Corresponding to the above.	Amber	Director of WOD	Apr 19
	1.5	**Health and Safety meetings management structure met.**	All Service and Clinical Boards have established H&S meetings that meet at least 4 times a year	Amber	Annual report identified shortfall within some Clinical Boards	Shortfall have now been rectified including Medline establishing a Group and will be monitored at Operational Group	Green	All	Oct 18
					Establish H&S Group for corporate functions	Role identified within the newly appointed H&S Adviser to co-ordinate suitable chair required.	Red	Director of Governance	Jan 19

2. Violence & Aggression

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	2.1	**Working within the scope of the Memorandum of Understanding for V&A**	Review of the MOU to meet service needs and support guidance based off NHS Chief Executive's launch together with police and the prosecution Service.	Green	Review current practise against revised approach	Health Board taking lead with partnerships, new document being appropriately progressed following Cardiff and Vale practice. Launch planned November 18.	Green	Senior Manager Health and Safety	Nov 18
					Monitor CPS and Police outcomes for comparison of criminal sanctions, community resolutions and police actions.	Annual report identified suitable sub divisions, national group progressing comparative standards across Health Boards.	Green	Senior Manager Health and Safety	Apr 19
					Pursue non criminal sanctions and monitor, including hazard warning markers, victim interviews and perpetrator internal sanctions.	Personal Safety section reviewing its monitoring to demonstrate efforts made within non criminal sanctions.	Amber	Head of Health and Safety	Jan 19
	2.2	**Lone Worker Devices**	Ensure those at risk within the community have systems in place for device or suitable assessment	Green	Monitor of consistent use, demonstrating effective management of device allocation.	Regular reports submitted to H&S Committee.	Green	Head of Health and Safety	Oct 18
					Review of contract due in 2019 to reflect current demands	Meeting with Procurement to establish spec in readiness for contract renewal in April 19	Green	Head of Procurement	Apr 19

			.		Local Management to establish appropriate risk assessment for justification.	Local Management approaching for additional devices are being supported by Advisory team and advice that items can be progressed by local funding.	Green	Head of Health and Safety	Oct 18
					Current devices with battery fault to be resolved by both identification and remedial action	Three devices of the 650 in operation found to have faulty batteries associated with their age. Investigation initiated. Replacement of whole batch being agreed by supplier.	Amber	Head of Health and Safety	Jan 18
	2.3	**V&A response competence**	Ensure sufficient trained staff to respond to V&A events	Amber	Review of training to ensure sufficient trained staff to respond.	Internal review with specialist trainers of V&A to ensure response and capabilities. Annual report identified low level of compliance.	Red	All	Apr 19
					Mechanism to monitor training against TNA	H&S department advising Clinical Boards of compliance status	Green	Head of Health and Safety	Apr 19
					Monitoring and support to local areas to give assurance effectiveness of training.	Clinical Board meetings to include training status.	Amber	Head of Health and Safety	Apr 19

3. Manual Handling

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	3.1	**Working to Revised All Wales NHS Manual Handling Passport and Information Scheme**	Implementation of the Revised All Wales NHS Manual Handling Passport and Information Scheme	Amber	Review of MH passport delivery to meet Agored Cymru standards.	Action plan initiated to meet required standards by December. Progress being monitored by LED, Agored Cymru and H&S.	Amber	Head of Health and Safety/Head of LED	Dec 18
			Ensure Manual handling training is based on need by risk assessment.	Amber	Review training against TNA	Clinical Board meetings to include training status.	Amber	Head of Health and Safety	Apr 19
					Monitor compliance against TNA requirements.	H&S department advising Clinical Boards of compliance status	Green	Head of Health and Safety	Apr 19
	3.2	**Pro-Act Audit**	Audit compliance of Hoisting and hygiene equipment against patient requirements.	Green	Re Audit Pro –act during winter demands	Re audit progressed and agreed with proact to commence in November 18, with report coming to January Committee.	Green	Head of Health and Safety	Jan 19
					Review of audit findings action shortfalls.	As above	Amber	Head of Health and Safety	Jan 19
					Review of slings against suitability of current slings used	Within Proact audit.	Amber	Head of Health and Safety	Jan 19
	3.3	**Bariatric patient compliance**	Assessment of bariatric patient compliance against	Amber	Undertake an Assessment of bariatric patient compliance against Manual	Manual handling Adviser working with medicine Clinical Board to assess best	Amber	Head of Health and Safety	Jan 19

			Manual handling aspects.		handling aspects.	practice including in proact audit.			
	3.4	**LOLER**	Meet LOLER inspection requirements	Green	Audit of mechanisms to meet LOLER inspection requirements Previous reports identified shortfall in LOLER inspection regime,	Action taken by Director of Planning to rectify LOLER inspection programme. All equipment re examined.	Green	Director of Planning	Oct 18
	3.5	**Management of the Hoverjacks**	Suitable quantities of equipment to respond to fallen patients needs	Red	Validation of Suitable of Hoover jacks quantities to respond to fallen patients needs	Project group being initiated by Ast Dir of Nursing to review usage and management of hoverjacks.	Red	Assistant Director of Nursing	Jan19
			Hoverjacks considered and maintained as a lifting compliance under LOLER		Hoverjacks considered and maintained as a lifting compliance under LOLER	As above	Red	Assistant Director of Nursing	Jan 19
			Ownership of existing stock is established.		Ownership of existing stock is established.	As above	Red	Assistant Director of Nursing	Jan 19
	3.6	**Suitable Glide/Slide Sheets**	Enhanced stock of material glide sheets to replace wear and tear.	Amber	Savings made from non use of paper glide sheets are converted into enhanced stock of material glide sheets to replace wear and tear.	A paper went to the Operational Health and Safety Group in September2017 recommending the central purchase of large reusable sheets.	Amber	Head of procurement	Apr 19

4. Health Issues

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	4.1	**Review of Health compliance**	Review of all Health related risks to ensure appropriate controls are in place	Red	Initiate a review of all Health related risks to ensure appropriate controls are in place	H&S Adviser co-ordinating a review to reflect concerns raised about all health initiatives.	Amber	Head of Health and Safety	Jul 19
					Identify status of Stress, MSD ,DSE, Workplace Environmental , Menopausal Effects	Working group being progressed	RED	Head of Health and Safety	Jul 19
	4.2	**Control of Substances Hazardous to Health**	Suitable and Sufficient Risk Assessments in Place	Amber	All areas has designated COSHH coordinators	Shortfall status tabled at each Clinical Board H&S Group for resolution	Amber	Chair of Operational Group	Apr 19
					Risk Assessment are valid	As above	Amber	Chair of Operational Group	Apr 19
					Monitoring that ensures high risk areas have complete compliance.	Review of Risk Assessments to establish high risk substance activities are ongoing, with enhanced descriptions.	Amber	Head of Health and Safety	Apr 19
			Identified Control Measures are implemented	Amber	Mechanism for minimising the effects of hazardous substances.	As above	Amber	Head of Health and Safety	Apr 19
					Safe use of peracetic acid in	H&S Adviser working with Clinical Board to establish best practice	Green	Head of Health and Safety	Oct 19

					sterilisation of medical instruments				
	4.3	**Work Place stressors**	The Health Board to have in place suitable response mechanism to staff experiencing stress and demands.	Amber	Review Policy and Access to Wellbeing service Policy out of Review period	Health Board has a wellbeing service and Occupational Health and is subject of a review of its policy and report to this committee.	Amber	Director of HR/Head of Occupational Health	Jan 19
			The HB has proactive approaches to identify areas of hotspot and diminish stressors prior to the acute event.	Red	proactive approaches to identify areas of hotspot and diminish stressors prior to the acute event .initiated	Wellbeing working group has ceased, H&S working towards identifying criteria with specialist partners on mechanism for identifying potential events.	Red	Head of Occupational Health /Head of Health and Safety	Jan 19
					Specialised group to monitor and develop proactive actions	As Above	Red	Head of Occupational Health /Head of Health and Safety	Jan 19
	4.4	**Hand arm vibration**	Activities which use devices at risk of hand arm vibration. are assessed	Amber	Review of activities which use devices at risk of hand arm vibration	HAV identified within Dental and Estates Areas. Full survey initiated in Dental , Identification mechanisms developed in Estates ,Other areas to be progressed	Amber	Head of Health and Safety	Apr 19
					Assessment of those areas requiring direct monitoring.	As Above	Red	Head of Health and Safety	Jan 19
					Complete monitoring to these areas.	As above	Red	Head of Health and Safety	Apr 19
	4.5	**DSEAR compliance to regulations.**	DSEAR compliance to regulations requires area of potential explosives to be assessed and control measures in place .	Amber	Assessment of DSEAR requirements against simple demand areas through localised assessments and remedial actions	Risk Assessment approach adopted based on industry standard	Amber	Head of Health and Safety	Apr 19
					Identification and full DSEAR assessment for complex areas	As above	Amber	CB Leads	Apr 19
	4.6	**Muscular Skeletal Risks**	Meet DSE Requirements	Green	Maintain assessment of display screen equipment database and complete assessment for those defined users.	Revised E-Data Based implemented	Green	Head of Health and Safety	Oct 18

