Bundle Health and Safety Committee 22 January 2019

Agenda attachments

Agenda.docx

0	Presentation: Employee Wellbeing Service - Nicola Bevan, Senior Occupational Health Nurse Presentation - Employee Wellbeing Service.docx
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 9 October 2018 Agenda Item 1.4 - Minutes of Meeting 9 October 2018.docx
1.5	Action Log Review Agenda Item 1.5 - Action Log.docx
1.6	Ratification of Committee's Terms of Reference Agenda Item 1.6 - Terms of Reference.doc
2	Deliver Outcomes that Matter to People
2.1	Obligatory Response to Violence in Healthcare Agenda Item 2.1 - Obligatory responses to Violence and Aggression in Healthcare.docx
3	Our Service Priorities
4	Sustainability
4.1	Board Assurance Framework (BAF) - Health and Safety Risks
4.2	Pedestrian Access Safety Strategy Agenda Item 4.2 - Pedestrian Access Strategy.docx
4.3	Fire Enforcement and Management Compliance Report Agenda Item 4.3 - Fire Enforcement Report.docx
4.4	Amendments to Smoking Policy Arrangements at Hafan y Coed Mental Health Hospital to meet the Fire Enforcement Notice Issued Agenda Item 4.4 HYC Enforement Notice.docx
4.5	Enforcement Agencies Report Agenda Item 4.5 - Enforcement Agencies Report.docx
4.6	Changes in Sentencing Update Agenda Item 4.6 - Changes in Sentencing.docx
4.7	Health and Safety Priority Improvemnet Plan - exception report Agenda Item 4.7 - Health and Safety Priority Improvement Plan.docx
4.8	Updated Health and Saftey Related Policies Schedule Agenda Item 4.8 - Policy Schedule.docx
5.1	Latex Allergy Policy - for approval Agenda Item 5.1 - Latex Policy Report.docx Agenda Item 5.1 (i) - Latex Allergy Policy.docx Agenda Item 5.1 (ii) - Latex Allergy Procedure.doc
5.2	Environmental Policy - for approval Agenda Item 5.2 - Environmental Policy Report.docx Agenda Item 5.2 (i) - Environmental Policy.docx Agenda Item 5.2 (ii) - Environmental Procedure.docx
5.3	Closed Circuit Television (CCTV) Policy - for approval Agenda Item 5.3 - CCTV Policy Report.docx Agenda Item 5.3 (i) - CCTV Policy.docx

Agenda item 5.3 (ii) - CCTV Procedure.doc

6 Part 2: Items to be Recorded as Received and Noted for Information bythe Committee

6.1 Work Programme 2019/20

Agenda Item 6.1 - Work Programme 2019-20.docx

6.2 Health and Safety Priority Improvement Plan - in detail

Agenda Item 6.2 - Health and Safety Priority Improvement Plan.docx

6.3 Waste Management Compliance Report

Agenda Item 6.3 - Waste Management Compliance Report.doc

6.4 Environmental Health Inspection Report of Ward Based Catering, UHW ON 23rd August and Ward based Catering, Rookwood Hospital on 17th July 2018

Agenda Item 6.4 - EHO Repot UHW and Rookwood Hospitals.docx

6.5 Environmental Health Inspection of Ward Based Catering, Llanfair Unit UHL on 16th October 2018

Agenda Item 6.5 - EHO Report Llanfair Unit.docx

6.6 Minutes from other Committees/sub Committees/Groups. Operational Health and Safety Group - August 2018

Agenda Item 6.6 - Minutes of Operational Health and Safety Group August 2018.docx

6.6.1 Fire Safety Group - September 2018

Agenda Item 6.6.1 - Minutes of Fire Safety Group September 2018.docx

6.6.2 Water Safety Group - September 2018

Agenda Item 6.6.2 - Minutes of Water Safety Group September 2018.docx

6.7 Review of the Meeting and Items to be raised at the Board and Other Committees

6.8 To note the date and time of the next meeting. 9.30am on Tuesday 9th April 2019 in the Corporate Meeting Rm , Headquarters

Health and Safety Committee
9.30am on 22nd January 2019
Corporate Meeting Room, Headquarters, University Hospital of Wales
AGENDA

PRESENTATION **Employee Wellbeing Service – Nicola Bevan, Senior Occupational Health Nurse**		
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 9 October 2018	*Chair*
1.5	Action Log Review	*Chair*
1.6	Ratification of Committee's Terms of Reference	*Chair*
2. Deliver Outcomes that Matter to People		
2.1	Obligatory Response to Violence in Healthcare	*Senior Manager Lead for Health and Safety*
3. Our Service Priorities		
4. Sustainability		
4.1	Board Assurance Framework (BAF) – Health and Safety Risks	*Director of Corporate Governance*
4.2	Pedestrian Access Safety Strategy	*Director of Capital, Estates and Facilities*
4.3	Fire Enforcement and Management Compliance Report	*Director of Capital, Estates and Facilities*
4.4	Amendments to Smoking Policy Arrangements at Hafan y Coed Mental Health Hospital to meet the Fire Enforcement Notice Issued	*Head of Health and Safety*
4.5	Enforcement Agencies Report	*Head of Health and Safety*
4.6	Changes in Sentencing Update	*Head of Health and Safety*
4.7	Health and Safety Priority Improvement Plan – exception report	*Head of Health and Safety*
4.8	Updated Health and Safety Related Policies Schedule	*Senior Manager Lead for Health and Safety*

5. Culture and Values		
5.1	Latex Allergy Policy – **for approval**	*Health and Safety Adviser*
5.2	Environmental Policy – **for approval**	*Director of Capital, Estates and Facilities*
5.3	Closed Circuit Television (CCTV) Policy – **for approval**	*Director of Capital, Estates and Facilities*
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 2019/20	*Senior Manager Lead for Health and Safety*
6.2	Health and Safety Priority Improvement Plan – ***in detail***	*Head of Health and Safety*
6.3	Waste Management Compliance Report	*Director of Estates, Capital and Facilities*
6.4	Environmental Health Inspection Report of Ward Based Catering, University Hospital of Wales on 23rd August and Ward Based Catering, Rookwood Hospital on 17th July 2018	*Director of Capital, Estates and Facilities*
6.5	Environmental Health Inspection Report of Ward Based Catering, Llanfair Unit, University Hospital Llandough on 16th October 2018	*Director of Capital, Estates and Facilities*
6.6	**Minutes from other Committees/sub-Committees/Groups** Operational Health and Safety Group – August 2018	*C Dalton*
6.6.1	Fire Safety Group – September 2018	G Walsh
6.6.2	Water Safety Group – September 2018	
6.7	Review of the Meeting and Items to be Raised at the Board and Other Committees	Oral *Chair*
6.8	To note the date, time and venue of the next meeting:- • 9.30am on Tuesday 9th April 2019 in the Corporate Meeting Room, Headquarters, University Hospital of Wales.	

Cardiff and Vale UHB Employee Wellbeing Service Update
Name of Meeting : Health and safety Committee **Date of Meeting** 22nd January 2019

Executive Lead : Executive Director of WOD
Author : Head of Employee Health and Wellbeing Services 02920743264
Caring for People, Keeping People Well: This report directly links to the Health Board's mission statement to care for people and keep people well. It underpins the Health Board's "Our Population", "Our Service Priorities", "Our Culture" and "Our Values" elements of the Health Board's Strategy
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact : It is widely recognized that there is a correlation between staff wellbeing and quality, safety and patient experience. Improving staff wellbeing will therefore have a direct positive impact on quality of care and the patient experience
Health and Care Standard Number: 7.1 Workforce
CRAF Reference Number
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Ongoing monitoring of the Employee Wellbeing Service's waiting times in comparison to Welsh Government targets
- Bi- monthly reporting to the Health and Wellbeing Advisory Group

The Strategy and Delivery Committee is asked to:

- **Note** the update and progress of the Employee Wellbeing Service

SITUATION

In 2017/18, 25% of the total sickness absence within the UHB was attributed to Anxiety/Depression/Stress/Other Mental Health, which equates to a financial cost of approximately £4.82 million.

Over the past two years the number of referrals to the Employee Wellbeing Service (EWS) has increased from 438 in 2016 to 587 in 2017. So far 618 referrals have been received in 2018.

There is a perception that waiting times in EWS are delaying access to psychological interventions.

Benchmarking EWS data against the Primary Mental Health Support Service target for access to assessment and the welsh government target for access to counselling has shown that the EWS is achieving these targets.

BACKGROUND

It is widely reported that one in four will experience a mental health problem each year. If applied to the UHB, this means that over 3,500 of our employees will experience mental health in 2018.

The EWS was established over 10 years ago to provide a self-referral counselling service for employees presenting with mild to moderate mental health conditions. EWS is not a crisis service and is not appropriate for individuals requiring long term and/or multi-disciplinary team interventions.

The EWS team consists of:
0.6 wte Band 7 lead counsellor
1.8 wte Band 6 Counsellors
0.5 wte clinic coordinator

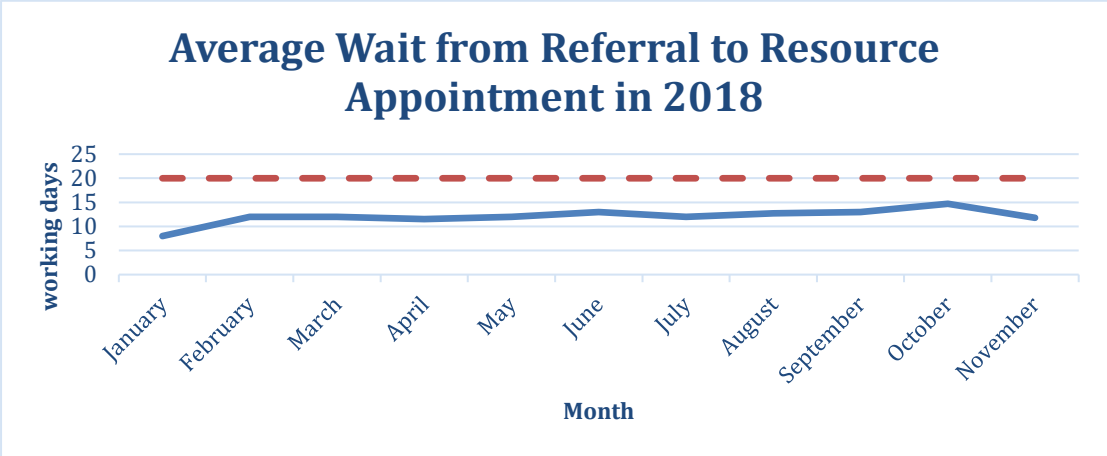
NHS Executive guidance recommends a ratio of one wte counsellor per 2,000 staff. Using this guidance to calculate the counselling resources for CAV UHB indicates the need for at least 7 wte counsellors.

The UHB is the only LHB in Wales with a designated PTSD service for employees who have experience traumatic events at work. This service provides rapid assessment and access to evidence-based treatments such as EMDR and trauma-focussed CBT, delivered by a specialist Psychologist. The service is accessed through Occupational Health or the Employee Wellbeing Service.

ASSESSMENT AND ASSURANCE

In 2016 a new referral pathway was introduced in EWS, whereby all referrals are seen for an hour-long resource appointment, the purpose of which is to establish the most appropriate intervention required e.g. self-help, counselling or onward signposting to GP and other specialist services, rather than going straight on to a counselling waiting list.
The average waiting time from self-referral to resource appointment is 12.18 working days. The Primary Mental Health Support Service (PMHSS) target for referral to assessment is 28 calendar days. It should be noted that EWS calculates working days not calendar days however if the PMHSS target was converted into working days (20 working days) the EWS waiting time is below this target.

Figure 1. EWS Resource Appointment Waiting Time Compared to PMHSS Target



PMHSS target
EWS Waiting time

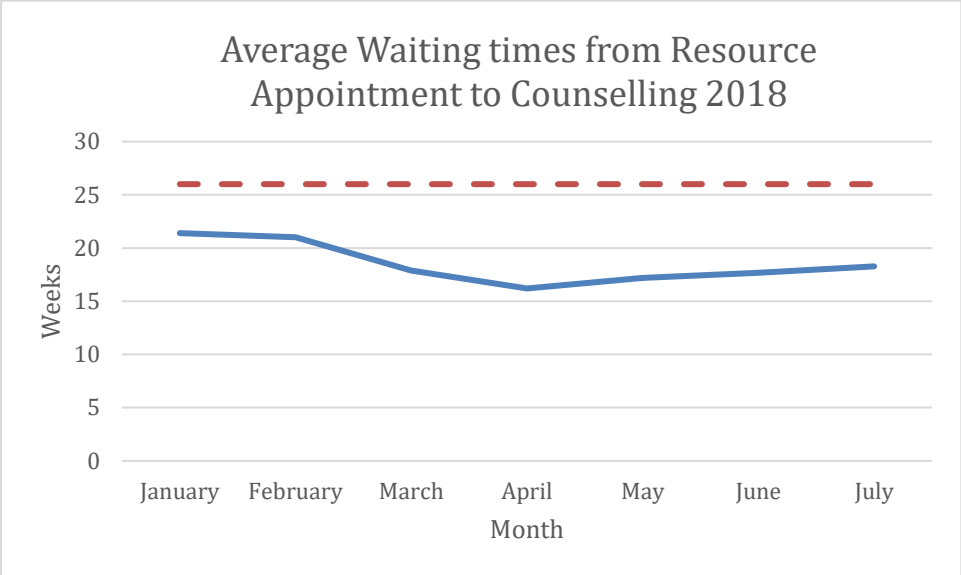
Evaluation of this model of delivery has shown that approximately 30-40% of self-referrals are discharged at the resource appointment stage.

For those whom counselling is identified as an appropriate intervention, they are advised on the options available to them on how to access this. This includes:

- EWS
- GP
- Trade Union – if available
- Health for Health Professionals Wales – Welsh Government funded service for Doctors
- Third Sector
- Private sector

The waiting time for EWS counselling is currently 19 weeks. Whilst it is acknowledged that this is not ideal, it is significantly below the welsh government target of 26 weeks.

Figure 2. EWS Waiting Time from Resource Appointment to Counselling in comparison to Welsh Government Target



- - - - - Welsh Government target
——— EWS Waiting time

Clients who choose to be placed on the EWS counselling waiting list, do not sit passively on the list without support. During the resource appointment they will be provided with resources appropriate for their needs.
This may include

- self-help materials
- EWS wellbeing workshops
- online CBT
- signposting to PMHSS education courses
- bibliotherapy
- mindfulness resources

Details of which are available via the EWS internet site which clients can access from home at:
http://www.cardiffandvaleuhb.wales.nhs.uk/ews-services-and-support-available

Future Service Developments

Although from the evidence provided, the EWS is achieving both the PMHSS and welsh government targets, it is acknowledged that more can be done to improve service delivery.

A new wellbeing practitioner role is currently being explored, which in accordance with matrics cymru guidance would enable low intensity interventions such as guided self-help to be offered. This post would enable the use of Silver cloud, an online CBT platform which uses evidence-based programs to address conditions like stress, depression, anxiety, diabetes, COPD and chronic pain.

Additional funding for a 1.0 wte Band 4 would be required for this to be implemented.

Opportunities for collaborative working with the Mental Health Clinical Board are also being explored however this is in the very early stages of discussion and no definite actions have been agreed.

Assurance

From the data collected, EWS is performing within both PMHSS and welsh government targets for access to assessment and access to counselling.

This performance is reported monthly to the Workforce and OD Director and is monitored as part of the Workforce and OD performance data.

Service development is ongoing to ensure that the services available are evidence based and align with welsh government recommendations.

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am on 9 OCTOBER 2018 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Michael Imperato	**Independent Member – Legal (Chair)**

In attendance:

Charles Dalton	Head of Health and Safety
Robert Jenkins	Solicitor – Shared Services Legal Risk (for agenda item HSC: 18/174)
Fiona Kinghorn	Deputy Director of Public Health
Peter Welsh	Director of Corporate Governance
Geoff Walsh	Director of Capital, Estates and Facilities

Apologies:

Carol Evans	Assistant Director of Patient Safety and Quality
Martin Driscoll	Director of Workforce and OD
Akmal Hanuk	Independent Member - Local Community
Charles Janczewski	Independent Member (Vice Chair)
Fiona Jenkins	Director of Therapies and Health Sciences

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 18/170 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting. It was noted the meeting was not quorate and therefore any items requiring decisions would be deferred to the next meeting.

HSC: 18/171 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. The Chair informed the Committee he was heavily involved in the infected blood enquiry and would have to excuse himself from discussions relating to medical records which did not have a health and safety relevance.

HSC: 18/172 MINUTES OF PREVIOUS MEETING

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

HSC: 18/173 UPDATED ACTION LOG

The Committee **RECEIVED** the Updated Action Log from the previous meeting.

HSC: 18/174 PERSONAL INJURIES CLAIMS PRESENTATION

Mr Imperato welcomed Mr Robert Jenkins – Solicitor for Shared Services Legal and Risk to the meeting.

Mr Jenkins provided the Committee with details of claims trends for the Health Board versus All Wales. He advised the Health Board does have a large violence and aggression portfolio compared to other Health Boards but we also have a large Mental Health Unit.

Mr Imperato queried how any defects/failures were fed back to the Health Board. Mr Jenkins advised they would be fed back to the Claims Team who would then liaise with the Directorate where the claim originated from. The Director of Capital, Estates and Facilities confirmed this was the process as the Directorate would be responsible for signing off the claim. The Senior Manager – UHL also advised lessons learnt were regularly shared with the Operational Health and Safety Group.

Mr Imperato thanked Mr Jenkins for his presentation.

HSC: 18/175 REVIEW OF THE COMMITTEE'S TERMS OF REFERENCE

The Senior Manager – UHL informed the Committee the terms of reference were being considered as part of their annual review and advised there were no significant changes.

In respect of 3.1 it was clarified that patient falls were discussed in relation to the environment and not the clinical aspects which were the responsibility of the Quality, Safety and Experience Committee. The Chair was concerned that potentially patient falls would not be picked up by either Committee, the Director of Therapies and Health Sciences confirmed the QSE Committee does discuss patient falls. Mr Welsh stated he would raise at the Governance Co-ordinating Group as there were number of areas that crossed a number of Committees.

ACTION – Mr P Welsh

The Director of Capital, Estates and Facilities queried what level of Executive representation was required as both he and the Director of Planning were members of the Committee and whether that was necessary. Mr Welsh stated there needed to be Executive representation on the Committee with members regularly attending and if they were unable to do so then ensuring they were appropriately represented. He advised he would discuss this further with the Board Secretary.

ACTION – Mr P Welsh

The Terms of Reference to be **RATIFIED** at the next meeting following clarification on the above points.

HSC: 18/176 CORPORATE RISK ASSURANCE FRAMEWORK (CRAF)

The Health and Safety Adviser informed the Committee she had received an update from the Head of Corporate Governance that the newly appointed Director of Corporate Governance was currently undertaking a piece of work with the Executive Directors to develop the Board Assurance Framework which would be a revision of the CRAF. The development of the e-datix risk module was also part of this work however a member of the datix team had recently left which had resulted in the Patient Safety Team having to reprioritise their work plan.

The Chair acknowledged the update but queried what were the risks the Committee should be focusing on in the interim. The Senior Manager – UHL advised the risk register was still being maintained and the Committee should be receiving assurances that the health and safety risks were being reviewed with appropriate mitigation. Mr Imperato requested a paper for the next meeting of the health and safety risks associated to the Committee and their current status, mitigation and assurance.

ACTION – Mrs N Foreman

HSC: 18/177 PEDESTRAIN ACCESS SAFETY STRATEGY

The Director of Capital, Estates and Facilities firstly apologised to the Committee for the length of time it had taken to complete the survey, it had been anticipated that it would have been completed by May 2018 but unfortunately there had been several disappointing lack of actions. Mr Walsh advised the draft document had now been received and was currently being reviewed which should be completed by the end of October/beginning of November, he also added the survey needed to be considered alongside the Travel Plan.

Mr Walsh advised the proposal, action plans and costs should be finalised by January 2019, the Chair requested these were brought to the next Committee meeting so that the health and safety aspects could be considered and assurances received that the proposals met the concerns raised by the Health

and Safety Executive regarding the requirement for the Health Board to develop a Pedestrian Safety Strategy.

ACTION – Mr G Walsh

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

HSC: 18/178 FIRE SAFETY ANNUAL REPORT 2017/18

The Director of Capital, Estates and Facilities presented the annual report to the Committee. Mr Walsh informed the Committee the Chief Executive and Director of Planning had recently met with the Chief Fire Officer to discuss the number of unwanted fire signals within the Health Board. Mr Walsh advised UHW has the greatest number of fire detection points of any building in the country and some of these were in excess of 25 years old. Unwanted fire signals were monitored by the Department and mechanisms were in place to try and reduce the number.

Mr Walsh wanted to highlight to the Committee the extremely worrying increased trend of fires in Hafan y Coed, UHL. It is the Fire Advisers belief that the removal of smoking shelters has added to the problem as there is now an increased risk of patients smoking in bedrooms and toilets. He advised South Wales Fire Service were considering prosecuting the Health Board and there would be a meeting with them on Friday 12th October 2018.

The Deputy Director of Public Health stated the Mental Health Clinical Board had been bold to implement no smoking within the building and had been working closely with public health but it had been a real challenge. The Clinical Board were keen to persist and recognise that a long term culture change was required.

Mr Walsh reiterated there was a potential risk of serious injury/death as there had been 2 serious incidents where fires had been started with lighters or other ignition sources which patients should not have had access to.

Mrs Kinghorn suggested an urgent meeting take place with all interested parties from Public Health, Estates/Fire, Health and Safety and the Mental Health Clinical Board.

ACTION – Mrs F Kinghorn

The report was **CONSIDERED** and **NOTED** by the Committee in relation to the on-going work to meet the requirements of the Fire Regulatory Reform (Fire Safety) Order 2005.

ASSURANCE was provided by:

- Identified issues in the fire risk assessments and audits carried out by the Fire Authority and NHS Wales Shared Services Partnership – Specialist Estates Services were being appropriately managed.

HSC: 18/179 **FIRE SAFETY MANAGEMENT AND COMPLIANCE REPORT**

The Director of Capital, Estates and Facilities advised the issues were discussed in the previous agenda item.

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: 18/180 **ENFORCEMENT AGENCIES CORRESPONDENCE REPORT**

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: 18/181 **HEALTH AND SAFETY IMPROVEMENT PLAN**

The Head of Health and Safety informed the Committee the Improvement Plan had been revised in line with the Annual Report.

Mr Dalton advised 4 key projects had also been added to the Improvement Plan which were being co-ordinated by the Health and Safety Advisers, these were:

- Health Aspects
- Risk Assessment and Control Improvement
- Health and Safety Competence
- Compliance and Priority Improvements

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: 18/182 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The updated schedule was received by the Committee. It was noted that a number of Policies which were approved by other Committees but had a health and safety inference were out of date. The Committee requested a concern be raised with the Director of Workforce and OD in relation to the out of date policies and request a definitive timescale of when they were to be reviewed.

