HEALTH AND SAFETY COMMITTEE

9.30am on Tuesday 18 July 2017
Seminar Room 1, Cochrane Building, UHW

CARING FOR PEOPLE
KEEPING PEOPLE WELL

Health and Safety Committee
9.30am on 18th July 2017
Seminar Room 1, Cochrane Building, University Hospital of Wales
AGENDA

PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral *Chair*
2	Apologies for Absence	Oral *Chair*
3	Declarations of Interest	Oral *Chair*
4	Minutes of the Health and Safety Committee meeting held on 25th April 2017	*Chair*
5	Action Log Review	*Chair*
Deliver Outcomes that Matter to People		
Our Service Priorities		
Sustainability		
6	Corporate Risk Assurance Framework	*Director of Corporate Governance*
7	Letter to CEO's re Health and Safety Assurances	*Director of Corporate Governance*
8	Health and Safety Annual Report – Presentation	*Head of Health and Safety*
9	Letter re Fire Safety Grenfell Tower	*Director of Corporate Governance*
10	Fire Safety Annual Report	*Director of Capital, Estates and Facilities*
11	Fire Enforcement and Management Compliance Report	*Director of Capital, Estates and Facilities/Head of Health and Safety*
12	Shared Services Fire Safety Audit of University Hospital Llandough	*Director of Capital, Estates and Facilities*
13	Enforcement Agencies Correspondence Report	*Head of Health and Safety*

14	Trend Analysis of Contractor Control Safety Breaches	*Director of Capital, Estates and Facilities*
15	Health and Safety Priority Action Plan - Exception Report	*Head of Health and Safety*

Culture and Values		
16	Incident Reporting Policy – for approval	*Head of Health and Safety*
17	Sharps Management Policy – for approval	*Health and Safety Adviser*
18	1st Aid Policy – for approval	*Head of Health and Safety*

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE Papers are available on the Health Board website		
19	Work Programme 2017/18	*Director of Corporate Governance*
20	Regulatory Review and Tracking Report	*Director of Corporate Governance*
21	Health and Safety Priority Action Plan (in detail)	*Head of Health and Safety*
22	Waste Management Compliance Report	*Director of Capital, Estates and Facilities*
23	Lone Worker Devices Report	*Head of Health and Safety*
24	EHO Report of Barry Hospital on 21st February 2017	*Director of Capital, Estates and Facilities*
25	EHO Report of Aroma Coffee Outlet, University Hospital Llandough on 20th June 2017	*Director of Capital, Estates and Facilities*
26	**Minutes from other Committees/sub-Committees/Groups** Operational Health and Safety Group – March 2017 Fire Safety Group – February 2017 Security and Personal Safety Strategy Group – February 2017	*P Welsh* *G Walsh* *C Dalton*

27	Updated Health and Safety Related Policies Schedule	*Director of Corporate Governance*
28	Review of the Meeting	Oral *Chair*
29	To note the date, time and venue of the next meeting:- • 9.30am on Tuesday 24th October 2017 in the Corporate Meeting Room, Headquarters, University Hospital of Wales.	

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UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am ON 25 APRIL 2017 IN THE CORPORATE MEETING ROOM, HQ, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Martyn Waygood	**Independent Member – Legal (Chair)**
Stuart Egan	Independent Member – Trade Union/Health and Safety Staff Lead

In attendance:

Charles Dalton	Head of Health and Safety
Fiona Jenkins	Director of Therapies and Health Sciences (from agenda item 17/034)
Fiona Kinghorn	Interim Director of Public Health
Catherine Salter	Staff Representative (RCN)
Geoff Walsh	Director of Capital, Estates and Facilities
Peter Welsh	Director of Corporate Governance

Apologies:

Carol Evans	Assistant Director of Patient Safety and Quality
Claire Radley	Assistant Director of Organisational Development

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 17/027 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting. Mr Waygood referred to the number of members who were absent from the meeting and the number of apologies not received.

The Director of Corporate Governance informed the Committee that although Mr Egan now attended the Committee in his capacity as Staff Representative Lead his Health Board role as Independent Member – Trade Union enabled the Committee to be quorate and subsequently be able to approve the Policies on the agenda.

HSC: 17/028 DECLARATIONS OF INTEREST

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

HSC: 17/029 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 24 January 2017 were **APPROVED** and **ACCEPTED** as a true record.

The Interim Director of Public Health referred to page 12 of the minutes and noted it was reported at the time as purchasing cigarettes but in fact should be purchasing e-cigarettes.

HSC: 17/030 UPDATED ACTION LOG

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

- HSC: 16/030 – the Director of Capital, Estates and Facilities informed the Committee it was not strictly a 'permit to work' that was being trialled as ultimately there would be too many to effectively manage, so a 'permit to access' had been introduced which covered a multitude of issues. Mr Walsh advised problems were still occurring with Contractors who abused the system and a number of yellow and red cards had been issued. He added problems were further exacerbated by contractors who were not under the control of the Estates Department and subsequently any schemes will now have to come through him for signing off.

  The Interim Director of Public Health queried whether guidance could be issued to Clinical Boards, the Health and Safety Adviser confirmed guidance had already been produced and issued following the Operational Health and Safety Group meeting in March and had also been raised at the Clinical Board's Health and Safety Group meetings.

  The Trade Union Representative - RCN queried whether the Training for Managers Course would include the Contractor Control Policy, the Head of Health and Safety confirmed it would.

  The Independent Member – Trade Union queried whether any other Health Boards were experiencing similar problems, Mr Walsh advised no other Health Board had an estate similar to ours so was difficult to benchmark against. He added it was disappointing that a number of breaches were through our own staff not managing the contractors correctly. Mrs Kinghorn requested whether a trend analysis on the number of yellow and red cards issued could be brought to the next meeting, Mr Walsh confirmed this could be produced.

  ACTION – Mr G Walsh

- HSC: 16/051 – the Head of Health and Safety informed the Committee 63 hoists that were either obsolete or in poor condition were being replaced following a capital investment of £400k and thanked Mr Walsh for his assistance in taking this forward.

- HSC: 17/006 – the Chair informed the Committee the Assistant Director of Organisational Development had requested clarification on what assurances the Committee required in respect of the Employee Wellbeing Service.

  Mr Waygood clarified concern was expressed at the last meeting that the external service was ceasing and as a result whether the same level of accessibility to services would still be available to staff and that they would still receive continued support.

- HSC: 17/013 – the Head of Health and Safety informed the Committee each Clinical Board had been written to advising devices would not be removed unless risk assessments had been completed and identified suitable alternative arrangements were in place. Mr Dalton highlighted compliance usage was currently at 70%.

  The Independent Member – Trade Union informed the Committee the devices were not classed as personal protective equipment under the Regulations, however staff side are clear if the risk assessment states a device is required then staff must use them. This was endorsed by the Committee.

HSC: 17/031 CORPORATE RISK ASSURANCE FRAMEWORK DOCUMENT (CRAF)

The Director of Corporate Governance informed the Committee the status of the CRAF had not changed since the last meeting. Mr Welsh advised a Risk Management Development Day was being held on Thursday 27th April which would look at how risk was managed within the Health Board. The outcomes from the day would be reported to the May Board meeting.

Mr Welsh queried the current status of passenger lifts across the Health Board, the Director of Capital, Estates and Facilities advised the position had improved however the risk rating related to the age and condition of the lifts and a replacement programme was required. Mr Walsh added the All Wales maintenance and servicing contract was currently being reviewed.

The Corporate Risk Assurance Framework Document was **RECEIVED** and **NOTED** by the Committee

HSC: 17/032 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee one new issue had arisen since the last meeting. Mr Dalton advised 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 resulting in a fracture of the elbow and nose. The incident was reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and

Dangerous Occurrences Regulation (RIDDOR) and the Health Board was contacted by the HSE for further information.

The incident was fully investigated and remedial actions indentified, this was then shared with the HSE. Whilst the HSE confirmed the proposed remedial actions were suitable and sufficient and closed the incident on the basis of the work being completed, they did highlight that the Health Board did not have a plan that considered pedestrian safety. It was agreed an overall strategy would be developed by the Head of Health and Safety and the Director of Capital, Estates and Facilities.

ACTION – Mr C Dalton and Mr G Walsh

The Independent Member – Trade Union thanked Mr Walsh and his team for installing the new beacons on the pedestrian crossings in University Hospital Llandough.

Mr Dalton advised the legionella incident had now been closed and the enforcement notice rescinded.

Mr Dalton also suggested that as no further correspondence had been received from the HSE in respect of passenger lifts that this issue would no longer be included in the report, this was **ENDORSED** by the Committee.

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: 17/033 FIRE SAFETY ANNUAL REPORT

This item was deferred to the July meeting.

HSC: 17/034 FIRE SAFETY MANAGEMENT AND ENFORCEMENT REPORT

The Director of Capital, Estates and Facilities highlighted to the Committee one enforcement notice for Whitchurch Hospital was still in force and would not be rescinded until the site was closed.

The Independent Member – Trade Union advised of an issue that was being continually raised on workplace inspections. Mr Egan stated fire doors were being wedged open and when challenged staff advised that they had been informed by the Fire Officer that as long as the room was occupied at the time this was acceptable. Mr Egan's concern was that staff representatives would not be aware of this and a clear steer from the Fire Officers was required.

The Trade Union Representative – RCN added it was agreed at the Operational Health and Safety Group meeting that a one page guidance would be developed that would be shared with the Clinical Boards and staff representatives. Mr Walsh agreed this would be helpful and would progress with the Senior Fire Safety Adviser.

ACTION – Mr G Walsh

The Chair expressed his concern at the low compliance for fire safety training and whether this should be brought to the attention of the Board. Mr Egan added a combination of methods to deliver the training was required and further thought needed to be given on how this could be achieved. The Head of Health and Safety suggested this was taken to both the Fire Safety Group and the Deputy Fire Safety Managers Group so that a strategic plan to improve compliance could be developed. This was **AGREED** by the Committee with feedback at the next meeting.

ACTION – Mr C Dalton

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

ASSURANCE was provided:

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

HSC: 17/035 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN EXCEPTION REPORT

The Head of Health and Safety informed the Committee two new red areas had been added to the plan, these were in relation to:

- Development of a Manager's Training Course.
- Monitoring Schedule

The Independent Member – Trade Union informed the Committee the Health and Safety Executive were focusing on three key areas, these being Stress, Musculoskeletal (MSKs) and Occupational Lung Disease and queried whether the Health Board should also be considering HSE prioritised areas. The Trade Union Representative – RCN confirmed the Maximising Attendance Group was also focusing on Stress and (MSKs) via multi disciplinary teams.

The Interim Director of Public Health added assurances was required from the Health and Wellbeing Group that policies were up-to-date and the issues being addressed. The Health and Safety Adviser stated the Management of Stress and Mental Health Wellbeing in the Workplace Policy was to be presented to the July Committee meeting as it was due for renew and the Char of the Health and Wellbeing Group was also a member of this Committee.

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

REASONABLE ASSURANCE was provided by:

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

HSC: 17/036 MANAGEMENT OF VIOLENCE AND AGGRESSION POLICY

The Head of Health and Safety informed the Committee this was a review of a current Policy to which minor changes had been made. Mr Dalton added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

The Independent Member – Trade Union referred to the Equality and Health Impact Assessment (EHIA) and suggested verbal abuse of the ethnic minority was not being fully considered. Mr Dalton added the incident reporting data did not suggest this was an issue but would re-visit the EHIA.

The Policy was **APPROVED** by the Committee

HSC: 17/037 LONE WORKER POLICY

The Head of Health and Safety informed the Committee this was a review of a current Policy to which minor changes had been made. Mr Dalton added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

The Policy was **APPROVED** by the Committee.

HSC: 17/038 MINIMAL MANUAL HANDLING POLICY

The Head of Health and Safety informed the Committee this was a review of a current Policy to which minor changes had been made. Mr Dalton added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

The Policy was **APPROVED** by the Committee

HSC: 17/039 WASTE MANAGEMENT POLICY

The Director of Capital, Estates and Facilities informed the Committee this was a review of a current Policy to which minor changes had been made. Mr Walsh added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

The Interim Director of Public Health noted a very comprehensive EHIA had been completed.

The Policy was **APPROVED** by the Committee

HSC: 17/040 WATER SAFETY POLICY

The Director of Capital, Estates and Facilities informed the Committee the Water Safety Policy superseded the previous Control of Legionella Policy as a broader policy was required. Mr Walsh advised the Policy had been agreed by the Water Safety Group and had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group. The Policy had also been viewed by the Health and Safety Executive who were satisfied with its content.

It was also suggested that the Chair of the Water Safety Group should be a member of the Health and Safety Committee. This was **AGREED.**

ACTION – Miss R Daniel

The Policy was **APPROVED** by the Committee

PART 2

HSC: 17/041 COMMITTEE WORK PROGRAMME FOR 2017/18

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

HSC: 17/042 REGULATORY REVIEW AND TRACKING REPORT

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

HSC: 17/043 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN (DETAILED)

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

HSC: 17/044 WASTE MANAGEMENT COMPLIANCE REPORT

This item was deferred to the July meeting.

HSC: 17/045 ENVIRONMENTAL HEALTH REPORT OF ST DAVIDS HOSPITAL OF WALES ON 17TH JANUARY 2017

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

HSC: 17/046 ENVIRONMENTAL HEALTH REPORT OF CENTRAL FOOD PRODUCTION UNIT (CFPU), UNIVERSITY HOSPITAL OF WALES ON 10TH MARCH 2017

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

HSC: 17/047 ENVIRONMENTAL HEALTH REPORT OF BARRY HOSPITAL ON 21ST FEBRUARY 2017

This item was deferred to the July meeting.

HSC: 17/048 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF DECEMBER 2016

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

HSC: 17/049 FIRE SAFETY GROUP MINUTES OF DECEMBER 2016

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

HSC: 17/050 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF NOVEMBER 2016

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

HSC: 17/051 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

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

HSC: 17/052 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

There were no items to bring to the attention of the Board.

ACTION – Mr M Waygood

HSC: 17/053 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 18 July 2017 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

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UP DATED ACTION LOG

NB: Following presentation to the Committee meeting in April 2017, those actions completed have been removed

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 16/030	25/04/17	Contractor Control	Trend analysis of red and yellow cards issued to be brought to the next meeting.	Mr Geoff Walsh	**COMPLETED** Agenda Item
HSC: 17/006	24/01/17 & 25/04/17	Employee Wellbeing Annual Report	The number of closed referrals and outcomes would need to be monitored to ensure necessary resources were being provided.	Mrs Claire Radley	**COMPLETED** A new Provider has been engaged by the Health Board.
HSC: 17/013	24/01/17 & 25/04/17	Lone Worker System Progress Report	Committee to be assured that all staff that required lone worker devices had access to them.	Mr Charles Dalton	**COMPLETED**
HSC: 17/032	25/04/17	Pedestrian Safety	Pedestrian Safety Strategy to be developed	Mr Charles Dalton/Mr Geoff Walsh	**ACTION STILL UNDERWAY** Mr Dalton and Mr Wash to meet to agree way forward

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/034	25/04/17	Fire Safety	One page guidance to be developed in respect of wedging fire doors open.	Mr Geoff Walsh	**ACTION STILL UNDERWAY** Discussed at Fire Safety Group, guidance to be produced and circulated
HSC: 17/034	25/04/17	Fire Safety Training	Fire Safety Training compliance to be taken to the Fire Safety Group and Deputy Fire Safety Managers Group so that a strategic plan to improve compliance could be developed	Mr Charles Dalton/Mr Geoff Walsh	**COMPLETED** Discussed at both the Fire Safety Group and Deputy Fire Safety Managers meeting.
HSC: 17/040	25/04/17	Water Safety	Chair of the Water Safety Policy to be invited as a member of the Health and Safety Committee	Miss R Daniel	**COMPLETED**

CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REPORT
Name of Meeting: Health and Safety Committee **Date of Meeting:** 18 July 2017

Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact: The CRAF includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number: 2.1
CRAF Reference Number: Not applicable
Equality and Health Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mitigation of our risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF requires strengthening.

The Health and Safety Committee is asked to:

- **CONSIDER** the CRAF Update Report and the extreme and high risks assigned to the Committee.
- **CONSIDER** whether the risk descriptors and controls identified are adequate to provide assurance to the Committee.

SITUATION

Each risk contained within the Corporate Risk and Assurance Framework is assigned to Board or a Lead Committee for oversight.

A report was presented to the May Board following the Board Development Day on Risk Management seeking agreement to review and renew the Risk Management Process. It is difficult to be entirely confident of our assurance and that provided to our stakeholders as the CRAF currently stands. Recent feedback from the Cardiff and Vale Community Health Council, and comment in the NNU independent review report illustrates this.

As part of the risk review, meetings will be held with Clinical Boards and Corporate areas to provide support in review/amendment of their registers so that we can strengthen the risk descriptor and controls narrative. Duration of risks will also be looked at as this is not always apparent from the CRAF.