5. **Environment Safety and Health and Safety Patient Issues**

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	5.1	**Ligature risk in Mental Health**	Complete comprehensive ligature assessment for areas where patients are at risk of self harm.	Amber	Complete audit and supported installation within Mental Health	Adviser completed audit and supported installation within Mental Health	Green	Head of Health and Safety	Oct 18

					Implement findings to minimise self harm risk.	Meeting established with H&S & Estates to verify status of remedial work	Amber	Mental Health Lead	Jan 19
	5.2	**Mental Health Smoking Cessation**	Implementation of an absolute smoking cessation approach with mental health establishment.	Amber	Smoking cessation implemented	Smoking cessation implemented however increased report of Fire and Violence	Green	Mental Health Lead	Jan 19
					Review of increased reports of Fire and Violence		Amber	Mental Health Lead	Jan 19
			Suitable support mechanisms for patients and access to safe electronic smoking and other devices.	RED	Project plan required non charging E Cigarettes E Cigarette Chargers if used must in suitable flame proof area ,	Fire officer report that E cigarettes chargers are being permitted against national advice	RED	Mental Health Lead	Jan 19
					Monitor smoking cessation compliance and report on enhanced staff risk related to fire and violence	Reports of increased lightering be smuggled in and increased violence related to control	RED	Mental Health Lead	Jan 19
	5.3	**Window Closures**	All windows at a height which may be a self harm or fall risk is fitted with suitable window restrictors. .	Amber	Survey of window undertaken and restrictors fitted.	Survey of window undertaken and restrictors fitted.	Green	Dir of planning	Oct 18
					Anti tamper devices fitted to all restrictors	Review of restrictor in self harm areas to fit anti tamper screws	Red	Dir of planning	Apr 19
	5.4	**Local control of Water Safety**	Low use water outlets are flushed at agreed intervals.	Red	Audit and monitoring of flushing mechanisms	. Complete audit tool and improve attendance at Water Safety Group	RED	Local HB Leads	Jan 19
	5.5	**Management of Bariatric Patients**	Suitable mechanism in place to care with dignity and without enhanced risk to staff very heavy patients.	Amber	Assessment of patient need	Assessment of patient need undertaken further work required to diminish fire, staff and dignity issues	Amber	Ast Dir Nursing	
					Specialised beds, hoisting and other support equipment are available as needed.	Bariatric care package in place with access to a range of equipment	Green	Ast Dir of Nursing	Oct 18
					Mechanisms of implementing care with dignity for bariatric patients that go beyond our standard profile.	Project to improve care being progressed between Manual Handling & Medicine	Amber	Ast Dir Nursing	Apr 19
	5.6	**Record Storage**	There is agreed policy for retaining paper records .	Amber	Progress Policy	The organisation has the requirement to safely store its mandated records for the agreed periods. Policy approved	Green	Dir of Governance	Oct 18
					There are suitable controls implemented within record storage areas to ensure that manual handling and fire risk are not breached.	Work undertaken to improve condition of storage in short term	Amber	Head of Medical Records	Apr 19
			Progress an enhanced programme to electronically store, where possible	Red	Progress an enhanced programme to electronically store, where possible medical records.	Project under review	Red	Head of Medical Records	Apr 19

			medical records.						

6. Fire Safety Management

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	6.1	**Fire Compartmentation**	Review and maintain compartmentation system.	Amber	Implement a prioritised programme for reviewing and maintain its compartmentation system	Priority plan being progressed	Amber	Dir of Planning	Jul 19
	6.2	**Unwanted False Signals (UFS)**	UFS's are minimised, investigated and monitored	Amber	Work Jointly with SWFRS and Specialist Services to reduce UFS	Joint working group	Amber	Dir of Planning	Apr 19
					Those UFS associated with aged automatic alarm systems are progressed through a prioritised approach.	Enhanced programme of replacement agreed	Amber	Dir of Planning	Apr 19
					UFS associated with inappropriate contractor work is diminished through enhanced through the job allocation form.	Fire Adviser working with Estates to enhance dust and hot work controls	Amber	Dir of Planning	Apr 19
					Mechanism to notify the fire service to stand down if known false alarm.	Fire Service progressing direct line number for speedier contact Training includes message relating to informing switchboard	Amber	Dir of Planning	Apr 19
	6.3	**Fire Incidents within Mental Health**	Fire incidents in Mental health associated with the smoking cessation campaign is minimised through effective control	Red	Fire incidents in Mental health associated with the smoking cessation campaign is minimised through effective control through a) removal of ignition sources b) meeting health care guidance on use of charging devices and c) local monitoring of internal areas.	Recent reports raised concern about increase fires in Mental Health and the effectiveness of ignition source control. Mental Health Lead progressing concerns	Red	HOD Mental Health /Dir of planning	Jan 19
	6.4	**Evacuation Mat/Chairs Training**	Establish mechanisms for training and refresher training in the use of evac chars and mats.	Red		Cascade Training given several years ago . further demand identified	Red	Sen Fire Adviser / FSM	Apr 19
	6.5	**Evacuation**	.Enhanced commitment to	Amber	Fire Group to devise an agreed programme of evac drills and		Amber	Dir of planning	Jan 19

		Fire drills	evacuation drills		local areas to co-operate in participation.				
	6.5	**Fire Audit - Annual Submission**	Annual submission of Fiore audit is submitted within a timely manner	Green	Submit Annual Report	2018 audit submitted	Green	Dir of planning	Oct 18

7.1 Health and Safety Estates Management.

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	7.1	**Water Safety/Legionella**	Water Safety Plan Implemented with increase assurance of compliance against flushing need	Amber	Legionella Survey and Risk Assessment audit package under development for completion by all area managers identifying all outlets and usage or flushing regime.	Package developed on MICAD System for dissemination to local areas	Green	Dir of Planning	Oct 18
					Water Safety Group has effective representation from all related areas	Current CB representation poor	Red	CB Leads	Jan 19
					Compliance against water safety plan and policy is reported to the H&S Committee.	Included within work programme	Green	Dir of Public Health	Oct 18
	7.2	**Contractor Control**	Contractor control within remit of **estates** has effective mechanisms for monitoring and reacting to safety breaches.	Amber	Reported at operational group	Reported at operational group	Green	Dir of Planning	Oct 18
			Permit system in place for contractor work of specified high risk areas.			Enhanced Permit system under development	Amber	Dir of Planning	Jan 19
			Contractor control within remit of **non estates** has effective mechanisms for monitoring and reacting to safety breaches.	Amber	Enhance non estates to same standard as Estates Contractor control	Adviser appointed to progress same standard of work , He has actively progress backlog since appointment	Amber	Head of Health & Safety	Jan 19
	7.3	**Asbestos**	Asbestos database to ensure that Asbestos register has evaluated asbestos status for all areas.	Green	Review of asbestos database to ensure that Asbestos register has evaluated asbestos status for all areas	External review undertaken	Green	Dir of Planning	Oct 18
					Effective asbestos management for all intrusive work within asbestos identified areas	As above	Green	Dir of Planning	Oct 18
					Action plan for resolving those areas not surveyed as part of the asbestos register.	Report 94 of the 8000+ areas surveyed Work on non surveyed areas halted until resurvey undertaken , report to progress "Black Areas " being prepared	Amber	Dir of Planning	Apr 19