ACTION – Miss R Daniel

PART 2

HSC: 18/183 COMMITTEE WORK PROGRAMME FOR 2018/19

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

HSC: 18/184 REGULATORY REVIEW TRACKING REPORT 1ST APRIL – 30TH SEPTEMBER 2018

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

HSC: 18/185 LONE WORKER SYSTEM PROGRESS REPORT

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

HSC: 18/186 ENVIRONMENTAL HEALTH INSPECTION REPORT OF MAIN WARDS, FOOD PRODUCTION AND RESTAURANT AREAS, UNIVERSITY HOSPITAL LLANDOUGH ON 14TH AUGUST 2018

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 3 had been achieved. The Director of Capital, Estates and Facilities expressed his disappointment with this score, he advised there had been basic operational issues and minor works not reported. The facilities were to be re-inspected today. He added the Health Board was assessed differently to high street amenities as we cater for patients.

HSC: 18/187 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF MAY 2018

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

HSC: 18/188 FIRE SAFETY GROUP MINUTES OF MAY 2018

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

HSC: 18/189 WATER SAFETY GROUP MINUTES OF MAY 2018

The minutes were **RECEIVED** and **NOTED** for information by the Committee. It was noted there was poor representation by the Clinical Boards at the meeting.

HSC: 18/190 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

Mr Imperato thanked everyone for their contributions, however he did note that the meeting was poorly attended which he hoped would be rectified by the review of the Terms of Reference.

He noted the Committee's concern in relation to the increased fires in Hafan y Coed, UHL and also the number of out of date policies.

The Fire Safety Annual Report would be presented to the Board for information purposes.

HSC: 18/191 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 22nd January 2019 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

UP DATED ACTION LOG

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

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 18/147	10/07/18 & 9/10/18	CRAF	To provide an update on the roll out of the revised CRAF. Health and Safety Risks to be presented to the Committee.	Mrs Nicola Foreman	**ACTION STILL UNDERWAY** Paper to be presented to January 2019 meeting
HSC: 18/175	9/10/18	Terms of Reference	Patient falls to be raised at Governance Co-ordinating Group as it falls between H&S and QSE Committee	Mr Peter Welsh	**COMPLETED**
HSC: 18/175	9/10/18	Terms of Reference	Representation to be raised with Board Secretary	Mr Peter Welsh	**COMPLETED**
HSC: 18/177	9/10/18	Pedestrian Safety Strategy	Findings of survey including proposals, action plan and costings to be presented to the January meeting.	Mr Geoff Walsh	**COMPLETED** Paper to be presented to January 2019 meeting
HSC: 18/178	9/10/18	Fire Safety Report	Meeting to be arranged to discuss the concerns relating to increased fires at Hafan y Coed.	Mrs Fiona Kinghorn	**COMPLETED**

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 18/182	9/10/18	Heath and Safety Policy Schedule	To raise Committee's concerns in relation to out of date policies with the Director of Workforce and OD and request timescale for review.	Miss Rachael Daniel	**COMPLETED**

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 – Environment 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.

Report Title:	Presentation of Obligatory Response to Violence in Healthcare							
Meeting:	Health and Safety Committee					**Meeting Date:**	22/01/2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**	√
Lead Executive:	Senior Manager							
Report Author (Title):	Head of Health and Safety							

SITUATION
The Health Minister has endorsed and on the 21st November 2108 the Director of General Health and Social Services signed on behalf of NHS Wales a NHS Anti-Violence Collaboration Obligatory Response to Violence in Healthcare, which superseded the previous Memorandum of Understanding between the NHS, CPS and Police.

BACKGROUND
Cardiff and Vale has consistently been a leading organisation in progressing the previous Memorandum of Understanding and indeed the new document reflects our best practice.

Violent and Aggressive events continue to account for more than half of the staff reported incidents, with nearly 1000 assaults in the last financial year within Cardiff and Vale.

Cardiff and Vale has worked closely with the Police and Crown Prosecution Service and pursue as shown in our annual report an average of one prosecution and three police involved events per week.

The previous Memorandum of Understanding was considered to have not been well known enough at staff and constable level throughout Wales, resulting in its full effect being lost.

ASSESSMENT & ASSURANCE
The Assaults on Emergency Officers Act 2018 has come into force and sentences for assaults in this area are effectively doubled.

The purpose of the document is to set out the responsibilities of the partners when dealing with violent and aggressive incidents relating to NHS staff, which needs to be addressed by the Criminal Justice System; this builds upon the previous agreement in Wales.

The NHS has the first responsibility to respond to violent incidents in order that the agreement can be implemented.

The new document has five strategic approaches, these being:-

- Prevent
- Capture
- Investigate
- Prosecute
- Deter

The Minister committed to giving this document Welsh Health Circular Status.

The Obligatory Response requires each Health Board to have a board level violence and aggression lead in place. They are required with the Head of Health and Safety to oversee the role of the NHS Violence and Aggression Case Manager who will act as a single point of contact, to support both the

victims and the process.

The Police will ensure that the single point of contact is designated at a strategic and operational level and the District Crown Prosecutors will act as a single point of contact for the CPS.

To manage the implementation, an Anti-Violence Collaboration Group has been established, which will review the effectiveness of this agreement.

To ensure the Health Board continues in its leadership of this pivotal risk, the Chair of the Security Strategy Group (SSG) together with the Senior Management Lead are reviewing the membership and terms of reference of the Personal Safety and Security Strategy Group with a view to it becoming the Cardiff and Vale Local Anti-Violence Collaboration Group, continuing to report as a subgroup into the Health and Safety Committee.

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the report and support the proposed actions

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	√
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration		Collaboration	√	Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**PEDESTRIAN ACCESS STRATEGY – Progress Update**								
Meeting:	**Health and Safety Committee**						**Meeting Date:**	**22/01/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**√**
Lead Executive:	**Director of Planning**								
Report Author (Title):	**Director of Capital Estates and Facilities (02920 743761)**								

SITUATION

The Health Board has engaged an external organization to undertake a Pedestrian Access study at University Hospital of Wales and from the findings develop costed recommendations for improved access and safety.

This report provides a progress update for the study and details the preliminary costed recommendations.

REPORT

BACKGROUND

Introduction

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. 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.

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.

Pedestrian Incident

There has been an incident at UHW whereby a pedestrian was involved in an incident with a vehicle and

the pedestrian suffered a broken leg. This resulted in an HSE investigation and the UHB prepared an action plan which was accepted by the HSE. This 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 were 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 including: Site visits and investigations and Consultation with stakeholders.

Stage 2 including: Development of pedestrian access preferred options, costed recommendations, priorities and next steps and actions. Final presentation of report.

There were performance and quality concerns with the works undertaken by ARUP. A series of meetings and discussions were held with ARUP who agreed to address the issues and complete the project to the satisfaction of the UHB.

ASSESSMENT

Progress Update

We have received the report for comment and discussion. There have been several iterations of the final draft report and it has been necessary to meet with ARUP to shape the quality and format of the report so that it meets the standards required by the UHB. A final meeting was held on 3/1/19 to agree amendments to the final report.

Pedestrian Access Strategy Recommendations

The following is a summary of the recommendations to be implemented at UHW:

- Pedestrian strategy to be developed for the UHB, including the establishment of a Pedestrian Access Steering Group to develop and implement the strategy.
- Additional pedestrian crossing points are required at certain locations.
- Improve pedestrian continuity for certain footways including widening narrow paths and ensuring paths have continuous levels. Additional footpaths are required at certain locations.
- Pathways created by pedestrian desire lines to be formalised where possible.
- Rationalise/remove parking bays adjacent to crossing points and/or areas of poor road visibility.
- Certain junctions require modification to minimise conflict/collision between vehicles and pedestrians.
- Access to buildings and Heath Park to be improved and signage needs to be enhanced.
- Wheel stops provided to ensure parked vehicles do not impede footpaths.
- Management measures including consistent site speed limits of 10-20 mph, deliveries to include banksmen and deliveries scheduled to avoid convoys of vehicles awaiting off loading, causing congestion/risk.

Preliminary indications (to be confirmed)are showing the areas of highest risk are:

- Allensbank Road entrance to the roundabout adjacent the multi-storey car park.
- Residential road / Heath Park way delivery / logistics areas.
- Access from footbridge over A48 / Dental Car park 6 to Gateway road.

These areas require a range of footpath, crossing points and management improvements.

ASSURANCE is provided by:

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the content of the report.

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2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	√	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration		Collaboration		Involvement	√

Equality and Health Impact Assessment Completed:	~~Yes / No /~~ Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Report Title:	**FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT**							
Meeting:	**Health and Safety Committee**					**Meeting Date:**	**22/01/2019**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	
Lead Executive:	Director of Planning							
Report Author (Title):	Senior Fire Safety Advisor							

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

The only audit SWFS have conducted in the last four month was in Hafan Y Coed following a number of fires started by patients. Following the audit carried out on the 12th October 2018 an Enforcement Notice was issued on the 31st October 2018.

The Enforcement Notice recorded four breeches of The Regulatory Form (Fire Safety) Order 2005 as follows:

- The University Health Boards smoking policy is not being adequately managed,
- The significant findings identified in the fire risk assessments have not been implemented,
- The fire detection system is inadequate for the type and use of the premises,
- Staff have not attended fire training sessions.

The Health Board was given 40 days to improve the situation after which SWFS returned to confirm they were now satisfied the premises currently demonstrates suitable and sufficient measures to satisfy the requirements of the Fire Safety Order. Formal notification that the Enforcement Notice was lifted was received on the 27th December 2018

- **ASSURANCE** is provided by:

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

RECOMMENDATION

The Health and Safety Committee is asked to:

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

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	Amendments to Smoking Policy Arrangements at Hafan y Coed Mental Health Hospital to Meet the Fire Enforcement Notice issued							
Meeting:	Health and Safety Committee					**Meeting Date:**	22/01/2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**	√
Lead Executive:	Executive Director of Planning							
Report Author (Title):	Head of Health and Safety							

SITUATION

The South Wales Fire and Rescue Service issued an Enforcement Notice under the Regulatory Reform (Fire Safety) Order 2005 against the premises Hafan Y Coed Adult Mental Health.

The Health Board was required to take steps to remedy the matters identified in the schedule by the 10th December 2018.

One of 4 key requirements related to the assessment that UHB Smoking Policy was not being adequately managed *resulting in uncontrolled ignition sources.*

BACKGROUND

In January 2018 the Mental Health Clinical Board, working closely with the Public Health team, implemented a smoking ban within the Mental Health Clinical Board. The decision was taken, collectively with mental health staff, to implement a complete ban in external enclosed grounds for mental health patients, alongside the existing arrangement of no smoking within all mental health wards at University Hospital Llandough (UHL).

The Fire Service visited Hafan Y Coed on the 12th October 2018 following a deliberate fire event; this was one of a series of fires at the unit over the past 9 months. The number of reported fires at Hafan y Coed is considered greater than other mental health units in the rest of Wales.

They also stated that, “during the audit there was evidence of illicit smoking found throughout the whole building. Additionally, there have also been a number of fires within the premises of which a high percentage has stemmed from smoking materials”.

At the October meeting the fire officers considered that this complete ban in external mental health grounds may have increased uncontrolled ignition sources.

ASSESSMENT & ASSURANCE

The number of fire incidents at Hafan Y Coed from 2013 – 2018 are outlined here. Whilst numbers are relatively small, incidents in Hafan Y Coed are an outlier across Wales.

Number of Fire Incidents at Hafan y Coed (Whole of Wales 2018 to date 15)

	Whitchurch			HYC	
Year	2013	2014	2015	2017	**2018**
No. of Incidents	1	4	3	3	**9**

The Executive Director of Planning, Interim Executive Director of Public Health, the Head of Delivery for Mental Health Services, Director of Estates and Facilities and the Fire Safety Manager met to consider the notice and required actions. The following was considered:

All fires that have occurred within Mental Health are within Adult Mental Health Wards, with all but 3 within internal areas, causing damage, with potential risk to others. In 7 of the 9 incidents cigarette lighters (ignition sources) were found on search.

These events were either, assessed as smoking or deliberate self harm and attributed to 8 different patients.

The implementation of the smoking ban in Mental Health had been successful within the older people's wards, low secure wards, and neuropsychiatry. Mental Health Clinical Board and all teams were commended for this work. However the ban has been more challenging for staff and patients within the 4 admission wards, and rehabilitation. Many of these patients are high risk, drawn from a wider geography than Cardiff and Vale, with a high level of smoking addiction. Whilst the ban had held well for the first few months, patients in these units have not complied since before the summer and staff have found this very challenging.

As a result of the smoking ban all Ozzy lighters were removed from the garden area, this has caused a recognised significant increase in the amount of cigarette lighters being smuggled into the Unit and despite efforts such as the use of the metal detectors most of the reported fires identified that a lighter or other smoking ignition sources had been involved.

There has also been a poor uptake of e-cigarettes and nicotine replacement products in these wards.

The number of violent incidents from January to August has increased by 33%. Data also shows that the number of violent incidents where smoking had been involved as a cause of violence and aggression events have increased from 5 to 31 during the period.

The schedule also required Mental Health to:

- implement significant findings identified in the Fire Risk Assessments carried out by the Health Boards Fire Adviser.
- Enhance training compliance from the current 65.4%.
- Reinstatement of the fire alarm system which at the time had been modified to reflect the risk of false alarms from steam.

Smoking Control
Given the challenge posed by instituting a complete ban in external mental health grounds, the following actions were agreed at the Management Executive Meeting:-

- Retain the smoking ban in areas where it has been successful - older people's wards, low secure wards, and neuropsychiatry (50% of all mental health wards at Hafan Y Coed). These are geographically separate from assessment and rehabilitation wards.
- Within assessment and potentially rehabilitation wards, a controlled smoking plan be implemented, where patients are allowed restricted access within the adjoining garden areas in Hafan Y Coed and Ozzy lighters be re-instated on the walls.
- Mental Health Clinical Board and the Public Health team would continue to work together to apply all possible measures around supporting patients to give up smoking, including a strengthening of the approach in community mental health.
- Continued vigilance by staff with regard to room inspections, removing lighters and use of the metal detectors would also be needed, in line with previous action plans.
- The above revisions would be reviewed after 6 months.

It should be noted that these changes are in line with the forthcoming provisions under the Public Health (Wales) Act.

Wider Required Fire Controls
A review of the type of metal detectors in place to ensure they are the best available equipment, together with surplus availability to cover potential out of service devices will be carried out. Enhanced use of the metal detectors for patients returning from day leave and greater vigilance with regards to visitors will be required.

An action plan has been put in place to implement the further requirements and is monitored by the Fire Safety Group.

The Management Executive team **APPROVED the** recommendations for a revision of the smoking controls within the Mental Health Clinical Board at Hafan Y Coed.

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the revision of the smoking controls within the Mental Health Clinical Board at Hafan Y Coed.

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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	Enforcement Agencies Report						
Meeting:	Health and Safety Committee					**Meeting Date:**	22/01/2019
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Senior Manager Lead for Health and Safety						
Report Author (Title):	Head of Health and Safety						

SITUATION

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

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

a) Hand Arm Vibration regulatory requirements following the submission of a RIDDOR event within Dental Services.
b) Cardiff University Category 3 Laboratories
c) Workplace concerns around vehicle and pedestrian risks outside the Dental Hospital, University Hospital of Wales (UHW).

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 previous Committee meetings 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 awaiting the HSE to formally 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.

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. **Item Closed**

New Item - Hand Arm Vibration (HAV) regulatory requirements following the submission of a RIDDOR event within Dental Services

Following a HAV reported RIDDOR event the HSE contacted the Health Board asking for our policy and actions to meet the regulatory requirements. A response was prepared outlining action taken to mitigate the risks and a commitment to progress a HAV procedure.

On the above basis the Inspector has closed the investigation.

New Item – HSE carried out an inspection of Cardiff University Category 3 laboratories, including those on the UHW site. They raised concerns about the lack of communication between the two organisations which could result in air flow and emissions risk. A meeting was jointly convened and a course of action agreed with the HSE Inspector. The Health Board has received correspondence from the HSE and a response is being prepared by the Capital, Estates and Facilities Service Board.

New Item – the HSE wrote to the Health Board regarding workplace concerns around vehicle and pedestrian risks, relating to cars waiting to park outside the Dental Hospital. A response was prepared by the Capital, Estates and Facilities Service Board outlining controls that were already in place and agreeing to some enhanced enforcements and road markings. The HSE was satisfied with the response. **Item Closed**

ASSURANCE is provided by the continued investigation, actions and monitoring referred to within the report.

RECOMMENDATION

The Health and Safety Committee is asked to:

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

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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	Changes in Sentencing								
Meeting:	Health and Safety Committee						**Meeting Date:**	22/01/2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	√	
Lead Executive:	Senior Manager								
Report Author (Title):	Head of Health and Safety								

SITUATION

From the 1st November, the Sentencing Council's new Definitive Guidance for manslaughter applies in England and Wales, regardless of the date of the offence. As a result, those responsible for serious workplace fatalities can expect sentences of up to 18 years.

BACKGROUND

The October 2016 Health and Safety Committee was briefed on larger fines imposed on organisations for health and safety and fire safety failings. The new sentencing guidelines will result in an increase in custodial sentences

The Sentencing Council's aim is to promote consistency in sentencing and transparency in terms of how decisions are reached

Under the guidance, Gross Negligence Manslaughter (GNM) offences are to be classified in one of four categories referencing a number of factors. Whilst other guidelines required an assessment of the risk of harm, in manslaughter cases harm caused will inevitably be of the utmost seriousness. A list of indicators is given for assessing culpability: 'very high' culpability may be identified by the extreme character of one or more 'high' culpability factors, and/or a combination including:

- The negligent conduct was motivated by financial gain.
- The offender was in a leading role if acting with others.
- The offender showed a blatant disregard for a very high risk of death resulting from negligent conduct.

The offence category indicates a starting point and range for sentencing, with an aggravating or mitigating factor applied alongside reductions for assistance given or guilty plea. There must also be consideration of whether compensation or another ancillary order is appropriate.

ASSESSMENT

There is now a requirement to consider whether the individual should be disqualified from acting as a director, and reasons for the sentence imposed must be given.

Directors and senior managers should take note that whilst Gross Negligence Manslaughter convictions for workplace fatalities are rare they are increasing, as regulators seek to punish individuals responsible for breaches.

The growing incidence of custodial sentences means it now looks likely that individuals ultimately held responsibile should expect more time in jail. As an example:

- ❖ In June 2017, director Richard Pearson of SP Fireworks Limited was sentenced to 10 years imprisonment following the deaths of an employee and a customer. He was found to have flouted safety regulations and licensing requirements. He may have been imprisoned for longer if

sentenced after 1 November – for 'very high' culpability, between 10 and 18 years may be imposed, with a starting point of 12 years.

ASSURANCE is provided by: The Health Board's Health and Safety Policy and Executive management arrangements.

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	Health and Safety Priority Improvement Plan 2018/19						
Meeting:	Health and Safety Committee				**Meeting Date:**	22/01/2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Senior Manager Lead for Health and Safety						
Report Author (Title):	Head of Health and Safety						

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 Board Assurance Framework (BAF) 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 has in turn produced its own Priority Improvement Plan based on the eight strategic areas.

The report has been reviewed to reflect the findings 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

The plan is being progressed by the Health and Safety Department to enhance its objectivity and implementation, together with a review of any compliance gaps and the revised approach to the Risk Register. Members will note that the plan is enhanced and segregates milestones from actions.

	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	4	9	3	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 Board Assurance Framework, which plans to more easily demonstrate the level of progress made.

The full plan contains details of each of the identified requirements.

The most significant change include plans to enhance progress in 4 keys areas and to facilitate this the Health and Safety Department has 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 Health and Safety 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 and 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-ordinators will need to work with these specialists to maximize the benefit.

ASSURANCE is provided by demonstrating progress against each strategic area and highlighting milestones 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.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	√
3. All take responsibility for improving our health and wellbeing	√	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	√

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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

LATEX ALLERGY POLICY	
Name of Meeting: Health and Safety Committee	**Date of Meeting:** 22/01/2019

Executive Lead : Senior Manager Lead for Health and Safety
Author : Health and Safety Adviser – 02920 746433
Caring for People, Keeping People Well:
Financial impact: The implementation of this policy will be undertaken within the resources of the UHB and any identified additional resource requirement will be brought to the Committee for approval.
Quality, Safety, Patient Experience impact: The policy requirements impacts on all services of the Health Board and directly/indirectly relates to all stakeholders and staff.
Health and Care Standard Number: N/A
CRAF Reference Number: 8
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

The Health and Safety Committee is asked to:

- **APPROVE** the Policy
- **APPROVE** the full publication of the Latex Allergy Policy in accordance with the UHB Publication Scheme

SITUATION

The Health Board must ensure that it has arrangements in place for assessing and managing the risks that latex may present in the clinical environment. The Health Board also has a duty to assess the risk from latex in accordance with the Control of Substances Hazardous to Health Regulations 2002.

The policy is revision UHB 3 and was previously reviewed in September 2015.

BACKGROUND

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

Whilst overall responsibility to provide and maintain safe and healthy working conditions, equipment and safe systems of work rests at the highest level of

management, every individual has a responsibility to ensure its implementation, so far as reasonably practicable.

THE AIM OF THE LATEX ALLERGY POLICY

The policy aims to:-

- To prevent the development of latex allergy;
- To prevent symptoms of latex allergy in both staff and patients;
- To minimise the risk from exposure to latex;
- Where latex allergy in patients and staff is suspected or known, control measures will be identified to allow healthcare to be provided and continued employment where possible;
- To ensure the Health Board complies with the Control of Substances Hazardous to Health Regulations 2002.

ASSESSMENT

Wide consultation has taken place to ensure that the policy meets the needs of the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 12th December 2018 and 9th January 2019;
- The document was shared with the Operational Health and Safety Group.
- Comments were invited via individual e-mails from the Operational Health and Safety Group.

Where appropriate comments were incorporated within the document.

The primary source for dissemination of this document within the UHB will be via the intranet. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: UHB 127 **Version Number:** 3	**Date of Next Review:** January 2022 **Previous Trust/LHB Reference Number:** 32

LATEX ALLERGY POLICY

Policy Statement

The UHB recognises its responsibility to implement safe working practices, in keeping with the principle Health and Safety legislation and therefore will, where reasonably practicable, undertake to reduce the risk of exposure to latex by staff and patients.

Policy Commitment

The introduction in 1987 of Universal Blood and Body Fluid Precautions aimed to reduce the risk of transmission between patients and staff of various pathogens, especially viruses. There has subsequently been a great increase in the use of latex gloves by health care workers.

As the frequency and duration of the use of latex products has increased, the emergence of various forms of latex sensitivity has been identified as a problem for both staff and patients. This sensitivity can vary from mild contact dermatitis to a severe reaction resulting anaphylactic shock. The Cardiff and Vale University Health Board (the UHB) must ensure that it has arrangements in place for assessing and managing the risks that latex may present in the clinical environment.

The UHB has a duty to assess the risk from latex in accordance with the Control of Substances Hazardous to Health Regulations 2002.

Supporting Procedures and Written Control Documents

This Policy describes the following with regard to Latex Allergy

- Prevention of the development of latex allergy
- Prevention of symptoms due to latex allergy in both staff and patients
- Provision of an environment where the UHB seeks to minimise the risk from exposure to latex
- Management - Where latex allergy in patients and staff is suspected or known, control measures will be identified to allow healthcare to be provided and continued employment where possible
- To ensure that the UHB complies with the Control of Substances Hazardous to Health Regulations 2002.