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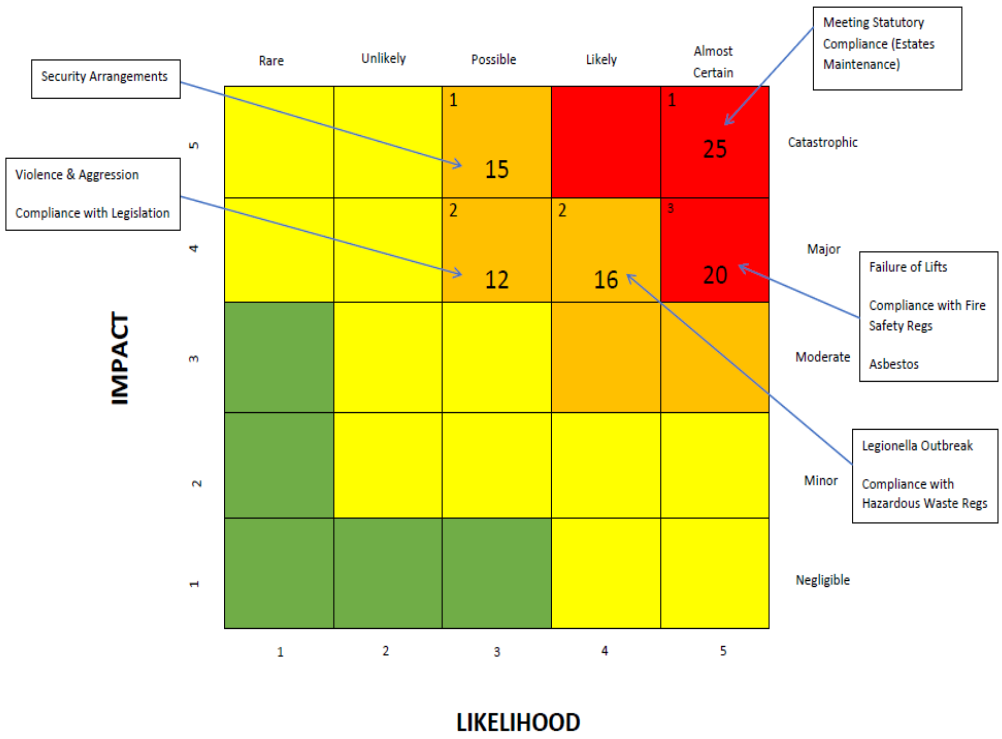
BACKGROUND

The Board agreed the production of more visual, less text based standardized reports that reflect all risks not only extreme ones. This report is prepared with that aim in mind albeit the detail is extracted from the CRAF in its current format (updated 9 June 2017). As work progresses, the Board, its Committees and our stakeholders should more easily be able to gain assurance from the CRAF.

ASSESSMENT AND ASSURANCE

The below Heat Map provides the profile of all risks currently assigned to the Committee.



The table at Appendix 1 provides the detail of the risks.

There have only been two changes since the report presented to the Committee in April 2017 as shown below:

Risk Ref	Risk Descriptor	Change	CB Score	Previous CB Score (if applicable)	Update	CRAF Score
6.4.6	Ensure appropriate security arrangements, monitoring and intervention.	C&W has added a risk in respect of no security staff to support opening and closing of Global Link.	16	N/A	New risk added	15
9.2 (also added to 5.1.7 Patient harm resulting from inadequate management of medication)	Protect staff from violence and aggression.	PCIC has added a risk in respect of medication in HMP Cardiff not being dispensed in accordance with policy leading to increased volatility of patients.	15	N/A	New risk added	12

The latest version of the full CRAF can be found at:

http://www.cardiffandvaleuhn.wales.nhs.uk/risk-register

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Appendix 1							
		Risks assigned to the Health and Safety Committee					
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
Objective 6 - 2014/15 - Resources - All the UHB's resources: money, staff, estates and equipment are maximized to deliver the best possible care.							
b) Estates and facilities							
1.	6.4.1	Meet statutory compliance in respect of estates maintenance.	Estates and statutory compliance audit process Prioritisation of maintenance requests Establishment of dedicated compliance team External audit of statutory compliance C,P& E - The emergency lighting requires specification and tendering to take place. Asset collation being progressed. Contract in place to service main plant. Currently progress OJEU tender for all medical gas compliance. New contract to start a phased approach to emergency lighting has commenced.	25		↔	H&S PPP

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No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
2.	6.4.2	Failure of lifts - potential to cause injury and disruption to services. Reports of statutory breaches of lift inspection to the Health & Safety Executive.	Lift failures reported to Estates maintenance. Contract for lift maintenance has been awarded to an alternative contractor.	20		↔	H&S PPP
3.	6.4.4	Prevent legionella outbreak.	Detailed programme of work with estates department to mitigate risk. Legionella prevention procedures - water safety risk register established. Inspection regimes now being supported by external contractors Excess cold water temperatures in CHfW phase 2 currently being controlled with dosing of chlorine dioxide Use BMS sensors to monitor HWS, CWS and CWST stored water temperatures to minimise resource requirements. Set up alarms to alert when temperatures fail to meet required level.	16		↔	H&S

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
4.	6.4.5	Comply with Fire Safety requirements.	Fire prevention programme. Fire procedures. Estates infrastructure and prioritisation processes. Mandatory staff training. Progress monitored through specific fire group.	20		↔	H&S
5.	6.4.6	Ensure appropriate security arrangements, monitoring and intervention.	Security services modernisation Secure access points CCTV Lone worker policy and safety devices C&W - Designated key holders assigned.	15		↔	H&S
6.	6.4.7	Risk of disturbing friable asbestos when maintaining infrastructure.	Detailed asbestos management plan in place.	20		↔	H&S
Objective 8 - 2014-15 - Governance - To have effective governance arrangements ensuring the UHB is compliant with relevant legal and regulatory frameworks and its processes for decision making are robust.							
7.	8.1.1	Failure to comply with Hazardous Waste Regulations.	Updated procedures and communication to staff. Internal environmental audits Action Plan agreed with Natural Resources Wales.	16		↔	H&S

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
8.	8.1.4	Compliance with Health and Safety legislation.	Policies, procedures and protocols Mandatory H&S training Strengthened arrangements regarding safety needles Health and Care Standard 2.1 - Managing Risk and Promoting Health and Safety Operational H&S Group to monitor progress across CB and Corp Departments.	12		↔	H&S
Objective 9 - 2014-15 - Values and behaviours - To rigorously uphold public sector values and be open, honest and acting in the public interest at all times. To actively demonstrate the behaviours required of staff: care, respect, trust, personal responsibility, integrity and kindness.							
9.	9.2	Protect staff from violence and aggression.	Security and police joint working arrangements Staff Personal Safety/Violence and Aggression training Bespoke courses (Care and Control) developed where this will suit needs of clinical area better e.g. Critical Care, Neurosciences, paeds Case Management support Lone worker policies and safety devices Pinpoint system to support staff safety in Hafan y Coed Alcohol Treatment Centre embedded into practice which reduces admissions to the Emergency	12		↔	H&S

			Department. Difficulties noted with additional requests by the Police and WAST to open ATC outside of existing agreement secondary to staff availability. Substance Misuse Nurse based within the Emergency/Acute departments Mon-Fri to support staff and patients PCIC - additional management support provided to HMP Cardiff by S&E Locality & monitoring of staff incidents.				
		Total		**9**		**0**	

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

NHS Chief Executives - NHS Local Health Boards and Trusts

Our Ref: AG/JD/JM

3 July 2017

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Dear Chief Executives

Health and Safety

From my recent discussions with the Health and Safety Executive and the tragic event and issues arising from the Grenfell Tower fire I wanted to reflect on the leadership priority given to meeting our organisational health and safety obligations. I would therefore ask that you satisfy yourselves and your board that the management of health and safety is sufficiently robust and that improvement plans are in hand where needed. I would expect this to feature within your performance objectives with a clear health and safety lead allocated to one of your Directors. I would like this to be picked up in our regular reviews and suggest it would be timely for this to feature in our next round of JET meetings.

You may find the advice published by the HSE useful
http://www.hse.gov.uk/pubns/indg417.pdf

Yours sincerely

Dr Andrew Goodall

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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HEALTH AND SAFETY ANNUAL REPORT 2016/17
Name of Meeting : Health and Safety Committee **Date of Meeting** 18/07/2017

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact : Not applicable
Quality, Safety, Patient Experience impact: The Annual Report covers staff and patient health and safety risks with specific reference to the 8 strategic areas.
Health and Care Standard Number 2.1
CRAF Reference Numbers: 8.1.4, 6.4.4, 6.4.5, 6.47
Equality and Health Impact Assessment Completed: Not Applicable

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ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Health and safety aspects being monitored and progressed as appropriate

The Health and Safety Committee is asked to:

- **NOTE** the content of this report

SITUATION

This report has been prepared to provide assurance to the Committee that the Health Board's health and safety risks have been appropriately managed during 2016/17.

The main driver of health and safety actions has been based on dealing with "real risks and practical solutions. The Health and Safety Executive refers to this as material breaches i.e. non compliances which are likely to result in injury and implementing practical solutions which then makes a meaningful difference.

The prioritised approach identified eight strategic areas for action, these being:-

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

8. Sharps Safety

The report covers the period the 1st April 2016 to the 31st March 2017, however it also refers to progress made since this date.

BACKGROUND

Cardiff and Vale University Health Board (UHB) is committed to ensuring that all of its health and safety statutory and mandatory obligations are met. In order to meet these requirements, it is necessary to monitor health and safety performance.

The Health and Safety Policy requires that an Annual Report is prepared for submission to the Board on progress and standards being achieved.

The Health and Safety Executive identifies that measuring performance is a key element of successful health and safety management.

NHS standards mandate the preparation of an annual report. It is therefore utilised as a significant document in demonstrating compliance within both the internal and external audit processes.

The previous 2015/16 report was considered at the July 2016 Health and Safety Committee.

ASSESSMENT

The attached report (Appendix 1) identifies a number of key aspects.

The Annual Report considers trends in incidents, training and management processes. It concluded that the trends of incidents and management processes continue to show progress in improving staff and health and safety risks.

Key issues highlighted included:

- Incident data collated from the Datix system is showing a high level of close out and management involvement (94% of the staff health and safety incidents were closed out and only 6 of nearly 3600 remain as awaiting review) .
- Whilst the number of RIDDOR events have remained constant there has been a continued increase in the number of patient behavioural incidents with has doubled over the last 2 years and up 28% on the previous period.
- The Health Board received its second HSE enforcement action since 2001 relating to compliance to Legionella requirements. An action plan was put in place and the Enforcement Action revoked by the Inspectors.
- The HSE were also active in visiting the Health Board and applying “Fees for Intervention”. They have also continued to pursue the investigation into the Contractor Fall with no decision if legal action is warranted.

- A change to the way fines are applied highlighted the significant potential risk of a fine being in the order of £1-2 million.
- The number of Prosecution and other Police inventions were significantly lower than previous years, however 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.
- Training compliance for both manual handling and violence and aggression has improved, although this mostly relates to e-learning module A and not tutor led training.
- Training improved although it is still not at the target level of compliance and some Clinical Boards are demonstrating low compliance or poor progress in improving the percentage of their staff trained. This is being pursued by the Mandatory Training Steering Group.
- Tutor led training continues to show a very high level of failure to attend on the day and this is being considered by the Health and Safety Operational Group.
- With the appointment of a new Staff Safety Representative Chair and Deputy the workplace inspection regime has been reviewed and enhanced local representatives involvement.
- Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period.
- It also reports on the improvement in the management of health and safety aspects through the priority action plan and the control of policy schedule, keys areas of progress include:

  (1) Acquiring approval from Welsh Government for renewal of £420k of patient hoists for implementation in early 2017/18.
  (2) Implemented improved re-usable glide sheets reducing injury risks whilst resulting in a saving.
  (3) Introduced new lone worker devices and improved usage from 20% - 74%.
  (4) Revised all health and safety policies within their required reviewed period.
  (5) Needle stick and sharp incidents were again lower than the previous period justifying the safer sharps devices introduced.
- Finally, performance has been summarised into a benchmarking type format, which allows for comparison by area and Clinical Board. This may be helpful in progressing assurance when Clinical Board's Health and Safety performance is considered as part of the Committee's work programme.

APPENDIX 1

SITUATION

This report has been prepared to provide assurance to the Committee that the Health Board's health and safety risks have been appropriately managed during 2016/17.

The main driver of health and safety actions has been based on dealing with "real risks and practical solutions. The Health and Safety Executive refers to this as material breaches i.e. non compliances which are likely to result in injury and implementing practical solutions which then makes a meaningful difference.

The reports covers the period the 1st April 2016 to the 31st March 2017, however it also refers to planned advancements and progress since this date.

The report takes the structure of the 5 key areas of responsibility of the Committee **SCRAP** - **Strategy, Compliance, Risk, Assurance and Policy.**

BACKGROUND

Cardiff and Vale University Health Board (UHB) is committed to ensuring that all of its health and safety statutory and mandatory obligations are achieved. In order to meet these requirements, it is necessary to monitor health and safety performance.

The Health and Safety Policy requires that an Annual Report is prepared for submission to the Board on progress and standards being achieved. NHS standards mandate the preparation of an annual report.

The Health and Safety Executive identifies that measuring performance is a key element of successful health and safety management.

The Annual Report is therefore utilised as a significant document in demonstrating compliance within both the internal and external audit processes.

The previous 2015/16 report was considered at the July 2016 Health and Safety Committee. The continued implementation of E Datix (Electronic Incident reporting) has allowed the report to be brought again to the Committee's attention at its July meeting.

ASSESSMENT

1.0 STRATEGY

1.1 HEALTH AND SAFETY MANAGEMENT STRUCTURE

The Health and Safety Committee is a full Committee of the Board, this ensures robust governance and effective communication within the Health Board. The Committee's membership includes Board Members, Management, Safety Specialists and Trade Union/staff representatives.

The Committee is chaired by an Independent Member and meets on a quarterly basis with a clear responsibility to provide assurance to the Board through a defined reporting structure. Quorum requirement is 2 Independent Members. It also has a significant role in complying with The Safety Representatives and Safety Committee Regulations 1977.

ATTENDANCE **Table 1**

	April 16	July 16	October 16	January 17
IM - Legal (Chair)	1	1	1	1
IM - Trade Union	1	1	1	1
IM - Local Authority	0	0	0	0
Director H&S Lead	0	1	1	1
Other Executive Directors (or Deputies)	2	1	2	3
Staff Safety Representative	2	1	1	2

Table 1demonstrates the Health and Safety Committee has met its terms of reference in both of frequency of meetings and quorum. It has also met the organisation's responsibilities to The Safety Representatives and Safety Committee Regulations 1977.

The Board Lead for Health and Safety and Personal Safety was transferred in December from the Director of Planning to the Director of Corporate Governance, however the Director of Planning still retains the lead for Fire Safety.

The Committee has three formal sub groups; these are the Operational Health and Safety Group which is chaired by the Director of Corporate Governance, the Fire Safety Group which is chaired by the Director of Capital, Estates and Facilities and the Personal Safety and Security Strategy Group which is chaired by Head of Health and Safety in the delivery of health and safety responsibilities.

Health and Safety Committee Reporting Structure

Chart 1

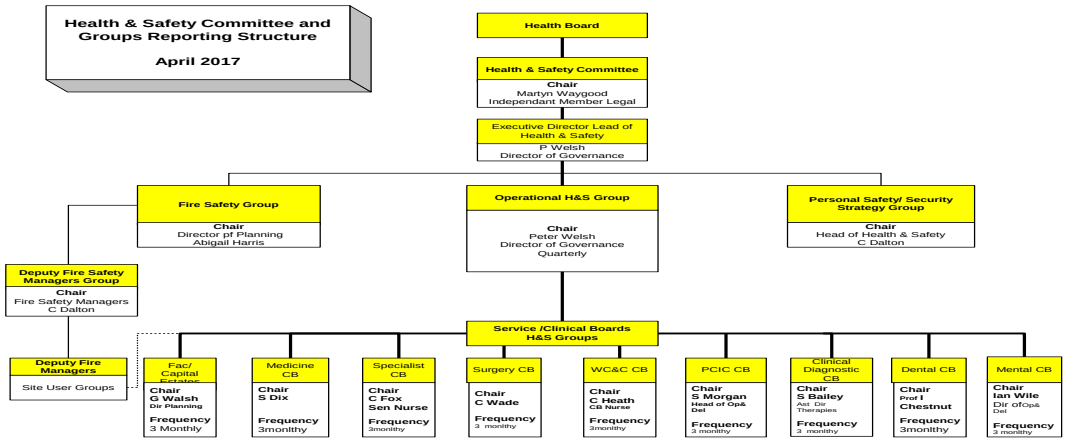


Chart 1 shows those groups reporting through the Board Director to the Health and Safety Committee.

Table 2 shows the number of meetings and deficiencies during the period.

Table 2

Health and Safety Strategic Groups	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Operational	P Welsh	3 monthly	4	5	+1
Fire Safety	G Walsh	3 monthly	4	4	0
Personal Safety	C Dalton	3 monthly	4	4	0

Table 3

Health & Safety Group	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Estates/Facilities	G Walsh	3 monthly	4	9	+5
Medicine	S Dix	3 monthly	4	1	-3
Specialists	C Fox	3 monthly	4	4	+1
Surgery	C Wade	3 monthly	4	6	+2
C&W	C Heath	3 monthly	4	4	1
PCIC	S Morgan	3 monthly	4	4	0
CD&T	S Bailey	3 monthly	4	6	+2
Dental	I Chestnut	3 monthly	4	4	0
Mental Health	I Wile	3 monthly	4	3	-1

Information based off Health and Safety Advisory invitation

8

Table 3 shows each Clinical Board has a designated Health and Safety Group Chair with an agreed frequency of meeting. In some cases these are incorporated into the Quality and Safety meeting but with an emphasis on health and safety.