	7.4	**Back log maintenance**	Backlog maintenance to evaluate those which potentially effects their safety compliance.	RED	Review of backlog maintenance to evaluate those which potentially effects their safety compliance	Resources available to estates in line with an increasing burden of ageing physical infrastructure, bringing increased maintenance costs and increased refurbishment costs.	Red	Dir of Planning	Apr 19
	7.5	**Pedestrian and Tunnel Safety**	Enhanced pedestrian and tunnel safety.	Amber	Undertake complete survey and specialist advice on enhancing pedestrian and tunnel safety.	Survey undertaken	Green	Dir of Planning	Apr 19
					Implement phased approach to zoning tunnel areas and minimising usage.	Plans being progressed	Amber	Dir of Planning	Apr 19
					Implement pedestrian safety within identified key high risk areas.	Within cost restriction being progressed	Amber	Dir of Planning	Apr 19
	7.6	**Estates compliance to LOLER requirements.**	Estates compliance to LOLER requirements are maintained for lifting equipment.	Amber	Planned Transfer of LOLER responsibilities to Clinical Engineering.	Agreement for transfer in April progressed	Green	Dir of Planning/Dir Therapies	Apr 19
					Comprehensive maintenance and inspection schedule maintained.	Link to above transfer	Amber	Dir of Planning/Dir Therapies	Apr 19
	7.7	**Category 3 Laboratories compliance**	Appropriate mechanisms are implemented to ensure that risk presented to the Health Board from these areas is controlled	Green	Appropriate mechanisms are implemented to ensure that risk presented to the Health Board from these areas is controlled by effective maintenance of their internal pressurised containment.	Regular meeting established	Green	Dir of Planning	Oct 18
					Formal mechanisms of communications between the relevant parties are formalised and recorded	Regular meeting established	Green	Head of Health & Safety n	Oct 18

8. Sharps Safety

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	8.1	**Safety Needles**	Requirement of Safety Sharps legislation are maintained	Amber	Re-engage staff in enhanced safe needles controls and appropriate disposal	Adviser lead pursuing through CB H& S Group	Amber	CB Leads	Apr 19

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
Latex Allergy	UHB 127	Health and Safety Adviser	October 2015 (2nd review)	October 2015	October 2018
Environmental	UHB 143	Director of Capital, Estates and Facilities	October 2015 (2nd review)	October 2015	October 2018
Closed Circuit Television (CCTV)	UHB 303	Director of Capital, Estates and Facilities	October 2015	October 2015	October 2018
Security Services	UHB 037	Director of Capital, Estates and Facilities	January 2016 (2nd review)	January 2016	January 2019
Contractor Control	UHB 163	Director of Capital, Estates and Facilities	July 2016 (3rd review)	July 2016	July 2019
Health & Safety	UHB 021	Head of Health and Safety	July 2016	November 2016 (Board approval)	November 2019

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE
Safe Working with Electricity	UHB 208	Director of Capital, Estates and Facilities	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	Waste and Compliance 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
Management of Asbestos	UHB 072	Director of Capital, Estates and Facilities	July 2018 (3rd review)	July 2018	July 2021
Fire Safety	UHB 022	Director of Capital, Estates and Facilities	July 2018 (3rd review)	July 2018	July 2021

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

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 – Trial of No Smoking	Case Management Support – Case Study	Personal Injury Claims	Stress Management
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**			√		
Minutes from Other Committees/SubCommittees/Groups – **CRAF No: 8.1**	√	√	√	√	√
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 Asbestos Management Policy – **CRAF No: 823**			√		
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 Safety 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 2018 – 30TH SEPTEMBER 2018	
Name of Meeting : Health and Safety Committee	**Date of Meeting** 09/10/2018

Executive Lead : Hospital Manager - UHL
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 2018 and 30 September 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 13 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 2018 - 31 March 2019															
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 9th October 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
4	**Health and Safety Executive**								**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*** **<u>Theme 3</u>: Effective Care *Standard 3.5 Record Keeping***								
5	12 September 2018	12 September 2018	UHW Grounds	Executive	Non reporting of an incident under RIDDOR	Incident was not reportable under the RIDDOR Regulations	Explanation provided to HSE as to why the incident was not reported.	Head of Health and Safety	Completed	No further action being pursued by HSE	Complete	Health and Safety - Michael Imperato		9 October 2018	Not applicable	
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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 9th October 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	21 February 2018	15 February 2018	Laboratories/ Teaching /Offices Link Block 5 UHW	Clinical Diagnostics & Therapeutics Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x management 2 x compliance	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 compliance - 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 9 October 2018		Yes
11	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 compliance	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.	1 x compliance - ongoing 1 x compliance - completed (compartmentation)	On-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	10 April 2018 9 October 2018		Yes
12	5 April 2018	12 March 2018	C3 Coronary Care UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1x compliance	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.		on-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 2018		Yes
13	10 May 2018	30 April 2018	Ward B4 UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1x compliance 2x management	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.		on-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 2018		Yes
14	10 May 2018	12 April 2018	Cardiff Royal Infirmary basement Glossop Road		Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2x estates 1x compliance		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		on-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 2018		Yes
15	4 June 2018	22 May 2018	Brecknock House, UHW		Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2x compliance		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		on-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 2018		Yes
16	9 July 2018	20 June 2018	Rehabilitation Day Hospital (MHSOP), UHL, CF64 2XW.		Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1x management 2x estates		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		on-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 2018		Yes
17	10 July 2018	25 June 2018	Cardiff Royal Infirmary ground floor Glossop Road CF24 0SZ		Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2x compliance 1x management 1x estates		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		on-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 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 9th October 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
18	10 July 2018	2 July 2018	Cardiff Royal Infirmary first floor Glossop Road CF24 0SZ		Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2x minor issues, 1x Estates 2x Compliance		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		on-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 2018		Yes
19	25 July 2018	16 July 2018	Ward East 8, UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2x Management		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		On-going	Health and Safety - Michael Imperato		9 October 2018		Yes
20	25 July 2018	16 July 2018	Ward West 6, UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 3x Management		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		On-going	Health and Safety - Michael Imperato	Estate and Capital issues reported to Estates and Fire Safety meeting	9 October 2018		Yes
21	**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***							
22	14 August 2018	16 August 2018	Main Wards, Food Production and Restaurant Areas, UHL	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 3 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		9 October 2018		
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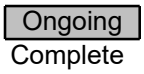

Ongoing
Complete

Fiscal year - Date of visit
In order of date of visit
IN01 - failed to comply
IN02 - not complied fully

Management - Fire Safety Training Outstanding until Health Board reached 85% compliance
Compliance - Fire Dampners completed with refurbs

LONE WORKER SYSTEM PROGRESS REPORT
Name of Meeting : Health & Safety Committee **Date of Meeting** 9/10/2018

Board Lead : Senior Manager - UHL
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 April 2018 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.

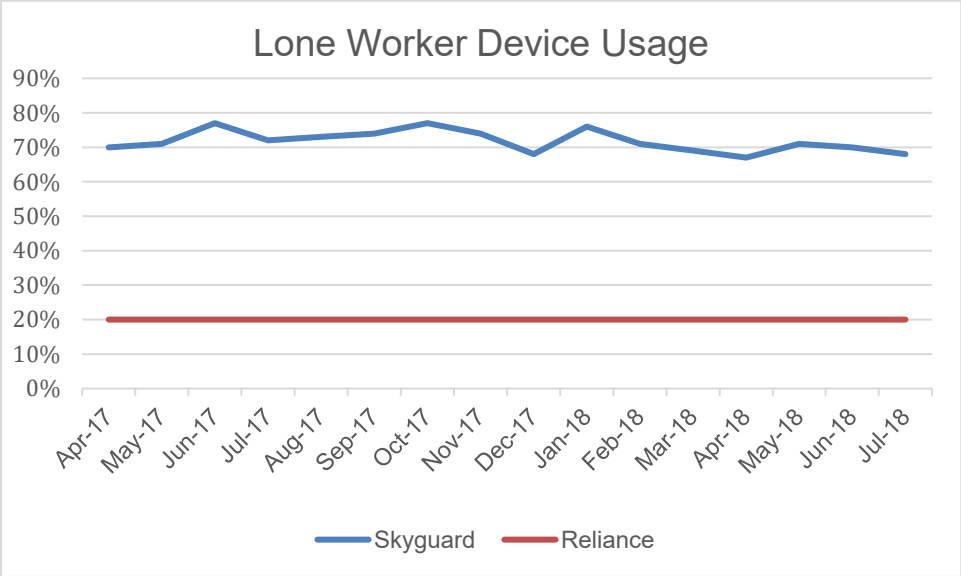
The Health Board recognises that there is a risk of injury to NHS staff working in the community from members of the public which are increased due to their remoteness. The Committee previously noted and supported that an important control measure in managing this risk is that relevant NHS staff are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

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.

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 72% month on month measured against device activity and movement. This has sustained the significant improvement over the previous contract.