Other supporting documents are:

- Health and Safety Policy
- Control of Substances Hazardous to Health (COSHH) Procedure

- Occupational Health Policy
- Managing Attendance at Work Policy All Wales
- Incident, Hazard and Near Miss Reporting Policy

Scope

This policy applies to all staff in all locations including those with honorary contracts

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact.
Policy Approved by	Health and Safety Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Group
Accountable Executive or Clinical Board Director	Chair of Operational Health and Safety Group

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
2	July 2017		Reviewed and updated in line with departmental and reporting structure changes
3	January 2019		3 yearly review period

Equality & Health Impact Assessment for

LATEX ALLERGY POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Chair of Operational Health and Safety Group
3.	Objectives of strategy/ policy/ plan/ procedure/ service	
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings	Considered all staff groups and patients that could come into contact with latex – clinical and non clinical staff. The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet).

	• research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All UHB Staff and those with honorary contracts, patients

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There does not appear to be any impact	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the policy would be made accessible to staff and service users in alternative formats on request or via usual good management practice.	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
medical conditions such as diabetes			
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff or service users regarding gender.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	There appears not to be any impact		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There appears not to be any impact.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	There appears not to be any impact on staff regarding race, nationality, colour, culture or ethnic origin.	Whilst there doesn't appear to be any impact, if a member of staff or service user was known to have difficulties with the	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers		written word, good management would dictate that alternative arrangements be made, such as individual meetings. Translators would be used where necessary to communicate with service users.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There appears not to be any impact.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	There appears not to be any impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless,	There appears not to be any impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
people who are unable to work due to ill-health			
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups or risk factors to take into account with regard to this Policy.		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	**N/A**	N/A	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels,	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
job security, working conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	**N/A**	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	**N/A**	N/A	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities, however, it is suggested that implementation of the policy will have a positive impact on the safety and wellbeing of UHB staff, Patients and Visitors.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	No Actions			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Approve Policy as there are no significant negative impacts.			

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** January 2022 **Previous Trust/LHB Reference Number:**

Latex Allergy Procedure

Introduction and Aim

The aim of this Procedure is to support the Latex Allergy Policy in it's duty to assess the risk from latex in accordance with the Control of Substances Hazardous to Health Regulations 2002.

Objectives

The Objectives of the procedure are to:-

- Prevent the development of latex allergy
- Prevent symptoms due to latex allergy in both staff and patients
- Provide an environment where the UHB seeks to minimise the risk from exposure to latex
- Manage - where latex allergy in patients and staff is suspected or known, control measures will be identified to allow healthcare to be provided and continued employment where possible
- To ensure the UHB complies with the Control of Substances Hazardous to Health Regulations 2002.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts.

Equality Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.*
Documents to read alongside this Procedure	Health and Safety Policy Control of Substances Hazardous to Health (COSHH) Procedure Occupational Health Policy Managing Attendance at Work Policy All Wales Incident, Hazard and Near Miss Reporting Policy
Approved by	Operational Health and Safety Group/Health and Safety Committee
Accountable Executive or Clinical Board Director	Chair of Operational Health and Safety Group
Author(s)	Health and Safety Adviser

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1		*TBA*	New Procedure in line with new UHB Policy arrangements

1 WHAT IS LATEX?

Latex is the protective fluid contained in tissue beneath the bark of the rubber tree, *Hevea brasiliensis.*

Natural rubber latex (NRL) is a cloudy white liquid, similar in appearance to cows milk, collected by cutting a thin strip of bark from the tree and allowing the latex to exude into a collecting vessel.

The latex collected from the rubber tree is composed of rubber particles, protein, water and other substances.

Processing of the latex (eg centrifugation and leaching) can affect the level of protein in the finished product. Some glove manufacturers wash the gloves in a chlorinated solution to reduce the tackiness of the latex to avoid having to powder the glove. Chlorination followed by prolonged leaching reduces the protein levels, producing a glove low in protein.

2. ROUTES OF EXPOSURE

The potential routes of exposure to latex allergens are:

- Cutaneous – via gloves, tapes, masks, urine drainage bags;
- Mucous membranes – via products used in dentistry, anaesthesia and rectal examinations, eye droppers;
- Inhalation – via aerosolisation of glove powder;
- Internal tissue – via latex products used in surgery;
- Intravascular – via latex products used in intravascular devices (e.g. IV cannulae) or devices used to deliver IV fluids and injectables (syringes and IV administration sets) or in the vial stopper or needle sheath of some injectable medicines;
- Gynaecological examinations.

3. TYPES OF REACTION

3.1 Irritant Contact Dermatitis

This is a common form of dermatitis, one example is “Housewives Hand Dermatitis”. In most cases it is caused by damage to the skin from repeated exposure over a long period of time to water, soap and other detergents (such as surgical scrub). It is not due to an allergy to latex.

3.1.1 Symptoms

It usually presents as a dry, itchy red rash on the back of the hands and fingers. There may be episodes of blistering and weeping of affected skin which may swell. After prolonged involvement, the skin may become dry, thickened and scaly. Symptoms may appear to be aggravated by latex gloves, largely through the effect of occlusion, friction or the powder.

3.1.2 Diagnosis

Diagnosis is based primarily on history and examination.

Patch tests which test for type IV delayed hypersensivity allergy to various common contact allergens are negative in irritant contact dermatitis.

3.1.3 Treatment

Treatment is with non-irritating soap substitute, emollient creams and topical steroids. Sufferers must reduce their irritant exposure. Paradoxically this usually involves recommending greater use of non powdered latex gloves for protection during wet work.

3.2 Allergic Contact Dermatitis (Type IV Delayed Hypersensitivity)

This is less common than irritant contact dermatitis, it is caused by an allergy to the residues of the rubber chemical agents used in latex glove manufacture.

3.2.1 Symptoms

The symptoms and signs are usually indistinguishable from irritant contact dermatitis as above, frequently the two conditions coexist. There may be dermatitis at other sites exposed to latex, such as under the waist-band or on the soles of the feet. Secondary spread of dermatitis to non-exposed skin can occur.

3.2.2 Diagnosis

Diagnosis is confirmed by demonstrating positive patch tests to one or more of the rubber accelerators. Once

established, this form of allergic response lasts for many years.

3.2.3 Treatment

Effective management requires the stringent avoidance of the responsible agent along with topical treatment as above. Although prolonged contact must be avoided, transient contact may not be a problem.

3.3 Immediate Hypersensitivity (Type 1)

This is much rarer than the above forms of contact dermatitis. However it is very important as it can cause severe and even fatal reactions.

3.3.1 The Role of Protein

Type 1 (immediate) hypersensitivity is due to an Immunoglobulin E (IgE) response to natural latex protein which happens in two stages. Stage one is when the body first becomes sensitised to allergen and the immune system makes antibodies called (IgE) against it. Stage two occurs if the person is exposed to the same allergen again, these antibodies then trigger an immune response to fight them off causing the symptoms of an allergic reaction. It should be noted that latex protein may adhere to particles of starch powder inside gloves, and the powder aerosol may thus also induce symptoms through inhalation.

3.3.2 Symptoms

Symptoms usually develop within 5 – 40 minutes of exposure and diminish rapidly once contact with the latex material has ceased. It may present with immediate itching and swelling of the fingers or hand when a latex glove is worn. This is more likely to occur at sites where the skin is broken or affected by dermatitis.

Immediate hypersensitivity may manifest as rhinitis, conjunctivitis or asthma.

More serious but uncommon are symptoms of anaphylaxis. These are more likely to occur when there has been latex contact with the mucous membranes or

body cavities (as in surgery). Anaphylaxis may present with any or all of the following:

- Local or generalised itching, urticaria and/or angio-oedema
- Rhinitis and/or conjunctivitis
- Asthma
- Extreme anxiety
- Nausea, vomiting and abdominal pain
- Tachycardia with or without hypertension
- Faintness or loss of consciousness
- Cardio-respiratory arrest

If anaphylaxis is suspected immediate medical assistance should be summoned.

4. DIAGNOSING THOSE AT RISK

4.1 Staff

4.1.1 Diagnosis

Employees who think they may have latex allergy, after discussion with their Line Manager should be seen by the Occupational Health Service. Managers who are concerned that an employee may have latex allergy must refer them to the Occupational Health Service for clinical investigation.

4.1.2. Management of Affected Employees

Advice regarding latex avoidance will be given and the Occupational Health Service will review latex allergic employees after avoidance advice has been given to ensure symptom control.

The condition of latex allergy may require reporting as an Occupational Disease under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Further advice on this matter is available from the Occupational Health Service and the Health, Safety and Environment Unit.

4.2 New Employees

The pre-employment health questionnaire asks about known allergies, including latex. If latex allergy is identified and confirmed in a prospective employee the Occupational Health Service will advise the management and the employee of any adjustments needed to the working practices or workplace to accommodate the employee. The Health Board will make any reasonable adjustments necessary to comply with this advice. The Occupational Health Service will review latex allergic employees after avoidance advice has been given to ensure symptom control.

4.3 Locums and Agency Staff

All locum and agency staff should be screened by their own agencies before commencing work within the Health Board however they would be expected to comply with the Health Board's policy/procedure whilst in post. If presenting with symptoms of a Latex Allergy, they should seek advice or clinical investigations from their own agency.

4.4 Patients

Certain conditions, occupations or those with a previous history of immediate reaction to skin-rubber exposure during various contact activities should alert the clinician to the possibility of latex allergy. For example:

- Atopy
- Spina Bifida
- Food allergy – avocado, banana, chestnut and kiwi represent the biggest risk of cross allergencity.
- Being a Healthcare Worker
- An allergy to rubber balloons, condoms and rubber gloves
- Multiple Surgical procedures

If latex allergy is suspected, further investigation may be requested from the Dermatology Department.

4.4.1 Management of Latex Sensitive Patient Admitted to Hospital

Effective communication between staff from all departments involved in the case of the patient is essential in maintaining patient safety.

- On admission, the named nurse will ensure that the patient is asked about any allergies.

- Patients notes must be labelled 'Latex Allergy', this is to be included in all relevant documentation i.e. nursing notes, medication chart, medical notes, on procedure request forms to other departments e.g. X-ray etc

- Notify all departments who are involved in treatment, investigation or care for the patient to ensure all necessary precautions are maintained e.g Theatres, X-ray etc.

- Do not use any product that contains latex for nursing, surgical, medical or any other procedure.

- Most equipment today is latex free, however check all labels and packaging before use to ensure they do not contain latex. If in doubt do not use the item until it has been determined that it is latex free. **(In the event of a resuscitation attempt this may not be possible).**

- Remove latex products from the patient's room to reduce the risk of inadvertent use of these products.

- Educate the patient about latex allergy and the possibility of obtaining a Medic-Alert bracelet or locket.

- Where Type I allergy is confirmed and surgery or other medical procedures are imminent, patients should be scheduled first on the theatre list to minimise risk of contamination with latex.

- For patients requiring emergency surgery, every effort will be made to schedule with the latex

allergy first on the emergency operating list. However when this is not possible due to clinical demand, all latex items will be removed from theatre prior to sending for the patient to prevent contact with the patient and to allow necessary air changes to occur.

- Obstetric patients who have known or have possible latex allergies should be noted at booking clinic, and all appropriate departments notified at this time i.e ward, theatres etc.

4.4.2 Management of Patients in the Community

- Do not use any product that contains latex for nursing, surgical, medical or any other procedure.

- Check all labels and packaging before use to ensure they do not contain latex. If in doubt do not use the item until it has been determined that it is latex free.

- Ensure non-latex gloves are used when attending to patients with latex allergy.

- Remember to check other items such as urinary catheters, syringes, IV giving sets and dressings or bandages.

- Educate the patient about latex allergy and the possibility of obtaining a Medic-Alert bracelet or locket.

- Ensure all documentation is labelled 'Latex Allergy', to ensure continuity of care. Update the patient's notes.

5. PREVENTION

5.1 Use of Low Protein Devices

Sensitisation can be prevented by the use of devices low in protein. Currently, the accepted method for assaying protein in latex devices is the Modified Lowry Assay.

The Surgical Materials Testing Laboratory carries out testing of medical devices for the All Wales Contracts. Part of this work includes assaying protein levels in medical devices. Reports are available from SMTL on request and on their Internet site http://www.smtl.co.uk, which documents protein levels in various medical devices including gloves and urinary catheters. More information can also be found at www.hse.gov.uk/latex.

5.2 Use of Non-Latex Devices

The use of non-latex devices is recommended in situations where staff or patients have a known latex allergy, and contact with the device is unavoidable. Appendix 1 lists products known to contain latex. As far as is reasonably practicable, all clinical areas should have latex-free items available in case of an emergency. This would include items such as latex-free gloves and all items on resuscitation trolleys.

5.3 General Measures

Good housekeeping practices should be followed to remove latex containing dust from the workplace. Areas potentially contaminated from latex devices should be identified for frequent cleaning.

Ventilation filters and vacuum bags should be changed frequently in these identified areas.

6. RESPONSIBILITIES

6.1 Chief Executive

The Chief Executive has overall responsibility for ensuring arrangements are in place for the implementation of the Latex Allergy Policy/Procedure.

6.2 Chair of Operational Health and Safety Group

The Chair of the Operational Health and Safety Group has delegated responsibility for ensuring arrangements are in place for the implementation of the Latex Allergy Policy/Procedure.

6.3 Clinical Board Managers/Nurses will:

Ensure through their Directorate/Locality/Department Managers that Departments have Local Procedures for managing latex allergy in their areas. 7.4.1 and 7.4.2 refers.

6.4 Directorate/Locality/Departmental Managers will:

Ensure that this procedure and appropriate arrangements are implemented into their areas of responsibility. This includes making staff aware of this procedure and providing adequate information to staff.

6.5 Lead Clinicians will:

- Ensure that the allergy history, including latex of any patient being considered for elective surgery is established and recorded in advance of admission. All conscious non-elective patients will be asked on admission to the Emergency Department if they have any known allergies. If the patient has a skin problem for which the diagnosis is not clear but in which a latex allergy is a possibility, the patient should be referred for a dermatological opinion.

- Ensure that if it is known that the patient has a latex allergy that this information is recorded and communicated to all parties who will be involved in the treatment and care of the patient.

6.6 Ward/Departmental Managers/Community Leads will:

- Ensure staff are made aware of the risks of latex allergy.

- Ensure that COSHH Assessments for latex are undertaken.

- Ensure only non-latex gloves (powder free, low protein latex gloves) are available for all employees and effectively manage provision through the risk assessment process and appropriate control measures.

- Ensure that where it has been identified that non-latex gloves must be used due to a specific clinical procedure, a risk assessment has been carried out and that these

risk assessments are reviewed and updated as necessary.

- Ensure non-latex products are available for employees who may be sensitised to latex.
- Ensure non-latex gloves and latex gloves are stored separately, if it has been risk assessed that latex gloves are required.
- Make use of a health surveillance programme including pre-employment screening to establish if a prospective employee has a history of latex allergy.
- Raise awareness of latex allergy by inclusion of the topic in the induction process for new starters.
- Ensure every reasonable precaution is taken to protect a latex sensitive member of staff.
- Manage exposure to latex through health surveillance and the annual appraisal system where appropriate. A Latex questionnaire is to be completed with the employee as part of their appraisal (Refer to Appendix 2). Positive results are to be referred to the Occupational Health Service.
- Ensure a latex free environment as far as reasonably practicable, if he/she is notified that there is a latex sensitive patient on ward/department.
- Ensure that every patient is asked if they have any allergies and is recorded on the patient notes.
- Ensure that all staff are made aware if a latex sensitive patient is on the ward/department and that this is clearly marked in the patient notes.
- Complete an E-Datix Incident Report Form if a patient suffers an adverse reaction as a result of being in contact with latex.

6.7 Occupational Health Service will:

- Refer to the process developed to deal with the assessment of latex allergy in staff before and during employment.

- Advise employees and their managers on restrictions necessary to safeguard their health.

- Ensure that staff with known Type 1 latex sensitivity receives health surveillance at appropriate intervals.

- Ensure that there is a follow up for staff that are diagnosed with latex allergy/sensitivity.

  Advise the Health, Safety and Environment Unit of any employees who have been diagnosed with contact dermatitis as the condition of latex allergy may require reporting as an Occupational Disease under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

- Advise the Health Board management through the Operational Health and Safety Group of significant issues as they arise.

6.8 Health, Safety and Environment Unit will:

- Provide advice and support in the completion of the COSHH Assessments.

- Provide advice and information with regard to potential hazards in the workplace.

- Advise on methods of risk assessment.

6.9 Procurement Department will:

- Provide advice to Managers on the purchase of gloves and other equipment.

- Ensure only non-latex gloves (powder free, low protein latex) are available for all employees and effectively manage provision through the risk assessment process and appropriate control measures.

- Assist in finding alternative products for staff and patients who are allergic to latex products.

- Provide information to managers from manufacturers.

6.10 Staff will:

- Report any skin allergy problems to their Line Manager and Occupational Health.
- Assume responsibility to read and understand the relevant sections of this procedure.
- Complete an E-Datix Incident Report Form if any skin allergy problems occur.

6.11 What Staff Can Do To Protect Themselves

The assessment of risk under COSHH and this Procedure should eliminate the use of latex gloves and restrict the use of other latex products with a high leachable protein content, as far as is reasonably practical. In practice, measures likely to be identified by a suitable and sufficient risk assessment will include having a procedure, which includes:

- not wearing gloves unnecessarily
- ensuring that powdered latex gloves **are not** used
- following good hygiene practices, such as washing hands after removing gloves.
- all staff must use reasonable measures to ensure their skin remains healthy and intact. Barrier creams can affect glove integrity and should not be applied to hands immediately before wearing gloves.
- reporting any skin allergy problems to their Manager and the Occupational Health Service as soon as possible.

12. REVIEWING THE PROCEDURE

The Procedure will be reviewed within three years of implementation or as the Health Board changes and/or when legislation, codes of practice and official guidance dictate.

REFERENCES

Control of Substances Hazardous to Health Regulations 2002
Management of Health and Safety at Work Regulations 1999

Royal College of Physicians and NHS Plus – Latex Allergy, Occupational Aspects of Management 2008

Medical Device Alert (1996) Latex Sensitisation in the Healthcare Setting 1996/01

National Patient Safety Agency (NPSA) Protecting People with Allergy Associated with Latex 2005/08

APPENDIX 1

COMMON MEDICAL DEVICES CONTAINING LATEX

Adhesive tape
Ambu bags
Band-Aids and similar
Bulb syringes
Colostomy pouch
Condom urinary collection devices
Dental cofferdams
Elastic bandages
Electrode pads
Enema tubing kits
Fluid warming blankets
Gloves - examination and sterile
Haemodialysis equipment
Mattresses on stretchers
Neonatal incubator
PCA syringes
Protective sheets
Rubber gloves
Rubber pads
Stethoscope tubing
Stomach and GI tubes
Tourniquets
Urinary catheters
Vial stoppers
Wound drains

Anaesthesia and Operating Room Equipment

Blood pressure cuffs (bladder and tubing)
Bile bags
Chest drainage units
Drapes
Electrode pads
Endotracheal tubes
Epidural catheter injection adapters
Eye shields
Head straps
Injection ports on iv bags
Laparoscopy insufflation hoses
Linear/Burr hole drapes
Latex cuffs on plastic tracheal tubes
Latex injection ports on iv tubing

Multidose vial stoppers
Needle counting systems
Naso-pharyngeal airways

Oral-pharyngeal airways
Porous tape
Penrose tubing
Rubber suction catheters
Rubber breathing circuits
Rubber ventilation bellows
Rubber masks
Rubber tourniquets
Surgical masks
Teeth protectors & Bite blocks
Vented basic solution sets

Miscellaneous Products Containing Latex

Adhesive tape
Balloons
Condom
Camera eyepiece
Diaphragm
Dummies
Household work gloves
Paint
Raincoats
Shower cap
Swimming fins
Tennis/squash shoes
Underwear

Reference source:
http://www.jr2.ox.ac.uk/bandolier/bandopubs/NHSSlatex.html

APPENDIX 2

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Latex Questionnaire for the Personal Development Appraisal Review

Name……..... Dept……..…..

DOB……... Location…….

Job title……... Date started in post……

Have you had any reactions to gloves you have used at work? Including the following:	**Yes**	**No**	**Details**
Runny nose or sore itchy eyes			
Eczema, rash or dermatitis on hands			
Eczema on any other part of body			
Red, sore skin on hands			
Wheezing or breathlessness at work			
Have you had any reactions to the gloves you use at work?			

Signature of employee……..

Name and post of person administering this questionnaire……..

Signature……

Name of manager…….

Refer any positive responses to the Occupational Health Department

Action: NO FURTHER ACTION REQUIRED AT THIS TIME/YES - REFER TO OH

Date of next due questionnaire…….

ENVIRONMENTAL POLICY	
Name of Meeting: Health and Safety Committee	**Date of Meeting:** 22/01/2019

Executive Lead : Director of Planning
Author : Director of Capital Estates and Facilities – 02920 744335
Caring for People, Keeping People Well: This policy underpins the Health Board Strategy in optimizing the use of resources and reducing waste.
Financial impact: This policy underpins the Health Board Strategy in optimizing the use of resources and reducing waste, this will therefore optimize/minimize financial expenditure for utilities and waste management
Quality, Safety, Patient Experience impact: The policy requirements impacts on all services of the Health Board and directly/indirectly relates to all stakeholders and staff.
Health and Care Standard Number: N/A
CRAF Reference Number: 6 and 8
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The continual monitoring of Environmental management through the Environmental management Steering Group.

The Health and Safety Committee is asked to:

- **APPROVE** the Policy
- **APPROVE** the full publication of the Environmental Policy in accordance with the UHB Publication Scheme

SITUATION

Cardiff & Vale University Health Board is committed to the prevention of pollution and reduction of adverse effects on the environment associated with its operations; it is also committed to the identification and compliance to all legal, regulatory and statutory requirements. It is the intention of the organisation to continually improve its environmental performance and this policy has been implemented to deliver the aims, objectives and targets with respect to Environmental Management.

The policy has been updated and is revision 3 and was previously reviewed in September 2015.

BACKGROUND

The UHB recognises its responsibilities towards protecting the environment as a promoter of quality healthcare in Cardiff and the Vale of Glamorgan. The UHB is one of the largest NHS Boards in the UK, with an annual budget circa £1 billion, employing over 14,000 staff. The delivery of healthcare services is provided from a diverse range of premises and buildings across the locality, including 2 multi service acute hospitals, 3 community hospitals, 1 specialist hospital and a significant number of community based premises such as health centres and clinics.

The Organisation has operated an environmental strategy and shall address its activities and their impacts on the environment with a view to compliance with legislation, regulations and NHS guidance.

The UHB has implemented an Environmental Policy to coordinate these activities including the establishment of an Environmental Management steering group to influence the strategic direction of Environmental Management within the UHB.

The UHB also operates the Environmental Management Standard ISO14001 which is independently assessed and audited.

THE AIM OF THE ENVIRONMENTAL POLICY

The Environmental Policy and its associated Statements, Commitments, supporting procedures/documents has the following aims:

1) To continually improve the Health Boards Environmental performance for all of its main operational activities where possible, ensuring patient care is delivered in the most environmentally conscious manner.