Advisory Team
Establishment during 2016/17

Table 4

Position	2016/17 WTE
Head of Health and Safety	1
Health & Safety Advisers (inc of Specialist Environmental Adviser (0.7wte)	2.4
Manual Handling Advisers	1.4
Personal Safety/Case Management	2
Manual Handling/Violence and Aggression Trainers	5
Health & Safety Support /Admin	3.71

In addition to the corporate team, the Capital, Estates and Facilities Service Board manage 1 WTE Health, Safety and Asbestos Manager and 1WTE Health, Safety and Asbestos Officer.

The Health and Safety Advisers are all Chartered Members of the Institute of Occupational Safety and Health and Registered Safety Practitioners; these are assisted by 0.4wte of an Assistant and supported by part time Administrators who also maintain assessment data bases and support the Datix System.

Staff Health and Safety Representatives

Staff re-organised it's Safety Representative structure during the period, it subsequently appointed a new Lead Health and Safety Staff Representative - Stuart Egan (Unison) and Catherine Salter (RCN) as deputy lead, both of which

were existing Committee members. All unions have come together within the last 12 months to raise the profile of Health and Safety within the Health Board.

To ensure Health and Safety Representatives participate at every level, the Lead and Deputy Lead Health and Safety Staff Side Representatives will sit on the Health and Safety Committee, Operational Health and Safety Group, Personal Safety/Security Strategy Group and the Fire Safety Group.

Other meetings now attended by Health and Safety Staff Side Representatives include the Quality and Safety Committee, Local Partnership Forums, Health and Wellbeing Steering Group, Maximising Attendance and the Mandatory Training Steering Group.

Monthly Staff Side Health and Safety meetings have been re-established. All active Health and Safety Representatives have been identified and their names have been supplied to the Head of Health and Safety. Staff Side plan on holding Health and Wellbeing events across the Health Board throughout the year.

The Lead and Deputy Lead Representatives meet with the Head of Health and Safety on a monthly basis to raise members concerns, influence the health and safety agenda and transfer health and safety information. Health and Safety Staff Side are now informed of any HSE involvement within the Health Board. Health and Safety Staff Side have now been granted access to all health and safety incidents on e-datix.

A working group has been set up between unions and health and safety staff to update the Workplace Inspection Form and formalise the process. The change in working practice has resulted in a more efficient way of working and communicating.

Staff Side have acknowledged the positive steps taken during this year by the Health and Safety team to engage with Staff Side and work in partnership to improve the health and safety of our staff. We look forward to continuing this positive work and supporting all staff within the Health Board.

1.2 STRATEGY - HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN

In 2011, the Health Board was required to submit to the Health and Safety Executive (HSE) along with all other Health Boards and Trusts, details of their health and safety priorities. These priorities have been updated each year to reflect both new areas of strategic risk and the progress made.

The Health and Safety Committee has received an update report on progress made at each of its meetings during the period. Equally progress on each of the identified requirements is actively monitored by the Operational Health and Safety Group and within local Health and Safety Groups.

The Health Board has continued to pursue a prioritised approach in eight indentified strategic areas for action, these being:-

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

Below summarises the status of the plan by the strategic area as at April 2017

Table 5

	Total no of require ments	Green	Amber	Red
Health and Safety Policy Management and Organisational Arrangement	4	0	2	2
Violence and Aggression (inc Lone worker)	6	2	4	0
Manual Handling	4	1	3	0
Health Issues	4	0	4	0
Patient and Environment Health and Safety	8	1	6	1
Fire Safety Management	3	1	1	1
Estate Health and Safety Management	5	0	3	2
Sharp Safety	1	0	1	0
Total	35	5	24	6

Table 5 demonstrates of the total of 35 requirements, 5 have been resolved and 6 remain as high priority and non compliant. A further 24 are identified as amber, thus meaning that the risk has been reduced as a result of action taken but further control measures are required. The plan is a live document and during the period a total of 12 key items have been added and progressed. Below outlines those areas progressed during the period.

Key Areas Progressed During the Period

AREAS OF PROGRESS DURING PERIOD

Table 6

Area	Requirement	Action	Status
2 V&A	Ensure effective implementation of Lone Worker system.	Report submitted to the Operational Health and Safety Group and Health and Safety Committee. Monthly named reports sent to local managers. Current compliance improved from 20 % to 72%	**Amber to Green**
2 V&A	Staff at risk has access to suitable lone worker system	Monitoring each Clinical Board and effective distribution of current budgeted devices	**Amber to Green**
2 V&A	Establish forum for violence associated with caring for Mental Health patients in an acute or non acute setting (non mental health environment).	Forum established on an all Wales basis with findings being progressed through the All Wales case management group and V&A advisory group.	**Amber to Green**

3 Man Hand	The lack of flat glide sheets which are essential Manual Handling equipment	Glide sheets have been delivered and are being dispatched to areas, with a mechanism for laundering and replacement.	**Amber to Green**
3 Man Hand	The Health Board has a contract to maintain hoist.	A procurement led group including H&S and estates has been established to improve mechanisms and simplify maintenance of hoists. The pro act audit findings has been adopted as the definitive database	**Red to Amber**
3 Man Hand	Restricted finance has resulted in aged hoisting stock.	UHB has purchased 60 new hoists on a legacy scheme, these will replace the oldest and poorest condition hoists within the UHB., delivery anticipated start of next financial year	**Amber to Green**
3 Man Hand	A procurement review of maintenance contract has resulted in delays in repairs to key items which compromises patient care.	Meetings held with procurement to discuss a change to the servicing contract, to speed up repairs existing level of service maintained, servicing only. The replacement of 60 old hoists within the UHB it is anticipated the breakdowns will be less, but not diminished.	**Amber to Green**
4 Health	Hydro therapy pools Evidence shows variance of agreed standards – lack of monitoring at the required frequency and outstanding maintenance issues.	Implementation Group has met and established and action plan; this is being progressed with extensive improvement and consistency across the Health Board pools. This is being progressed through the Water Safety Group.	**Red to Amber**
5 Pat Environ	Lack of control of Legionella Assessment & Flushing at local level HSE Improvement Notice	Legionella Policy approved and Water Safety Group established Enhance monitoring established	**Red to Amber**
5 Pat Environ	Hoover Jacks have been procured for UHW& UHL to safely move fallen patients with risk of spinal injuries	2 Devices purchased from CB budget.	**Amber to Green**
6 Fire	Fire Risk Assessments shows no direct progress. Revision of Deputy Fire Safety Manager responsibility and local area ownership.	Deputy Fire Safety Managers meetings and agreement via HOD's of DFSM areas. Progress reports on actions to be submitted to the Health and Safety Committee.	**Amber to Green**
7 Estates	Passengers lifts HSE wrote requiring confirmation of suitable plans to coordinate the findings of the inspection with the maintenance company.	Maintenance Contract reviewed and improvement noted. Contractor changed enhanced maintenance no further HSE reports.	**Amber to Green**
7 Estates	Policy and AMP requires only controlled breach of asbestos	Enhanced contractor control introduced.	**Amber**
8.5 Sharps	Enhanced protection for staff against needle stick injuries and implement requirements of the EU Directive	Review of other safety devices. Audits received from clinical areas to be reviewed to identify further use of safety sharps devices.	**Red to Amber**

Table 6 shows progress in each of our strategic priority areas during the period.

1.3 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

Table 7 below shows policies that have been submitted and approved at each meeting and that all health and safety policies under the remit of the Health and Safety Committee have been reviewed within the appropriate timescale.

Below is a list of those policies reviewed during the year 2016/17.

Table 7

POLICY	REF NO	SUBMISSION TO H&S COMMITTEE	REVIEW DATE
Contractor Control	UHB 163	July 2016	July 2019
Health and Safety	UHB 021	October 2016	October 2018
Safe Working with Electricity Policy	UHB	January 2017	January 2020

Table 8 is a list of those Policies which were not submitted during the year as they remain within their review period.

Table 8

POLICY	REF NO	SUBMISSION TO HEALTH & SAFETY COMMITTEE	REVIEW DATE
Management of Violence and Aggression	UHB 035	January 2014 (2nd review)	April 2017
Lone Worker	UHB 034	January 2014 (2nd review)	April 2017
Minimal Manual Handling	UHB 036	January 2014 (2nd review)	April 2017
Waste Management	UHB 038	January 2014 (2nd review)	April 2017
Control of Legionella (now Water Safety)	UHB 091	April 2017 (previously Quality and Safety December 2014 review)	April 2017
Management of Stress and Mental Health Wellbeing in the Workplace	UHB 071	July 2014 (2nd review)	July 2017
Management of Asbestos	UHB 072	July 2014 (2nd review)	July 2017
First Aid at Work	UHB 093	July 2014 (2nd review)	July 2017
Fire Safety	UHB 022	July 2015 (2nd review)	July 2017
Closed Circuit Television (CCTV)	UHB 303	October 2015	October 2018

Table 9 shows policies which are health and safety related but approved through other Committees of the Board, these have also been added to the committee policy schedule to facilitate the timely progress of these documents.

Table 9

POLICY	REF NO	APPROVING COMMITTEE	REVIEW DATE
Safe Use of Ionising Radiation	UHB 031	Quality and Safety	December 2019
Safety Notices and Important Documents	UHB 069	Quality and Safety	August 2014
No Smoking and Smoke Free Environment	UHB 073	UHB Board	July 2019
Occupational Health	UHB 103	Workforce and OD	March 2015
Incident, Hazard and Near Miss Reporting	UHB 138	Quality & Safety	August 2015
Mandatory Training	UHB 080	Workforce and OD	June 2016
Risk Management	UHB 023	Audit	July 2016
Working Time	UHB 168	People, Performance and Delivery	July 2017
Domestic Abuse, Violence against Women & Sexual Violence	UHB 167	People, Performance and Delivery	March 2018

1.4 HEALTH AND SAFETY EXECUTIVE/ENVIRONMENTAL HEALTH ENFORCEMENT ACTION

A presentation made to the Health and Safety Committee meeting in October by Legal and Risk Services, highlighted key changes to the sentencing charges that courts now apply for offences under the Health and Safety at Work Act 1974.

They advised fines would now be related to the size of the companies turn over and as such a fine applied against the Health Board would generally fall in a high range of up to £3million with a starting point of the higher category of degree of accountability up to 1.2million. The briefing warned that such a fine would have significant financial consequences to any Health Board and that recent prosecutions had demonstrated public service bodies would not be treated any differently to private companies.

During the period the HSE were involved in 6 issues with regards to incidents within the Health Board. These being:-

- Passenger lifts
- Patient fall from bed on Ward B5, UHW
- Needle stick risk associated with the needle exchange service
- Monitoring arrangements of the hydrotherapy pool
- Legionella incident on Ward C4, UHW
- Contractor fall from height.

Subsequently one Improvement Notice was issued in regards to the management of Legionella flushing for which an action plan was implemented and the Inspector confirmed compliance**.**

In addition to the above “Fees for intervention” were made in relation to:

- the Passenger lifts for LOLER compliance,
- hydrotherapy pool monitoring COSHH and
- the Contractor fall from height.

The Contractor fall from height is subject to an ongoing investigation by the HSE with no determined outcome as yet. With the exception of this the HSE have completed their involvement and satisfied with the remedial actions implemented. There remains however continued working groups progressing ongoing requirements of these issues.

During the period there were no Enforcements issued by Environmental Health, there were however a number of satisfactory food hygiene audits, which are detailed later in the report.

1.5 INCIDENT STATISTICS

In January 2015 the Health Board commenced its introduction of the E-datix Electronic Incident Reporting System. This report details incident data statistics in

relation to staff and patient health and safety. All incidents are investigated in the first instance by the local manager and subject to an assessment by the relevant Adviser a more detailed investigation may be undertaken. Incident data allows the Health Board to identify opportunities to learn lessons and minimise reoccurrences.

All incidents are reported via the e-datix electronic incident reporting system. Information detailed below is taken from this system. The Health and Safety Department continue to send letters to all incidents reporting staff injuries to the employee to ensure we collate all RIDDOR events.

Table 10

All Incidents	2013/14	2014/15	2015/16	2016/17
Injuries affecting visitors, or the public	104	71	122	136
Incidents affecting the staff/contractors (exc rejected)	**4147**	**3891**	**3337**	**3537**
Patient *	16181*	14686*	13582	15157
Organisation	N/a *	436*	1251	1139
Totals:	**20432**	**19084**	**18292**	**19969**

Table 10 shows that the total number of incidents reported increased by 9.2% during the period with staff incidents increasing by 6%.

8

Number of Incidents relating to no action or not closed off

Chart 2

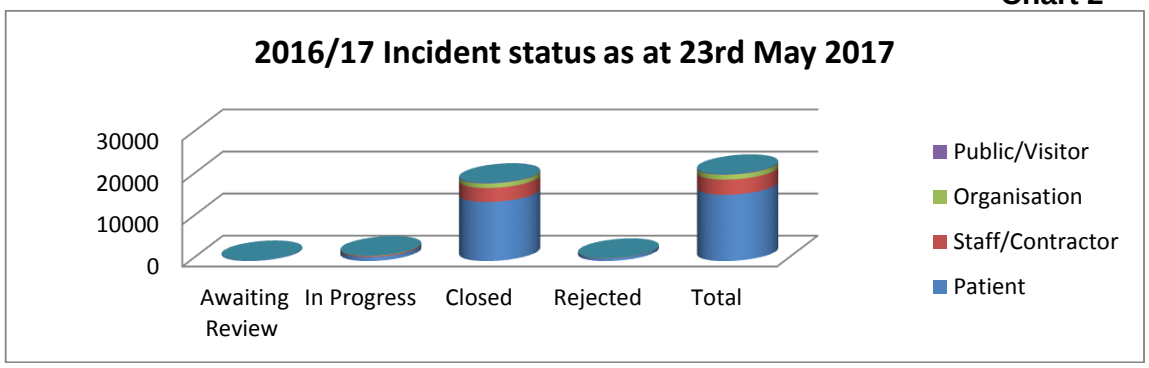


Table 11

	Awaiting review	Being Reviewed	Final Approval	Rejected	Total
Total 2015/16 (as at 3/7/16)	192	955	16565	610	18322
Total 2016/17 (as at 23/5/17)	**175**	**1242**	**18553**	**686**	**20656**
Staff/Contractor	6	223	3308	62	3599

Chart 2 shows as at 23rd May 2017 94% of reported events have been closed. Only 6 of the 3599 staff incidents remain awaiting review, this may be related to manager's absence.

1.5.1 REPORTING OF DISEASES AND DANGEROUS OCCURANCES (RIDDOR)

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations requires the reporting of over seven days' incapacitation and some specified injuries such as broken bones. It also relates to reporting dangerous occurrences and certain occupational health events.

RIDDORS 2015/16 & 2016/17 **Table 12**

Staff RIDDORs	Total 2015/16	Total 2016/17
Contact with Sharps	**4**	**4**
Contact/Collision with Object/Animal	**16**	**22**
Entrapment	**2**	**1**
Lifting/Manual Handling	**34**	**32**
Slip/Trip or Falls	**27**	**27**
Inappropriate/Aggressive Behavior	**31**	**28**
Exposure to unhygienic Environmental Conditions	1	0
Exposure to unsafe Environmental Conditions	1	1
Other	0	1
Workplace Stressors/Demands	1	0
Total	**117**	**116**

These must be reported within 10 -15 days of the date of knowledge.

Table 12 and Chart 3 shows there were 116 total RIDDOR events during the year; this is a small decrease of 1 over the 117 reported in 2015/16. Lost time events relating to violence have reduced but contact injuries have increased. The trend since 2008/9 shows a sustained reduction in the number of manual handling reportable events.

Chart 3

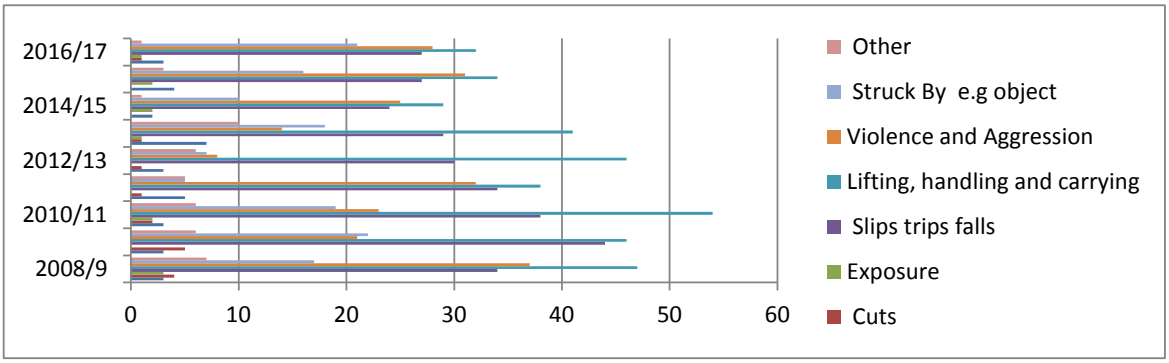


Table 13

	Sharps	Cuts	Exposure	Slips trips falls	Lifting, handling and carrying	Violence and Aggression	Struck By e.g object	Other	Total
08/09	3	4	3	34	47	37	17	7	152
09/10	3	5	0	44	46	21	22	6	147
10/11	3	2	2	38	54	23	19	6	147
11/12	5	1	0	34	38	32	5	5	120
12/13	3	1	0	30	46	8	7	6	101
13/14	7	1	1	29	41	14	18	10	121
14/15	2	0	2	24	29	25	10	1	93
15/16	4	0	2	27	34	31	16	3	117
16/17	3	1	1	27	32	28	23	1	116
Totals	33	15	11	287	367	219	135	45	1114

RIDDOR EVENTS by Clinical Board 2015/16 & 2016/17

Table 14

	Accidents/Falls		Violence and Aggression		Total	
	15/16	**16/17**	**15/16**	**16/17**	**15/16**	**16/17**
Mental Health	11	**6**	16	**15**	27	**21**
Surgical Services	12	**12**	4	**2**	16	**14**
Capital, Estates & Facilities	27	**25**	2	**1**	29	**26**
Specialist Services	10	**15**	4	**1**	14	**16**
Medicine Services	9	**15**	4	**7**	13	**22**
Children and Women's	4	**5**	1	**1**	5	**6**
Clinical Diag and Therapies	5	**2**	0	**0**	5	**2**
PCIC	3	**5**	0	**0**	3	**5**
Executive and Corporate Services	4	**2**	0	**1**	4	**3**
Dental Services	1	**1**	0	**0**	1	**1**
Total	82	**88**	30	**28**	117	**116**

Table 14 relates to RIDDOR events by Clinical Board and category. Medicine Clinical Board shows a notable increase over the period, both in relation to accidents and violence and aggression, whilst Mental Health Clinical Board has seen a significant reduction in the number of non violence RIDDOR events.