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

A number of departments have reviewed their need with a view to expand the number of devices required for their staff considering the management actions have been limited. Departments have been advised that further devices are available if local funding can be found.

During the period a small number of faulty devices were reported. The company undertook a prompt investigation and a justified and proportionate

action plan has been implemented to replace a number of devices as a precautionary measure.

Managers continue to 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.

FOOD HYGIENE INSPECTION OF WARDS, MAIN FOOD PRODUCTION KITCHEN and RESTAURANT at UNIVERSITY HOSPITAL LLANDOUGH (UHL)
Name of Meeting : Health and Safety Committee
Date of Meeting: 9th October 2018

Executive Lead : Director of Capital, Estates & Facilities
Author: Commercial Services Manager (Tel. No. 029 2074 3246)
Caring for People, Keeping People Well: Consistent implementation of the documented Food Safety Management System will ensure compliance with Food Safety Regulations and provide a safer experience for all stakeholders.
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number: 2.1 and 2.5
CRAF Reference Number: Objective 8.1 / Sub 8.1.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE is provided by:

- The maintenance of the Food Hygiene Rating with score of 3 (Satisfactory).

RECOMMENDATION

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Food & Port Health) report.
- **SUPPORT** the submission of a re-inspection following rectification of all the actions identified.
- **SUPPORT** the appointment of an internal position of a food safety inspection officer UHB wide.

SITUATION

An inspection of the main wards, food production kitchen and restaurant areas at the University Hospital Llandough took place on 14th August 2018, the outcome of which was confirmed in writing in a letter report dated 16th August 2018 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the service areas as listed at the University Hospital Llandough were awarded a score of 3 (Satisfactory) in the National Food Hygiene Rating Scheme.

BACKGROUND

It is a legal requirement that each hospital or food unit is registered as a food premises with the Local Authority and is therefore subject to an annual inspection by the Commercial Services Officer.

ASSESSMENT AND ASSURANCE

On receipt of the letter report, a high level action plan produced by Senior Managers within the Capital, Estates and Facilities Service Board was managed and monitored to address the issues raised and is attached as an appendix to this report**.** The areas will continue to be monitored within the services.

Subsequent to all actions being completed, a rescore application has been submitted on 11th September 2018 to the Local Authority and the services are awaiting a food hygiene re-inspection.

The Service Board are looking to employ a food hygiene person on a UHB wide basis in conjunction with developing a compliance team to oversee mandatory and statutory obligations.

Management Action Plan: UHL Ward & Food Production from EHO visit 14th August 2018

ID	Issue identified	Action	Lead	WBC Action	Commercial Action	Status
1	During the inspection, utensils and metal containers were being stacked while still wet. This will support microbiological growth. You must ensure all equipment is dried thoroughly before being stacked. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3***	Equipment to be stored dried on storage racks. Add to HACCP Document – completed.	Simon Williams			Completed
2	The wash hand basin in the serving area of the restaurants only had lukewarm water coming out of the tap. I was informed by a member of staff working in this area that only lukewarm water is available at this wash hand basin. You must ensure that the wash hand basin is provided with hot and cold, or suitable mixed running water. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para***	Estates maintenance for repair. Further investigation in basement or fit under sink point of use heater. NM 30/08/18 New hot water return pipe work and valves to be installed. Pipe work installed, asbestos has now been removed from valves, planned shutdown Friday night for new valve to be fitted then works complete Extra Works: 3 sinks to be sealed with mastic and loose fixings replaced	Simon Williams			Completed Completed
3	At the time of the inspection, a pouch of D10 suma bac was found in the dispenser in ward west 4 with an expiry date of June 2018. The expiry date is the date up until which the manufacturer guarantees the effectiveness of the cleaning chemical. Therefore you must ensure the expiry dates are checked on all cleaning chemicals and only cleaning chemicals within their expiry date are used. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3***	Check dates on all wards. Replace as necessary. To be picked up as part of audits. Training checked for compliance.	Norman Mitchell			Completed Completed Completed Completed

4	During the inspection, I also found a bottle of D10 sanitiser which was filled with clear liquid. On questioning the ward based caterer what was in the bottle, she replied with just water as the sanitiser had run out. You must ensure that an adequate supply of sanitiser is available at all times in the ward based kitchens and the ward based caterer is using sanitiser to clean and disinfect areas as necessary. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para***	Ensure Suitable D10 Is available. Check training for WBC. Ensure D10 is on audit schedule.	Norman Mitchell			Completed Completed Completed
5	During the inspection, it was identified that 6 of the wards we visited (Ward West 2, Ward West 4, Ward East 10/12 and Ward East 14/16) did not have any probe wipes available to clean and disinfect the probe thoroughly before and after each use. Some ward based caterers said they would use a dry white paper towel to clean the probe while others said they would use D10 sanitiser and a white paper towel. You must ensure the probe thermometer is cleaned and disinfected thoroughly with probe wipes before and after each use; this is to prevent cross contamination. A supply of probe wipes must be readily available in all wards. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3***	Probe wipes to be made available. (Stock level of two). Check to be included on supervisor audit. (to include form filling as per HACCP doc) WBC Disciplinary Counselled.	Norman Mitchell			Completed Completed Completed
6	At the time of the inspection, a mop head was located on the wash hand basin unit in Ward East 14/16. You must ensure the wash hand basin is kept clear of items at all times and is only used for staff to wash their hands. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 4***	Mop located and removed. Area decontaminated and cleaned. WBC Disciplinary Counselled.	Norman Mitchell			Completed Completed Completed

7	On entry in to the main kitchen from the restaurant area, the bin located next to the wash hand basin did not have a foot pedal so the lid has to be opened using your hands. This poses a risk of contamination. You must ensure the bin is non-hand operated in order to reduce the risk of contamination. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3***	Remove / replace bin. New bins ordered - complete	Simon Williams			Completed
8	There was no wash hand basin provided for food handlers working in the 'theatre kitchen'. Whilst it was noted that there was no direct handling of food as tongs were used by staff. The nature of the food being handled (raw burgers and chicken breasts) along with ready to eat foods such as burger buns and salad requires you to provide a wash hand basin which is easily accessible to staff. We were advised that staff would use the hand wash basin located behind the chilled display unit. This requires staff to open a door to leave the theatre kitchen, therefore potentially contaminating the door handle. We do not believe this to be easily accessible and suitably located. You need to provide a wash hand basin in the 'theatre kitchen' with adequate supplies of hot and cold, or appropriately mixed, running water, soap and hygienic means of drying hands. The basin should be connected to the drainage system and all staff should understand that it is for hand washing only. Alternatively, as discussed, you could relocate the 'theatre kitchen' to where the chilled display chiller is which would enable staff to easily access the hand wash basin located on the wall behind the counters. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 4***	Referred to Estates maintenance for installation of wash hand basin (WHB) in addition to nearby WHB behind adjacent servery. Advice being sought from EHO with possibility of moving cooking range. NM30/08/18 New stainless wash hand basin fitted, new electrical supply installed and cooking equipment moved from the island to another counter. Hand towel dispenser and soap dispenser to be fitted 03/09/18 Dave Evans. Mastic to be topped up on pipe work under sink 03/09/18 Dave Evans Completed	Simon Williams			Completed Completed Completed Completed

9	One of the lights in the walk-in chiller located along the outside wall of the building is not working. Replace the bulb and maintain in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Estates maintenance for repair. 5 x bulbs ok / 1 x bulb to replace. Completed	Simon Williams			Completed
10	There is debris and engrained dirt in the joins of the walk-in chiller and freezer door handles. Thoroughly clean the handles and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Thoroughly clean joins of walk-in Review if disciplinary action to be taken. Remove old temp gauges 3/09/18 Gareth Thomas	Simon Williams			Completed Completed
11	The large colanders on the metal shelving unit near the pot wash area are in a poor condition as they are buckled and sliced in a few areas. You must dispose of these colanders and maintain equipment in good repair and condition as to minimise any risk of contamination. ***Regulation (EC) No. 852/2004, Annex II, Chapter V, Para 1***	Remove equipment unfit for use.	Simon Williams			Completed
12	The rinser taps at the equipment sinks are dirty around the joins and handle areas. Thoroughly clean the rinser taps and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Thoroughly clean taps. Review if disciplinary action to be taken.	Simon Williams			Completed
13	The large green handled knife blade tip has broken off. You must dispose of the knife and ensure that all knives are maintained in good repair and condition as to minimise any risk of contamination. ***Regulation (EC) No. 852/2004, Annex II, Chapter V, Para 1(b)***	Remove knife from use. Check all other items	Simon Williams			Completed