2) Reduce Carbon Emissions by 3% per annum.

3) To comply with all relevant and applicable Environmental Legislation.

4) To work towards and support the National and Welsh Government Carbon Targets of an 80% CO2 reduction by 2050 and decarbonisation by 2030.

ASSESSMENT

The policy has been amended to incorporate organisational, administration and legislation/environmental standard changes. The Policy has been incorporated into the new UHB format.

Consultation has taken place to ensure that the policy meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document was as follows:-

- The Policy was presented to the Environmental Management Steering Group for consultation and comments.
- The document was issued for consultation on the UHB's intranet.
- The document and its amendment was discussed locally within Capital Estates and Facilities.

Where appropriate comments were incorporated within the document.

The primary source for dissemination of this document within the UHB will be via the intranet. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: *UHB143* Version Number: 3	Date of Next Review: January 2022 Previous Trust/LHB Reference Number: 13, 97, 194

ENVIRONMENTAL POLICY

Policy Statement

Cardiff & Vale University Health Board is committed to the prevention of pollution and reduction of adverse effects on the environment associated with its operations; it is also committed to the identification and compliance to all legal, regulatory and statutory requirements and to the requirements of all interested parties. It is the intention of the organisation to continually improve its environmental performance. This policy has been implemented to deliver the aims, objectives and targets with respect to Environmental Management.

Policy Commitment

This Environmental Policy is intended to provide an unambiguous commitment applicable to all the activities conducted by Cardiff &Vale University Health Board and to all the premises it operates.

Supporting Procedures and Written Control Documents

- Environmental Management System Core Elements
- Register of Environmental Aspects and Impacts
- Register of Environmental Legislation
- Environmental Management System Objectives and Targets
- Environmental Management Internal and External audits

Other supporting documents are:

- Documentation and Document Control
- Compliance policies and procedures
- Environmental Management System Steering Group
- EUETS and CRC program and permits

Scope

This policy applies to all activities of the UHB including operational, support services and Clinical and Healthcare activities where appropriate.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be either no impact or a positive impact.
Policy Approved by	Health and Safety Committee.
Group with authority to approve procedures written to explain how this policy will be implemented	Capital Estates and Facilities Health and Safety Group and Environmental Management Steering Group.

Accountable Executive or Clinical Board Director	Director of Capital, Estates and Facilities

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	09/10/2012	31/10/2012	This UHB policy supersedes a combination of polices of the former Trust.
2		23/09/2015	Policy review. Policy amended to reflect standard corporate format. Organisational chart amended.
3			Policy review. Policy amended to incorporate organisational, administration and legislation/environmental standard changes. Policy incorporated into new format.

Equality & Health Impact Assessment for

ENVIRONMENTAL POLICY

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Environmental Management Policy - Reference No UHB143
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Capital Estates and Facilities Director of Capital Estates and Facilities. 02920744335
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The Key Aims of the Environmental Management Policy are: • To continually improve the Health Boards Environmental Performance for all of its main operational activities where possible, ensuring patient care is delivered in the most environmentally conscious manner.

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

		• Reduce carbon emissions by 3%. • To comply with all relevant and applicable Environmental Legislation. • To work towards and support the National and Welsh Government Carbon Targets of an 80% CO2 reduction by 2050 and de - carbonisation by 2030. The policy details the UHB's strategy for Environmental Management to minimise environmental impact, improve sustainability and ensure Legislative compliance. The UHB has achieved the international standard ISO14001 accreditation certified and audited by BSI.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's	• Key Environmental representatives were consulted to initially review and update the policy. • The amended policy was then presented and issued to the Environmental Management Steering Group for comment and further amendment. Membership of the group includes Capital, Estates, Facilities, Commercial services, Clinical Boards, Cardiff University and other stakeholders. • Research undertaken to ensure that the content of the Policy includes where appropriate the principles of ISO14001. • The Policy has been presented and issued to the Capital Estates and Facilities Health and Safety Group for comment.

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf

	'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	• The Policy has been presented and issued to the Operational Health and Safety Group for comment and further amendment.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The Environmental Policy affects all staff, patients, visitors and contractors within the organisation.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A

[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.7 People with a religion or belief or with no religion or belief.		N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
The term 'religion' includes a religious or philosophical belief	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.10 People according to their income related group:			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	The nature, content and requirements of the policy have been reviewed and it is concluded that there is no/neutral Equality and Health impact.	N/A	N/A

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	N/A	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and	N/A	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	N/A	N/A	N/A
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the	The intent of the Environmental Policy is to reduce energy usage improve air quality, reduce pollutants and improve the physical environment.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	N/A	N/A	N/A
7.6 People in terms of macro-economic, environmental and	The intent of the Environmental Policy is to reduce energy usage	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	improve air quality, reduce pollutants and improve the physical environment. The policy also includes the UHB's approach to Sustainability and the Wellbeing and Future Generations Act 2015.		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	The aims, objectives and intent of the Policy will result in positive impacts including: • Reduced Energy, water and raw material usage. • Reduced cost and carbon emissions. • Reduced waste generation and disposal. • Improved air quality • Improved biodiversity and green spaces • Reduced minor environmental impacts e.g. noise, visual impact etc.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	N/A			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

8.4 What are the next steps?
Some suggestions:-
• Decide whether the strategy, policy, plan, procedure and/or service proposal:
  o continues unchanged as there are no significant negative impacts
  o adjusts to account for the negative impacts
  o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  o stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review
	N/A			

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** January 2022 **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Environmental Management Procedure

Introduction and Aim

The purpose of this Procedure is to support the Environmental Policy and its associated Statements, Commitments, supporting procedures/documents and to achieve the following aims:

1) To continually improve the Health Boards Environmental performance for all of its main operational activities where possible, ensuring patient care is delivered in the most environmentally conscious manner.

2) Reduce Carbon Emissions by 3% per annum.

3) To comply with all relevant and applicable Environmental Legislation.

4) To work towards and support the National and Welsh Government Carbon Targets of an 80% CO2 reduction by 2050 and decarbonisation by 2030.

Objectives

The Objectives of the procedure are to:-

a) Comply fully with all environmental legal requirements, relevant codes of practice and regulations.

b) Prevent pollution to land, air and water.

c) Encourage efficient use of all energy, utilities and natural resources, especially where these are non-renewable

d) Minimise consumption through the reduction, reuse or recycling of materials as much as possible.

e) Minimise waste and increase recycling within the framework of our waste management policy.

f) Ensure that services are sensitive to visual amenity, and encourage a positive sustainable ecological impact on natural habitats with a positive approach to tree planting or green areas where appropriate.

g) Purchase products and services that do the least damage to the environment and encourage others to do the same.

h) Provide suitable training to enable employees to deal with their specific areas of environmental control.

i) Implement travel strategy that takes account of environmental issues as far as reasonably practical and encourages where possible the use of feasible alternative means of transport.

j) Ensure that all employees and contractors understand our environmental policy and conform to the high standards required.

k) Ensure the physical environment of buildings and grounds on health premises are continually improved, and that staff welfare, health and comfort are foremost in design of new builds or refurbishment.

Scope

This procedure applies to all activities of the UHB including operational, support services and Clinical and Healthcare activities where appropriate.

Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be either no impact or a positive impact.
Documents to read alongside this Procedure	• Environmental Management System Core Elements. • Register of Environmental Aspects and Impacts. • Register of Environmental Legislation. • Environmental Management System Objectives and Targets. • Environmental Management Internal and External audit. • Documentation and Document Control. • Compliance policies and procedures. • Environmental Management System Steering Group. • EUETS and CRC program and permits.
Approved by	Capital Estates and Facilities Health and Safety Group/ Environmental Management Steering Group/Health and Safety Committee.

Accountable Executive or Clinical Board Director	Director of Capital Estates and Facilities
Author(s)	Head of Energy and Performance

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1		*TBA*	New Procedure in line with new UHB Policy arrangements

Environmental Management Procedures

CONTENTS

1.0 INTRODUCTION

The UHB recognises its responsibilities towards protecting the environment as a promoter of quality healthcare in Cardiff and the Vale of Glamorgan. The UHB is one of the largest NHS Boards in the UK, with an annual budget circa £1 billion, employing over 14,000 staff. The delivery of healthcare services is provided from a diverse range of premises and buildings across the locality, including 2 multi service acute hospitals, 3 community hospitals, 1 specialist hospital and a significant number of community based premises such as health centres and clinics.

The Organisation shall address its activities and their impacts on the environment with a view to compliance with legislation, regulations and NHS guidance, which may be applied to the Organisation's activities, consistent with maintaining the Organisation's responsibility to provide high quality patient care, quality teaching and research.

The Organisation will adopt specific measures to enhance the quality of the environment for both staff and patients, and consequently the health of the local population, through a positive policy on safety in the workplace, control of pollution and care of the local environment.

The UHB operates the Environmental Management Standard ISO14001 and Clause 5.0 of ISO 14001states:

Top management shall establish, implement and maintain an environmental policy that, within the defined scope of its environmental management system:
a) is appropriate to the purpose and context of the organization, including the nature, scale and environmental impacts of its activities, products and services;
b) provides a framework for setting environmental objectives;

c) includes a commitment to the protection of the environment, including prevention of pollution and other specific commitment(s) relevant to the context of the organization;

d) includes a commitment to fulfil its compliance obligations;

e) includes a commitment to continual improvement of the environmental management system to enhance environmental performance.

The environmental policy shall:

- be maintained as documented information;
- be communicated within the organization;
- be available to interested parties.

This document aims to demonstrate compliance with this requirement.

2.0 POLICY STATEMENT

Cardiff and Vale University Health Board recognises that the day-to-day operations of the Board can impact both directly and indirectly on the environment. We aim to protect and improve the environment by complying with all relevant legislation and Government guidance, through good innovative management and being pro-active in adopting best practice wherever operationally and practically possible. The UHB will work to integrate environmental considerations into our business decisions and adopt sustainable alternatives wherever possible, throughout our operations.

Cardiff and University Health Board are committed to environmental management and sustainable development demonstrated with the achievement of ISO14001 in 2003. This Policy covers Environmental Management, Sustainable Development and Energy Management under one policy.

An Environmental Management Steering Group shall guide and influence the strategic/operational direction of environmental management within the Organisation and act as a focal point of contact for matters relating to environmental management. An organisational diagram showing reporting arrangements is shown in Appendix 1.0.

Waste management and Sustainable Procurement will continue to operate separate policy documents. As energy and utilities usage is the most significant Environmental impact within the UHB a separate section is included in appendix 2 of this Environmental Policy. A sustainable development plan is also included in Appendix 3.

3.0 AIMS

The key aims of the Environmental Policy are:

- To continually improve the Health Boards Environmental performance for all of its main operational activities where possible, ensuring patient care is delivered in the most environmentally conscious manner.

- Reduce Carbon Emissions by 3% per annum.
- To comply with all relevant and applicable Environmental Legislation.
- To work towards and support the National and Welsh Government Carbon Targets of an 80% CO2 reduction by 2050 and decarbonisation by 2030.

4.0 OBJECTIVES

The principle objectives of this policy are to:

- Comply fully with all environmental legal requirements, relevant codes of practice and regulations.
- Prevent pollution to land, air and water.
- Encourage efficient use of all energy, utilities and natural resources, especially where these are non-renewable
- Minimise consumption through the reduction, reuse or recycling of materials as much as possible.
- Minimise waste and increase recycling within the framework of our waste management policy.
- Ensure that services are sensitive to visual amenity, and encourage a positive sustainable ecological impact on natural habitats with a positive approach to tree planting or green areas where appropriate.
- Purchase products and services that do the least damage to the environment and encourage others to do the same.
- Provide suitable training to enable employees to deal with their specific areas of environmental control.
- Implement travel strategy that takes account of environmental issues as far as reasonably practical and encourages where possible the use of feasible alternative means of transport.
- Ensure that all employees and contractors understand our environmental policy and conform to the high standards required.
- Ensure the physical environment of buildings and grounds on health premises are continually improved, and that staff welfare, health and comfort are foremost in design of new builds or refurbishment.

5.0 RESPONSIBILITIES/IMPLEMENTATION

5.1 The Board

To give corporate commitments, outline strategic objectives and agree major investment decisions.

5.1 Director of Planning

Executive responsibility and accountability for meeting Environmental Performance targets and compliance with Legislation and associated requirements.

5.4 Director of Capital, Estates and Facilities

Responsible for development and implementation of the Environmental Policy. Accountable to the Director of Planning.

5.3 Managers

Ensure appropriate training is delivered to those involved. Share best practices with colleagues and demonstrate that this is being done. Actively participate in Environmental Management including Energy and Waste Management and other programs as necessary.

5.5 Environmental and Energy Management Steering Group

To guide and influence strategic/operational direction of environmental management within the Organisation, and for keeping the Board informed on progress in improving the Organisation's overall environmental performance. To act as a focal point of contact for matters relating to environmental management within the UHB including ISO 14001 accreditation.

5.6 Members of Staff/Employees

To act as Champions and to assist in the delivery of the Boards Environmental Management program, by adopting good practice (as appropriate) in the workplace to minimise environmental impact.

Good practice shall include:

- Appropriate waste segregation and disposal.
- Turning off energy consuming equipment when not in use and at the end of each working day.
- Engaging in Sustainable Transport Policies/procedures.

- Any other UHB Environmental Management procedure/protocol.

6.0 RESOURCES

Resources for environmental management, requisite training, operation, monitoring and auditing of performance are in place. These include:

- A full time Energy manager will also focus on environmental management based in Capital, Estates and Facilities
- The potential for Private Sector investment will be pursued as appropriate, for major capital investment initiatives.
- The UHB will participate in the Welsh Health Environmental Forum administrated by Shared Services and other associated forums as required including the Energy Price Risk Management group.

7.0 TRAINING

The UHB will ensure through the managerial arrangements that all personnel engaged in energy management duties will have received appropriate training, and are competent to discharge their duties, delivered on an on-going basis as necessary. This will be delivered via the UHB's training and induction programme, augmented with specialist training such as tailored training sessions to suit individual needs of employees or departments.

8.0 IMPLEMENTATION

The implementation of this policy uses ISO14001 as the management system. ISO14001 contains clear objectives and targets for the management of the environment.

9.0 FURTHER INFORMATION

- ISO14001 EMS Manual
- Shared Services Websites and Journals
- Welsh Assembly Government Environmental Strategy for Wales and associated publications

10.0 EQUALITY

Cardiff and Vale University Local Health Board is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan & Equality Objectives. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB.

We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was either no impact or a positive impact to the equality groups mentioned.

11.0 AUDIT

Adherence to the requirements of this policy will be monitored via a number of different methods, primarily the external ISO 14001 accreditation audits.

Progress on implementing this Policy will be monitored by the Environmental Management Steering Group and the Health and Safety Committee with reports issued to the Director of Planning.

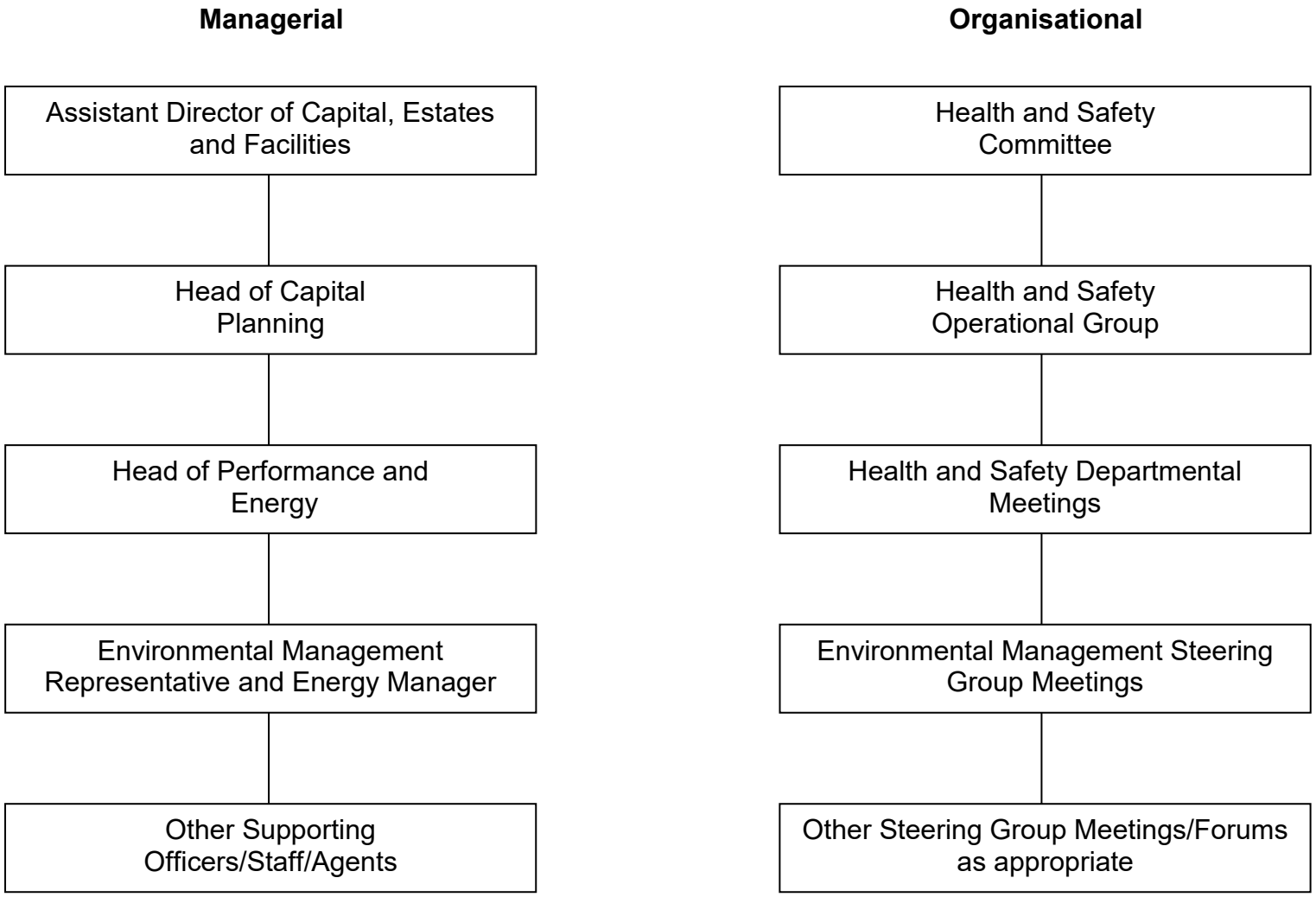
An annual written Sustainability report outlining performances and achievements for the year will be prepared and issued to the Assistant Director of Planning.

12.0 REVIEW

This Policy will be reviewed on a three yearly basis.

APPENDICES

Appendix 1 – Management and Organisational Structure



Appendix 2 – Energy/Carbon Management Plan

ENERGY AND CARBON MANAGEMENT PLAN

INTRODUCTION AND BACKGROUND

Energy and Utilities consumption within Cardiff and Vale University Health Board (UHB) is the most significant Environmental aspect and impact, resulting in nearly 40,000 tonnes of C02 emissions being released to the atmosphere per annum. Energy prices have escalated dramatically in the last 10 years and the UHB's utilities expenditure is now over £9 million per annum.

During the last 5 years the UHB has introduced a range of procurement and technical measures to ensure that utilities are acquired at the most economic level and to reduce consumption. These programs will be continued and enhanced including the introduction of new initiatives, technologies and strategies.

KEY ENERGY/CARBON OBJECTIVES

1) To reduce/minimise the Health Boards Energy/Carbon impact for all of its main operational activities where possible.
2) To comply with all relevant and applicable Energy Legislation.
3) To reduce/minimise where possible and appropriate the Health Boards resource/utilities consumption and costs by 3%.

ENERGY MANAGEMENT STRATEGY AND PROPOSED INITIATVES

1) Operation of 4.4MWe CHP facility at University Hospital of Wales.
2) The UHB will develop an action plan for each financial year detailing the projects, capital costs and savings which will be implemented. The UHB will also explore other opportunities through third-party organisations.
3) Participation in the Governments Refit program whereby large scale strategic schemes are delivered through a third party contractor. Capital funding is provided through a Welsh Government program and repaid with no interest charges. The contractor develops, designs, implements, commissions, tests and operates the new plant, equipment and systems for an 8 year program. The energy savings released, repays all funding and charges and results in a net energy cost saving for the UHB.
4) Proactive monitoring and targeting programmes are in place to reduce energy and water consumption and cost.
5) Staff awareness initiatives implemented to promote energy awareness and provide advice on how to reduce energy and water consumption.
6) Feasibility studies and audits are conducted as appropriate, to identify opportunities for carbon emission and cost reductions.
7) Benchmarking to identify how the Health Board is performing in comparison to other Hospitals and norms and standards.

8) Regular energy and carbon management reviews and amending the plan in line with the outcome of the review.

Appendix 3 Sustainable Development Plan

INTRODUCTION AND BACKGROUND

Sustainable development is the process by which the UHB moves towards sustainability and is about shaping our own future in ways which ensure a better quality of life for everyone, now and in the future. It recognises that the quality of people's lives and our communities are affected by a combination of economic, social and environmental factors. Lasting solutions to global problems can only be achieved by making these linkages.

The inter-linked principles associated with sustainable development include:

- Living within environmental limits
- Ensuring a strong, healthy and just society
- Achieving a sustainable economy
- Using sound science responsibly
- Promoting good governance

SUSTAINBLE DEVELOPMENT STRATEGY AND PROPOSED INITIATVES

1) Respecting environmental limits so that resources are not irrecoverably depleted or the environment irreversibly damaged.
2) Maximising the awareness and potential of employees to contribute towards sustainable development.
3) Environmental policy and an accredited environmental management system - EMS in accordance with the international standard ISO 14001. The strategy will be in line with the requirements of the UHB's program to satisfy the requirements of the Well Being and Future Generations Act 2015, Environment (Wales) Act 2016 and associated principles.
4) Conserving energy, water, wood, paper and other resources – particularly those which are scarce or non-renewable – while still providing a safe and comfortable working environment.
5) Purchasing activity on behalf of the Board will be conducted in accordance with the sustainable elements of the Procurement Policy and Procedures.
6) Ensuring that all new buildings occupied by the UHB are designed, constructed and operated to improve their environmental performance, and to promote natural ventilation and light, when planning new or substantially refurbished buildings.
7) Reducing waste through re-use and recycling and by using refurbished and recycled products and materials where appropriate.
8) Encouraging more sustainable travel to work options via a Sustainable Travel Plan.
9) Communicate our action plans and progress on a regular basis

CCTV Policy and Procedure	
Name of Meeting: Health and Safety Committee	**Date of Meeting:** 22/10/2019

Executive Lead : Director of Planning
Author : Head of Security Services Tel no: 02920 744080
Caring for People, Keeping People Well: This Policy underpins the UHB Strategy for Caring for People, Keeping People Well by improving Security and personal safety with effective utilization of the CCTV systems at the CAVUHB
Financial impact: The implementation of this policy will be undertaken within the resources of the UHB and any identified additional resource requirement will be brought to the Committee for approval.
Quality, Safety, Patient Experience impact: This Policy will improve Quality, Safety and Patient Experience by enhancing Health and Safety through improved utilization of the CCTV systems at the CAVUHB
Health and Care Standard Number: N/A
CRAF Reference Number: 8
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Policy continuing to provide enhanced Security and personal safety with effective utilization of the CCTV systems at the CAVUHB

The Health and Safety Committee is asked to:

- **APPROVE** the CCTV Policy and Procedure

and

- **APPROVE** the full publication of the CCTV Policy and Procedure Policy in accordance with the UHB Publication Scheme

SITUATION

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements regarding the management of CCTV Policy and Procedure.