8

1.5.2 ALL STAFF INCIDENTS
Staff Incidents by Clinical Board

Incidents by Incident date and Category **Table 15**

	Staff injury inc needle stick	Cuts	Exposure to Unsafe Environ/Unhygienic/ Substances	Slips, trips and falls	Lifting, handling	Contact/entrapment /Struck By eg object	Contact with potential infectious material	Other	Work related ill health	Workplace stressor demands	VA - Assault	VA - Verbal V and A	Behavioural other /property	Total
10/11	398	41	153	300	469	281	5	64	17	0	1066	1480		4297
11/12	324	62	152	251	341	219	10	67	53	0	878	1558		3929
12/13	445	63	135	261	351	197	7	99	18	0	864	1454		3907
13/14	413	52	116	212	361	207	11	115	15	0	881	1729		4137
14/15	311	44	102	197	266	185	11	101	13	0	1062	1581		3891
15/16	298	NA	255	198	211	246	0	85	0	196	951	839		3279
16/17	258	NA	293	216	229	226	61	54	0	241	935	903	121	3537

Chart 4

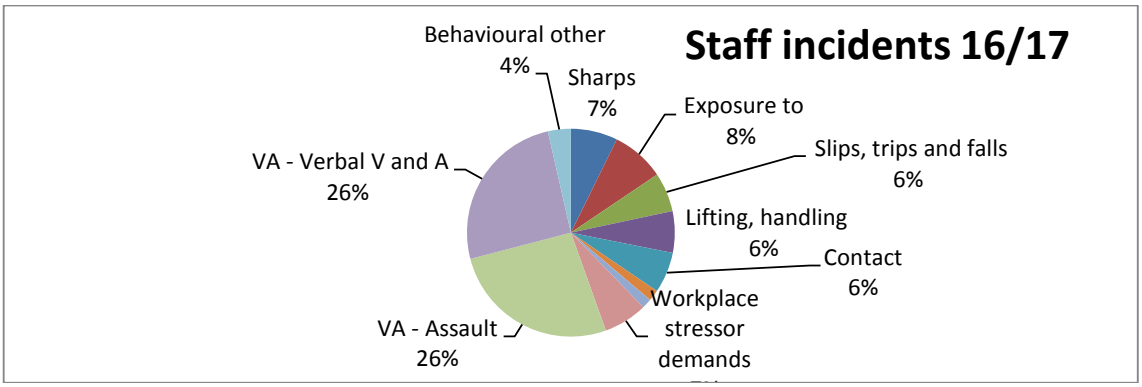


Chart 4 identifies that 56% of all reported staff incidents are violence and aggression/behavioral, 7% are sharps injuries and 7% are workplace stressor. Staff Incidents are catagorised into 4 classes as shown in Table 16.

Table 16

Staff Incident by Tier 1 Category	
Accidents/Falls	1031
Behaviour (Including Violence and Aggression)	1900
Exposure to Environmental Hazards	534
Property	72
Total	3537

ACCIDENTS/FALL BY CLINICAL BOARD AND CATEGORY **TABLE 17**

Staff accident by clinical board	&Facilities Capital, Estates	Children & Women's	CD&T	Dental Services	Executive	Medicine	Mental Health	PCIC	Specialist	Surgical	No value	Total
Contact with Sharps	11	21	42	48	2	30	12	9	30	46	7	258
Lifting/Manual handling	28	18	15	3	6	31	32	14	42	33	7	229
Slip/Trip or Fall	36	26	20	10	12	28	19	13	21	24	7	216
Contact/Collision with Objects	66	16	20	5	7	21	13	5	28	24	7	212
Contact with Infectious Materials	1	6	7	0	0	9	0	0	18	13	7	61
Other	8	2	2	5	0	5	1	7	5	4	2	41
Entrapment	6	2	0	0	0	1	0	0	2	3	0	14
Total	156	91	106	71	27	125	77	48	146	147	37	1031

Behaviour (Including Violence and Aggression) Table 18

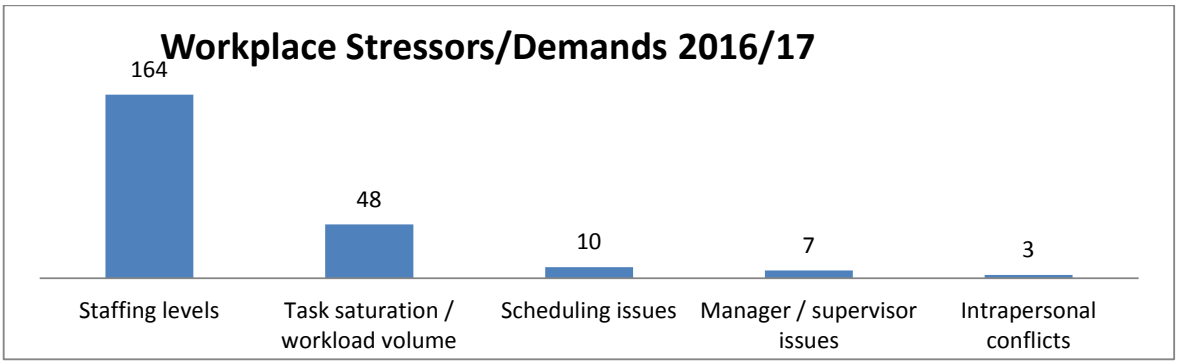
Staff accident by clinical board	&Facilities Capital, Estates	Children & Women's	CD&T	Dental Services	Executive	Medicine	Mental Health	PCIC	Specialist	Surgical	No value	Total
Inapp/Aggressive Behaviour towards Staff by a Patient	45	45	48	16	94	344	701	48	112	72	37	1562
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	4	37	11	0	6	44	25	18	16	14	4	179
Inappropriate/Aggressive Behaviour towards Staff by Staff	5	10	5	2	1	22	5	4	6	26	11	97
Other	1	0	6	1	3	8	9	9	3	11	3	54
Persons Performing Unauthorised Acts	0	0	1	0	0	1	1	2	0	1	1	7
Use/Possession of Prohibited/Stolen Goods	0	0	0	0	0	0	1	0	0	0	0	1
Grand Total	**55**	**92**	**71**	**19**	**104**	**419**	**742**	**81**	**137**	**124**	**56**	**1900**
From Above Staff V&A												
Physical contact (actual assault)	28	13	15	3	60	212	447	12	79	45	21	935
Verbal Abuse	10	57	35	10	28	118	97	41	33	46	11	487
Physical threat (no contact)	10	6	2	0	6	39	131	8	6	8	8	224
Psychological abuse (bullying and harassment)	2	15	8	4	2	16	33	5	9	10	7	111
Sexual (including harassment and indecent exposure)	2	0	2	0	2	12	12	3	3	1	0	37
Verbal abuse with racial content	2	1	0	0	1	10	6	0	3	1	1	25
Verbal abuse with gender content	0	0	1	0	1	2	4	0	1	1	3	13
Verbal abuse with disability content	0	0	1	1	1	1	1	1	0	0	0	6
Total Staff V&A	**54**	**92**	**64**	**18**	**101**	**401**	**731**	**70**	**134**	**112**	**51**	**1838**

Exposure to Environmental Hazards Table 19

Tier 3	Exposure to Hazardous Substances	Exposure to Unhygienic Environmental Conditions	Exposure to Unsafe Environmental Conditions	Workplace Stressors/Demands	Total
Staffing levels	0	0	0	164	164
Task saturation / workload volume	0	0	0	48	48
Chemical agent	37	0	0	0	37
Incorrectly disposed medical sharps (non needle)	0	0	30	0	30
Incorrectly disposed needle	0	0	25	0	25
Blood or body fluids	19	0	0	0	19
Heat	0	0	17	0	17
Floors/walls	0	16	0	0	16

Machinery/equipment	0	0	16	0	16
Infectious agent	0	0	15	0	15
Unhygienic furnishings	0	14	0	0	14
Buildings infrastructure (walls, floors)	0	0	12	0	12
Materials (e.g. asbestos)	11	0	0	0	11
Biological agent	10	0	0	0	10
Scheduling issues	0	0	0	10	10
Others	3	13	55	19	90
Total	80	43	170	241	534

Chart 5



The total number of incidents reported during the fiscal year was 3537. This is 258 more incidents than the previous year however includes 126 behaviour or property incidents reported. Most notable increase relates to workplace stressors/demands and increase of 23% to 241which as shown chart 5 mainly relate to staffing levels or workload, in addition to this there was a further 517 insufficient professional or support staff events reported as organisational incidents.

1.5.3 PATIENT HEALTH AND SAFETY INCIDENTS

Patient Slips, Trips and Falls

The Patient Falls Strategy is led by the Director of Therapies and Health Sciences. Health and safety and particularly manual handling work in close liaison and sit on a number of joint working groups including the Safe Guarding Adults Group and support falls reduction approaches.

Detailed below are those events classified as patient health and safety incidents. A total of 5341 events were reported during the year, 66% of these events related to witnessed or un-witnessed slips, trips or falls, including faints.

Chart 6

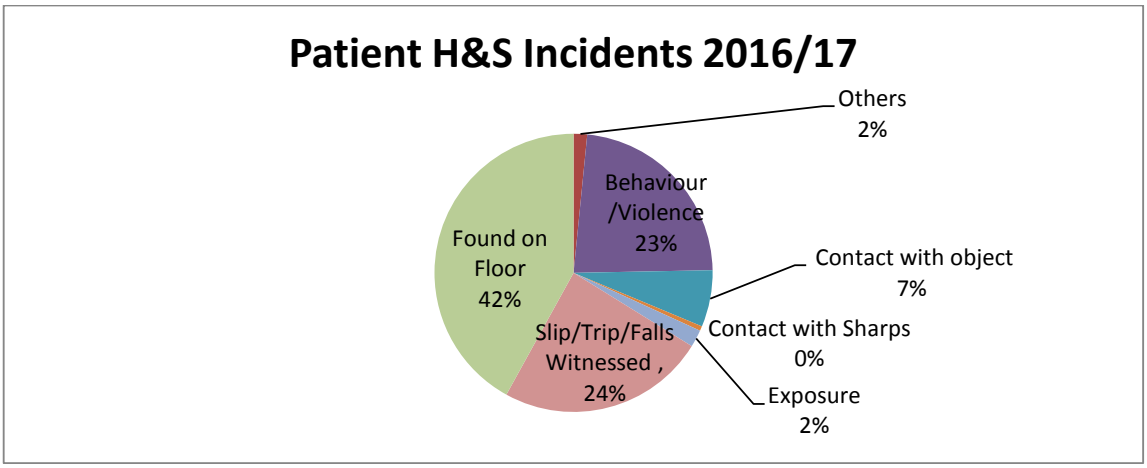


Table 20 demonstrates a 4.5% increase in the total number of events which were previously classified as patient health and safety events, however the new e-datix incident reporting system has revised categories and these classifications are chosen by the reporting member of staff.

Most significant is a continued increased in behavior reports of 28.4% to 1235 which is notable given that there was no decrease in the number of staff violence events which therefore cannot be considered as staff generalizing on its violence incidents.

Table 20

	2012- 13	2013/14	2014/15	2015/16	2016/17
Patient Incidents by Category	**Category**				
Others (inc injury form unknown origin)		**78**	**74**	**109**	**84**
Infrastructure Problems		**14**	**21**	**111**	
Behaviour/Violence	**510**	**461**	**588**	**962**	**1235**
Collision/ Entrapment/ Contact with object	**402**	**312**	**337**	**290**	**352**
Contact with Sharps	**37**	**17**	**18**	**31**	**29**
Exposure	**49**	**33**	**27**	**84**	**107**
Slip/Trip/Falls Witnessed , (inc Faints)	**2128**	**1899**	**1723**	**1276**	**1292**
Found on Floor (Unwitnessed inc Faints)	**2566**	**1921**	**1565**	**2248**	**2242**
Totals:	**5692**	**4735**	**4353**	**5111**	**5341**

1.6 HEALTH AND SAFETY TRAINING

The Health Board aims to achieve 85% training compliance, this is considered an achievable target when reflecting on long-term sickness, staff turnover and maternity leave.

Is 85% training compliance achievable?
All stats have been rounded up and do not include Strategies and Interventions for Managing Aggression (SIMA) training delivered by the Mental Health team.

Manual handling training – 5 part time Trainers = 105 hours per week x 52 weeks per year = 5460 hours. 5460-A/L & BH (90 hours x 5 Trainers = 450) = 5010 training hours per year (668 days).

The Training Needs Analysis (TNA) identifies that 3809 staff require patient handling per annum. With an 11% staff turnover rate we can estimate that 419 staff would require the 2 day foundation and 3390 staff would require the 1 day update, therefore 4228 training days are required.

The TNA also identifies that 2165 staff require inanimate training per annum. As both the foundation and update are ½ day in duration this equates to 1083 days per annum required.

To summarise – 668 training days x 8 spaces per Trainer = 5344 are available each year with a demand of 5311 training spaces required. Therefore we would be able to meet 100% compliance (101%) if all spaces offered were effectively utilised. With training currently not utilised at full capacity, this allows us to provide income generation training. Module A is completed as e-learning.

S.I.M.A. (Violence & Aggression) training – 3 part time Trainers = 60 hours per week x 52 weeks per year = 3120 hours. 3120 A/L & BH (90 hours x 3 Trainers = 270) = 2850 training hours per year (380 days).

The TNA identifies that 203 EU/Security staff require a 2 day course annually. 688 staff requires Care Control level training per annum and with an 11% staff turnover rate we can estimate that 76 staff would require the 2 day course and 612 staff would require the 1 day update therefore 967 training days are required.

The TNA also identifies that 2824 staff require Module B&C training per annum. With an 11% staff turnover rate we can estimate that 311 staff would require the 1 day B&C and 2513 staff would require the 1/2 day Module C update therefore 1568 training days are required.

To summarise – 380 training days x 8 spaces per Trainer = 3040 are available each year with a demand of 2535 training spaces required. Therefore we would be able to meet 100% compliance (120%) if all spaces offered were effectively utilised. With training currently not utilised at full capacity, this allows us to provide income generation training and to supplement the violence and aggression training. Please note that the above calculations do not include temporary staff (Nurse Bank), volunteers or candidates from the Work Ready Programme. Modules A&B are completed as e-learning.

The Health and Safety training department has updated the TNA in 2017 to reflect the new Clinical Board layout.

The S.I.M.A. course for staff working in paediatric areas has been running since July 2014 and even though feedback on the content has been positive, attendance levels remain low. The Senior Trainer has met with the Quality and Safety Group within Paediatrics to promote this training. Modules A&B are now completed via e-learning (instead of the separate ½ day course).

Modules A&B are now completed via e-learning and are being discussed for all staff in the Health Board (in line with other UHB's in Wales). This would mean all staff at risk of physical assault or those required to use safe holding (restraint) techniques would continue to attend their classroom based training, however those staff only at risk of verbal abuse would not need to attend any classroom training and e-learning would be sufficient. This has resulted in additional practical courses being offered instead.

Refresher courses continue to be popular as now staff only need to attend a refresher course which is half the duration of the foundation course rather than repeating the whole course every year e.g. 1 day refresher course for the 2 day Care Control/Older Peoples course and a ½ day refresher course for module C for the 1 day B&C course. All manual handling foundation courses continue to be accredited with Agored Cymru.

The Health and Safety Trainers have been training alongside the Mental Health S.I.M.A. Trainers to deliver the EU/Security Module D courses. These commenced in January 2016 (with 1 course of 15 places offered every month) and the feedback on training has been very positive however several courses have been cancelled due to Trainers and staff attending not being available (due to sickness, department demands and so on).

Specialist courses for manual handling continue and this offers areas such as Dental or Theatres to focus on specific equipment and techniques commonly used. The ½ day Out-patients update courses are not only shorter in duration, but allow staff to only practice techniques relevant to their areas. We have delivered several of these courses in various departments and feedback from these are all positive, however attendance on the courses planned for individuals to book on in the training unit have been poor and several have been cancelled.

As well as delivering training to staff working within the Health Board, the Training Department has increased its training arrangement with local Universities and has continued to train a local NHS Trust. This is beneficial because many students then going on to seek employment within NHS organisations and the additional income ensures that the training team are in post and are able to offer the number of spaces for Health Board staff to meet the TNA.