14	There is some lime scale build-up to some of the wash hand basin taps in the kitchen and the tap tops in the trolley holding area. Thoroughly clean the taps and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Thoroughly clean WHB taps. Review if disciplinary action to be taken.	Simon Williams			Completed
15	The seals around the pipes by the wash hand basin on entry to the kitchen need resealing. You must ensure this area is maintained in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para***	Estates maintenance for repair. Meeting held with contractor and all repairs due to be finished.	Simon Williams			Completed
16	There is some food debris on the floor under the salad preparation sink. Thoroughly clean the floor and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Thoroughly clean area. Review if disciplinary action to be taken.	Simon Williams			Completed
17	The brush strip going up through the centre of the double doors to the right of the salad preparation sink is loose in areas and needs re-securing. You must ensure the brush strip is re-secured and the doors are adequately pest-proofed. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 2(c)***	Estates maintenance for repair. Completed	Simon Williams			Completed
18	Some of the seals to the floor throughout the kitchen are starting to split and the floor is becoming unstuck at junctions in a few areas throughout the kitchen. You must ensure the floor surfaces are maintained in a sound condition and be easy to clean. ***Regulation (EC) No. 852/2004, Annex II, Chapter II, Para 1(a)***	Estates maintenance for repair.	Simon Williams			Completed

19	There are holes in the cladded walls near the boilers and raw plugs in the walls in the boiler area. The wall cladding at a low level in the trolley holding area near the trolley for ward east 10/12 is cracked. Wall surfaces are to be maintained in a sound condition and be easy to clean. Remove the raw plugs and fill the holes in the wall. ***Regulation (EC) No. 852/2004, Annex II, Chapter II, Para 1(b)***	Repair as necessary. Staff to be briefed on the importance of identification and reporting such issues. To be completed tonight Some holes missed to be completed Dave Evans (Estates) Conduit at back of pot wash bent and needs replacing Chris Watts (Estates)	Simon Williams			Completed
20	There are some gaps around the pipes into the ceiling tiles in the dishwashing area. You must fill these holes and ensure the ceiling is finished so as to prevent the accumulation of dirt and the shedding of particles. ***Regulation (EC) No. 852/2004, Annex II, Chapter II, Para 1(c)***	Estates maintenance for repair. Additional Works: Ceiling tiles to be fitted properly and mastic around pipe work in small pot wash room Dave Evans	Simon Williams			Completed Completed
21	The hot water tap lid to the sink in the pot wash area is missing. Replace the lid of the tap and keep in a clean condition and maintained in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Estates maintenance for repair. New cover required for ventilation 03/09/18 Chris Watts (Estates) 2 ceiling fans to be removed and replaced with tiles 03/09/18 Chris Watts	Simon Williams			Completed Completed
22	The blue chopping board stored on the metal shelving unit near the pot wash area is dirty. I was informed these boards have been put through the dishwasher and blue chopping board is disused. You must ensure the blue chopping board is thoroughly cleaned and maintained in a clean condition.	Blue board - remove from area.	Simon Williams			Completed

	Regulation (EC) No. 852/2004, Annex II, Chapter V, Para 1(a)					
23	In the raw meat preparation room, the floor is peeling away from the wall in the area right of the oven. Secure the floor to the wall and maintain in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Estates maintenance for repair. Have spoken to the contractor and all repairs due to be finished. Sealant to be run on top of repair Dave Evans (Estates)	Simon Williams			Completed Completed
24	There is some debris under the racking of the dry goods store. Thoroughly clean under this area and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Clean under racking of dry stores including wheels on racking. . Review if disciplinary action to be taken.	Simon Williams			Completed
25	The window in ward west 2 was open and no fly screen was fitted. You must ensure a fly screen is fitted to the window in order to reduce the likelihood of flying insects from gaining access into the kitchen. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 2(c)***	Fit Fly Screen alternative suppliers to be sourced. Ensure WBC & Supervisors know importance of such and report gaps to Estates.	Norman Mitchell			Completed Completed
26	A small area of painted wall next to the dishwasher in ward west 4 is damaged. Ensure the wall is maintained in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Repair as necessary	Norman Mitchell			Completed
27	The handle areas to the double fridge in ward east 10/12 are dirty. Thoroughly clean the handles and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II,***	Cleaned as necessary. WBC Disciplinary Counselled.	Norman Mitchell			Completed Completed

	Chapter I, Para 1					
28	The electronic fly killer in ward east 14/16 has a missing lead. Replace the lead and maintain the fly killer in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Replace lead and commission. Check Condition of appliance.	Norman Mitchell			Completed Completed
29	Whilst reviewing your current HACCP, I identified the following which must be addressed: • It does not make it clear what your critical control points are; • It does not state how often probe calibration should be completed; and • The cleaning schedule does not include all items of equipment and structure to be cleaned. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	EHO to be contacted for clarification – completed. Actions as below. HACCP to review following inspection. EHO to be contacted by Senior Manager for clarification purpose on HACCP which was previously 'fit for purpose.' Amend HACCP to state frequency. Amend HACCP and cleaning schedule following clarification from EHO.	Simon Williams			Completed
30	There is confusion over the weekly cleaning schedule as it does not make it clear when items are cleaned. You must ensure the cleaning schedule is revised and amended to clearly state what items must be cleaned daily and what items must be cleaned weekly. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Amend HACCP and cleaning schedule following clarification from EHO - Completed	Simon Williams			Completed
31	The patient meal order form/WBC trolley check is confusing as it states do not serve food below 63°C on top of the form, however	Review Temps and confirm and train Temp confirmed as 63°C. Forms to be amended to reflect this.	Norman Mitchell			Completed

	in the table it states mid service temperature check minimum 65°C. You must review and amend this form to ensure consistency between temperatures. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***					
32	The dishwasher monitoring form states 80°C for rinse cycle and 55°C for wash cycle, however section 7.2 of your HACCP states 85°C for rinse cycle and 55°C for wash cycle. You must ensure the monitoring form is amended to ensure consistent temperatures with your HACCP. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Update and standardise HACCP & Monitoring Form. Train and monitor. Final rinse temperature confirmed as 82°C all paperwork to be amended to reflect this.	Norman Mitchell			Completed
33	Whilst reviewing the temperature records, I identified the following: • On the daily fridge and freezer temperatures, I identified a number of occasions when the temperatures recorded for the display fridge restaurant had been recorded as 5.4°C on 10th August 2018, 6°C on the 4th August 2018 at 6:30am and 12:30pm and the walk-in fridge was 7.4°C on 9th July 2018. No corrective action had been recorded for these temperatures. Your critical limit is 5°C, therefore you must ensure that staff are aware to take and record corrective action as necessary; • On the daily fridge and freezer temperatures, I identified the freezer in the trolley area had been recorded as -11°C on the 11th August 2018 and the corrective action recorded is “door open”. This is not corrective action; you must ensure that all staff are aware of the	Instruct ALL staff to ensure we record where corrective action has been taken for all monitoring forms. Management to monitor daily / weekly. Review if disciplinary action to be taken.	Simon Williams			Completed

	most appropriate corrective action to take and record; • On the 10th August 2018, three food products were recorded as 74°C, 72°C and 71°C on the crèche food service and delivery sheet and on the 3rd August 2018, one food product was recorded as 74°C. You must ensure that all staff are aware of the cooking temperatures of food and the corrective action which must be taken should the food not reach the correct temperature; • On the hot holding temperature form, beef bourguignon was recorded at 62°C at 1 hour and 60°C at 1.5 hours on the 9th August 2018, and omelette assorted was recorded at 62°C and 60°C at 1.5 hours on the 9th August 2018 with no corrective action recorded at the 1 hour stage. Your hot holding limit is 63°C, therefore you must ensure all staff are aware of this and are taking and recording corrective action; • On the 20th July 2018, the dishwasher was recorded as having a rinse temperature of 78°C, however the minimum temperature your HACCP states for rinsing is 85°C. No corrective action or comments had been recorded. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***					
34	In the ward based catering HACCP, it does not state the corrective action of what to do if food is below 63°C during plating and storage of hot meals on ward service hot trolley. You must ensure this section of the HACCP is reviewed and updated.	HACCP document to be updated to confirm “Do not Serve!”	Norman Mitchell			Completed

	Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1					
35	In the ward based catering HACCP, it states that 2 tubs of probe wipes must be available at all times. However as identified on 6 of the wards viewed during the inspection, no probe wipes were available. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Action same as Compliance **Item 5**	Norman Mitchell			Completed
36	The forms which are attached to the walk-in chiller and freezer doors refer to a critical limit of 8°C. You must ensure these forms are amended to reflect your current critical limit of 5°C. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Replace forms displayed on two doors to reflect critical limit of 5°C.	Simon Williams			Completed
37	Whilst reviewing the fridge temperature record sheet on East Ward 10/12, it was identified that a temperature of 6°C had been recorded and no corrective action had been noted. You must ensure that if the fridge is reading above 5°C, then suitable corrective action is taken and recorded. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Training update – Further knowledge required on set point, form filling and procedures. WBC to sign for training.	Norman Mitchell			Completed
38	Due to not having D10 sanitiser available on ward west 4, the spray bottles of D10 sanitiser being under diluted on ward west 2 and ward east 10/12, and the D10 sanitiser pouch being passed the expiry date on ward west 4, you must ensure that staff are trained in effective disinfection methods. Staff must know when disinfection is essential and how to do it properly. It is therefore critical that all staff are trained and verified as competent in	WBC Disciplinary Counselled. Training checked and includes dilution procedures – WBC Trained.	Norman Mitchell			Completed

	disinfection techniques before being asked to dilute and apply disinfectants. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1 & Annex II, Chapter V, Para 1(a)***					

MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9AM on TUESDAY 29TH MAY 2018 – BOARDROOM, LLANDOUGH HOSPITAL

Present:

Peter Welsh- Chair	Director of Corporate Governance
Charles Dalton	Head of Health and Safety
Frank Barrett	Senior Fire Adviser
Nicola Bevan	Occupational Health
Rachael Daniel	Health and Safety Adviser
Stuart Egan	Staff Representative

Clinical/Service Board Representatives

Claire Wade	Surgery
Ian Wile	Mental Health
Rowena Griffiths	Dental Services
Heather Gater	Women and Children

Apologies:

Caroline Murch	Environmental Health and Safety Adviser
Claire Mahoney	Associate Infection Prevention Control Nurse
Gareth Jenkins	Specialist Services
Jon McGarrigle	Estates Services
Karen Lewis	Claims Manager
Matthew Price	Specialist Services
Rhys Davies	Primary, Community and Intermediate Care
Rachael Sykes	Health and Safety Adviser
Sue Morgan	Primary, Community and Intermediate Care
Sue Bailey	CD&T
Sarah Dix	Medicine Clinical Board
Tina Bayliss	Surgery Services

OHSG: 16/18 Minutes of the Meeting held February 2018

The minutes of the meeting held on the 28th February 2018 were accepted as a true record.

OHSG: 17/18 Action Log

- **06/18.1 Fire Safety – update on meeting with Fire Service**
  The Senior Fire Safety Adviser reported that the meeting scheduled for 5th March 2018 with the Fire Service had been cancelled; the Health Board had requested an alternative date, however had not received any further correspondence to date.

- **06/18.2 Fire Safety – Feedback from the Mandatory Training Group**
  The Head of Health and Safety informed the Group that the Mandatory Training Steering Group met on Thursday the 24th May and reported that frequency and level of training was discussed. It was noted that the Group was progressing a more targeted training programme/modules to reflect training needs by location and job role.

OHSG: 18/18 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 reported that many of the items discussed at the last Health and Safety Committee in April was also on the agenda for this meeting.

It was noted that the representative from Mental Health – Mr I Wile attended the last Committee to report on the implementation of the smoking ban within mental health. Ms R Daniel highlighted that this received positive feedback from members of the Committee.

OHSG: 19/18 Pro-Act Audit Priority Action Plan

The Head of Health and Safety informed the Group that following the Pro-Act audit findings a Priority Action Plan had been established.

It was reported that as a result of the audit, 39 hoists had been identified as obsolete and therefore would not pass the next service due to parts not being available; this would be a failing under LOLER regulations.

It was noted that as a result of the above, the identified 39 obsolete hoists had been replaced and old stock discarded during the period.

Concerns were raised in relation to the maintenance of hoists. The Head of Health and Safety reported that discussions are underway to confirm who will have responsibility of maintaining hoists for the Health Board. It was reported that this may come under Clinical Engineering, however in the interim period Arjo are continuing to carry out repairs.

The Head of Health and Safety highlighted that the current process for reporting of faults is lengthy; therefore as part of these discussions a more efficient process will be sought.

The Group were also informed that Arjo had agreed to carry out another audit in October/November 2018 to reflect winter demands as there had been a 23% increase in the number of patients requiring additional aids from the first audit carried out in 2015 and the audit completed in 2017.

OHSG: 20/18 Enforcement Agencies Correspondence Report

The report was received and noted by the Group.

The Head of Health and Safety gave an overview of the report, highlighting that the number of Health and Safety Executive (HSE) visits to Health Board Sites over the past few years had increased. He reported that the Health Board to date had been charged £4k for intervention by the HSE and that this had resulted in an increased workload within the Health and Safety Department.

The Group were informed that there had been an additional three concerns during the period, raised by the HSE; one related to a lift being out of service, the second related to contractor work being carried out near X-Ray and the third was in connection with concerns raised from an inspection of the Public Health Laboratories.

The Head of Health and Safety reported that each of these concerns was investigated by the Health Board and a response was submitted to the HSE.

It was noted that the HSE were happy with the Health Boards response and no further action was required, however in relation to the Public Health Laboratories, Public Health Wales (PHW) was issued with an Improvement notice, which requires greater communication between them and the Health Board and as a result meetings between the both organisations would be established.

It was reported that full details could be found in the attached report.

OHSG: 21/18 Fire Safety Management and Enforcement Report

The Group were informed that there were no Enforcement Notices issued during the period.

The Senior Fire Adviser reported that a total of 466 unwanted fire signals occurred in the last twelve months with the major cause being equipment failure, smoking, cooking, contractors and accidental activation.

He highlighted that although this is a significant number it is a 10% reduction on the previous year.

It was also noted that during the past twelve months 15 fires occurred across Health Board sites; three of which were started deliberately in the mental health unit one discarded smoking materials and the rest were the result of electrical faults.

The Senior Fire Adviser reported on the continued improvement of the fire Training Compliance, noting that there had been a month on month increases in percentage compliance, with the current figure at 66%. He also highlighted that Dental had gained 85% compliance, reaching the Health Boards Target.

OHSG: 22/18 Health and Safety Priority Action Plan

The Head of Health and Safety informed the Group the Improvement Plan was being reviewed in line with the development of the CRAF and findings. It was noted that meetings are taking place to progress.

OHSG: 23/18 Pedestrian Safety & Tunnel Safety

The Head of Health and Safety informed the Group that the Director of Capital Estates and Facilities had appointed a consultancy firm to carry out a survey on traffic management, which included pedestrian safety.

It was noted that as part of this service the Health Board had requested that the survey be extended to also include the Tunnels, due to several recent incidents with high potential to cause serious injury, primarily involving vehicles and pedestrians.

The Head of Health and Safety added that a task and finish group had been formed, which includes Estates, Health and Safety, Security and related users of tunnels, such as Dental, Surgery and Waste, to look at minimising access.

As a result of the above, it was highlighted that additional TDSI doors would be installed and a review essential users.

OHSG: 24/18 Health Care Standard

A report was received and noted by the Group, it was highlighted that this document had been submitted to NHS Wales and had been circulated and brought to this meeting for information purpose**.**

OHSG: 25/18 Staff Group Inspections

Concerns were raised in relation to Medical records. Staff Side representative reported that although there had been an improvement during the period, this still remains a concern.

It was noted that Treforest was not big enough to store the volume of records the Health Board has and as such the Staff side Representative felt that this issue needed to be escalated to the Health and Safety Committee. **Action CD**

The Senior Fire Adviser highlighted that this was also a fire risk.

OHSG: 26/18 Control of Contractors Update

The Head of Health and Safety reported that the Health Board is looking to enhance resource for Contract Control for non Estate areas. The appointed person will be working closely with Estates to ensure same standards are being applied.

OHSG: 27/18 Lone Worker

The Head of Health and Safety reported a slight dip in usage in April, with compliance showing 69%; however positive feedback continued to be received and these devices had been extended to victims of domestic violence.

OHSG: 28/18 Clinical/ Service Board Feedback

Mental Health
Representative – Mental Health reported on poor conditions within community settings. It was noted that a number of these buildings are being vacated over the next two years; however concerns were raised in working conditions for staff in the interim period.