The CCTV Policy and Procedure Policy documents the risks, the various processes for managing and controlling CCTV and the hierarchy of responsibility. The Policy was due a periodic review and while the majority of the content has remained unchanged, amendments to reflect changes in the structure of the Capital, Planning & Facilities Department have been made.

BACKGROUND

The CCTV Policy and Procedure of the Cardiff and Vale University Health Board (UHB) sets out the CCTV arrangements which are to be implemented in all areas of Cardiff and Vale UHB.

CCTV in Cardiff and Vale UHB is concerned with the provision of safeguards to protect the safety of those who work for the UHB and those using UHB premises and property.

This policy once approved will replace the current version of the CCTV Policy and Procedure.

ASSESSMENT

Consultation has taken place to ensure that the policy/procedure meets the needs of the UHB and our stakeholders and was prepared in conjunction with Capital Estates and Facilities professionals.

The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 12th December 2018 and 9th January 2019;
- The document was shared with the Operational Health and Safety Group.
- Comments were invited via individual e-mails from the Operational Health and Safety Group.

Where appropriate comments were taken on board and incorporated within the draft document.

The Policy will be reviewed every 3 years unless legislation, guidance, the UHB or other factors dictate otherwise. Approval will then be sought from the Health and Safety Committee.

The primary source for dissemination of the CCTV Policy and Procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

The CCTV Policy and Procedure will continue to provide enhanced CCTV management and improved control. This will improve the Health and Safety of all patients, visitors, staff and stakeholders who use/visit the UHB's premises.

Reference Number: UHB 303 **Version Number:** 2	**Date of Next Review:** January 2022 **Previous Trust/LHB Reference Number:** N/A

Closed Circuit Television (CCTV) Policy

Policy Statement

The purpose of this policy is to ensure that Cardiff and Vale University Health Board:

- Complies with relevant legislation, while also protecting and providing security to individuals, property and/or land which the organisation owns and controls. In order to assist in fulfilling its duty of care to provide protection and security for employees and others who use these properties the organisation has a Closed Circuit Television (CCTV) surveillance system in place at many of these locations.
- Surveillance of any sort can be intrusive and impact on people's privacy. No CCTV will be initiated, installed, moved or replaced until a full Privacy assessment has been undertaken by the security manager. Installation, positioning, movement or replacement of CCTV will take account of the balance of risks to safety and/or security as well as the outcome of the impact assessment.
- The purpose of CCTV is to protect people. It should not be used for management/ HR purposes in disciplinary actions except where there is evidence of criminal behaviour.
- Any changes to this policy will require the approval of the Chief Executive. This policy will be reviewed annually to ensure that it continues to be effective and comply with existing legal requirements.
- There will be operational procedures to underpin this policy.

Policy Commitment

The primary purpose of Closed Circuit Television (CCTV) schemes is to help reduce the fear of crime for Health Board staff (particularly those on shifts who are entering and leaving the Health Board premises during the hours of darkness) and to protect Health Board premises from criminal activity.

In addition CCTV may be used to monitor areas that are difficult for staff to monitor areas where patient or public safety could be an issue.

CCTV may be installed in areas where close supervision is required when there is a fear the patient may harm themselves or others.

The particular purpose of all schemes, unless specifically identified as targeted monitoring are in accordance with the following rational

- To detect, prevent and reduce the incidence of crime on Health Board property so maintaining the security of individuals and property in all areas.

- To protect/maintain the wellbeing of patients, staff and Service users and all other persons on UHB property to prevent and detect crime and facilitate the apprehension and prosecution of offenders.
- To reduce incidences of vandalism and criminal damage to property belonging to the Health Board, its employees and visitors.
- To monitor the difficult to observe areas on Health Board sites where there is a real potential for patients to abscond or do harm to themselves or others.
- To provide reassurance and promote a safer environment for all
- To assist in major incidents

Supporting Procedures and Written Control Documents

This Policy and the *'supporting procedures'*

- CCTV Procedure
- Operational Guidance for installation and use of CCTV
- CCTV Maintenance Log
- Daily CCTV Log Sheet
- Guidance on Viewing of CCTV Images
- Guidance on Subject Access Refusals
- Guidance on Image Provisions to 3rd Party or to Police for Legal Proceedings
- Application to Access CCTV images
- Operational Guidance on Body Worn Cameras
- Health and Safety policies

Other supporting documents are:

- Data Protection Act 1998 - http://www.legislation.gov.uk/ukpga/1998/29/contents
- General Data Protection Regulation - General Data Protection Regulation (GDPR) – Final text neatly arranged
- CCTV Code of Practice, revised edition, 2008: Information Commissioner's Office - https://ico.org.uk/for_organisations/data_protection/topic_guides/cctv
- Human Rights Act 1998 - http://www.equalityhumanrights.com/your-rights/human-rights/what-are-human-rights/human-rights-act
- Regulation of Investigatory Powers Act 2000 - http://www.legislation.gov.uk/ukpga/2000/23/contents
- Freedom of Information Act 2000 (section 40) - http://www.legislation.gov.uk/ukpga/2000/36/section/40
- Information Commissioner's Office – www.ico.gov.uk

- Guidance for the Police use of Body-Worn Devices published July 2007, Police and Crime Standards Directorate - http://library.college.police.uk/docs/homeoffice/guidance-body-worn-devices.pdf
- Data Protection CCTV Code of Practice - www.ico.org.uk
- Operational Procedures for the Control and Use of CCTV
- Guidance on Body Worn Devices (BDW)

Scope

This policy covers all employees, persons providing a service, patients and visitors whose image(s) may be captured by CCTV owned and operated by Cardiff and Vale University Health Board.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be no impact.
Health Impact Assessment	A Health Impact Assessment is not required for this policy.
Policy Approved by	Health and Safety Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Personal Safety/Security Strategy Group
Accountable Executive or Clinical Board Director	Director of Planning

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	6 October 2015	23/08/2016	New document
2			3 yearly review of document

Reference Number: UHB 303 **Version Number:** 2	**Date of Next Review** **Previous Trust/LHB Reference Number:** T103

CCTV Control and Use Operational Procedures

Introduction and Aim

A Closed Circuit Television (CCTV) system has been introduced to the Cardiff and Vale Health Board, which comprises of a number of cameras installed at strategic locations. The operational capabilities of the cameras are varied; some are PTZ (pan, tilt and zoom), while others are static cameras presenting fixed images.

Monitoring and control facilities are located at sites within the Cardiff and Vale Health Board, recording facilities are only located within CCTV monitoring rooms.

The 'owner' and 'data controller' of the system is the Cardiff and Vale Health Board and for the purposes of the General Data Protection Regulation the 'Data Controller' is the Cardiff and Vale Health Board representative, the Data Protection Officer. The 'System Manager' with day- to-day responsibility for the data is the Cardiff and Vale Health Board Security Manager.

The Head of Commercial Serviced is the Cardiff and Vale Health Board representative of the CCTV system owners and will have unrestricted personal access to the CCTV monitoring room and receive regular reports from the manager of the system. The Cardiff and Vale Health Board 'Security Strategy' committee has specific responsibility for receiving and considering these reports.
Data will be processed in accordance with the principles of the General Data Protection Regulation which summarised are, but is not limited to:

- All personal data will be obtained and processed fairly and lawfully.
- Personal data will be held only for the purposes specified.
- Personal data will be used only for the purposes, and disclosed only to the people, shown within this policy.
- Only personal data will be held which are adequate, relevant and not excessive in relation to the purpose for which the data are held.
- Steps will be taken to ensure that personal data are accurate and where necessary, kept up to date.
- Personal data will be held for no longer than is necessary.
- Individuals will be allowed access to information held about them and, where appropriate, permitted to correct or erase it.
- Procedures will be implemented to put in place security measures to prevent unauthorised or accidental access to, alteration, disclosure, or loss and destruction of, information.

The purpose of this prpcedure is to state the intention of the owners and the managers, as far as is reasonably practicable, to support the objectives of Cardiff and Vale Health Board CCTV System. The purpose and reason for implementing the CCTV system is as

previously defined and in order to achieve the objectives of the Cardiff and Vale Health Board

Objectives

- The objective of the procedure is to ensure the use of CCTV cameras throughout the Health Board will be in installed and used in compliance with the principles of the General Data Protection Regulation, Human Rights Act 1998, Regulation and Investigatory Powers Act 2000 and other relevant legislation.

- The Regulation of Investigatory Powers Act 2000 regulates the use of covert/directed surveillance and is subject to a strict code of practice. Use of CCTV in these circumstances or for any other reason other than that authorised in accordance with this procedure is not covered by this procedure and in such circumstances further guidance should be sought.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be no impact.
Documents to read alongside this Procedure	• CCTV Closed Circuit Television Policy • General Data Protection Regulation https://gdpr-info.eu/ • Data Protection Act 1998 - http://www.legislation.gov.uk/ukpga/1998/29/contents • CCTV Code of Practice, revised edition, 2008: Information Commissioner's Office - https://ico.org.uk/for_organisations/data_protection/topic_guides/cctv • Human Rights Act 1998 - http://www.equalityhumanrights.com/your-rights/human-rights/what-are-human-rights/human-rights-act • Regulation of Investigatory Powers Act 2000 - http://www.legislation.gov.uk/ukpga/2000/23/contents • Freedom of Information Act 2000 (section 40) - http://www.legislation.gov.uk/ukpga/2000/36/section/40

	• Information Commissioner's Office – www.ico.gov.uk • Guidance for the Police use of Body-Worn Devices published July 2007, Police and Crime Standards Directorate - http://library.college.police.uk/docs/homeoffice/guidance-body-worn-devices.pdf
Approved by	Security/Personal Safety Strategy Group
Accountable Executive or Clinical Board Director	Director of Planning and Operations
Author(s)	Case Manager/Personal Safety Advisor

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	06/10/2015	23/08/2016	Supersedes previous Trust document reference number 103

Contents Page

Appendices

Application to Access CCTV Images

Body Worn CCTV System for Security Officers

CCTV Control and Use Operational Procedure

1. Purpose

The purpose of this document is to ensure:

- That the use of the Health Boards Closed Circuit Television (CCTV) adheres to the principles of the General Data Protection Regulation, Human Rights Act 1998, Regulation Investigatory Powers Act 2000 and other relevant legislation
- That the CCTV system is not abused or misused
- That the CCTV is correctly and efficiently installed and operated
- That the CCTV is only accessible to authorised individuals

The overall purpose of CCTV schemes is to help in the reduction of and investigation of crime, to protect Health Board staff and to protect Health board premises from criminal activities. The purposes are in accordance with the following rationale:

- To assist in the prevention and detection of crime against both persons and property.
- To facilitate the identification, apprehension and prosecution of offenders in relation to crime.
- To ensure the security of property belonging to Health Board employees and visitors to the Health Board.

2. Scope

The Procedure Applies to all employees of the Health Board and for whatever purpose is present on Health Board premises.

3. Ownership and Operation of CCTV

The Cardiff and Vale University Health Board is the ‘data controller’ for all CCTV systems operating on its premises. The Health Board is responsible for all cameras, monitors and data collection and retention processes.

4. Principles

- The system will be operated in accordance with all the requirements and articles of the Human Rights Act 1998.
- The operation of the system will also recognise the need for formal authorisation of surveillance as required by the regulation of investigatory Powers Act 2000, in particular Part 2 of the Act.

- The system will be operated in accordance with the General Data Protection Regulation at all times.
- The system will be operated fairly, within the law, and only for the purpose for which it was established and identified within this procedure.
- The system will be operated with due regard to the principle that everyone has the right to respect for their private family life and their home.
- The public interest in the operation of the system will be safeguarded by ensuring the security and integrity of operational procedures.
- Throughout this procedure it is intended, as far as reasonably possible, to balance the objectives of the CCTV system with the need to safeguard the individuals rights.
- Every effort has been made throughout the procedure to indicate that a formal structure has been put in place, including a complaints procedure, by which it can be identified that the system is not only accountable, but is seen to be accountable.
- Participation in the System by any organisation, individual or authority assumes an agreement by all such participants to comply fully with this policy and to be accountable under the Office of the Information Commissioner's Code of Practice.

5. General Data Protection Regulation

The Health Boards Data Protection Manager will identify and include all its schemes within the notification which is required to do so under the terms of the General Data Protection Regulation

All schemes will operate in accordance with the guidelines set out in the 'CCTV Code of Practice' published by the Information Commissioners Office. In order to conform to this Code of Practice, the following guidelines must be adhered to:

- The Health Boards Head of Commercial Services , Security Services operating such schemes, will be responsible for overseeing that monitoring of all images are in accordance with this policy and that suitable operation, back up, retention, destruction and maintenance of all storage media is conducted in accordance with the written operational procedures manual kept within the site control room.
- Cameras will not be hidden from view and appropriate steps must be taken, e.g. by signing and displaying posters, to inform the public of the presence of the system and its ownership at all times.
- To ensure privacy, images from the system are viewed by trained and authorised staff, where a camera is there not to protect patients or staff, but property, then the camera's should be fixed and focused.
- Images from the cameras are appropriately recorded with existing operational procedures.

6. Directed Surveillance

Directed surveillance can be undertaken with the consent of the proper authorities and in accordance with the Law, The regulation of investigatory Powers Act 2000 regulates the use of directed surveillance of this type and is subject to a strict code of practice.

The Health Board should satisfy itself that there are grounds for suspecting criminal activity or equivalent malpractice and that notifying individuals about the monitoring would prejudice its prevention or detection. It should only be considered in exceptional circumstances, any member of staff wishing to use directed CCTV surveillance should consult the Security Manager and the Data Protection Manager.

Directed surveillance should be strictly targeted at obtaining evidence within a set timeframe and should not continue after the investigation is complete. Cameras should not be placed in areas which you would reasonably expect to be private (e.g. toilets). There may be exceptions to this in cases of suspicion of serious crime whereby there is police involvement.

The minimum number of people possible should be involved in the investigation. Prior to each investigation, clear rules should be set up limiting the disclosure and access to the information obtained.

Directed surveillance can only be carried out with the authorisation/instruction from the Head of Commercial Services, Security Services and or the Police. The Health Boards Chief Executive should be notified to inform that covert surveillance is being carried out.

7. Roles and Responsibilities

It is the responsibility of the Chief Executive as overall owner and data controller of the CCTV system. He has delegated these responsibilities to the Director of Planning.

The following members of staff have specific responsibility for the management of the CCTV systems on Health Boards sites.

7.1 Health Board Head of Security

Is responsible for the operational management of the CCTV systems operated by the security staff, The Manager will ensure that the use and management of the system is in keeping with the CCTV policy, monitor compliance and report any breaches to the Head of Health and Safety, Security Services.

The Security Manager shall be responsible for ensuring that future development of CCTV Systems is approved in accordance with the requirements of legislation. Act as the link with the Head of Commercial Services, Security Services, and Data Protection Manager with respect to the legislation covered by this policy.

To notify persons on Health Board property where CCTV is installed and that a CCTV scheme is in operation by clear notices placed around the sites and areas of CCTV.

7.2 Head of Health and Safety, Security Services

The Head Commercial Services has overall responsibility for the Strategic planning of the CCTV.

7.3 Health Board Data Protection Manager

Shall be responsible for ensuring that all the Health Board CCTV schemes are adherent to the Data Protection Act 1998, and the associated Code of Practice. The Data Protection Manager will also be responsible for updating the Health Board on any changes in legislation and for ensuring that the Health Board's registration with the information Commissioner is accurate and up to date.

7.4 Security Staff

Security staff will ensure adherence to this Code of Practice. All staff involved in the handling of the CCTV equipment, both directly employed and contracted, will be made aware of the sensitivity of handling CCTV images and recordings. Staff will be fully briefed in respect of all functions, both operational and administrative relating to CCTV control operations.

8. Management of CCTV Schemes

No part of the CCTV system should be initiated, installed, moved or replaced without prior approval by the Head Security Services Management Team, to approve such schemes; it must also comply with the General Data Protection Regulation.

All schemes are required to meet all the following standards and must be formally approved (as above) prior to installation;

- Establish who the person(s) legally responsible for the proposed scheme within the Health Board.
- Assess the appropriateness of the reasons for, using CCTV or similar surveillance equipment.

- Document this assessment process and the reasons for the installation of the scheme.
- Establish and document in accordance with current legislation the purpose of the scheme.
- Ensure the notification lodged with the Office of the Information Commissioner covers the purposes for which this equipment will be used.
- Establish and document the person(s) or organisation(s) that are responsible for ensuring the day-to-day compliance with the operational requirements of such scheme and this policy.

This must be done jointly by the Security Manager and the Data Protection Manager.

All CCTV equipment should be purchased and installed in conjunction with the Health, Safety and Security Services Department and Shared Service Procurement Department. If a member of staff wants to implement a new CCTV system they should contact the Health Boards Security Manager.

9. Digital CCTV

- All digital CCTV systems installed onto the Health Board premises must have the storage capacity to hold a minimum of 31-day footage. In certain circumstances it may be considered appropriate to retain data for a longer period, a full risk assessment must be taken before making a decision for a longer retention period.
- If police require access to CCTV footage an area should be made available for viewing. This area is designated as the Security Control Room at the University Hospital of Wales. A trained member of staff to be available at all times to ensure timely downloading to ensure the prompt investigation of incidents.
- If the police require a copy of the footage, two copies must be made. One copy to be retained by the Health Board and the other given to the police. The event will be noted in the security log and details and signature of the recipient obtained.
- All statements within the policy apply to the use of digital CCTV including guidance outlined above. If the police request access, above guidance must be adhered to, in addition to the section on access to digital images.

10. Recording

Systems are supported by the hard drive recording facilities which will function as appropriate. In addition incidents can be recorded in real time when necessary.

In the event of the recorded footage being required for evidence, it will be retained for a period recommended by the Health Boards Legal department and/or the police.

It will be separately indexed and securely stored in the Security Managers safe to avoid accidental re-use.

All footage that has been retained to record information remains confidential and copyright at all times and remains the property of Cardiff and Vale University Health Board.

11. Positioning of Camera and Signs

The location of the equipment must be carefully considered, the following points must be taken into consideration before installing either a new CCTV camera or a full CCTV system.

- Equipment should be situated so they can monitor the area that is intended to be monitored.
- Equipment should be situated so they can only monitor the predefined purpose.
- Cameras cannot be positioned in areas where it would be considered private e.g. toilet, changing room, private office. (There maybe exceptions to this in cases of suspicion of serious crime whereby there is police involvement).
- If the CCTV area borders private property every effort should be made to ensure the private area cannot be viewed.
- Signs that CCTV cameras operating shall be displayed at the perimeter of the area covered by the scheme and at other key points.
- The signs shall inform the public that cameras are in operation and allow people entering the hospital to make a reasonable approximation of the area covered by the scheme.
- Signs should identify the Cardiff and Vales University Health Board and give an official address.
- Any system implemented must be periodically reviewed to maintain its effectiveness and to ensure blind spots are eliminated where possible; more importantly areas covered remain a priority and that any new emerging hot spots are taken into consideration. Health and Safety policies should assist in this process. Consider implementing a system which factors in flexibility to tackle emerging risks at a later date?

12. Administration and Procedure

A log will be maintained with the control room/viewing area and kept secure. Brief details of incidents will be noted together with any consequential action taken.

It is recognised that the images obtained are sensitive and subject to General Data Protection Regulation. All DVDs, digital images and copies will be handled in accordance with working procedures, which are designed to ensure the integrity of

the system. A DVD log will be kept on-site for the purposes of recording the use of DVDs, their use and retention for evidential purposes.

Other than authorised staff investigating untoward incidents, digital images will only be viewed at the request of the police or through subject access procedures. Copies of DVDs will only be made for the purposes of crime detection, evidence for prosecutions or where required by law.

13. Camera Control

On each occasion an incident is recorded, a report setting out the time, date and detail of the incident will be submitted by the relevant CCTV operator to the Security Manager.

Adjustment and alteration to siting or use of cameras should be made by staff that has the appropriate authority. Data protection principles should be considered during this process.

DVD handling procedures are in place to ensure the integrity of the image information held.

14. The Control Room/Viewing Area

Images captured by the systems will be monitored on-site, in the Security Control Room. Unauthorised personnel or visitors should not be able to see the monitors.

Access to view monitors or DVD and digital images activity will only be granted to persons with a legitimate reason or those who have followed the subject access procedures. Identify and authorisation will have been presented and validated to the responsible officer. Visitors will be required to complete and sign an access log. Details recorded will include name, department or organisation, the person who granted the access, time of entry and exit, and the DVD or digital image referenced and extracts viewed.

Criteria for the viewing of the hard drive non-security related personnel;

At the discretion of the Security Manager, Data Protection Manager or on-call Site Manager out of hours. Individuals may be allowed to view the Hard Drive in the viewing area:-

- If they are investigating an untoward incident.
- In the case of a missing patient.
- To identify persons relating to an incident.

Areas which would normally result in permission for access to the viewing area being refused include:

- Where a person wishing to view has no connection with the incident or has no management role relating to the incident.
- Where viewing is purely salacious.
- Where the performance of a member of staff not relating to crime, fraud or the investigation of untoward incidents is involved.
- For occurrences that relate to damage to private property for which the Health Board has no responsibility.

Access to view the monitors, within the security control room whether to operate the equipment or to view the images is restricted to staff with that responsibility.

The daily log book shall record staff on duty each shift, and the names of any person groups that have been authorised by the individual with day to day responsibility for the scheme to have access to the control room and/or view the monitors.

A responsible operator shall be present during the operation of the monitors. If monitors are to be left unattended, the area in which they are kept shall be secured against unauthorised entry.

Public access to or the demonstration of monitors shall not be allowed except for lawful, proper and sufficient reason, and after informing the Security Manager.

Arrangements for the control room shall include the following requirements to ensure that the control room is secure at all times:

- Routines and procedure and any other facilities necessary to ensure that the control room is protected from unauthorised access.
- Records are kept of all access to the control room including operation and duty, recording details of the individual concerned, and times of arrival and departure.
- Operation times and numbers of staff on shift are clearly defined and complied with.
- Access to the control room is restricted to operating staff and their managers according to prearranged shifts and on production of valid identification.
- Technical repairs and cleaning and similar activities should be carried out in controlled circumstances.
- Access by visitors shall be carefully defined and be the responsibility of the Health Board.
- Any manager outside of direct responsibility to the operation of the control room who requests to view recorded images for any other purpose than that for which the scheme was designated must be directed to the Security

Manager. If this occurs out of normal working hours, access to view should politely be denied or the request shall be redirected to the Senior Manager on duty who must consult with and adhere to this policy.

15. Disposal of images

At the end of their useful life, all DVDs will have their images magnetically erased and disposed of as confidential waste and spot checked for erasure prior to being destroyed or disposed of. Confidential waste should be shredded or placed in the appropriate bag for disposal and the appropriate serves to collect the confidential waste.