The new Health and Safety Training Unit in Llandough Hospital has proved a success with the venue being fit for purpose and increasing our presence on the Llandough site.

As of October 2016, the management of the Trainers has transferred to a different member of staff within the Department as the Senior Trainer's Union facility time has increased. Senior staff within the department are working together to try and address this loss within the team.

The health and safety department have been looking into ways of increasing training compliance and during this year, presented a paper to the Operational Health and Safety Group to approve charging Clinical Boards for staff who do not attend training (with no notice). It was suggested by the group that higher penalties

should be considered as well as other avenues to explore. This work is ongoing and another paper will be taken to the group.

The health and safety department are in the process of devising a health and safety training course for managers. The need for this has been acknowledged and it is anticipated to have this in place by July 2017.

1.6.1 FIRST AID AT WORK COURSE

Table 21

Month	Places Offered	Places Booked	Attended	FTA	Pass
3 Day FAW Totals	48	48	45	3	100%
2 Day Requalification	38	20	17	3	100%
Total	86	68	62	3	100%

Table 21 demonstrates a 79% up take of booked places with 6 failures to attend, this is considered to be related to imposing a cost for non attendance without justification.

1.6.2 RISK ASSESSMENT/WORKING SAFELY IN THE NHS

These courses are offered to all managers and staff who undertake risk assessments. The course is carried out by the health and safety team and covers topics such as the general health and safety risk assessment process, manual handling, COSHH, violence and aggression and personal safety which includes lone worker.

Table 22

No of Course	Places Offered	Places Booked	Number of Attendees	FTA	Withdrawn
Total 6 delivered	160	143	120	23	22

1.6.3 MANUAL HANDLING TRAINING STATISTICS

Manual Handling Training Trend Statistics April 2014 – March 2017 **Table 23**

Annual Total	Spaces Offered	Spaces Booked	Spaces attended	% of spaces booked that attended
2014/15	4600	3796	2385	63%
2015/16	4293	3857	2591	67%
2016/17	**4059**	**3670**	**2315**	**63%**

Table 23 shows that the number of spaces offered were 234 lower than previous years, this was mainly as a result of the relocation of training rooms to Llandough Hospital and reduced availability of training staff due to 1 employee taking up safety representative duties and a member of staff on long term sickness . It also shows that 37% of staff that booked onto the courses failed to attend.

Table 24

			Overall			2015/16	Patient Handling		Object Handling		E learning	
By Clinical Board	Staff in Post	TNA	Annual Comp Need	No Trnd	% Compliance	% Comp Variance 15/16	Nos trnd	% traind	No's traind	% trg	No's trg	% Trg
Capital, Estates & Facilities	1310	1466	987.	297	**30%**	-13%	13	**63%**	53	**11%**	231	**47%**
Children & Women	2029	1905	1534	612	**40%**	14%	133	**26%**	80	**24%**	387	**61%**
CD&T	2277	2049	1448	1145	**79%**	21%	259	**77%**	206	**54%**	647	**95%**
Dental	557	621	443	275	**62%**	13%	43	**32%**	14	**14%**	216	**104%**
Corp/Executive Services	224	174	101	149	**100%**	94%	33	**213%**	21	**131%**	95	**169%**
Finance	103	85	30	18	**59%**	N/a	0	**100%**	0	**0%**	18	**64%**
Medical	107	79	53	31	**58%**	N/a	6	**38%**	4	**36%**	21	**80%**
Medicine	1832	1751	1302	640	**49%**	1%	315	**52%**	10	**9%**	315	**54%**
Mental Health	1383	1335	1025	386	**38%**	15%	135	**39%**	27	**16%**	209	**47%**
Nursing	104	101	60	18	**30%**	N/a	0	**0%**	2	**9%**	16	**48%**
Primary, Com Int Care	852	1268	952	279	**29%**	-20%	106	**24%**	8	**12%**	160	**38%**
Public Health	78	66	46	19	**41%**	N/a	0	**100%**	5	**21%**	12	**55%**
Specialist Services	1769	1719	1305	724	**55%**	1%	310	**59%**	34	**24%**	344	**60%**
Surgical Services	2017	1887	1465	641	**44%**	3%	283	**46%**	48	**28%**	285	**45%**
Workforce & OD	144	134	99	23	**23%**	N/a	0	**0%**	2	**5%**	21	**47%**
Grand Total	**14776**	**14640**	**10853**	**5257**	**48%**	**5%**	**1636**	**46%**	**514**	**25%**	**2977**	**61%**

Table 24 demonstrates that overall compliance has improved by 5% over the previous year, this however is mainly related to higher numbers undertaking the module A e-learning course for those who have no significant manual handling role**.**

It also shows some very low compliance within a number of the Clinical Boards both in terms of patient and object handling.

1.6.4 VIOLENCE AND AGGRESSION TRAINING STATISTICS

Violence and Aggression Training Trend Statistics April 2015 – March 2016

Table 25

Annual Total	Spaces Offered	Spaces Booked	Spaces attended	% of spaces booked that attended
2013/14	1920	1517	891	59%
2014/15	2615	1806	1120	62%
2015/16	2216	1527	948	62%
2016/17	**1787**	**1483**	**701**	**47%**

Table 26

		Overall	+/- 15/16	Module D &C+		Module B & C		Module A	
By Division	Staff in Post	TNA	Annual Comp Need	No Trnd	% Comp liance	% Comp Vary 15/16	Nos trnd	% traind	No's traind	% trg	No's trg	% Trg
Capital, Estates & Facilities	1310	1466	673	318	**47%**	-26%	4	**7%**	63	**49%**	251	**51%**
Children & Women	2029	1905	1428	762	**53%**	35%	32	**78%**	349	**74%**	379	**60%**
Clinical Diagnostics & Ther	2277	2049	1173	1323	**113%**	43%	19	**53%**	596	**131%**	708	**104%**
Dental	557	621	385	391	**100%**	0%	0	**100%**	171	**103%**	215	**104%**
Medicine	1832	1751	1302	694	**53%**	2%	102	**52%**	272	**93%**	320	**55%**
Mental Health	1383	1335	1361	778	**57%**	12%	351	**54%**	228	**88%**	209	**47%**
Primary, Com Int Care	852	1268	983	373	**38%**	16%	0	**100%**	189	**33%**	178	**42%**
Specialist Services	1769	1719	1203	848	**70%**	46%	59	**24%**	367	**96%**	422	**74%**
Surgical Services	2017	1887	1174	568	**48%**	39%	10	**13%**	246	**53%**	312	**50%**
Overall Grand Total	**14776**	**14640**	**10023**	**6438**	**64%**	**24%**	**657**	**42%**	**2600**	**73%**	**3181**	**65%**

8

The percentage compliance for violence and aggression training significantly improved to 65% overall, although Level D training for Mental Health dropped, this mainly relates to the transfer of staff and patients to its new location. This meant a halt to training of a 2 - 3 month period.

3.0 VIOLENCE AND AGGRESSION MANAGEMENT

Violence and aggression continues to be one of the most significant risks to staff within Cardiff and Vale. The Health and Safety Committee receives regular reports on progress made in tackling violence and aggression within the Health Board.

The Department has approached this progress from 5 key elements:

- Review of Incident Data
- Personal Safety
- Violence and Aggression Training
- Case Management (Victim Support)
- Lone Worker

3.1 VIOLENCE AND AGGRESSION INCIDENT STATISTICAL DATA

Chart 7

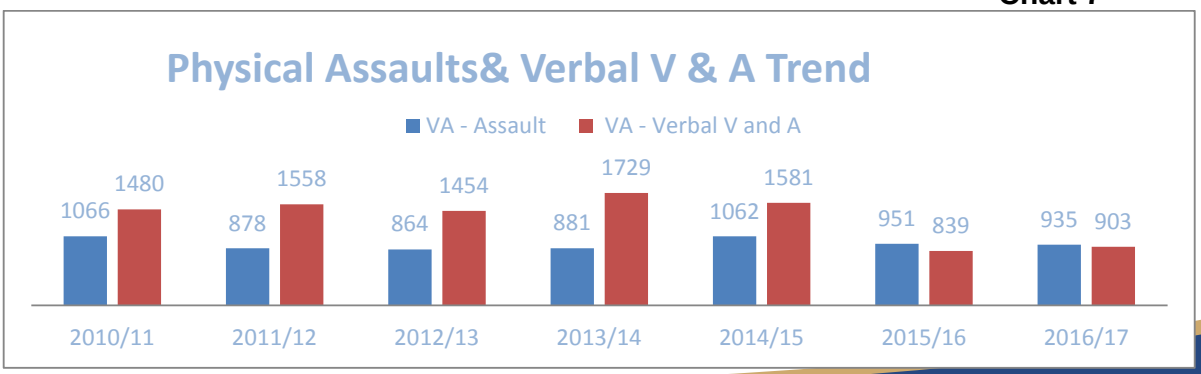


Table 27

	2012- 13	2013/14	2014/15	2015/16	2016/17
Patient Behavior/Violence Incident	**510**	**461**	**588**	**962**	**1235**

Overall the statistical data illustrated in Chart 7 identifies that there has been no significant trend change over the period. However patient incidents reported by staff of behavior and violence has increased significantly over the period by over 28% from 962 to 1235 and since 2014/15 has more than doubled from the then 588.

3.2 VIOLENT WARNING MARKERS

In 2013/14 the Violent Warning Marker Procedure was developed and implemented within Cardiff and Vale on both the Paris and PMS electronic patient records.

A patient warning marker may be applied in instances of intentional and non intentional violence. It is important to state that the marker is not a mechanism for attributing blame but is a process for alerting staff to the possibility of violence.

A marker does not just apply to circumstances where the individual abusing the staff member is a patient, but may equally apply where the person is the patient's associate – for example their guardian, friend, or relative.

Table 28 details the alerts that have been received by the Case Management Team and actions taken.

Table 28

	Alerts Received	No action	Alerts	Violent markers	Safe Haven Markers	Violent Markers Removed
2014/15	527	136	193	63	32	15
2015/16	465	147	228	74	16	16
2016 -17	220	0	220	107	19	146

Alerts Received – this includes alerts received via PARIS and incident forms.

No action – where attempts to contact staff have been made but no response received.

Alerts –where staff have indicated the only risk is to working in the community.

3.3 CASE MANAGEMENT SERVICE

The function of the Health Board's Case Management Team has been fundamental to the success of reducing violence and aggression within the Health Board. It uses structured case management and support for the victim achieved through early and effective actions.

The service operates in addition to existing support arrangements within the Health Board. Case management is not a clinical or counseling service and must not impede the support relationship offered by local management or formal support services. The team adopts a sympathetic approach to the victim, and operates as a 'listening friend', albeit one who can provide practical advice to both the victim and their manager. Strong emphasis is placed upon the advantages of formal support mechanisms for staff that are experiencing ongoing difficulties.

Case management service continues to support victims following violence either through the criminal system or by internal sanctions and support. During the period the number of Police inventions has reduced. However a review of the Memorandum of Understanding between the NHS, Police and Crown Prosecution Service is being progressed which is considered will enhance the interventions in the coming year.

3.4 COMMUNICATION

Numerous means of communication have been utilized to promote the service and personal safety awareness including, seminars, meeting attendance, promotional stands, posters, press releases and also social media.

Communication links with Primary Care have strengthened during the period and processes devised to enable information sharing between the Health Board and Primary Care services. Information on violent warning markers placed by the Health Board is shared with GP Surgeries, Health Centres and the Out of Hours Service.

Communication/information sharing with South Wales Police has been problematic during 2016/2017 due to the police not being able to pass police occurrence numbers or weekly reports to the Case Management Team. This has led to a decrease in reported incidents and convictions as shown in table 29. The Case Management Team has requested changes i.e. disclosure to the police to the DATIX form to make information sharing more readily available to the police.

3.4.1 Direct Victim Support

The Team has directly met with numerous victims and continues to provide the essential post incident support. Where necessary this will include accompanying witnesses to court. Many staff incidents reviewed by the team are followed up by both face to face meetings and telephone conversations. The support offered will continue until the victim is satisfied that the team have done all they can to ensure that the most appropriate sanctions have been applied.

3.5 CRIMINAL SANCTIONS

Table 29

Year	No referred to Police	Number of Convictions	Other Sanction ASBO, Internal etc
2009/10	27	17	2
2010/11	118	55	130
2011/12	176	58	121
2012-13	110	48	47
2013 -14	97	49	55
2014-15	132	57	86
2015- 16	171	57	195
2016- 17	93	27	24
Totals	924	368	660

Table 30 further demonstrates prosecutions and other criminal sanctions applied.

Health Board Successful Outcomes April 2009 to March 2016

Table 30

Year	Cautions	ASBO Referrals	PNC	Convictions	Restraining Orders/Crasbos	Police actions
2009 – 2010	2	0	2	17	0	21
2010 – 2011	5	23	2	55	1	86
2011 – 2012	8	136	6	85	1	306
2012 – 2013	10	29	8	43	2	90
2013 – 2014	15	29	11	49	0	104
2014- 2015	4	68	2	57	1	132
2015- 2016	11	80	7	57	1	171
2016 – 2017	**6**	**9**	**1**	**24**	**0**	**84**
Totals	61	374	39	387	6	994

3.6 LONE WORKING

The lone worker alert system is a discreet communication device. When a ‘red alert’ is activated a channel is opened to the Alarm Receiving Centre (ARC). Trained operatives listen to the call and determine the appropriate action to take, including the deployment of emergency services if needed. In addition to this, audio evidence can be secured and used in cases that are progressed through the criminal justice system.

It is necessary for the Health Board to have suitable control measures in place to manage these low frequency high risk events as it is to protect against the frequent violent events experienced by our staff.

At the commencement of the fiscal period the Health Board decided to replace the Reliance Lone Worker devices with an updated contract as the existing contract was 5 years old and the devices were obsolete and required upgrading.

Concern was also raised in relation to the poor usage for these devices which was shown to be at around 25% and was considered partly related to the dislike of the current device.

A new lone worker contract was implemented in June 2106 replacing the previous system, the new system has a much improved device and greater flexibility of system.

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

Number of Contracted Devices **Table 31**

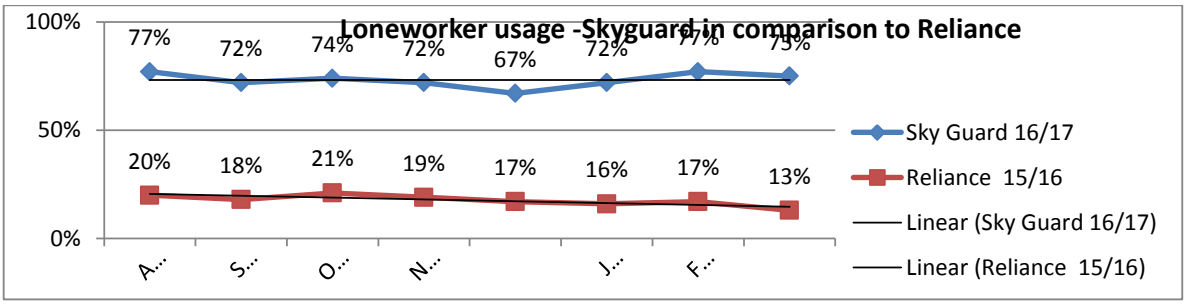
	Nov	Dec	Jan	Feb	Mar
Reliance 15/16	626	604	600	600	600
Skyguard 16/17	457	480	487	576	613

The Clinical Boards currently have 613 Skyguard devices in use, this compares to the 600 devices which were in use prior of the Reliance System (excluding the termination period).

The Health and Safety Committee has asked for reconfirmation that those staff at risk have either a device or suitable alternative arrangements in place.

Percentage Utilisation

Chart 8



The above overall data shows that average utilisation was 73.25% for the 8 month period from 1st August 2016 to the 31st March 2017.

This demonstrates a significant improvement over the previous system and relates to an extremely high level of compliance given the likelihood of non usage due to holidays and term time working and sickness absence.

The system administrator passes details on to each Clinical Board of non usage by name, for local review and remedial action.

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

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

4.0 MANUAL HANDLING

Chart 9

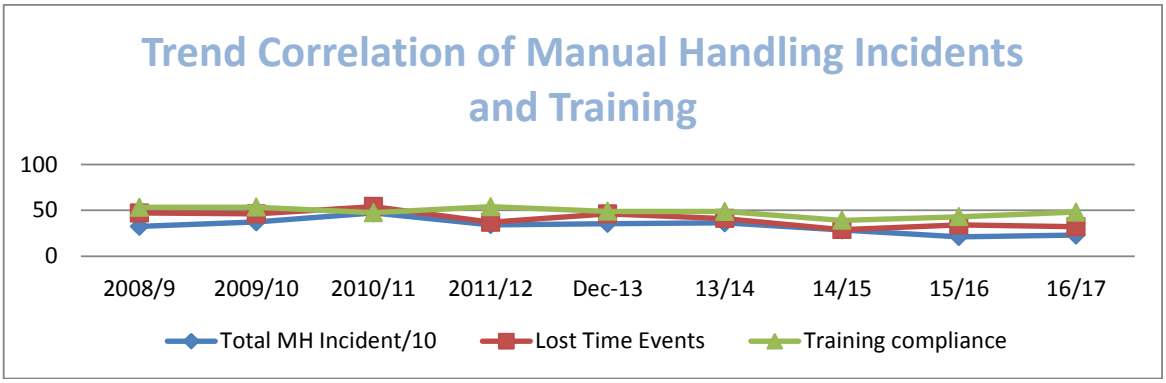


Table 32

	2008/9	2009/10	2010/11	2011/12	12/13	13/14	14/15	15/16	16/17
Total MH Incident/10	32.3	37.3	47.1	34.2	35.4	36.2	28.5	21.1	22.9
Lost Time Events	47	46	54	37	46	41	29	34	32
Training compliance	53.21	53.41	47.37	53.82	48.91	48.68	39	43	48

Chart 9 shows the Health Board's training compliance has improved to 48% over previous years and the total number of manual handling lost time incidents have subsequently reduced, although the total number of related incidents has slightly increased.