Concerns were raised in the level of stress related sickness within Mental Health, it was reported that this continues to be monitored and efforts are being made to look at ways to improve this.

Fire
The Senior Fire Advisor informed the Group that the annual fire audit submission to the Welsh Government was due, it was noted that he had written to all areas and was waiting response.

The Head of Health and Safety agreed to raise this at the next Deputy Fire Safety Managers meeting for close out. **Action CD**

Surgery
Representative Surgery reported on ongoing refurbishment work within surgery and the plan to close Heulwen Ward within a year.

General
The Chair reported on the Memorandum of Understanding (MOU), informing the Group that it's a joint working between the Police, Welsh Government and The Health Board, whereby they help staff who have been a victim of Violence and aggressions.

It was noted that the MOU had recently been reviewed to ensure better working relations and communication between the organisations.

The Chair also highlighted that a new consultation document was circulating in relation to no smoking on Health Board/school premises, outlining the intention to issue a £70 fine for those breaching the policy.

The Group were informed that under the Health Boards current policy, a £70 fine is issued for littering onsite but not smoking, however staff caught smoking will face disciplinary action.

The Health and Safety Adviser raised concern in relation to debris on the hospital roof (UHW). It was reported that she had visited the area of main B block with Estates and found a number of items such as needles, cups etc.

It was highlighted that although some items may have fallen from window sills by accident, it was evident that deliberate littering had taken place.

The Group was asked to take this back to their local areas for information.

OHSG: 29/18 Policies and Procedures

The Fire Safety and Asbestos Policy and Procedure were out for review, the Group were asked that any comments be sent to the authors by the 22nd June.

OHSG: 30/18 DATE AND TIME OF NEXT MEETING
28th August at 2PM – Corporate Meeting Room HQ, UHW

MINUTES OF THE FIRE SAFETY GROUP HELD AT 9AM ON 22 MAY 2018 – MEETING ROOM1, 2nd FLOOR LAKESIDE OFFICES

Present:	Geoff Walsh	Dir of Capital, Estates and Facilities **(Chair)**
	Abigail Harris	Executive Director of Planning
	Charles Dalton	Head of H&S/Fire Safety Manager
	Stuart Egan	Staff Side Representative
	Frank Barrett	Senior Fire Safety Adviser
DFSM	Ian Fitsall	Estates & Facilities
	Kate Leney	Women and Children
	Nick Gidman	Specialist Services
	Sarah Congreve	PCIC Vale
	Scott Gable	DFSM – CD&T

Apologies:

Cheryl Evans	DFSM C&W– O&G Directorate
Dick Jones	South Wales Fire Service
Lynne Topham	DFSM - PCIC
Ian Wile	Mental Health
Peter Welsh	DFSM Executives - Director of Governance
Rowena Griffiths	DFSM Dental /Nurse Manager

In Attendance:

Zoe Brooks	Health and Safety

18/13 Minutes of the Meeting

The minutes of the meeting held on the 15th January 2018, were accepted as a true record, with one amendment to the attendance list. Kate Leney confirmed that she attended the meeting in January; however the minutes did not reflect this. **Action:** Zoe Brooks to amend.

18/14 Action Log

18/03 DSEAR
The Fire Safety Manager confirmed that a check list had been created and agreed to circulate to the group.

18/07 Medical Records
Both the Staff side representative and Senior Fire Advisor confirmed that the risk assessment for Medical Records had been received.

The Chair highlighted that this is an ongoing issue that will continue to be reviewed.

18/08 Evacuation Drills
The Chair reminded the Group of the planned evacuation that was to take place in October last year, however due to lack of support from Clinical Boards the evacuation was unable to go ahead. He confirmed that this item had been raised with the Executive Director of Planning for further escalation.

It was noted that this is a requirement set by the Fire Service and continues to be raised as an issue.

The Executive Director of Planning suggested that the Chair link in with the Chief Operating Officer's meeting to highlight this issue and attain commitment from Clinical Boards. **Action**: GW

The Chair requested that the Senior Fire Adviser liaise with Tony Ward - Projects Officer Mechanical to locate an empty ward in-order to start planning an evacuation drill.

18/11 Staff side to receive copy of the Andre Goodall letter
The Group received and noted a copy of this letter. **Item Closed**

18/15 Enforcement Notice Status/ IN01-02

The Senior Fire Adviser reported that there were no enforcement notices in place, however nine IN01's had been issued during the period. He highlighted that many of the items related to Fire Dampers and compartmentation, in which both are under project and are being progressed on a priority basis.

Concerns were also raised in relation to storage in corridors – B Block. The Group received photographs of the area, showing an issue with bins overflowing; causing a fire risk.

The Chair requested that the DFSM - Estates & Facilities look into the issue with waste and report back at the next meeting. **Action:** IF

18/16 Fire Risk Assessment Status

The Fire Safety Manager reported that the DFSM's met in February to discuss fire risk assessment in relation to managerial actions. It was noted that Mental Health had many outstanding actions; however they also have the most actions generated.

The Executive Director of Planning queried whether there had been an improvement with the management of these actions, in which the Fire Safety Manager confirmed that there had been a significant improvement, with many items being closed out.

The Fire Safety manager highlighted that the full notes of the DFSM meeting and summary had been circulated to the Group for information.

The Chair queried whether the Estates actions were also being addressed, the Senior Fire Adviser reported that actions are being completed, however not as promptly as they should. The Chair asked that the DFSM - Estates & Facilities look into this. **Action:** IF

18/17 False Alarms, Automatic Detectors and Responses

The Senior Fire Adviser reported that 472 false alarms had been raised by the Health Board over the past twelve months and although the Fire Service considers this to be very high, there has been a 10% reduction within the past year.

The Chair highlighted that as a result of the concerns above, he had invited the Fire Service to hold an information stand in concourse and also to meet on several occasions, however he had not received any correspondence to confirm.

18/18 Evacuation Drills

The Group were informed that during the period two evacuation drills were conducted within community settings; the Pendine Centre and Global Link. The Senior Fire Adviser reported that he had not yet seen the report and would report back on its findings at the next meeting. **Action:** FB

18/19 NWSSP-FS Audit 18/19

It was reported that 2017 report had been submitted in February 2018; however 2018 submission was now due at the end of May.

The Senior Fire Adviser highlighted that he had written to the responsible DFSM's for a response, however had not received any responses to date. He reported that the NWSSP -Fire Service had stated that they would not wait so long next time for a response and would report zero data to the Welsh Government.

The Fire Safety Manager agreed to raise this in the next DFSM meeting in June. **Action**: CD

18/20 Any Other Business

18/21.1 Fire Safety Policy and Procedure
The Group were informed that the Fire Safety Policy had been reviewed and updated to reflect format and structural changes and to include the DFSM meeting and the implementation of the No smoking within Mental Health.

It was reported that this Policy and Procedure will be taken to the H&S Committee in July for approval. The Group were asked to report any comments to Frank Barrett by the 22nd June 2018.

18/21.2 Fire Training Compliance
The Fire Safety Adviser highlighted the continued progress of Fire Safety training compliance and reported that the current overall compliance rate is around 67%, with Dental hitting the Health Boards target of 85%.

18/21.3 Andrew Goodall – Grenfell Letter
It was noted that an inspection of all buildings owned by the Health Board will take place shortly in line with the letter sent by Andrew Goodall in relation to the cladding.