16. Quality of Images

It is important the images produced by the equipment are as clear as possible in order that they are effective for the purpose(s) for which they are intended. Upon installation, an initial check should be undertaken to ensure that the equipment performs properly.

The medium on which the images have been recorded should not be used when it has become apparent that the quality of images has deteriorated.

If the system records features such as the location of the camera and/or the date and time reference, these should be accurate. When installing cameras, consideration must be given to the physical conditions in which the cameras are located e.g. infrared equipment may need to be installed in poorly lit areas.

Cameras should be properly maintained and serviced to ensure that clear images are recorded. They should be protected from vandalism in order to ensure that they remain in working order. If a camera is damaged, there should be clear procedures for defining the person responsible for making arrangements for ensuring the camera is fixed within a specific time. The quality of the maintenance work should be monitored and checked before being permanently sited to eradicate obstacles which may affect its view

17. Breaches of the Policy

The Health Board reserves the right to take disciplinary action against any employee who breaches this policy in accordance with the Health Boards Disciplinary procedures.

As a major purpose of these schemes is assisting to safeguard the health and safety of staff, patients and visitors, it should be noted that intentional or reckless interference with any part of the monitoring equipment, including

cameras/monitors/back up media, may be a criminal offence and will be regarded as a serious breach of Health Board Policy. Where a serious breach occurs, the Health Board must appoint a Senior Manager independent of the operation of the scheme to investigate the breach with advice from the Security Management, make recommendations to the Health Board on how the Breach can be remedied.

18. Complaints Procedure

Complaints regarding the operation of the Health Boards CCTV system must be progressed through the Health Boards Concerns Department.

19. Monitoring Compliance

Compliance is monitored in the following ways:

- Police architectural/liaison Officer will conduct a review of the CCTV system to ensure that it meets the data protection requirements on a bi annual basis and report findings to the Security Manager.
- The Security Manager and Data Protection Manager will, together, on an annual basis, conduct a site inspection of the CCTV signage, camera locations and an inspection of the DVD log to ensure compliance with the policy and General Data Protection Regulation. The results will be assessed by the Security Manager. Any areas of non-compliance or concern will be submitted to the information governance group, as part of the annual information governance report.

20. Procedure Review and Awareness

Following ratification, this Procedure will be reviewed every three years by the Health Boards Security Manager and Data Protection Manager.

Application to Access CCTV Images

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Data Protection Declaration

Application to access CCTV images under the **General Data Protection Regulation**

I declare that the information given is correct to the best of my knowledge and that I am entitled to apply for access to CCTV Image Records referred to above under the terms of the Data Protection Act 1998

Surname

Please place a tick in the appropriate box below

Forename(s)

1.		I am the applicant
2.		I have been asked to act by the applicant and attach their written consent
3.		I am acting on behalf of the applicant who lacks capacity to consent
4.		I have Legal Rights to conduct affairs on behalf of the Patient (evidence must be provided)

Address

Post Code

Date of Birth / /

DETAILS

NAME

Date of recording / / Approx Time

SIGNATURE OF APPLICANT

Location			**TO BE COMPLETED BY INDEPENDENT WITNESS**
Please circle appropriate response below			
I require access only to the recorded image	Yes	No	I have known the applicant for **.....** years as an employee/client/patient/personal friend *****and have witnessed the applicant signing this form
I require a copy of the recorded image	Yes	No	***Delete as appropriate**
			NAME
			ADDRESS
			SIGNATURE

Application to Access CCTV Images		
Office use only		
Scheme Operator (Name)		
Access provided on date		
Proof of Identity (type)		

Further Action		
Applicant notified outcome	YES/NO	
Copies provided	YES/NO	
Copying fee	YES/NO	
Fee Received	£	
Signature	Date	
Access Denied	Date	
Further action taken(by whom)		

Cardiff and Vale University Health Board

Body Worn CCTV System for Security Officers

Introduction

Body Worn Video (BWV) is an overt method by which staff can obtain and secure evidence at incidents. This document is intended to enable staff to comply with legislation and guidance to create evidence suitable for use ultimately in court proceedings if required. In addition to providing compelling supportive evidence for court it has been found that BWV can furnish other benefits such as;

- Raise standards of service.
- Reduce incident escalation.
- Augment opportunities for evidence capture.
- Reduce complaints.

BWV equipment provided for users should be compliant with the recommendations in the 'Technical specifications' section of the Guidance for the Police use of Body-Worn Video Devices published July 2007 by the Police and Crime Standards Directorate (http://library.college.police.uk/docs/homeoffice/guidance-body-worn-devices.pdf).

This document explains the process by which Cardiff and Vale University Health Board will utilise BWV devices. It will ensure a consistent and effective system is adopted throughout the organisation, benefiting both members of the public and staff.
BWV devices will be used by staff. It has the potential to significantly prevent, stop escalation, and record events involving conflict. In cases which involve legal redress it can improve the quality of evidence provided by members of the organisation. It will also raise standards of service providing a good reference for staff development.
BWV can be used across a wide range of operations and in all cases users and supervisors must use professional judgment with regard to the use of this equipment.

There are some examples of situations where the use of BWV is not appropriate; the following list is for guidance only and is not exhaustive.

- Legal privilege – users must be careful to respect legal privilege and must not record material that is, or is likely to be, subject to such protections.
- Private dwellings – users must consider the right to private and family life (Article 8 of the ECHR) and must not record beyond what is necessary for the requirements of the individual case.
- Managers must ensure that the use of the cameras is widely advertised prior to the start programme of ensuring 'fair processing' a requirement of the General Data Protection Regulation. At an individual case level the use of BWV must be made clear by staff making a verbal announcement to those persons who may be recorded. In some cases it will not be practical to make such an announcement, on these occasions this announcement must be made as soon as practicable. Staff may also wear a sign/symbol in order to ensure fair processing is achieved in compliance with the Data Protection Act.

BWV cameras might be small, but they are not to be worn or used in a hidden or covert manner ensuring maximum impact on prevention and escalation of an incident.

The decision to record or not to record any incident remains with the user. The user must be mindful that failing to record an incident may require explanation. Therefore, if the user is present at an encounter where BWV can be used the user should record the incident.

Recording should be incident-specific: users should not indiscriminately record entire duties and only use recording to capture video and audio at incidents that would normally require reporting, whether or not these are ultimately required for use in evidence

PERSONNEL

Head of Security is – Damian Winstone

Authorised users of the system are

i) Security Team Leaders
ii) Security Officers
iii) Other Health Board staff authorised in writing by a member of the Joint Management Team

GROUNDS FOR RECORDING PERSONAL INFORMATION

The general principle is that the CCTV **must be switched on** when an incident of violence is taking place or where there is an identified risk to a staff member. The CCTV is a visible and overt deterrent to any potentially aggressive person, making a clear statement that their actions will be recorded, and so will the actions of the officer, thereby reducing the scope for false allegations. These issues are particularly relevant to staff working within the Emergency Unit. Cardiff and Vale Health Board shall ensure that the use of the shoulder mounted CCTV system is both proportionate and necessary. As such the following principles underpin its effective and lawful use:

Practical day-to-day use

i) That such use is overt and conveyed to such persons whose data maybe captured;
ii) That such use is displayed in a prominent and visible manner on the Officer's uniform;
iii) That such use is also conveyed in an audible manner where possible to those whose data maybe captured.

Subsequent Data Management

iv) All Team Leaders and Security Officers are trained in data-handling and management to the standard required in this policy;
v) That the necessary equipment and infrastructure for effective data management and handling is in place and installed at all times.

OPERATING PROTOCOL

CCTV hardware will be signed out by the Team Leader daily

Team Leaders, Security Officers using the equipment will displayed this badge

- Once a recording has been made it MUST be retained and downloaded prior to finishing duty.
- Customers should be informed verbally that a recording is taking place stating CEO number and the reason for the recording i.e. “Under Section 29 – Crime and Taxation of the Data Protection Act”
- All recordings will be stored in an access controlled area of the system with access limited to the Parking and Traffic Management Team Leader, Parking Supervisor (Enforcement) and the IRMO
- No CCTV recordings or images should be tampered with as this could lead to disciplinary action. Please note that the system provides a good evidential trail from recording to deletion.

Responsibilities

User

- The User of the BWV will have received basic instruction in the use and legislation surrounding BWV prior to any use.
- It is the responsibility of the BWV user to ensure that:
- Equipment is checked prior to deployment to ensure it is working correctly.
- That the batteries are charged prior to use (consider taking spare batteries) and immediately recharged on return.
- That the time and date settings are accurate.
- That camera lenses are clean and the picture quality is suitable.
- The camera lens is aimed and focused appropriately to capture evidence.
- Compliance with legislation and guidance.
- View only footage they have a bona-fide reason for viewing.

Viewing of images shall be limited to:-

- Security Management, Assistant Security Manager, Case Manager, Security Team Leaders and Security Officers
- Police Officers, for operational reasons, as authorised by the Police Duty Officer;
- Any other persons or organisations shall only be allowed to view the system with the authorisation of the Data Protection Manager, Security Team Leader, (out of Hours)
- Images shall be retained for 31 days then automatically deleted unless they form part of an ongoing investigation

REQUESTS FOR INFORMATION

Details of recorded information shall only be released with the permission of the Data Protection Manager.

Requests for information by the Police shall require the authorisation of the Police Duty Officer.

Directed surveillance will be in accordance with section 6 of the CCTV procedure

LOGS

The Security Team Leader shall be responsible for ensuring that the following records are maintained and audited in accordance with the CCTV Policy

i) Incident Log;
ii) Media Copy log
iii) Viewing Log;
iv) Video Stills Log;
v) Signing in and out Log

How should material be stored?

Conclusion: It is important to manage the material in accordance with DPA legislation. The most efficient method is to use software specific to BWV use.

"The solution will ideally be computer (PC) based and should allow the user to:

- *download video from the body-worn camera;*
- *review video on the system;*
- *create master and working copies of evidential material on WORM media; and*
- *store non-evidential material for 31 days before deletion."*

HEALTH AND SAFETY COMMITTEE WORK PROGRAMME 2019 - 2020

Meeting Date / Agenda Item	**January 2019**	**April 2019**	**July 2019**	**October 2019**	**January 2020**
Presentation/Staff Story	Employee Wellbeing Service	Arjo Proact Survey Findings			
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/Sub-committees/Groups – **CRAF No: 8.1**	√	√	√	√	√
Regulatory and Review Body Tracking Report – **CRAF No: 8.1**		√		√	
Enforcement Agencies Report – **CRAF No: 8.1.4**	√	√	√	√	√

Meeting Date / Agenda Item	January 2019	April 2019	July 2019	October 2019	January 2020
Pedestrian Safety Strategy – **CRAF No: 8.1.4**	√				
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**		√			
Review of Contractor Control Policy – **CRAF No: 8.2.3**			√		
Review of Health and Safety Policy – **CRAF No: 8.2.3**				√	
Review of Safe Working with Electricity Policy – **CRAF No: 8.2.3**					√
Waste Management Compliance Report – **CRAF No: 8.1.1**	√		√		√
Fire Safety Annual Report - **CRAF No: 6.4.5**				√	
Lone Worker Devices Report – **CRAF No: 9.2**		√		√	

Health and Safety Priority Improvement Plan

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 Health and Safety Policies covering all legislative requirements	Amber	Gap analysis of policies by reviewing policies and procedures of other health boards	Project lead identified within the Heath and Safety 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 ensuring any changes or new legislation incorporated into policies and procedures	Amber	Head of Health and Safety	Apr 19
			Health and Safety Policies are appropriately reviewed and communicated to all relevant staff	Amber	Ensure link to all current health and safety policies and procedures are on health and safety web page	Departmental review of health and safety polices undertaken. Reviewed at each Health and Safety Committee and approved policies add to web	Green	Director of Corporate Governance	
					Status of related Health and Safety Policies approved by other committees requires progress through relevant committees	Those policies outside of review period identified	Amber	Director of Corporate Governance	Jan 19
	1.2	**Risk Assessments**	Health and Safety Risk Assessments are included within the BAF register	Amber	Implement new BAF format	BAF pilot project of Dental and Capital Planning & Estates progressed. Rollout of revised risk register approach being progressed	Amber	Director of Corporate Governance/ Head of Risk Governance	Apr 19
					Review health and safety items on clinical / service board's risk register and ensure high risk health and safety items included on priority improvement plan	Being progressed jointly with above	Amber	Head of Health and Safety	Apr 19
			Managers maintain 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 Corporate 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 health and safety to progress risk assessment status and control measures for health and safety issues.	Amber	Head of Health and Safety	Jun 19

	1.3	**Managers Safety Course**	Managers competency in their health and safety role is enhanced	Red	Allocate health and safety resource to develop training package	Role identified in newly appointed Health and Safety 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 health and safety 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 Health and Safety Committee, further progressed with training plans during period.	Amber	Director of WOD	Jan 19
			Mandatory training compliance - Health Board target 85%		Monitoring of mandatory training compliance - Health Board target 85%	Annual report showed successful 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 Clinical and Service Boards have established health and safety meetings that meet at least 4 times a year	Amber	Annual report identified shortfall within some Clinical Boards	Shortfall has now been rectified including Medline Clinical Board establishing a Group and will be monitored at Operational Health and Safety Group	Green	All	Oct 18
					Establish Health and Safety Group for corporate functions	Role identified within the newly appointed Health and Safety Adviser to co-ordinate, suitable chair required.	Red	Director of Corporate Governance	Jan 19

2. Violence and 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 violence and aggression**	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 2018	Green	Senior Manager Lead for 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 Lead for Health and Safety	Apr 19
					Pursue non criminal sanctions and monitor, including violent warning markers, victim interviews and	Personal Safety section reviewing its monitoring to demonstrate efforts made within non criminal sanctions.	Amber	Head of Health and Safety	Jan 19

					perpetrator internal sanctions				
	2.2	**Lone Worker Devices**	Ensure those at risk within the community have systems in place for device or suitable assessment	Green	Monitor for consistent use, demonstrating effective management of device allocation	Regular reports submitted to Health and Safety Committee	Green	Head of Health and Safety	Oct 18
					Review of contract due in 2019 to reflect current demands	Meeting with Procurement to establish specification in readiness for contract renewal in April 2019	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 been 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 violence and aggression to ensure response and capabilities. Annual report identified low level of compliance	Red	All	Apr 19
					Mechanism to monitor training against TNA	Health and Safety 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 manual handling passport delivery to meet Agored Cymru standards.	Action plan initiated to meet required standards by December. Progress being monitored by LED, Agored Cymru and Health and Safety.	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	Health and Safety 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	Green	Proact re-audit during winter demands	Re-audit progressed and agreed with proact to commence in November	Green	Head of Health and Safety	Apr 19

			against patient requirements.			2018, with report coming to April Health and Safety Committee			
					Review of audit findings and action shortfalls.	As above	Amber	Head of Health and Safety	Apr 19
					Review of slings against suitability of current slings used	Within Proact audit	Amber	Head of Health and Safety	Apr 19
	3.3	**Bariatric patient compliance**	Assessment of bariatric patient compliance against manual handling aspects.	Amber	Undertake an assessment of bariatric patient compliance against manual handling aspects	Manual Handling Adviser working with Medicine Clinical Board to assess best practice including proact audit	Amber	Head of Health and Safety	Jan 19
	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 Hover jacks quantities to respond to fallen patients needs	Project group being initiated by Assistant Director 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 September 2017 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	Health and Safety 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 Health and Safety Group for resolution	Amber	Chair of Operational Health and Safety Group	Apr 19
					Risk Assessments are valid	As above	Amber	Chair of Operational	Apr 19

								Health and Safety Group	
					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 sterilisation of medical instruments	Health and Safety Adviser working with Clinical Board to establish best practice	Green	Head of Health and Safety	Oct 19
	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 Employee Wellbeing Service. Policy out of review period	Health Board has a wellbeing service and Occupational Health Service and is subject to a review of its policy and report to the Health and Safety Committee	Amber	Director of WOD/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, health and safety 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	HAVs identified within Dental and Estates Areas. Full survey initiated in Dental, identification mechanisms developed in Estates, other areas to be progressed	Green	Head of Health and Safety	Apr 19
					Assessment of those areas requiring direct monitoring	Progressed as a rolling programme based on risk priority	Green	Head of Health and Safety	Jan 19
					Complete monitoring to these areas	As above	Amber	Head of Health and Safety	Apr 19
	4.5	**DSEAR compliance to regulations**	DSEAR compliance to regulations requires areas 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	Clinical Board 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 Database 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 support 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 health and safety and 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 reports of fire and violence and aggression events	Green	Mental Health Lead	Jan 19
					Review of increased reports of fire and violence and aggression events		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 be in suitable flame proof areas	Fire Officer reported e-cigarette 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 and aggression	Reports of increased lighters being smuggled in and increased violence and aggression 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 windows undertaken and restrictors fitted	Survey of windows undertaken and restrictors fitted.	Green	Director of Planning	Oct 18
					Anti tamper devices fitted to all restrictors	Review of restrictors in self harm areas to fit anti tamper screws	Red	Director 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 Health Board Leads	Jan 19
	5.5	**Management of Bariatric Patients**	Suitable mechanisms in place to care for bariatric patients with dignity and without enhanced risk to staff	Amber	Assessment of patient need	Assessment of patient need undertaken further work required to diminish fire, staff and dignity issues	Amber	Assistant Director of 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	Assistant Director 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 and Medicine Clinical Board	Amber	Assistant Director of 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	Director of Corporate Governance	Oct 18
					There are suitable controls implemented within record storage areas to ensure that manual handling and fire risks 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 medical records	Red	Progress an enhanced programme to electronically store, where possible medical records	Project under review	Red	Head of Medical Records	Apr 19

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 maintaining its compartmentation system	Priority plan being progressed	Amber	Director 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	Director of Planning	Apr 19
					Those UFS associated with aged automatic alarm systems are progressed through a prioritised approach	Enhanced programme of replacement agreed	Amber	Director of Planning	Apr 19
					UFS associated with inappropriate contractor work is diminished through enhanced job allocation form	Fire Adviser working with Estates to enhance dust and hot work controls	Amber	Director 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	Director of Planning	Apr 19
	6.3	**Fire Incidents within Mental Health**	Fire incidents in mental health associated with the smoking cessation campaign is minimised	Red	Fire incidents in mental health associated with the smoking cessation campaign is minimised through effective controls: a) removal of ignition sources, b)	Recent reports raised concerns about increased fires in Mental Health and the effectiveness of ignition source control. Mental Health Lead progressing concerns	Red	HOD Mental Health /Director of Planning	Jan 19

			through effective controls		meeting health care guidance on use of charging devices and c) local monitoring of internal areas				
	6.4	**Evacuation Mat/Chairs Training**	Establish mechanism for training and refresher training in the use of evacuation chairs and mats	Red		Cascade training given several years ago, further demand identified	Red	Senior Fire Adviser/Fire Safety Manager	Apr 19
	6.5	**Evacuation Fire drills**	Enhanced commitment to evacuation drills	Amber	Fire Safety Group to devise an agreed programme of evacuation drills and local areas to co-operate in participation		Amber	Director of Planning	Jan 19
	6.5	**Fire Audit - Annual Submission**	Annual submission of Fire audit is submitted within a timely manner	Green	Submit Annual Audit	2018 audit submitted	Green	Director 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 increased 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	Director of Planning	Oct 18
					Water Safety Group has effective representation from all related areas	Current Clinical Board representation is poor	Red	Clinical Board Leads	Jan 19
					Compliance against water safety plan and policy is reported to the Health and Safety Committee	Included within work programme	Green	Director 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 Health and Safety Group	Reported at Operational Health and Safety Group	Green	Director of Planning	Oct 18
			Permit system in place for contractor work of specified high risk areas			Enhanced permit system under development	Amber	Director 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	Health and Safety Adviser appointed to progress same standard of work. Has actively progressed backlog since appointment	Amber	Head of Health and 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	Director of Planning	Oct 18
					Effective asbestos management for all intrusive work within asbestos identified areas	As above	Green	Director 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	Director of Planning	Apr 19
	7.4	**Back Log Maintenance**	Backlog maintenance to evaluate those areas which potentially affect their safety compliance.	Red	Review of backlog maintenance to evaluate those areas which potentially affect 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	Director 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	Director of Planning	Apr 19
					Implement phased approach to zoning tunnel areas and minimising usage	Plans being progressed	Amber	Director of Planning	Apr 19
					Implement pedestrian safety within identified key high risk areas	Within cost restriction being progressed	Amber	Director 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 2019 progressed	Green	Director of Planning/ Director of Therapies and Health Sciences	Apr 19
					Comprehensive maintenance and inspection schedule maintained	Link to above transfer	Amber	Director of Planning/ Director of Therapies and Health Sciences	Apr 19
	7.7	**Category 3 Laboratories compliance**	Appropriate mechanisms are implemented to ensure risks presented to the Health Board from these areas is controlled	Green	Appropriate mechanisms are implemented to ensure risks presented to the Health Board from these areas is controlled by effective maintenance of their internal pressurised containment	Regular meeting established	Green	Director of Planning	Oct 18
					Formal mechanisms of communications between the	Regular meeting established	Green	Head of Health and Safety	Oct 18

					relevant parties are formalised and recorded				

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	Health and Safety Advisers are pursuing through Clinical Boards Health and Safety Groups	Amber	Clinical Board Leads	Apr 19

Report Title:	**Waste Management Compliance**								
Meeting:	**Health & Safety Committee**						**Meeting Date:**	**22/01/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	✓	**For Information**		
Lead Executive:	**Director of Planning**								
Report Author (Title):	**Waste & Compliance Manager**								

SITUATION

Compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 and other waste legislation remains consistently high at 99.7%. Compliance has remained consistent to the previous report presented to the Health and Safety Committee in July 2018.

ASSESSMENT

During the period May 2018 and October 2018 a total of 283 internal waste audits have been undertaken, 4749 samples were taken to assess compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016, the overall compliance was 99.7%.
Of the 4749 samples taken 16 non conformities (0.3%) were identified against the Environmental Protection (Duty of Care) Regulations (1991) and Hazardous Waste (England and Wales) (Amendment) Regulation 2016 were identified, of those;

- 13 orange sharps (81%) were identified as containing medication or unidentifiable to the area.
- 2 yellow sharps (13%) were unidentifiable to the area where waste was produced.
- 1 clear bag (6%) was identified as containing recyclable materials and/or waste not appropriate for landfill.

ASSURANCE is provided by:
A breakdown of samples audited:-

Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
685	828	15	7	1103	547	709	576	279

Month on month compliance per waste stream, where no data is present no samples taken during the audits.

2018	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
May	100	100	100	100	100	100	100	99.2	100
June	100	100	100	100	100	99.3	99.57	100	100
July	100	100			100	100	100	97.8	100
August	100	100			100	100	98.8	98.9	100
Sept	100	100		100	100	100	100	100	100
October	100	100	100	100	100	100	100	91.25	100
Total	**100**	**100**	**100**	**100**	**100**	**99.9**	**99.7**	**97.9**	**100**

The table below shows comparative compliance per waste stream between November 2017 and April 2018, compliance against the Environmental Protection (Duty of Care) Regulations 1991 and Hazardous Waste (England and Wales) (Amendment) Regulation 2016 was 99.7%.