4.1 PROVISION OF SUITABLE GLIDE SHEETS

An investment of £24K secured purchase of reusable flat slide sheets following risks identified when using the "paper" style version. The Health Board was able to purchase approximantly*1200* new glide sheets that are a uniquely identifiable colour (bright yellow) within Wales, with the aim to reduce loss especially from Greenvale laundry. These were labeled and distributed to all Cardiff and Vale Health Board sites in June 2016 according to the needs identified in the Pro-Act Audit.

The new sheets have proved to be a far superior product compared to the "paper" style sheets although these may continue to be used in areas of high patient turnover e.g. theatres. The Manual Handling Department has received very positive feedback from staff using the new yellow sheets and no in-patient Datix incidents concerning slide sheets have been reported in this period.

There has been considerable cost saving by purchasing the fabric slide sheets.

4. 2 PROACT AUDIT

A comprehensive audit of patient manual handling equipment was carried out in September 2015 which indicated urgent replacement of patient hoisting equipment to ensure the Health Board fulfilled its requirement under the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Results from the audit identified 150 passive and 103 active hoists with 117 of these over 10 years old and obsolete making them difficult to repair.

Funding was secured from Welsh Government end of year monies for replacement of 60 hoists (39 passive and 21 active hoists) under a legacy scheme where the old hoist is taken away in “part exchange” and a discount applied. This also saves the Health Board scrappage and battery recycling costs.

Funding was also provided for 10 high specification mechanical shower chairs suitable for wet room areas which reduce the risks for patients and staff when showering.

Distribution of the hoists and a follow up audit are planned for June 2017 to include an update of the current stock of fabric/reusable hoist slings, batteries and chargers.

4. 3 POLICY AND PROCEDURE UPDATE & APPROVAL

The Minimal Manual Handling Policy and Procedure were approved at the Health and Safety Committee in April 2017

The Patient Hoist Sling Inspection Procedure is due for renew but this has been postponed until after the next ProAct audit has been carried out and the range of fabric slings within the organisation can be rationalised. The training for inspecting slings is included as part of the Manual Handling Link Worker Course.

4. 4 CONTINUING PROJECTS

- Hoverjack Training – the Manual Handling Advisers continue to provide ad hoc training to staff in the use of the Hoverjack to ensure the organisation can fulfil the requirements of the National Patient Safety Alert. The product has proved to be most useful in enabling the retrieval of fallen patients in a dignified, comfortable and timely manner that other Hospital sites are considering/have purchased Hoverjacks.
- Specialist Training - the Health Board and Local Authority Manual Handling Advisers provide specialist joint update training for District Nurses and Occupational Therapists in the more appropriate environment of the Local Authority training rooms. The integration of training and approach to manual handling has benefitted the skill levels of those involved and ensured a more joined up approach between the organisations.

- Specialist Advice – the Manual Handling Advisers offer specialist assessment, advice and risk control measures to all areas of the Health Board. Following the results of the health and safety audit they have concentrated on assisting managers on the formal manual handling risk assessment process for areas especially those identified as deficient.
- Joint Working – the Manual Handling Advisers have developed and strengthened links with their colleagues by
    - Chairing the All Wales NHS Manual Handling Group.
    - Developing assessment tools with Senior OT Managers in Health Board and Local Government.
    - Carrying out joint assessments for complex patients.
    - Working closely with Medstrom, the organisation's bed management company in training, assessment and feedback in use of their products within the Health Board, identifying suitable products.
    - Developing links with Cardiff University looking at training.
- Bariatrics - the Manual Handling Advisers continue to offer a weighing service to ensure patients are within the safe working load of equipment used within the organisation.
- Link Worker – 62 Link Workers have been trained in the period of April 2016/17 by the Manual Handling Advisers and a list of active link workers is being updated. The Link Workers continue to support manual handling in their area by local induction of new staff, assessing fabric slings, audit of manual handling equipment and training frequency assessment of their colleagues. They help fulfil the organisation's duties under Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), Provision and Use of Work Equipment Regulations (PUWER) and Management of Health and Safety at Work Regulations.
- New Practice/Equipment – the Manual Handling Advisers aim to keep themselves updated in new developments in clinical practice, health and safety law/regulations, social care and equipment innovations by attending local and national meetings and exhibitions and close working with fellow NHS and Social Service colleagues.

4.5 ONGOING WORK/FUTURE DEVELOPMENT

- Establish a process for controlled procurement.
- Re undertake the Proact audit to verify progress since 2015
- Implement the revised requirements of the All Wales Passport Scheme

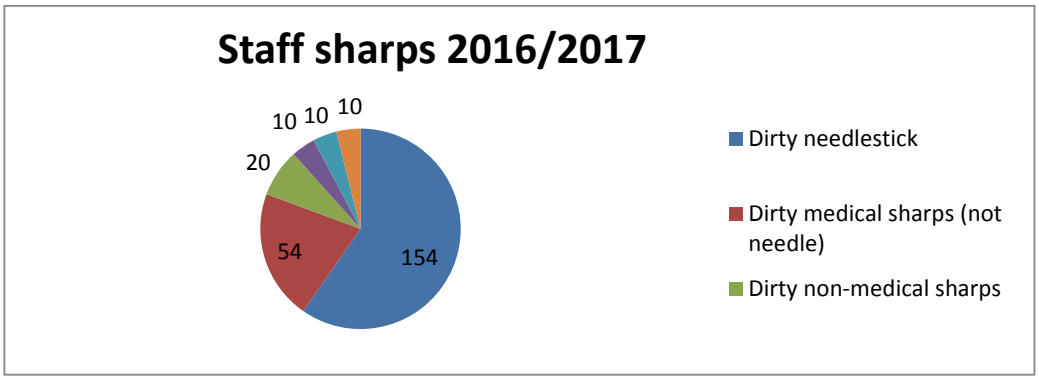
5.0 SHARPS/NEEDLESTICK EVENTS

5.1 INCIDENT STATISTICS

Table 33

Staff Sharps 2016/2017	
Dirty needle stick	154
Dirty medical sharps (not needle)	54
Dirty non-medical sharps	20
Clean medical sharps (not needle)	10
Clean needle stick	10
Clean non-medical sharps	10
Total	258

Chart 10



Incidents by Managing Clinical Board and Incident Code Tier 3 2016- 2017

Chart 11

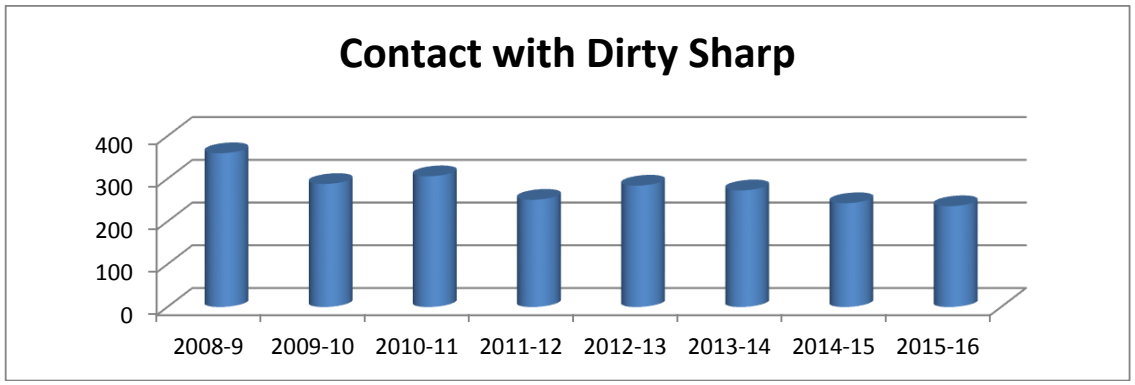


Chart 11 demonstrates that the number of dirty sharps injures were 3% lower than the previous year and is showing a consistent trend reduction since the introduction of the safety sharps approach.

6.0 CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH)

The Health Board is required to complete risk assessments for all hazardous substances in use. This is to ensure sensible steps are taken to prevent ill health. The Health Board uses local COSHH co-ordinators to identify hazardous substances in use. The Alcumus COSHH management database is then used to generate appropriate COSHH assessments for substances. Progress has been made in meeting this requirement, there are currently 3182 identified hazardous substances with 8513 COSHH assessments on the database.

There are approximately 246 COSHH co-ordinators in place across all Clinical Boards, covering 263 areas.

The overall compliance rate has remained fairly stagnant over the past few years and it is therefore recommended that the COSHH compliance rates are taken to each Clinical Board quarterly health and safety meeting where performance is monitored and improved.

Table 34

Clinical Board	No. COSHH Co-ordinators	Approx No. Identified Areas	No. of Areas Compliant/ in date	% Compliance 15/16	% Compliance 16/17	Change since last year
Children and Women	32	32	27	88%	84%	↓
Clinical Diagnostics & Therapies	47	47	32	74%	66%	↓
Dental	2	2	2	100%	100%	↔
Medicine	32	42	24	51%	57%	↑
Mental Health	51	52	40	62%	77%	↑
PCIC	6	6	3	67%	50%	↓
Specialist Services	33	33	20	76%	61%	↓
Surgery	33	39	11	46%	28%	↓
Other (Exec, CEF)	10	10	5	50%	50%	↔
Total	246	263	164	66%	62%	↓

7.0 ENVIRONMENTAL MONITORING APRIL 2016 – MARCH 2017

7.1 MONITORING AND OCCUPATIONAL HYGIENE

8

The Department has undertaken environmental monitoring surveys and reports to ensure compliance with legislation in areas of high risk or responding to areas of concern raised by Clinical Boards. This includes hazardous substances monitoring, thermal comfort (temperature and humidity), noise surveys, light surveys, room space assessments and flooring slip assessments.

The following formal monitoring reports have been completed for areas of higher risk during the period, a substantial number of informal visits/responses to queries have also been undertaken.

Table 35

Higher Risk Survey Type	Total
Hazardous Substances	16
Temperature /Humidity	8
Noise	2
Lighting	1
Office Environment/Space	2
Total	29

The Environmental Adviser has additionally:

- Co-ordinated Capital/Estates Contractor Control Group and action plan following HSE intervention regarding serious contractor incident.
- Facilitated meetings and action plan with physiotherapy and estates teams regarding HSE intervention on hydrotherapy pools.
- Coordinated responses to HSE following continued intervention with previous lift contractor.

- During this period of intensive intervention by the HSE, environmental monitoring was prioritised based on risk and some items postponed until 2107/18. This item was added to the Health & Safety Priority Action Plan and communicated in the Health and Safety Committee.
- Supported the strategic approach for health and safety by completing Dental Hospital health and safety inspections and assisting with prioritising actions and following up occupational hygiene/environmental related issues.
- Continued to provide general health and safety advisory support for the Dental Clinical Board, Executive Team and Capital, Estates and Facilities Service Board.

7.2 FOOD HYGIENE

During the period there have been a total of 8 Environmental Health Inspections of kitchens or cafés within the Health Board, as can be seen from Table 36 the inspections score attained either the highest level of 5 or 4.

Table 36

Kitchen	Aroma Cafe	SPAR SHOP, UHL	Teddy Bear Nursery	UHW Central FPU	UHL	Llanfair Unit	Rookwood	Y Gegin	Whitchurch	I Jones	West Wing	St Davids	Barry	Average
Score 13/14		N/A	5	N/a	4		4	5	4	4	4	5	5	4.25
14/15		N/A	5	N/a	4	5	4			4		5	4	4.5
15/16	5	N/A	4	(2)(3) 5	5		4	5	5	4		5	5	4.66
16/17	5	5	4	(5) 5	4		5	5	N/A		N/A	5		4.75

7.3 WASTE MANAGEMENT

Overall compliance with the Hazardous Waste Regulations 2005 (Amended 2009) and other waste legislation remained consistently high at 99%. Compliance has improved by 0.68% compared to the previous report presented to the Health and Safety Committee in April 2016.

Of the 5,470 samples taken 45 non conformities (0.8%) were identified against the Environmental Protection (Duty of Care) Regulations (1991) and Hazardous Waste Regulations 2005 (Amended 2009).

March –September compliance per waste stream, **Table 37**

2016 Mar-Aug	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
Total	**100**	**99.9**	**100**	**100**	**99.3**	**99.7**	**97.1**	**97.95**	**98.17**

Compliance Audits relating to September to March is planned to be submitted to the Committee early in the new fiscal year.

8.0 FIRE

A detailed Annual Fire Report will be submitted to Health and Safety Committee in July 2017 as a separate agenda item.

9.0 HEALTH AND SAFETY ESTATES

Progress continues to be made within Capital Planning and Estates with regular reports on compliance and progress in the key areas of:

- Asbestos
- Legionella
- Control of Contractors
- Health and Safety at Work Act
- Electricity at Work

Other statutory/mandatory legislative issues include: medical gases, ventilation, pressure system regulations, COSHH, autoclaves, lifts, energy/environmental management and the current status of compliance for these areas are being assessed and progressed.

9.1 ESTATES HEALTH AND SAFETY COMPLIANCE

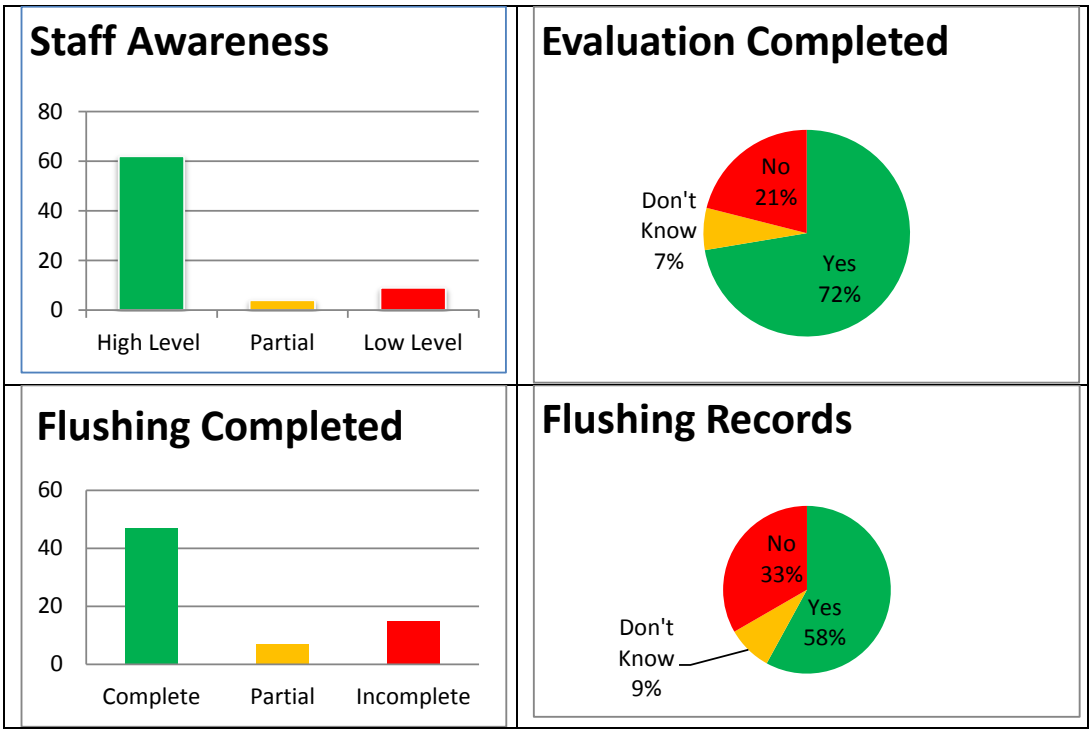
A Compliance and Performance Section is based in the Capital Planning and Estates Management Department. A monthly compliance and performance/safety group is supported by task and finish teams formulated to undertake the strategic elements of statutory compliance.

A Head of Statutory Compliance and Programme Delivery and an Estates Health, Safety and Asbestos Manager have since the Contractor Fall event significantly progressed enhanced contractor control including the introduction of a red & yellow card system of banning/warning contractors.

9.2 WATER SAFETY

Estates play a pivotal role in monitoring the status of Legionella. Intervention during the year by the HSE identified that whilst the Estates Department had undertaken the relevant central role, Clinical Boards were deficient in undertaking the required flushing regime as referenced earlier in the report. The Compliance and Performance Section therefore maintain a database and reports to the Water Safety Group.

Chart 12



Analysis of the Audit completed by the Estates Department shows that whilst staff awareness of the requirements are high, evaluations of which water outlets require flushing and undertaking the flushing is lower. Equally those maintaining records are even lower.

During the 2016/17 period 54 areas were audited with a further 21 undertaken in April 2017, below are the findings.

Please note N/A refers to no Audit undertaken in these Clinical Board areas.