18/21 Date of Next Meeting
13th September 2018- 2PM – Manual handling Unit, Denbigh House UHW

Water Safety Group

Date of meeting: Wednesday 09th May 2018

Time of meeting & Venue: 10:00 am, Geoff Newman Room, UHW

Present:

Name	Title
Eleri Davies (ED), Chair	DIPC
Mike Quest (MQ)	Authorising Engineer (Water)
Keith Sims (KS)	Maintenance Engineer, Cardiff University
Debbie Charles (DC)	PHW Scientific Head FW&E Lab
Charles Dalton (CD)	Head of Health & Safety
Jon McGarrigle (JMcG)	Head of Energy Performance
Norman Mitchell (NM)	Responsible Person for Water, Estates Manager
Greg Williams (GW)	Deputy Lab Manager, Microbiology
Gareth Simpson (GS)	Estates Manager
Amanda Watkins (AW)	PCIC Locality Vale Op Manager
Orla Morgan (OM)	Lead Nurse for Critical Care
Yvonne Hyde (YH)	Senior Nurse, IPC
Victoria Daniel (VD)	IPC scientist
Alun Morgan (AM)	Assistant Director of Therapies, CD&T
Jim Blackie (JM)	Dialysis Technical Services & Clinical Engineering
Tony Ward (TW)	Discretionary Capital & Compliance
Heather Gater (HG)	Therapy Manager, Acute Child Health
Marc Janici Jevic (MJJ)	Maintenance Officer, (DRP), Cardiff Uni
Jenna Maltby (JMa)	Technical Service Supervisor, Engie

In attendance: Reanne Reffell (minutes)

Apologies: Melanie Wilson, Julie Woolls, Anthony Powell, Paul Davies, Dean Matthews, Maxine Gronow, Paul Bracegirdle, Ceri Chinn, Paul Morgan, Rishi Dhillon, Gavin Forbes, Mark Bennian, Sue Bailey, Ian Fitsall

		Actions
1.	**Welcome/introductions** Introductions were made around the table and ED welcomed all to the meeting.	
2.	**Apologies** were noted as above.	
3.	**WSG Personnel / Appointment changes** The group were advised that Gareth Simpson will take up the position of 'Approved Person' in replacement of Ian Fitsall. **Chairmanship of Water Safety Group** ED advised that her role has changed, and asked for expressions of interest as Chair of the Water Safety Group in order to start succession planning.	
4.	**Minutes of previous meeting (14.02.18)** The minutes of the previous meeting were agreed as an accurate record	

	following on from the below adjustment: • Page 2. It was noted that JMcG is the formal document controller of the Water Safety Plan.	
5.	**Matters arising/Actions from previous meeting (14.02.18)** The action summary from the previous meeting was updated. *Refer to page 5 for ongoing actions.* The WSP was updated to reflect the NICU transfer to C2. **Action: Complete** **Water Control Measures- Out of Specification Results & Action Taken** Jim Blackie advised of a water wastage issue with the water dialysis plant on T5 which needs to be addressed. This has been taken forward. **Action: Complete** **Flushing Audits** TW to consider amending the new flushing form in terms of dates. Update: Flushing record to stay as is, with a note at the bottom that the dates can be changed on an individual ward basis. **Action: Complete** **Ward managers training** JMcG has updated the Legionella presentation slightly and will request its inclusion in Mandatory May training. **Action: Complete**	
6.	**<u>Water Safety Plan (WSP)</u>** JMcG advised that minor changes have been made to appendix C of the WSP. It was noted that the Water Safety Group would be able to approve future amendments to the plan. RR to circulate a link to the WSP once it is uploaded to the internet. http://www.cardiffandvaleuhb.wales.nhs.uk/health-and-safety-policies/	
7.	**<u>Current / Closed Incidents for consideration</u>** **<u>Legionella counts PHW microbiology laboratories, update of actions</u>** GS advised that a number of dead legs will be removed as part of an ongoing project. Further actions outlined in the action plan on page 5. **St Marys** JB advised of hot water failed due to heating (TVR's) at St Mary's. Estates will action remedial works once Fieldway's external report is received.	
8.	**<u>Risk Assessments</u>** **Risk Assessment Action Plan (Legionella)**	

	The risk assessment action plan is 85% complete. Remedial works should be complete by July, although immediate risks are being dealt with as a priority. **Changes to Augmented Care Areas- IPC** N/A	
9.	**Water Sampling Results:**	
9.1	**Legionella Team** Legionella sampling results were discussed. Legionella sampling is undertaken as part of a continued rolling programme of augmented care areas, and in response to particular outbreaks. Further work will be undertaken outside of the meeting to remove POU filters, including education and training. DC commented that an overarching plan for UHW and UHL would be helpful to manage laboratory workload. Work is being undertaken to validate and get accreditation for less than 20 coliform units on the new methods; proposed completion by the Autumn. **Pseudomonas aeruginosa** No concerns were noted.	
9.2	**Other water sampling** • **Rinse Water** It was noted that there was no Medicine clinical board representative. Intermittent results are received and acted upon but there are no issues to note. • **Heater Cooler Unit (H/C unit)** ED advised that results have improved and therefore the health board is assured that the risks are being managed. The H/C units remain outside of theatres. OM will check theatre 10 usage. • **Hydrotherapy pool** AM completed a round of safety walkarounds with GS on the 20th April. High level assurance has been received that all work is being carried out. All recommendations from the HSE have been closed off. Ongoing testing has been fine. The Hydro user group are developing a combined single use policy and are sharing good practice.	**OM**
10	**Flushing Audits** TW advised that the flushing record has been delayed but should be disseminated by July. CD advised that he continues to report attendance at the WSG in the H&S report and actions that are being undertaken by estates in terms of flushing. ED will highlight attendance at the IPCG meeting.	
11.	**Water Control Measures- Out of Specification Results & Action Taken** GS advised that significant work has been undertaken in the CHfW,	

	which should be completed within the next 6 -8 weeks. A period of sampling will then be required, with the impact monitored. NM advised that the Chlorine Dioxide unit at UHL is being installed.	
11.	**Department Updates:** 1.1. IPC- no additional issues to raise. 1.2. Estates- ED noted good attendance. 1.3. H&S- no additional issues to raise. 1.4. There was no attendance from Medicine, Dental or Surgery CB. 1.5. Specialities- No additional issues to raise. 1.6. Clinical Diagnostics & Therapeutics- will inform the board about the water issue at St. Marys. 1.7. Primary Care & Intermediate Care- no issues to raise. 1.8. Women & Children- requested guidance on installation of an ice machine on Owl ward. Estates requested a more detailed request for consideration. CD&T would like to take advice from the Labs on whether it is required for tests. YH will liaise with Ceri Chinn on Main Theatres ice machine. 1.9. Cardiff uni- no additional issues to raise. 1.10. PHW- no additional issues to raise. 1.11. St. David's- JMa, Engie advised on the recommended removal of 8 old arjo baths no longer in use. CD is due to meet with Arjo and will discuss with them.	
13.	**Property Occupation Changes** Planed refurbishment of ward was noted. Pelican ward is fully complete, there are no water issues.	
14	**Changes to Augmented Care Areas- IP&C** N/A	
15.	**Training / Competence Matters** N/A	
16.	**Water Safety Audit Status / Progress with Action- put just after legionella risk assessments on next agenda.** N/A	
17.	**Action Plan / next steps** See the action plan on page 5.	
18.	**Any other business** A query was raised in regards to the decontamination of TOE's. OM agreed to find out the process and update ED. KS requested approval for a water fountain, which would be implemented and maintained by Estates. This was approved and would be taken forward outside of the meeting.	
19.	**Date & Time of Next Meeting:** Wed 12th Sept 2018, 10:00am, PHW library, C1 Link Corridor	

Action Summary (Water Safety Group): 09.05.18

All actions due by next meeting unless otherwise stated.

	Action	Who	Status

14/02/18			
	Microbiology Laboratory Update: GS will follow up daily flushing requirements in the lab. GW will forward a list of MR's for little used outlets to be removed to Gareth Simpson.	GS GW	
	Hydrotherapy pool Discussion also took place regarding the medium flow and maintenance of normal filters. AM asked for Estates assurance in writing. NM agreed to re-send previous assurance and confirmation provided.	NM	GS will take forward for confirmation at the next meeting.
	NM highlighted that the Estates department do not support water dispensers and advised on an incident whereby staff drank cleaning fluid from a piped water bottle. ED to contact the clinical boards and corporate areas in order to request an audit of their areas. Keith Sims agreed to forward to ED the detail of actions undertaken within his areas. Discussion took place regarding the water sampling undertaken within the dental hospital. Although sampling is not a legal requirement, ED would advise that if sampling is undertaken, it should be done an accredited level. PB to discuss with Melanie Wilson.	**ED / KS** **Paul Braceg irdle**	Outstanding ED will check for updates from Melanie Wilson.
09/05/18			
	Guidance / approval of ice machine on Owl ward C&WH to forward details of the request to Estates. YH will liaise with Ceri Chinn in regards to the Main Theatres ice machine.	HG YH	
	OM to review Heater Cooler units in Theatre 10.	OM	
	A query was raised in regards to the decontamination of TOE's. OM agreed to find out the process and update ED.	OM	

Date	TIME	Venue
Wed 12th Sept 2018	10:00 am – 12:00 pm	PHW library, 1st Floor C block
Wed 5th Dec 2018	10:00 am – 12:00 pm	PHW library, 1st Floor C block