2017-18	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
November	100	100	100	100	100	99	100	98	100
January	100	100	100		100	100	100	98	100
February	100	100	100		100	100	100	100	100
March	100	100			100	100	96	97	100
April	99	100	100	83	99	100	92	93	100
Total	**99.8**	**100**	**100**	**91.5**	**99.8**	**99.8**	**97.6**	**97.4**	**100**

RECOMMENDATION

The Health and Safety Committee is asked to note the Waste Management Compliance report as assurance of compliance against the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 and other associated waste Legislation.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**Environmental Health Office Report - Ward Based Catering University Hospital of Wales and Rookwood Hospital**						
Meeting:	**Health & Safety Committee**				**Meeting Date:**	**22/01/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Operational Services Manager (North)**						

SITUATION

The Ward Based Kitchens in the Cardiff and Vale University Health Board are inspected by the Environmental Health Office on an annual basis to ensure that the current UK and European food safety legislation is complied with and that staff are applying and monitoring good hygiene practice.

ASSESSMENT

In line with statutory requirements, the Environmental Health Office undertook food safety audits at Rookwood Hospital in July 2018 and at the University Hospital of Wales in August 2018.

The outcome of the audits were positive with the following scores being achieved:

University Hospital of Wales (UHW) Grade 4
Rookwood Hospital Grade 4

ASSURANCE is provided by:

The completion of the action plans for both UHW and Rookwood Hospitals by complying with the recommendations of the Environmental Health Officer. The action plans are attached below:

University Hospital of Wales EHO Action Plan – Appendix 1

Rookwood Hospital EHO Action Plan – Appendix 2

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the Environmental Health Office Report -Ward Based Catering as assurance of our compliance with the current UK and European food safety legislation and our staff's application and monitoring of good hygiene practice.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable

Kind and caring / Caredig a gofalgar
Respectful / Dangos parch
Trust and integrity / Ymddiriedaeth ac uniondeb
Personal responsibility / Cyfrifoldeb personol

Appendix 1
Management Action Plan: UHW Ward Kitchen EHO visit 23rd August 2018

ID	Issue identified	Status as of: 23RD August 2018	Action	Lead	WBC Action	Target Completion Date
1	Red onions for salad are peeled and cut on the green chopping board. This exposes a food to a risk of contamination. You must ensure that if you are to continue using unprepared onions for salad that you introduce a brown colour coded board to peel the onions on and then these can be sliced (following washing) on the green board. A number of staff questioned said that they would clean the board before slicing or turn the board over. As there was no onion being prepared at the time of my visit I am unable to corroborate this. *Regulation (EC) No 852/2004 Annex II Chapter IX para 3*		All Onions removed from the menu and therefore no further risk. This risk has been removed as above.	John Smith		**24/8/18**
2	The drinks trolley in C1 ward kitchen was right next to the hand wash basin. This subjects the mugs on the trolley to possible contamination from water splashing onto it when washing hands. You must either relocate the drinks trolley away from the wash hand basin, or, alternatively install a plastic splash barrier to		Review of all wards have been undertaken and hydration trolleys have been removed from the hand wash basin areas.			24/8/18 24/9/18

	prevent splashing. *Regulation (EC) No 852/2004 Annex II Chapter IX Para 3*					
3	The floor covering in a number of ward kitchens visited (C7, C1, B5, B1, A7) were dirty especially at floor/wall junctions and behind or below equipment. Thoroughly clean the floors and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*		Areas of floor include behind or under equipment that is fixed so unable to clean sufficiently. Colour coded vacuum cleaner have been purchased and are now in place.	John Smith		**7/9/18**
4	The tops to some of the taps of wash hand basins were showing evidence of lime scale. Thoroughly clean all tap tops and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1*		All taps have been cleaned and will be monitored by the C4C. Review with maintenance for replacement of taps. Taps will be replaced as and when necessary.	John Smith		24/8/18 24/9/18

5	The handles to the fridges and freezers in B5 ward were dirty. Thoroughly clean the handles and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*		Fridge and freezers cleaned and will continue to be monitored via C4C.	John Smith		24/8/18
6	You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations; • Insulated containers with ice packs are used for delivering sandwiches to the children's wards, staff then check the temperature of food when they return from lunchtime service and any food requiring refrigeration that is found to be above 5˚C is thrown. Your monitoring records need to include the temperature of chilled food at the end of service and any food which is then thrown; • The delivery of sandwiches to patients in the Children's wards is different to that of the other hospital wards, in that an insulated container with ice pack is used. This process step must be included in your HACCP document (the current document only covers hot food service); • The dishwasher monitoring form states		HACCP document reviewed and recommended changes made. HACCP document reviewed and recommended changes made.	John Smith		24/9/18 24/9/18

	80°C for rinse cycle and 55°C for wash cycle, however 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. • There were a number of occasions where temperatures for fridges had been recorded above the critical limit of 5˚C. However there were no corrective actions documented. You must ensure that staff are aware to take and record corrective action as necessary; • On the 10th August a probe calibration check for one of the fridges on B2 (Col) ward had been recorded at 6.1˚C, the critical limit for chilled storage is 5˚C. No corrective actions were documented; • Calibration checks for the freezers on B4(N) ward had been recorded at -14.2˚C and -15.9˚C, the critical limit for your freezers is -18˚C and colder. No corrective actions were documented; • When questioning David Howells on B5 ward, he stated that the critical limit for the fridges was 6˚C and cooking food 74˚C. All staff must ensure that fridges operate below 5˚C and that food must be cooked to at least 75˚C for 30 seconds or 85˚C for 6 seconds as stated in your HACCP. I was pleased to note that all monitoring records for cooking indicated food achieved core temperatures above 80˚C. However, on		HACCP document reviewed and recommended changes made to monitoring form. Fridge / Freezer temperature monitoring sheet amended to include a corrective action section on document. Fridge / Freezer temperature monitoring sheet amended to include a corrective action section on document. Fridge / Freezer temperature monitoring sheet amended to include a corrective action section on document. Ongoing training is being undertaken.			24/9/18 24/9/18 24/9/18 24/9/18

	the 22nd August AM a temperature of 7˚C had been recorded for the small fridge with no corrective action; • The probe wipes on ward B1 kitchen had expired on the 16/6/2018, staff must ensure they check the expiry date on the probe wipes. Using wipes past the use by date may affect their disinfection properties; *Regulation (EC) 852/2004 Article 5*		Fridge / Freezer temperature monitoring sheet amended to include a corrective action section on document. Out of date probe wipes discarded on day of inspection. Probe wipe check included in supervisors check list documentation. Supervisors to monitor on a weekly basis.			24/8/18
7	I was pleased to see one of the newly renovated ward kitchens (B1) I understand a re-flooring and refurbishment program of ward kitchens is currently on going. This is very positive going forward, ensuring that standards are continuing to be improved year on year.		No Action required	John Smith		
8	No calibration checks had been recorded for the fridges or freezers on C7 ward kitchen for this week. Whilst there were still the mid-morning and evening temperature checks to be taken. I would recommend that the calibration checks are staggered throughout the week and not left until the last day.		Calibration check sheets amended stating which day's calibration of fridges and freezers should be undertaken. HACCP document amended.	John Smith		7/9/18 7/9/18
9	Remove the elastic bands wrapped around some of the probe thermometers in the ward kitchens as they can harbour dirt and bacteria.		All elastic bands discarded on day of inspection. Pouches to be purchased for probes.	John Smith		24/8/18

Appendix 2
Management Action Plan: Rookwood Ward Kitchen EHO visit 17th July 2018

SCHEDULE A

Food Hygiene & Safety Procedures	Management Response / Action	Time Scale / Update	Lead
No contraventions noted at time of visit.	N/A		

Structural / Cleaning Issues	Management Response / Action	Time Scale / Update	Lead
1. There was lime scale beginning to develop around some of the tap tops to the wash hand basins. Clean the taps and maintain in a clean condition. *Regulation 852/2004, Annex II, Chapter I, paragraph 1* *Regulation (EC) No 852/2004 Annex II Chapter I Para.4*	Taps all cleaned and informed supervisors to check on a weekly basis when undertaking credits for cleaning audits	Completed 19.7.18	
2. There were cobwebs noted at low level in the main kitchen and storeroom. Thoroughly clean the floor and lower walls and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	All bins/fridges/freezers have been pulled out All corners and edges cleaned Main area of the floor scrubbed	Completed 20.7.18	
3. The painted wall covering near the bin in ward 7 kitchen was becoming damaged. Renew or repair the wall covering and leave in a sound easy to clean condition. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(b)*	Estates request has been placed Job number 696000	Completed 27.7.18	

4. The hole above freezer 3 in the main kitchen had received a temporary fix since my last inspection. However, this temporary fix was failing at the time of my visit and the gaffer tape used to stick the board to the ceiling was coming away. You must ensure a permanent fix to the hole, this is to prevent pest access points into your kitchen. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(c)*	This has now had a permanent fix	Completed 18.7.18	
5. The window sill in ward 5 kitchen was beginning to peel paint. Repair and redecorate the window sill making sure the finished surfaces are easy to clean. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	Estates request has been placed Job number 696033	Completed 27.7.18	
6. The hot water to the wash hand basin in the pot wash was too hot (62.4˚C) this may result in staff failing to wash hands correctly. You must reduce the temperature to the hot water tap or provide a mixer tap to the wash hand basin. *Regulation (EC) No 852/2004 Annex II Chapter I Para 4*	Estates dept have ordered mixer taps Estates request has been placed Job number 695711	Completed 20.8.18	

7. There were small areas of exposed wood to the worktops in ward 5 and 6 kitchens. Repair or renew the affected areas to allow them to be thoroughly cleaned and where necessary disinfected. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	Estates request has been placed <u>Ward 5</u> Job number 696035 <u>Ward 6</u> Job number 696039	Completed 2.8.18	
8. The bottoms of some of the cupboard doors (under the sink unit) in ward 7 kitchen were beginning to peel and expose wood. Repair/renew the affected areas to allow them to be thoroughly cleaned and where necessary disinfected. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c*	Estates request has been placed Job number 696042	Completed 8.8.18	

Confidence in Management / Control Procedures	Management Response / Action	Time Scale / Update	Lead
Audit of the current food safety policy document and monitoring records identified the following:			
• Your HACCP specifies that Food Hygiene refresher training will be carried out annually	HACCP document changed/updated to (Refresher training carried out on a regular basis)	Completed 19.7.18	
• However, there was little evidence to demonstrate this was happening in practice. In some instances the last recorded Food Hygiene Training was in 2013 for Carl Jones and Jacquelyn Higham and 2016 for other staff. It was also noted that there were no certificates available for Liz Mitchell, Maria Martinez and Andrew Wood;	Carl Jones/Jackie Higham/Maria Martinez To attend refresher training Liz Mitchell/Hayley Champion level 3 Now on notice board Barbara Grigg/Andrew Wood Being enrolled for level 3	Refresher training booked for 23rd&24th august completed Kevin Nunney To arrange	
• There was no evidence to demonstrate that your HACCP had been reviewed since 2016 despite a review date of July 2017 stipulated on the front page of your HACCP;	HACCP reviewed and updated By Keith Prosser/Andrew Wood	Completed 19.7.18	
• There were some occasions where a delivery temperature hadn't been recorded, but the temperature range had been circled. As staffs are required to monitor and record the delivery temperature then a specific temperature needs to be recorded;	All catering staff to have refresher training on delivery notes	completed 3.8.18	

• Your HACCP states that the final rinse temperature on the dishwasher must achieve 85˚C, however having put the dishwasher in the main kitchen on 3 cycles the highest temperature achieved on the final wash was 84˚C;	Engineer from electron Wales has tested the dishwasher and the dishwasher is reaching 85˚C;	Completed 20.7.18	
• Staffs were relying on strip thermometers or the digital displays to monitor and record the fridge temperatures on the wards. As discussed, you must ensure independent probe checks are carried out weekly as you do in the main kitchen;	Ward temperature sheets updated to show that supervisors will laser probe fridges on a weekly basis	Completed 20.7.18	
• Coleslaw and tuna mayo was found in the walk in fridge with an opened on and use by date of Mon (16th July). Barbara Grigg told me that usually a day plus 2 day shelf life would be applied to open packets and amended the label to use by 18/7. However, the coleslaw had a manufacturers use by date of the 17th July;	the catering staff/supervisors to complete refresher training on all food labeling	Completed 27.7.18	
• I was pleased to see that independent probe checks of fridges and freezers were being carried out on a weekly basis. However, as discussed you must ensure staff record the actual temperature and don't round the temperature up or down. This was raised at the last inspection. *Regulation (EC) No. 852/2004 Chapter II Article 5*	informed supervisors that they need to record the accurate reading and not round temperatures up or down	Completed 21.7.18	

Recommendations and Advice **Health and Safety Advice**	**Management Response / Action**	**Time Scale/ Update**	**Lead**
• 1The emergency release button to the walk in freezer was frozen at the time of my visit, this required several hard hits to enable it to unlock. As discussed, you must periodically check the emergency release button to ensure it works correctly. Please note that testing the emergency release button must not be carried out alone • There was a faint smell of drains near the steam ovens in the kitchen. I suggest you investigate the cause of this smell to ensure it doesn't becoming any worse. • The air temperature of the staff fridge in ward 6 kitchen was too high at 13.8˚C. Whilst no patient food is stored in this fridge, as staff store their lunch in this fridge I suggest you check the fridge temperature to ensure it can store food below 8˚C.	Informed supervisors to test the freezer door On the 1st of every month Estates request has been placed Job number 695998 Informed day hospital manager that the reading on the fridge is to high and advised to order a new fridge	Added to monthly check list Estates dept investigating Now being laser probed Weekly	

• The light fitting in the walk in freezer in the main kitchen was not working. This should be repaired/replaced by a competent person.	Estates request has been placed Job number 696115	Completed 27.8.18	
• There were a number of dead insects noted in the light diffuser of ward 7 kitchens. Clean the light diffuser and maintain in a clean condition.	Diffuser cleaned by estates 4 weeks ago New estates request has been placed Job number 696114	Completed 27.8.18	

Report Title:	**Environmental Health Office Report - Ward Based Catering, Llanfair Unit, University Hospital Llandough**							
Meeting:	**Health & Safety Committee**					**Meeting Date:**	**22/01/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**	
Lead Executive:	**Director of Planning**							
Report Author (Title):	**Estates and Operational Services Manager (South)**							

SITUATION

The Ward Based Kitchens in the Cardiff and Vale University Health Board are inspected by the Environmental Health Office on an annual basis to ensure that the current UK and European food safety legislation is complied with and that staff are applying and monitoring good hygiene practice.

ASSESSMENT

In line with statutory requirements, the Environmental Health Office undertook a food safety audit at the Llanfair Unit, University Hospital Llandough in October 2018.

The outcome of the audit was positive with a score of 4 being achieved.

ASSURANCE is provided by:

The completion of the action plans for both UHW and Rookwood Hospitals by complying with the recommendations of the Environmental Health Officer. The action plans are attached below:

Llanfair Unit EHO Action Plan – Appendix 1

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the Environmental Health Office Report -Ward Based Catering as assurance of our compliance with the current UK and European food safety legislation and our staff's application and monitoring of good hygiene practice.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable

Kind and caring / Caredig a gofalgar
Respectful / Dangos parch
Trust and integrity / Ymddiriedaeth ac uniondeb
Personal responsibility / Cyfrifoldeb personol

APPENDIX 1

Action Plan

Llanfair Unit University Hospital Llandough, Food Hygiene Inspection
Undertaken Tuesday 16th October 2018 by the Vale of Glamorgan Shared Regulatory Services

SCHEDULE A			
Food Hygiene & Safety Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
1. At the time of the inspection, no hand drying materials were available at the wash hand basin in the housekeepers' room. You must ensure an adequate supply of hand drying materials e.g. blue roll are available the wash hand basin. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 4***	Hand towels replaced at the time of the inspection	Completed16/10/18	
2. During the inspection, raw shell eggs were stored on the shelf above boxed cooked scrambled eggs in the walk-in chiller. You must ensure raw shell eggs are stored separate and below any ready-to-eat and cooked foods in the chiller. ***Regulation (EC) No. 852/2004, Annex II, Chapter x, Para 3***	Staff reminded to ensure raw eggs are stored on the bottom shelf of the chiller	Completed 16/10/18	
Structural / Cleaning Issues	**Management Response / Action**	**Time Scale / Update**	**Lead**
3. The following areas are dirty and require cleaning and maintaining in a clean condition: • The door handles to the larger hot trolley are dirty; • The extraction filters in the canopy are dusty; • The D1 dispenser in the dishwashing area is greasy. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Cleaned Maintenance request 709180 Cleaned Maintenance request to remove dispenser 709184	Completed 16/10/18 Completed 31/10/18 Completed 16/10/18 Submitted 23/10/18	AOSM

4. The plastic mesh cover on the extraction canopy is broken. Repair or replace the cover and maintain in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Maintenance request 709183	Submitted 23/10/18	AOSM
5. There are rusty areas on the legs of the equipment sink in the dishwashing area. Rust cannot be kept clean and can harbour dirt and bacteria. Thoroughly clean these areas on the legs and keep in a clean condition and maintain in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Maintenance request 709179	Submitted 23/10/18	
6. A ripped red delivery bag was found in the walk-in freezer. Dispose of this delivery bag and maintain these bags in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	Bag disposed of at the time of the inspection	Completed 16/10/18	

Confidence in Management / Control Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
7. 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;	HACCP document under review	Finalised January 19	AOSM
• Section 18 states for chilled deliveries to be between 0 - 8°C and it also states these temperatures in the HACCP table; this needs to be amended to between 0 - 5°C;	Amended	Completed 18/10/18	
• Section 26.1 relating to thermometer probe calibration and the weekly probe calibration testing verification form must be amended for the hot water temperature check. The monitoring form and HACCP must be amended to reflect that the thermometer should be placed in a rolling boil of hot water or a suitable equivalent.	Under review linked to 8 below		
Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1			
8. When calibrating the probe in hot water, the temperature should read between 99°C and 101°C. The method currently used for probe calibration states for the top of the thermometer probe to be placed into the steam of a boiling kettle. This is not an adequate method for hot water calibration of the probe and it is probably the reason why the probe thermometers are not reaching temperatures of between 99°C and 101°C. I also identified that only hot water temperatures checks are being made. You must ensure that both iced water and hot water	Therma 20 probes and calibration caps ordered removing the use of hot water / iced water	Delivery January 19	AOSM

temperature checks are being carried out and recorded as necessary. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***			
9. The dishwasher monitoring form states 82°C for rinse cycle, however section 6.2 of your HACCP states 85°C for rinse cycle. You must ensure the HACCP is amended to ensure consistent temperatures with your monitoring form. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Amended	Completed 18/10/18	
10. Whilst reviewing the temperature records, I identified the following: • The delivery monitoring form for frozen and chilled products states for chilled food to be between 5°C and 15°C. You must amend the form to reflect chilled food deliveries should be between 0°C and 5°C; • The fridge and freezer temperatures for the kitchen were missed on 15th October at 7:30am, 30th September and 5:30pm and 2nd September at 5:30pm. You must ensure the fridge and freezer temperatures are being taken and recorded three times each day; • The fridge and freezer temperature record sheet for the kitchen states for fridges to be between 1°C and 4°C. You must ensure these temperatures are amended on this form to reflect what is states in your HACCP; • A number of items are being missed on the daily cleaning schedule e.g. waste bins,	Amended All staff reminded and signed off All staff reminded / signed off	Completed 18/10/18 Completed between 18/10/18 and 23/10/18 Completed between 18/10/18 and 23/10/18	

toaster, hand basin and sink etc. You must ensure these items are being cleaned and signed to say they have been cleaned each day; • The supervisor daily ward catering inspection audit sheet had been missed on 15th October. You must ensure these checks are being made each day and signed to say they have been completed; • The fridge temperatures had been missed at 5:30pm on the 29th and 30th August in the Daffodil ward. The fridge temperatures had been missed at 5:30pm on 29th August, 12:30pm and 5:30pm on 30th August and at 7:30am on 1st September in the Meadow ward. You must ensure the fridge temperatures are being taken and recorded three times a day in both wards; • In the Meadow ward, the hot hold warm temperature for roast turkey and stuffing had been missed on 15th October. You must ensure the hot holding temperatures are being recorded each day as appropriate. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	All staff reminded / signed off All staff reminded / signed off All staff reminded / signed off All staff reminded / signed off	Completed between 18/10/18 and 23/10/18 Completed between 18/10/18 and 23/10/18 Completed between 18/10/18 and 23/10/18 Completed between 18/10/18 and 23/10/18	

SCHEDULE B – RECOMMENDATIONS These recommendations provide advice on good practice:-			
I recommend a separate cling film in the raw food area and this is labeled for raw food use only.	Implemented	Completed 16.10.18	
I recommend a separate sanitizer spray is used in the raw food area and this is labeled for the raw food area only.	Implemented	Completed 06.12.10	
I recommend non-hand operated taps to the wash hand basin in the kitchen.	Maintenance request 717952		AOSM
I recommend that independent thermometers are placed into the walk-in chiller and freezer and these are used to check the fridge and freezer temperatures.	Implemented	Completed 16.10.18	
I strongly recommend all food in the ward fridges are labeled as staff or patient use. At the time of the inspection, a punned of green grapes was found in the Meadow ward fridge unlabeled and beginning to turn brown.	All staff reminded / signed off	Completed between 18/10/18 and 23/10/18	
Key - AOSM Assistant Operational Services Manager (South)			

MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 2PM on TUESDAY 28TH AUGUST 2018 – CORPORATE MEETING ROOM, HQ UHW

Present:

Peter Welsh- **Chair**	Director of Corporate Governance
Charles Dalton	Head of Health and Safety
Caroline Murch	Environmental Health and Safety Adviser
Frank Barrett	Senior Fire Adviser
Jonathan Davies	Health and Safety Adviser
Jon McGarrigle	Estates Services
Nicola Bevan	Occupational Health
Rachael Daniel	Health and Safety Adviser
Rachael Sykes	Health and Safety Adviser
Stuart Egan	Staff Representative

Clinical/Service Board Representatives

Emma Stone	Dental
Rhys Davies	Primary, Community and Intermediate Care
Jennie Palmer	Medicine

Apologies:

Andrew Hynes	Legal & Risk
Claire Wade	Surgery
Claire Mahoney	Associate Infection Prevention Control Nurse
Gareth Jenkins	Specialist Services
Hayley Dixon	Dental
Heather Gater	Women and Children
Ian Wile	Mental Health
Jane Maddison	Women and Children
Karen Lewis	Claims Manager
Matthew Price	Specialist Services
Rowena Griffiths	Dental Services
Sue Morgan	Primary, Community and Intermediate Care
Sue Bailey	CD&T
Sarah Dix	Medicine Clinical Board
Tina Bayliss	Surgery Services
Wendy Bridges	Staff Side Representative

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

The minutes of the meeting held on the 29th May 2018 were accepted as a true record.

OHSG: 17/18 Action Log

- **OHSG 25/18 –** Medical Records, it was noted that this was an agenda item.

- **OHSG 28/18 –** Annual Fire Audit Submission – The Head of Health and Safety confirmed that this audit had been completed and item closed out.