Table 38

	Cap & Fac	C&W	CD&T	Dental	Exe	Med	MH	PCIC	Spec	Surg	Overall
Legionella Awareness	91%	100%	100%	N/A	N/A	100%	68%	70%	100%	100%	83%
Legionella evaluation	91%	100%	100%	N/A	N/A	100%	68%	50%	50%	100%	72%
Water flushing	82%	100%	100%	N/A	N/A	100%	33%	43%	25%	100%	68%
Water flushing records	91%	100%	100%	N/A	N/A	100%	22%	20%	25%	100%	58%

9.3 SUMMARY BENCHMARKING

Although no benchmarks have been agreed with the exception to those within the Priority Action Plan, the following table is a summary of some of the key measurable health and safety report findings.

These could be considered as the format for the assurance reports to be submitted to the Health and Safety Committee as Service/Clinical Boards attend the meeting as part of its work plan.

It is recognised that the summary contains no data relating to fire; however this could be adopted from information within the Annual Fire Report such as Fire Training Compliance and status of Fire Risk Assessment Actions.

Table 39

Strategic Priority Area		Capital, Estates and Facilities	Children and Women	Clinical Diagnostics Therapeutic	Dental	Executive Corporate	Medicine	Mental Health	Community Intermediate care	Specialist	Surgical	Overall
1 Management	Frequency of CB Health and Safety Meeting	4	4	4	4	N/a	1	3	4	4	4	3.55
1 Management	Frequency of CB Rep at Op Health and Safety Group (4)	3	2	1	2	4	0	3	1	2	4	2.2
1 Management	RIDDOR Variance	1	1	-3	0	0	9	-5	2	2	-2	-1
1 Management	Staff Incident Variance	-20	18	27	25	44	59	9	-9	58	58	
1 Management	Healthcare Standard Status	3	3	3	3	n/a	3	3	3	3	3	3
2 V&A	V&A Training Compliance	47%	53%	100%	100%	100%	20%	53%	38%	70%	48%	
2 V&A	V&A raining Improvement 16/17	-26%	35%	43%	0%	55%	2%	12 %	16 %	46 %	39 %	22%
2 V&A	Lone Worker Utilisation	N/A	75%	66%	N/A	100%	92%	57%	76%	77%	N/A	73%
3 Man H	MH Training Compliance	30%	40%	79%	62%	100%	49%	38%	29%	55%	44%	
3 Man H	MH Training Improvement	-13%	14%	21%	13%	94%	1%	15%	-20%	1%	3%	
3 Man H	MH Incident Variance	-5	2	1	3	0	-9	20	-2	10	-1	
4 Health	Legionella Awareness	91%	100%	100%	100%	100%	100%	68%	70%	100%	100%	83%
4 Health	Legionella evaluation	91%	100%	100%	100%	100%	100%	68%	50%	50%	100%	72%
4 Health	Water Flushing	82%	100%	100%	100%	100%	100%	33%	43%	25%	100%	68%
4 Health	Water Flushing Records	91%	100%	100%	100%	100%	100%	22%	20%	25%	100%	58%
4 Health	COSHH Compliance	50%	85%	66%	100%	50%	57%	77%	50%	61%	28%	62%
5 Patient Enviro	Patient Accident (inc falls) improvement	4	-9	24	8	-1	101	-45	9	88	54	273
6 Fire Safety												
8 Sharps	Sharp Injury Variance	2	-11	6	-4	-2	-19	4	-8	-5	-1	

Table 39 allows for performance analysis both by key Priority Area and by Service/ Clinical Board.

CONCLUSION

The Annual Report considers trends in incidents, training and management processes. It demonstrates significant progress in the improvement of staff and patient health and safety risks.

Incident Data collated from the Datix system is showing high level of close out and management involvement (94% of the staff health and safety incidents were closed out and only 6 of nearly 3600 remain as awaiting review).

Whilst the number of RIDDOR events have remained constant there has been a continued increase in the number of patient behavioural incidents which has doubled over the last 2 years and up 28% on the previous period.

The Health Board received its second HSE enforcement action since 2001 relating to compliance to Legionella requirement. An action plan was put in place and the Enforcement Notice was subsequently revoked by the Inspectors.

The HSE were also active in visiting the Health Board and applying “Fee for Intervention”. They also continue to pursue the investigation into the Contractor Fall with no decision if legal action is warranted.

Advice given to the Health and Safety Committee about changes that came into force in February 2016 to the revised health and safety sentences charges meant a significant potential risk of a fine being brought against the Health Board could result in a cost of between 1 to £2million.

The number of Prosecutions and other Police inventions were significantly lower than previous years, however 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.

Training compliance for both manual handling and violence and aggression has improved, although this mostly relates to e-learning module A and not tutor led training.

Although training has improved, it is still not at the target level of compliance overall with some Clinical Boards demonstrating low compliance or poor progress in improving the percentage of their staff trained. This is being pursued by the Mandatory Training Steering Group.

Tutor led training continues to show a very high level of failure to attend on the day this is being considered by the Health and Safety Operational Group.

With the appointment of a new Staff Safety Representative Chair and Deputy the workplace inspection regime was reviewed and enhanced local representative’s involvement.

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

It also reports on the improvement in the management of health and safety aspects through the priority action plan and the control of policy schedule, keys areas of progress include:

(1) Acquiring approval from Welsh Government for renewal of £420k of patient hoists for implementation in early 2017/18.
(2) Implemented improved re-usable glide sheets reducing injury risks whilst resulting in a saving.
(3) Introduced new lone worker devices and improved usage from 20% - 74%.
(4) Revised all health and safety policies within their required reviewed period.
(5) Needle stick and sharp incidents were again lower than the previous period justifying the safer sharps devices introduced.

Finally, performance has been summarised into a benchmarking type format, which allows for comparison by area and Clinical Board. This may be helpful in progressing assurance when Clinical Board's Health and Safety performance is considered as part of the Committee's work programme.

**Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol**

**Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group**

Llywodraeth Cymru
Welsh Government

To all Health Board:

Chief Executives
Directors of Planning
Head of Estates

21 June 2017

9

Dear Colleagues

FIRE SAFETY

The recent tragic fire at the Grenfell Tower block in London has reinforced the particular importance of having highly effective fire evacuation procedures in place that reflect the buildings' condition and the importance of fire safety training for staff in the healthcare sector.

The incident at Grenfell Tower involved the unexpected and rapid fire spread across the building's facade. At this stage we have limited information as to the specific type and installation detailing of the external cladding used at Grenfell Tower which contributed significantly to the speed of fire development; however we understand that it was marketed under the trade name of Reynobond. This is an aluminium composite material that consists of two thin aluminium sheets bonded to a non-aluminium core, and is available with either a polyethylene or mineral fibre core. As further information becomes available this will be sent to you by NHS Shared Services Partnership – Specialist Estate Services (NWSSP-SES). An email from NWSSP-SES has already been sent to the Head of Estates at each health board offering their advice and assistance and highlighting particular sites where it was felt there may be an issue in respect of external cladding.

I am writing to ask you to review with immediate effect fire safety precautions for your buildings where external cladding systems have been utilised. There is also a need to look at the status of fire safety training and if necessary, to implement prioritised Action Plans to address identified key risks for these aspects of fire safety.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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CF10 3NQ

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Gwefan • website: www.wales.gov.uk

Actions

I would ask you to:

- Review your property portfolio to establish where similar cladding systems have been utilised, and report to NWSSP-SES on the findings.
- Confirm that you have or are undertaking an urgent review of your fire risk assessments for the buildings identified to ensure they are up to date and reflect the potential fire risks of the cladding system utilised.
- Review with immediate effect, fire evacuation plans for these buildings to ensure that they are robust and detail the action to be taken in case of fire. This includes procedures to be followed during evacuation, particularly those associated with the movement of patients, the arrangements for contacting the emergency services and the identification of staff with responsibility for supervising, controlling and putting into effect the plan for the building.
- Review with immediate effect, the status of staff fire training and in particular training for those staff that have additional responsibilities for supervising, controlling and putting into effect the fire evacuation plan for the building.
- Implement prioritised Action Plans to address identified risks for these particular aspects of fire safety.
- Finally, could you provide a statement of assurance by 28 June 2017 that the above actions have been completed.

Any enquiries regarding this letter should be directed to either Richard Barr at Richard.barr@wales.gsi.gov.uk on 0300 0253987 or Nigel Davies at NWSSP-SES at Nigel.Davies4@wales.nhs.uk on 029 20 904088.

Yours sincerely

Dr Andrew Goodall

cc: Simon Dean
Val Whiting
Steve Pomeroy, Head of Fire & Rescue Services, Welsh Government
Neil Davies, NHS Shared Services
Nigel Davies, NHS Shared Services
Richard Barr

9

FIRE SAFETY ANNUAL REPORT 2016/17
Name of Meeting : Health and Safety Committee **Date of Meeting** 18/07/2017
Executive Lead : Director of Planning
Author : Senior Fire Safety Adviser 02920 742292
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : The report is strategic with direct cost being identified as required
Quality, Safety, Patient Experience impact: The completion of all remedial actions detailed in the Enforcement Notices and Informal Notices as a result of Fire Service Audits will improve patient, visitor and staff fire safety. Fire risk within the UHB, further enforcements and potential prosecution for non compliance will also be reduced. The fire safety action plan will improve fire safety and reduce the fire risk.
Health and Care Standard Number: 2.1 **CRAF Reference Number** 6.4.5
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

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

The Health and Safety Committee is asked:

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

10

SITUATION

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

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

1) **INO2 Informal Notice:** Remedial actions will be noted during the SWFS audit and will need to be addressed. Within 12 months the Fire Service will re-visit the area to ensure all actions are complete. Failure to complete all the high risk actions will result in an Enforcement notice.

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

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

ASSESSMENT

1.0 FIRE RISK ASSESSMENTS

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

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

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

2.0 ENFORCEMENT NOTICES

We currently have two Enforcement Notices issued by South Wales Fire Service in force. One is for the Whitchurch Site which expires in July 2017. This Notice should be withdrawn as soon as the premises are vacated which is scheduled to be completed in July 2017.

The second Notice is in relation to failing to adequately control smoking on the premises in Hafan Y Coed. Following a meeting with the Mental Health Team an action plan to resolve the issues was agreed and has been approved by the Fire Authority. If the remedial actions proof to be effective then the Enforcement Notice will be withdrawn.

3.0 AUDITS

3.1 NHS Wales Shared Services Partnership

Specialist Estates Services have just issued an in-depth fire audit of the Llandough site. An action plan has been compiled with all the necessary remedial actions with relevant completion dates and responsibilities. The action plan has been presented to the Fire Safety Group Meeting for consideration and will be monitored by the group.

3.2 South Wales Fire Service Audits

Regular fire audits are carried out by SWFS and all recent visits have resulted in IN02's with no serious issues. The reports are sent to the

local management and their Deputy Fire Safety Managers, Estates and Capital Planning to address the issues they are responsible for.

4.0 UNWANTED FIRE SIGNALS

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

Running Total of Fire Incidents 01 April 2016 – 31March 2017

Hospitals	FIRE	Malicious	Good intent	Accidental	Cooking	Smoking	Other	System fault	Contractor	Management	Unknown	Total
Total	28	8	11	54	32	8	86	135	21	28	99	510

There have been 28 reportable fires in the last 12 months. Electrical faults were the main cause with Mental Health patients causing the remainder.

SWFS have advised us that they revising their response to fire alarm activations. Their intention is that during the day, between the hours of 08.00 and 18.00, instead of sending three fire appliances to our hospitals they will send just one to carry out an investigation, unless we can confirm there is an actual fire. During the night when people are at the greatest risk from fire they will continue sending the full pre-determined attendance of three appliances.

The delayed fire fighting response carries an obvious risk to the Health Board of increased property damage and life safety in the event of a fire.

It is now imperative that if staff become aware of a fire they must notify our switchboard straight away so the information can be relayed to SWFS so they will mobilise adequate resources to tackle a fire.

5.0 FIRE TRAINING

The Health Board's ESR data base for training is currently being enhanced; this has led to a restricted ability to access training compliance data for the period. It is understood that the update will shortly be completed when training figures will then be available from LED. Last available data was February 2017 which identified fire training to be at 50.9% for the Health Board.

Despite our best efforts to support managers with flexibility to obtain compliance with the mandatory training requirement; releasing staff continues to be an obstacle to achieving the Health Boards aim of 85% attendance.

6.0 COMPARTMENTATION

The fire strategy involves restricting a fire to a limited area by fire resisting construction so that patients can be safely moved horizontally to a safe location. Over a period of time the structural fire compartmentation has been compromised by passing cables, pipes and other services through fire compartment walls and ceilings and not carrying out the required fire stopping to these penetrations.

We have a rolling programme of remedial work which is being carried out on a priority risk basis and are currently completing works in the Women's Hospital before moving on to Barry Hospital.

7.0 APPOINTMENT OF DEPUTY FIRE MANAGERS

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

8.0 RECENT FIRE IN GRENFELL TOWER

Following the tragic incident in London this month we were asked by the NHS Wales Chief Executive to review with immediate effect the fire safety of any building with external cladding systems.

We have listed all building with the cladding and if considered necessary tests on the insulation will be carried out. Middle rise buildings at the Heath with cladding are protected by a sprinkler system and other buildings with cladding are low rise. With sprinklers and comprehensive alarm systems, which will give early warning of fire which if necessary will lead to a staff lead evacuation we are of the opinion there is no significant risk from our insulation panels.

9.0 ACTION PLAN

- Amend and update all existing fire risk assessments for all Cardiff and Vale Health Board premises in compliance with legislation 'The Regulatory Reform (Fire Safety) order 2005'. Develop action plans to overcome identified risks and communicate these to responsible managers.

- Continue training programme for Fire Wardens on a Health Board wide basis.

- Continue trying to improve fire training figures by engaging local managers.

- Continue the investment programme to meet Firecode and Statutory Requirements.

- To continue investigating all unwanted fire signals and where possible take action to reduce occurrences

- To promote personal development and skills of the Fire Safety Advisory Team.

FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT
Name of Meeting : Health and Safety Committee **Date of Meeting** 18/07/2017

Executive Lead : Director of Planning
Author : Head of Health and Safety – 02920 743751/Senior Fire Safety Adviser 02920 742292
Complying for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : The report is strategic with direct cost being identified as required
Quality, Safety, Patient Experience impact: The completion of all remedial actions detailed in the Enforcement Notices and Informal Notices as a result of Fire Service Audits will improve patient, visitor and staff fire safety. Fire risk within the UHB, further enforcements and potential prosecution for non compliance will also be reduced. The fire safety action plan will improve fire safety and reduce the fire risk.
Health and Care Standard Number: 2.1 **CRAF Reference Number** 6.4.5
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

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

The Health and Safety Committee is asked:

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

SITUATION

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

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

BACKGROUND

The South Wales Fire Service undertakes a programme 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

We currently have two Enforcement Notices in force. The Notice at Whitchurch Hospital which was issued due to fire incidents relating to patients and smoking materials. South Wales Fire Service (SWFS) have confirmed they will lift the notice once has been fully vacated.

The Enforcement Notice was due to expire on 27th January 2017 by which time it was proposed to fully vacate the premises. Due to slippage in the transfer of staff to alternative accommodation an application was made to extend the Notice which has been granted and is now due to expire on 27th July 2017. The last staff located at Whitchurch are due to be relocated by the 7th July.

We have been issued with a further Enforcement Notice at Hafan y Coed, following two fires in patient bedrooms, for failing to control smoking.

The mental health team have proposed additional controls and procedures and the action plan has been approved by the Fire Authority. If the measures prove to be effective the Notice can be lifted.

SHARED SERVICES FIRE AUDIT UHL REPORT
Name of Meeting : Health and Safety Committee **Date of Meeting** 18/07/2017

Executive Lead : Director of Planning
Author : Senior Fire Safety Adviser 02920 742292
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : The report is strategic with direct cost being identified as required
Quality, Safety, Patient Experience impact: The completion of all remedial actions detailed in the Enforcement Notices and Informal Notices as a result of Fire Service Audits will improve patient, visitor and staff fire safety. Fire risk within the UHB, further enforcements and potential prosecution for non compliance will also be reduced. The fire safety action plan will improve fire safety and reduce the fire risk.
Health and Care Standard Number: 2.1 **CRAF Reference Number** 6.4.5
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

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

The Health and Safety Committee is asked:

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

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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).

In November 2016 NHS Wales Shared Services Partnership - Specialist Estates Services carried out an in-depth fire safety audit at Llandough Hospital.

BACKGROUND

This report provides the assurance to the Board that the issues are being managed on a priority bases and monitored by the Fire Safety Group.

ASSESSMENT

The action plan from the fire audit was presented to the Fire Safety Group and responsibilities and a time frame on a priority bases has been agreed for each issue. This is now an agenda item for the Group which will closely monitor progress.

The action plan is attached as an appendix.