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 gave an overview of the report highlighting that the Case Management Team attended the July Committee to give a presentation on Personal Safety and Case Management support. It was noted that this was well received.

It was highlighted that the Head of Corporate Governance updated the Committee on the progress of the revised Corporate Risk Assurance Framework, reporting that a meeting was due to take place to finalise the process.

The Health and Safety Adviser – Ms R Daniel also reported that both the Fire Safety and Asbestos Management Policies were approved at this Committee meeting, adding that amendments related to management structure and format changes.

OHSG: 19/18 Annual Report Presentation

The Head of Health and Safety presented the Annual report to the Group, reporting on the eight strategic areas; highlighting good practices and also areas where further progress was needed.

The key points were highlighted:

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

- 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.

- 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.

- 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.

He informed the Group that this report was taken to the Health and Safety Committee in July, where it was well received and also submitted to the Committee of the Board for information. It was reported that the full document was available on the Intranet.

It was noted that findings of this report would be incorporated into the revised Priority Implementation Plan for progress and resolution.

It was also highlighted that although Fire Safety was a key strategic area under Health and Safety, a full report is submitted to the Committee separately.

OHSG: 20/18 Enforcement Agencies Correspondence Report

The report was received and noted by the Group.

During the Annual Report presentation, the Head of Health and Safety reported on the number of Health and Safety Executive (HSE) visits and involvement during the year, which included Road Traffic accident, concerns around the Hydrotherapy pool, Asbestos issues as well as continued correspondence relating to the contractor fall in 2016.

It was noted that a number of these concerns had been closed out with the exception of the Contractor Fall, where the Health Board were waiting on further correspondence from the HSE.

In addition to the above the Head of Health and Safety reported on the Improvement notice issued to Public Health Wales (PHW) due to concerns relating to maintenance within the laboratories and communication between PHW and the Health Board. It was reported that regular meetings will be taking place to ensure that the action plan is being discussed and worked to.

OHSG: 21/18 Fire Safety Management and Enforcement Report

The report was received and noted by the Group.

The Senior Fire Adviser reported that there were no enforcement notices issued during the period.

It was also highlighted that South Wales Fire Service continued to send one appliance during the hours of 8am and 6pm, unless a fire is confirmed.

Concerns were raised in relation to the volume of unwanted fire signals (UwFS) throughout the Health Board in particular UHW, with a total of 418 UwFS reported in the last twelve months. It was noted that the major issue identified relates to the number of UwFS occurring in old detectors, with many detectors in the Heath Board over 20 years old which is in excess of their expected operational use.

It was reported that following the detection upgrades in Llandough and Rookwood, there had been significant reduction in UwFS; a quote for a further upgrade in the fire alarm system is being prepared for consideration and meetings are being arranged between the Health Board, Shared Services and South Wales Fire Service to look at all possible options to reduce the volume of UwFS.

The Senior Fire Adviser raised concerns with regards to the number of fire incidents within mental health since the introduction of the No smoking ban. He highlighted that 14 fire incidents had occurred in the past twelve months with 6 taking place within Hafan Y Coed, due to ignition items.

He also highlighted that fire training compliance continues to improve with June performing at 69%.

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 of the Annual Report. He advised that a full report would be brought to the next meeting.

OHSG: 23/18 Pedestrian Safety & Tunnel Safety

Mr J McGarrigle updated the Group on the progress of the pedestrian and tunnel safety project. It was noted that although there had been a slow starts from the consultancy firm, they had now progressed and a workshop was held in July to discuss the findings of the survey.

He reported on the key findings, which included pathway obstructions, no continued route for pedestrians, the need for signage improvements as well as better lighting. He added that further meetings are to take place to address these issues.

In addition, a findings presentation is being developed for November, with a full report being circulated shortly.

OHSG: 24/18 Health Aspects

The Head of Health and Safety informed the Group that COSHH was highlighted as a concern at the last Health and Safety Committee, through the annual report.

He advised that the Chair of the H&S Committee noted the lack of COSHH Co-ordinators, with 36% of areas having no coverage and asked that this be brought to this Group for progressing.

Health and Safety Adviser – Ms C Murch reported that a list of co-ordinators will be taken to each Clinical Board H&S meeting by the relevant H&S Adviser, where shortfalls can be seen and addressed.

The Head of Health and Safety also highlighted that the Annual Report shows an increase in the number of work related stressors being reported through the DATIX system and felt that a project approach was needed.

Senior Occupational Health Nurse – Ms N Bevan agreed that this was a concern and felt that the DATIX figures did not reflect the real life number and therefore highlighted underreporting. It was also noted that this had been raised previously through the Priority Action Plan.

It was agreed that The Head of Health and Safety would form a Group to tackle these issues. **Action** CD

OHSG: 25/18 Staff Group Inspections – Medical Records

Staff Side Representative – Mr S Egan reported that concerns in relation to medical records had been raised at the Health and Safety Committee, where it was agreed to be escalated on to the Board.

It was reported that there had been an improvement within UHW and UHL; however this did not address long term issues as well as Community settings.

It was agreed that feedback from the Board meeting in September, be brought to the next meeting. **Action** SE

OHSG: 26/18 Control of Contractors Update

The Head of Health and Safety welcomed the new Health and Safety Adviser – Mr Jonathan Davies.

He highlighted that one of Jonathan's job role included contractor control management for non estate areas such as IT, however he would be working closely with Estates to ensure a consistent approach.

OHSG: 27/18 Lone Worker

The Head of Health and Safety reported that he had met with Procurement to review the Skygard contract and had agreed to renew for a further three years.

OHSG: 28/18 H&S Training for Managers

Health and Safety Adviser – JD informed the Group that he was in the process of developing a training package for managers to help them understand their obligations and responsibilities to Health and Safety.

It was noted that this would be a 2 to 3 day course and offerings will be available in the New Year.

OHSG: 28/18 Clinical/ Service Board Feedback

Health and Safety Adviser – RS raised on behalf of the Women Clinical Board the following concerns:-

Obstetrics & Gynaecology concerns around lifts – it was noted that this is an ongoing issue across the Health Board.

School Nurses concerns around condition of buildings. It was highlighted that this concern had also been raised by other Clinical Boards such as PCIC and Mental Health. It was agreed that this would be an agenda item or the December meeting. **Action** PW

Concerns had been raised that there were not enough devices for new starters in Health Visiting in September. The Head of Health and Safety advised that in the first instance they would need to look at usage of the devices already allocated to determine whether any could be re-allocated.

If additional devices were required then the H&S unit could manage the administration of the devices but there was no more central funding so they would need to be funded by the Directorate.

The Chair informed the Group that the revised Memorandum of Understanding (MOU) was being launched in November to help support staff that are victims of violence. It was agreed that the revised document would be brought to the next meeting for information. **Action PW**

The Chair also reported that Barry Hospital was changing its parking system as of the September to include plate recognition.

OHSG: 29/18 Policies and Procedures

The Incident Reporting Procedure was attached to the Agenda for Information.

OHSG: 30/18 DATE AND TIME OF NEXT MEETING

12th December 2018, 9-11, Corporate Meeting Room, HQ UHW

MINUTES OF THE FIRE SAFETY GROUP HELD AT 2PM ON 13 SEPTEMBER 2018 – MANUAL HANDLING UNIT, DENBIGH HOUSE UHW

Present:	Charles Dalton	Head of H&S/Fire Safety Manager **(Chair)**
	Stuart Egan	Staff Side Representative
	Frank Barrett	Senior Fire Safety Adviser
DFSM	Eleri Crudgington	PCIC
	Ian Fitsall	Estates & Facilities
	Kate Leney	Women and Children
	Mathew Price	Specialist
	Peter Welsh	Executives
	Scott Gable	CD&T
Apologies:	Abigail Harris	Executive Director of Planning
	Geoff Walsh	Dir of Capital, Estates and Facilities
	Cheryl Evans	DFSM C&W– O&G Directorate
	Dick Jones	South Wales Fire Service
	Lynne Topham	DFSM - PCIC
	Ian Wile	Mental Health
	Nick Gidman	Specialist Services
	Rowena Griffiths	DFSM Dental /Nurse Manager
	Sarah Congreve	PCIC Vale
In Attendance:		
	Zoe Brooks	Health and Safety

An apology was given by the Chair of the Group, Mr G Walsh. The Head of Health and Safety/Fire Safety Manager chaired this meeting on his behalf.

18/22 Minutes of the Meeting

The minutes of the meeting held on the 22nd May 2018 were **APPROVED** and **ACCEPTED** as a true record.

18/23 Action Log

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

18/03 DSEAR
The Fire Safety Manager reported that this was still outstanding. It was noted that external advice had been sought during the period. To be progressed by the next meeting. **Action** CD

18/14 Evacuation Drills
Previously concerns were raised in relation to lack of commitment from Clinical Board to participate in evacuation drills – update to be given at the next meeting. **Action**: GW

18/15 Storage – Block B
DFSM – Estates and Facilities reported that a cleanup had been undertaken by the Waste Team, however dumping of items remain an ongoing concern. The Senior Fire Adviser reported that he had observed waste in corridors and bins overflowing. DFSM – Estates and Facilities reported that a walk about is being planned with the aim to look at the frequency of collections.

18/16 Fire Risk Assessment Status – Estates
It was noted that previous meetings had highlighted the lateness in which the Estates actions are taking to being closed out. The Chair Mr G Walsh requested an update at this meeting – The DFSM Estates and Facilities confirmed that this is still an ongoing issue, however progress is being made.

18/24 Enforcement Notice Status/ IN01-02

It was reported that no enforcement notices had been issued during the period; the Health Board had received 6 IN01/02's, however no major issues raised.

The Senior Fire Adviser raised concerns in relation to the number of fire incidents at Hafan Y Coed and the control of ignition source relating to the smoking ban, with particular reference to the action plan sent to the fire service.

It was considered this item should be highlighted to the Chair and taken to the next Health and Safety Committee. **Action** CD

18/25 Fire Risk Assessment Status

The Group **received** and **noted** the notes of the DFSM meeting on the 14th June 2018.

The Fire Safety Manager reported that the DFSM's continue met quarterly to discuss fire risk assessment in relation to managerial actions. It was noted that the last DFSM meeting took place on the 14th June 2018. Further details can be found in the full report.

18/26 Fire Annual Report

The Group were informed that the Fire Annual report was to be submitted to the Health and Safety Committee in October 2018. It was noted that this report would be on the agenda for the next Fire Safety Group and any

comments and feedback from the Health and Safety Committee will be discussed.

18/27 False Alarms, Automatic Detectors and Responses

The Fire Safety Manager informed the Group that a meeting took place between the Health Board, NWSSP-FS and South Wales Fire Service to discuss concerns relating to the number of false alarms at UHW site; the purpose of the meeting was for joint working to consider mechanisms to minimise the number of unwanted fire signals (UWFS), resulting in unnecessary tender visits; the target was aimed at a 10% reduction.

It was noted that the data from the 1st June- 30th August 2018 was considered, it was identified that the largest source of cause was system faults, through a faulty detector. It was agreed that a faulty detector after its first failure would not upgraded.

It was also noted that faults associated with contractor working, were the second most significant failing. It was highlighted that significant effort is now being placed on Contractor control and reviewing their work methods.

18/28 Evacuation Drill

The Senior Fire Adviser reported that an evacuation drill was conducted at both Pendine Centre and Global link during the period. He advised that a full report is available which identifies some lessons to be learnt.

Concerns were raised in relation to the lack of a robust system in place to ensure that staff are trained in using of evacuation mat/chairs. The Fire Safety Manager reported that previous training was provided initially to individuals to cascade, however many of these trainers have now left or are no longer in post.

It was noted that this concern had been raised on a number of occasion in the past and the Group agreed that this issue should be an agenda item at the next meeting in December for further discussion.

18/29 NWSSP-FS Audit Return

Confirmation was given that this audit report had been signed off and submitted.

18/30 Any Other Business

Concerns were raised in relation to the poor conditions of the community buildings in particular the Lynx Building at CRI. It was noted that although many of these buildings will be closing within the next few years, the conditions for working are poor and require imminent resolution for the staff working at these locations.

The DFSM – Executive Services reported that three Mental Health Community buildings are due to close as they are relocated to Barry Hospital. He queried whether there was a closing down process in relation to Fire and Security.

The Senior Fire Adviser reported that those vacating the building are asked to ensure that all items are removed and the building is left empty.

DFSM – PCIC reported that they had been involved with many community building closures and meetings/procedures were established to cover all aspects from waste and removals to fire safety and security.

The DFSM – Executive Services felt that other Clinical Boards could benefit from the PCIC's experience and procedures and suggested that this item is taken to the Operational Health and Safety Group for further discussion.

18/31 Date of Next Meeting

3rd December – Corporate Meeting Room, HQ UHW at 9AM.

Water Safety Group

Date of meeting: Wednesday 12th September 2018

Time of meeting & Venue: 10:00 am, PHW Library, UHW

Name	Title
Eleri Davies (ED), Chair	Consultant Microbiologist
Mike Quest (MQ)	Authorising Engineer (Water)
Keith Sims (KS)	Maintenance Engineer, Cardiff University
Debbie Charles (DC)	PHW Scientific Head FW&E Lab
Paul Morgan (PM)	Legionella Management & Control Supervisor
Jenna Maltby (GM)	Rep for St David's Hospital
Norman Mitchell (NM)	Responsible Person for Water, Estates Manager
Maxine Gronow (MG)	NW ops manager, PCIC
Gareth Simpson (GS)	Estates Manager
Tony Ward (TW)	Discretionary Capital and Compliance
Jonathan Davies (JD)	Health and Safety
Yvonne Hyde (YH)	Senior Nurse, IPC
Victoria Daniel (VD)	IPC scientist
Alun Morgan (AM)	Assistant Director of Therapies, CD&T
Melanie Wilson (MW)	Dental Clinical Board
Ian Fitsall (IF)	Interim Head of Estates/Facilities
Dean Matthews (DM)	Water Safety Surveyor
Tara Cardew (TC)	Lead Nurse Gastroenterology/Dermatology/Rheumatology
Ceri Chinn (CC)	Lead Nurse Perioperative Care
Gavin Forbes (GF)	Consultant Microbiologist
Michelle Peters (MP)	PHW Microbiology

Present:

In attendance: Jennifer Lewis (ACNS in IP&C)

Apologies: Amanda Watkins, Rachel Edwards, Jim Blackie, Rachel Coombes, Jon McGarrigle, Orla Morgan, Heather Gater

		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 there have been no changes since the last meeting	
4.	**Minutes of previous meeting (9th May 2018)**	

	The minutes of the previous meeting were agreed as an accurate record	
5.	**Matters arising/Actions from previous meeting (9th May18)** **Water sampling in Dental CB** MW provided an update: The Dental Hospital treatment units contain an integral metered biocide. The most critical element in assuring quality is adherence to the waterline flushing regimen; signed sheets are collected and checked for compliance monthly. Although there is no requirement for microbiological testing with the systems used, random TVC testing of a small number of units is undertaken on a rolling programme. Testing is not required, however structured testing regimen focuses minds on water safety and the pictures of bacterial isolates serve as a useful educational tool; consequently compliance with flushing is improved. The counts are not used for QA purposes and are not undertaken in an accredited laboratory. **Guidance / approval of ice machine** YH will liaise with Ceri Chinn in regards to the Main Theatres ice machine. **Action: CC will follow up again with theatres what the ice is used for** **Heater Cooler units in Theatre 10**. Work has been undertaken to have the units in a designated area between theatres 10 and 11. Theatre 10 not used for Cardiothoracic surgery at present (Theatre 10 is used for CEPOD), theatre 3 is used instead. Heater coolers are used within theatre 3. **Action: CC will look into precautions being undertaken to reduce risk** **Decontamination of TOE probes** A query was raised in regards to the decontamination of TOE's. The issue has been discussed at the Decontamination Group meeting. Following the development of the Cardiology Outpatient space the Health Board is looking to procure a UV unit for Cardiology, however this requires capital that is unavailable. The Health Board has asked Welsh Government if there is capital resource for this and is awaiting a response. **Ongoing**	**CC** **CC**
6.	**<u>Water Safety Plan (WSP)</u>** The plan needs to be amended to include how the risk assessments are to be undertaken. KS requested a copy as University staff do not have access to C+V Intranet. ED requested the plan be shared with members of the WSG as parties external need to have access. AM suggested ED contact the Safeguarding team to ask how they share information with external stake holders. **Action: ED to follow up with Safeguarding, Capital to share plan with KS** **Note:** Internet link http://www.cardiffandvaleuhb.wales.nhs.uk/health-and-safety-policies/	**ED/TW**

7.	**<u>Current / Closed Incidents for consideration</u>** Legionella counts PHW microbiology laboratories. **Closed** DC queried if water samples needed to be taken in the Virology, she was advised no however outlets are to be flushed in line with the procedure **Action: MP to reinforce with lab staff**	**MP**
8.	**<u>Risk Assessments</u>** **Risk Assessment Action Plan (Legionella)** There is a contract in place for getting the risk assessments completed, currently 80% of the information has been obtained. Work will be undertaken around the risks identified to date. The Health Board will have up to date schematic drawings with all required remedial works included. Much of this work will be undertaken when wards/areas are being refurbished. TW was pleased to note there was less work required than originally thought.	
9. **9.1** **9.2**	**Water Sampling Results:** **Legionella** PM provided an overview of sampling results. SAMPLES OVERVIEW 2018.xlsx He reported that again the POU filters had been removed from some outlets on B7 **Action: TC to follow up with the ward** **UHL** - PM reported that the since the installation of the Chlorine Dioxide dosing system 128 samples had been obtained. Of these 31 were positive (24%). An audit of flushing practice and knowledge has been undertaken by estates which highlighted a lack of knowledge amongst clinical staff about the requirements and poor recording practice is some areas inc. incorrect form being used in Critical care. It was suggested that Medicine CB have legionella risk on the agenda for their Q+S meeting. **Action: TC to discuss with Rebecca Aylward** DC reported that the laboratory method of testing the water samples has now changed. This has resulted in cost increase but a 6 month notice will be given to HB's. ED suggested that a copy of the new method be circulated to WSG members and sent to the holder of the SLA for the Health Board. **Action: DC** **Pseudomonas aeruginosa** No concerns were noted. PM to develop a sampling plan and share with DC and IP+C. **Action: PM**	**TC** **TC** **DC**

	Other water sampling: • **Rinse Water** There are no issues to note. • **Heater Cooler Unit (H/C unit)** it was brought to the attention of the Group that the machines are now in Theatre 3 during procedures as Cardiac surgeons have refused to operate in theatre 10. • **Hydrotherapy pool** No issues noted	**PM**
10	**Flushing Audits** TW advised that the flushing record has been revised and that we will be moving to an electronic recording system which will be accessible via the intranet. It will involve a 4 click process to ensure ease of use for staff. Hoping to commence roll out on Oct 2018. AM raised concerns that IT access may be difficult for some staff and that it may increase the workload of junior staff, TW acknowledged that these are valid concerns and will be looked into during roll out. CC and TC suggested a pilot prior to roll out, this will be considered.	
11.	**Water Control Measures- Out of Specification Results & Action Taken** IF advised that remedial work in the CHfW is now complete. The have been no positive samples since but there has been no increase in water consumption which may indicate that flushing is not being undertaken as it should which will increase the risk for users. A flushing audit was suggested, estates have agreed to undertake **Action: PM**	**PM**
11.	**Department Updates:** 11.1 IPC- no issues to raise. 11.2 Estates - no issues to raise 11.3 HSDU - no one in attendance 11.4 H&S- no one in attendance. 11.5 Medicine – TC queried how to dispose of empty pericetic acid containers as waste refused to remove them. Discussion followed and she has been advised to dilute with water and discard the remnants down the sink. 11.6 Surgery – no issues to raise. 11.7 Specialist – no one in attendance. **11.8** CD&T- queried if the automatic dosing system has been installed in the hydrotherapy, **GS will update AM after the meeting** 11.9 Mental Health – no one in attendance 11.10 Primary Care & Intermediate Care- no issues to raise. 11.11 Women & Children - no one in attendance 11.12 Dental – no issues to raise. 11.13 Cardiff uni- no issues to raise.	**GS**

	11.14 PHW- MP reported that there was water leaking into one of the labs from the floor above. **Action: GS will follow up** 11.15 St. David's – no issues to raise.	**GS**
	Property Occupation Changes Refurbishment of Neale Kent is complete. Pelican ward is fully complete, there are no water issues.	
14	**Changes to Augmented Care Areas- IP&C** Nil of note at present however need to bear in mind when areas move temporarily e.g. T5 moving to A2South, water needs to be tested prior to any moves in future. A more robust method of updating the current list is required. **Action: to be discussed at the next IPC/Capital and Estates meeting** It is noted that there are plans in place to open extra Critical Care beds, **Action: YH to identify where they will be for a risk assessment to be undertaken re. Water sampling**.	**YH/JH** **YH**
15.	**Training / Competence Matters** N/A	
16.	**Water Safety Audit Status / Progress with Action- put just after legionella risk assessments on next agenda.** YH will discuss with JMcG re: strengthening the PPT used for training. Action: **YH to follow up** There will be one contractor, ACORN, starting in October, they will undertake all legionella work and an audit will be undertaken in Jan/Feb 2019	**YH**
17.	**Action Plan / next steps**	
18.	**Any other business** The energy department have advised they would like to trial a system to reduce water consumption, the device is a bag (HIPPO) which is put into the cistern of a toilet. MQ and KS raised concerns as they felt there may not be enough water in the system to flush solids. Advised caution therefore the group are not fully supportive of the trial	
19.	**Date & Time of Next Meeting:** Wed 5th December 2018, 10:00am, PHW library, C1 Link Corridor	

Action Summary (Water Safety Group): 05/12/2018

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	**Complete**
	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	**Complete**
	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** **Complete**
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**	**Complete** **Complete**
	OM to review Heater Cooler units in Theatre 10.	**OM**	**Complete**
	A query was raised in regards to the decontamination of TOE's. OM agreed to find out the process and update ED.	**OM**	**Ongoing**

12/09/2018			
	CC will check what precautions are being taken with the Heater Cooler units in theatre 3 when cardiac surgery is undertaken	**CC**	**Outstanding**
	CD&T- queried if the automatic dosing system has been installed in the hydrotherapy, GS will update AM after the meeting	**GS**	**Outstanding**
	ED to follow up with Safeguarding for new ways to share Health Board policies/procedures with partner agencies, Capital to share plan with KS	**ED/TW**	
	MP to reinforce the requirement/importance of flushing with staff in the Virology department	**MP**	
	TC will follow uo with the sister on B7 why the POU filters are being removed from some outlets by staff	**TC**	
	TC will discuss with Med CB having Legionella as an agenda item on the Q+S agenda	**TC**	
	DC will share with the WSG members the new laboratory method for water testing	**DC**	
	PM will undertake an audit of flushing in the CHfW	**PM**	
	Estates will follow up on the leak reported by PHW into the lab area from the floor above	**GS**	
	YH to discuss with Capital at the monthly catch-up meeting a way of updating the Augmented Care Area list in a timely manner	**YH**	
	YH will follow up with OM where the extra Critical Care capacity will be	**YH**	**Complete – they will be within the current footprint**
	YH will discuss with JMcG strengthening the teaching presentation	**YH**	

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