Ref. No.	Recommendation	Risk Rating	Lead	Date
4.3.1	The Board should continue to ensure risk assessments are periodically reviewed and maintained up-to-date, in accordance with the review frequency stipulated in the fire risk assessments.	L	FB	Completed
4.3.2	The Board should review the existing fire risk assessments to reflect the aspects identified in this report.	L	FB	Dec-17
4.3.3	The Board should consider enhancing the 'Project Design Protocol' with the inclusion of an action to review fire risk assessments following completion of any schemes.	L	FB	Completed
5.3.1	The Board should consider the guidance in WHEN 09/16 and the recommendations of this report, when developing/refining the site specific documentation.	L	FB	As Required
5.3.2	The Board should ensure the drawings reflect the 'as installed' standards for all fire related provisions and that they are maintained up-to-date.	L	TW	9/1/2017

5.3.3	The Board should retain relevant fire documentation preferably in a fire information box located at the main entrance or in the existing security lodge.	**L**	FB	Completed
5.3.4	The Board should ensure any future building alterations / proposals are considered in the light of the fire documentation as detailed in the existing policy.	**L**	JH	As required
5.3.5	The Board should introduce a procedure to periodically review the documentation to ensure it remains up-to-date.	**L**	FB	As required
6.3.1	The Board should ensure fire wardens are appointed in all wards and departments as stipulated in the Fire Policy and promote a consistent approach to routine fire safety checks.	**M**	Department Heads	3/1/2018
6.3.2	The Board should review the functionality and content of the dedicated fire safety section on their intranet site to improve the dissemination of fire related information.	**L**	FB	9/1/2017

6.3.3	The Board should continue to ensure the current high standard of general house-keeping within the patient areas is maintained and improve the aspects identified through this report and the fire risk assessments including management cooking facilities.	**M**	LW	Completed
6.3.4	The Board should continue with its endeavours to improve cylinder management, ensure schematics of medical gas pipe routing are available and the ASVUs labelled, protected/maintained.	**L**	Pharmacy	Ongoing
6.3.5	The Board should ensure uncontrolled smoking practices are managed accordingly.	**M**	CD	Ongoing
6.3.6	The Board should ensure the measures to mitigate the potential arson and security risk are maintained.	**L**	CD	Ongoing
6.3.7	The Board should ensure portable appliance testing is conducted for all equipment as necessary, and ensure electrical risks are detailed in the fire risk assessments and prioritised for action accordingly.	**M**	TW	Completed
6.3.8	The Board should continue to improve training performance.	**M**	Department Heads	12/1/2017

7.3.1	The Board should undertake a full review of the fire alarm installation and system infrastructure to reconfigure and establish zoning arrangements that reflect the compartmentation and departmental boundaries.	**H**	GE	3/1/2018
7.3.2	The Board should review the device address descriptions to remove any ambiguity as to the location of the individual devices and reflect the zoning arrangements.	**M**	GE	3/1/2018
7.3.3	The Board should ensure accurate zone plans are displayed adjacent to all fire alarm panels.	**L**	TW	3/1/2018
7.3.4	The Board should develop a C&E schedule detailing all ancillary devices interfaced with the fire alarm and ensure the C&E is fully validated on an annual basis.	**M**	GE	3/1/2018
7.3.5	The Board should ensure a full set of accurate as installed drawings is available which also details the interfaces to any ancillary equipment linked to the fire alarm system.	**L**	GE	3/1/2018
7.3.6	The Board should continue with a phased programme to replace the obsolete detectors and upgrade to an L1 standard where necessary.	**M**	GE	3/1/2018

7.3.7	The Board should ensure the fire risk assessments address the omission of the magnetic lock over-ride facilities as required by BS 7273:4.	**L**	GE	3/1/2018
7.3.8	The Board should ensure non-conformities identified through maintenance inspections are prioritised for action including rectification of repeater panel displays.	**M**	GE	3/1/2018
7.3.9	The Board should ensure the complete fire alarm system is maintained in accordance with BS 5839:1; reference should also be made to the 'Users responsibilities' as defined in the above standard.	**M**	GE	3/1/2018
7.3.10	The Board should review the incident reporting arrangements to improve performance management and further reduce the incidence of false alarms.	**L**	FB	Ongoing
8.3.1	The Board should review the site fire drawings to accurately illustrate all compartment and sub-compartment walls, hazard room enclosures and any other passive protection such as enclosures to protected shafts and protected routes.	**M**	TW	3/1/2018

8.3.2	The Board should instigate a procedure that ensures designated elements of fire construction achieve the requisite period of fire resistance and are adequately fire stopped with suitable materials.	**M**	TW	Phased programme in place
8.3.3	The Board should ensure the potential for external fire spread and space separation requirements are reflected in the response procedures and addressed in the fire risk assessment with action prioritised as necessary.	**L**	FB	Ongoing
8.3.4	The Board should conduct a survey of the ventilation system and prepare an up-to-date set of 'as installed' drawings illustrating the whole ventilation system, following which fire damper provisions should be assessed accordingly.	**M**	TW	3/1/2018
8.3.5	The Board should review the maintenance regime for the mechanical ventilation to ensure maintenance/testing of fire dampers is conducted at least annually in accordance with BS9999.	**M**	TW	Ongoing
8.3.6	The Board should ensure all other specialist ventilation and smoke extract systems are suitably tested and maintained.	**M**	TW	3/1/2018

8.3.7	The Board should consider the necessity for the remaining smoke extract hoods with a view to decommissioning these if they are deemed to be unnecessary through a risk assessed approach.	**L**	JH	3/1/2018
8.3.8	The Board should ensure all fire doors are subject to a six-monthly maintenance regime and continue to address the fire doors deficiencies as identified through the fire risk assessment process and this report.	**M**	LW	Ongoing
8.3.9	The Board should ensure that all designated escape routes are appropriately signed, illuminated, safely usable and clear of obstructions at all times. Details of which should be recorded in the fire risk assessments.	**M**	LW	3/1/2018
8.3.10	The Board should prepare drawings detailing the extent of, and assess the existing emergency escape lighting provisions. Any areas identified as not having sufficient escape lighting should be upgraded as necessary.	**M**	TW	3/1/2018

8.3.11	The Board should review the escape lighting testing regime to ensure compliance with BS5266 including the annual 3 hour duration testing and continue to ensure any future upgrades include self-testing facilities to support future maintenance.	L	TW	3/1/2018
8.3.12	The Board should ensure that all facilities for fire fighting purposes are referenced in the fire manual as well as the fire risk assessments which should also consider the benefit of extending the internal fire main along the street.	L	FB/TW	3/1/2018
9.3.1	The Board should undertake a complete review of the Llandough response procedures which should then be reflected in site specific documentation.	H	FB	8/1/2017
9.3.2	The Board should develop department specific procedures, particularly for areas accommodating very high dependency patients and areas where a higher level of control may be required.	L	FB	9/1/2017
9.3.3	The Board should develop and display fire evacuation plans complying with the principles of BS ISO 23601.	L	TW	3/1/2018

9.3.4	The Board should review the arrangements for vertical evacuation ensuring availability of suitable evacuation aids recognising the patient's condition (including bariatric) and the location and likely number of aids required for effective evacuation of mobility impaired persons.	**H**	CD	3/1/2018
9.3.5	The Board should ensure that revised any procedures are disseminated to staff and reflected in the training syllabus, including the use of evacuation aids and lift operations.	**M**	FB	8/1/2017
9.3.6	The Board should conduct scenario based evacuation exercises including interaction with the Fire and Rescue Service.	**M**	TW	8/1/2017
9.3.7	The Board should continually review and update its procedures to reflect the outcomes of future exercises.	**L**	FB	Ongoing

ENFORCEMENT AGENCIES REPORT
Name of Meeting : Health and Safety Committee **Date of Meeting** 18/07/2017

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

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Health and Safety Committee is asked to:

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

SITUATION

As briefed at the April meeting there has been no further Health and Safety Executive (HSE) events with regards to passenger lifts, however Legionella, Hydrotherapy Pool and Contractor fall has continued to be progressed. In addition the Principle Inspector of HSE has agreed that the HSE should meet with the Staff Safety Representatives.

This report updates the Committee on progress for each event.

Background

Road Traffic Accident at UHW

The Health Board has a duty under Regulation 17 of the Workplace Regulations to organise the workplace in such a way that pedestrians and

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vehicles can circulate in a safe manner. This includes sufficient separation of traffic routes for vehicles and pedestrians.

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 incident was reported under the RIDDOR Regulations and the HSE subsequently contacted the Health Board for further investigation details and remedial actions.

HSE Meeting

At the request of Staff Safety Representative the Head of Health and Safety wrote to the HSE requesting a meeting with the Safety Representatives to enhance the joint understanding of their role.

Legionella

Previous reports to the Committee informed the meeting the HSE had issued an Improvement Notice under the COSHH regulations, following an event on Ward C4North at UHW.

The Improvement Notice mandated the Health Board to take action by the 31st January 2017, with the main requirement of the notice being to enhance the management of legionella, in particular the flushing of infrequently used outlets.

Hydrotherapy Pool

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

Contractor Fall

The HSE has 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.

Assessment

Road Traffic Accident at UHW

As briefed previously, the investigation identified there were a number of factors contributing to the event.

The investigation report was submitted to the HSE. The Health Board has committed to improve the signage and put barriers along the footpath to a) segregate the pedestrian area and b) stop vehicles mounting the curb and action has also been taken against the contractor.

The HSE has confirmed that the 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.

HSE Visit

Whilst under the work load of the HSE non investigatory meetings are uncommon, the Principle Inspector for our sector has agreed for the local Inspector to meet with the Staff Safety Representatives on a non specific topic area to improve the joint understanding of their role.

Legionella

The Water Safety Plan was approved at the Water Safety Group meeting and an enhanced regime for auditing and monitoring shortfalls was implemented. A review of the Leginonella Policy to a Water Safety Policy was also completed which was submitted to this Committee for approval.

The HSE received a timely response and confirmed that subject to the proposed actions being implemented, they considered the enforcement action to be complied with.

The Water Safety Group is monitoring the auditing and flushing regime and will be amending the Water Safety Plan to reflect the commitment given to the HSE.

Hydrotherapy Pool

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

Contractor Fall

Further to the previous briefings in relation to the Contractor Fall, the HSE has visited the site and formally interviewed three Estates Staff and viewed our enhanced contractor control approach.

The HSE has again returned during the period to interview Estates personnel in relation to the status of the beam that was used by the contractor, for evidence that this had been decommissioned.

They have yet to indicate any decisions with regards to any subsequent enforcement action. Although it is known they have equally been in contact with the contracting company.

TREND ANALYSIS OF CONTRACTOR CONTROL SAFETY BREACHES	
Name of Meeting : Health and Safety Committee	**Date of Meeting** 18 July 2017

Executive Lead : Director of Planning
Author : Estates Health, Safety & Asbestos Support Officer
Caring for People, Keeping People Well: This report underpins the Health Board's Sustainability avoiding harm waste and variation**.**
Financial impact :
Quality, Safety, Patient Experience impact :
Health and Care Standard Number : 1.1, 2.1,2.3
CRAF Reference Number: 6.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Ongoing monitoring and challenging of contractors on site
- Monthly analysis of contractor control

The Health and Safety Committee is asked to:

- **AGREE** the ongoing contractor control measures

SITUATION

During the last Health & Safety meeting a request was made for a trend analysis of red & yellow cards being issued to contractors as part of the enforcement of and monitoring of the Contractor Control System.

BACKGROUND

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

A number of new procedures have since been put in place but the most significant of these was to allocate a resource to undertake Contractor monitoring across the UHB sites. The Contractor Monitoring has involved challenging contractors present on site and auditing them on their paperwork, risk assessments, working procedures and induction status.

Where the audit highlights minor procedural issues (having incorrect paperwork, not being signed in or site inducted) the contractors are issued a

yellow card and are asked to refer back to the site contact to rectify the issues and return the contractor to work. Yellow cards are kept on a company's record for 3 months. Two yellow cards within a 3 month period become a red.

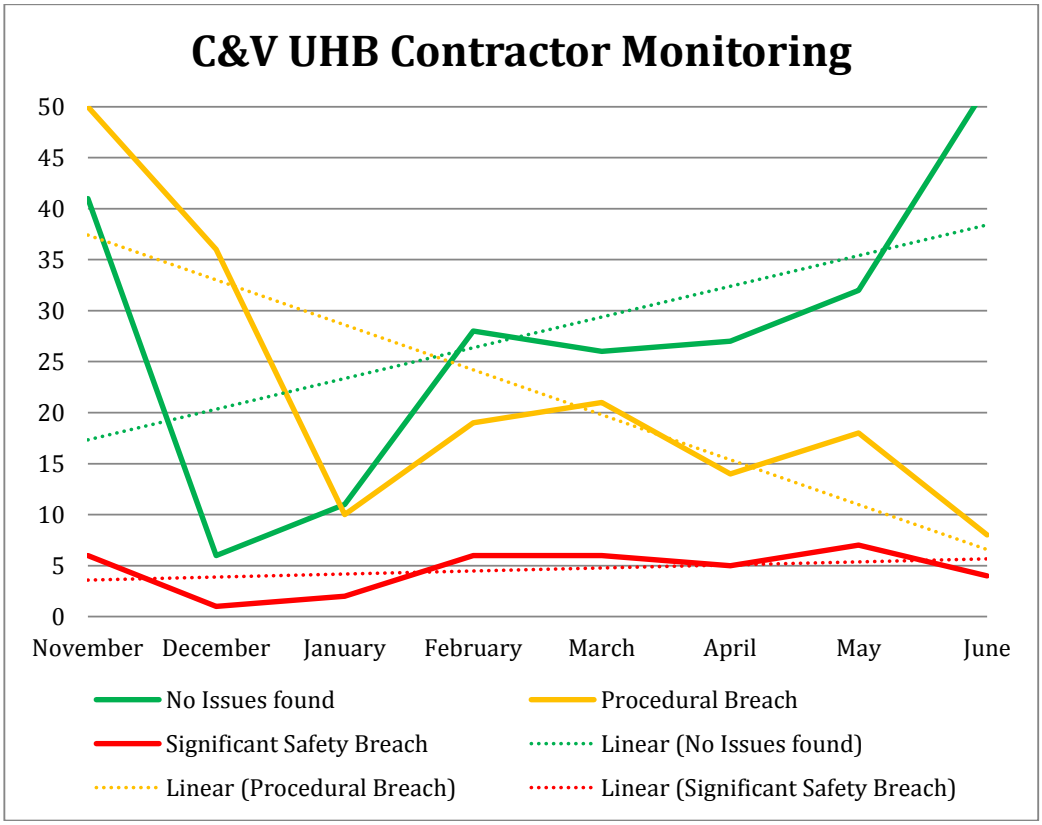
Where significant safety breaches are identified or a second yellow card is given then the contractor is removed from site. The site contact and their relevant Departmental Manager are informed and the company needs to prove the issues of concern are completely resolved before being allowed to return to site. Again red cards are kept on a company's record for 6 months.

Where 2 red cards are issued within a 6 month period the company is removed from site and the decision as to whether they are allowed to return then rests with the Director of Capital, Estates and Facilities.

ASSESSMENT AND ASSURANCE

Initial Contractor Control monitoring in November showed that of all the contractors challenged only 42% were found to have no issues. The majority, 52%, were found to have procedural breaches and received yellow cards and 6% were found to have significant safety breaches and were red carded.

Over the 7 months since, the proportion of challenges which result in procedural breaches being recorded has dropped significantly, to only 13% during June. During the same period the number of challenges recorded as having no safety issues has risen in inverse proportion to that of the procedural breaches. The number of significant safety breaches has increased slightly over the duration of the monitoring.



The number of red cards and the types of issues being recorded is still concerning but it should be noted that the Contractor Monitoring process deliberately targets inherently unsafe work practices and as such there is a skew towards red cards over work with no safety issues.

There are some themes among the red cards issued. 9 have been issued to companies due to issues with scaffolding, 8 have been issued to asbestos companies for poor performance or to companies undertaking work in asbestos containing areas without prior approval. 6 cards have been issued for issues surrounding the security of their work areas, 3 have been due to issues when using MEWP's and another 3 have been issued to company's undertaken hot works without the necessary permits in place.

One of the more notable issues was an insurance inspector being seen adjacent to an open bay door in plant room 19 (5 storeys up) without a harness.

Assurance is (definition)

It has been noted that our contractors are becoming increasingly aware of the more stringent UHB Health & Safety requirements and are starting to ensure that the necessary inductions, method statements and safe working practices are being undertaken as a matter of course. Increased site presence from the UHB staff managing the projects is aiding this and it is envisaged that the procedural and safety breaches will continue to decline as a result. The

monitoring and evaluation of the Contractor Control System is due to continue and this should ensure that standards of quality are being met by our contractors and the UHB staff managing them.

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HEALTH AND SAFETY PRIORITY ACTION PLAN 2017/18
Name of Meeting: Health and Safety Committee **Date of Meeting:** 18/07/2017

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

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- Demonstrating progress against each strategic area and highlighting 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 Action Plan

SITUATION

The Health Board has initiated a Health and Safety Priority Action Plan to monitor its progress on key health and safety strategic areas. The 2017/18 plan builds upon the previously considered 2016/17 plan. The action plan is revised at each meeting; being updated to current status and adding any new priority items as they arise.

The Priority Action Plan is the Health Board's strategic approach to tackling significant health and safety risks and has proved successful at reducing risks and progressing on the basis of real risks and practical solutions. This can be demonstrated by both the number of completed action areas (green) and the reduction in incidents as demonstrated in the previously submitted Annual Report.

BACKGROUND

The Priority Action Plan is 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 Action Plan based on the eight strategic areas.

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

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

The Clinical Boards and Capital, Estates and Facilities Risk Registers include identified risks within this Health and Safety Action Plan, whilst centrally managed risks are included within the Corporate Management Risk Register.

ASSESSMENT

Below summarises the status of the plan by the strategic area

Table 1

	Total no of requirements	Green	Amber	Red
Health and Safety Policy Management and Organisational Arrangement	4	0	2	2
Violence and Aggression (inc Lone worker)	6	1	5	0
Manual Handling	4	1	3	0
Health Issues	4	1	3	0
Patient and Environment Health and Safety	8	3	4	1
Fire Safety Management	3	1	1	1
Estate Health and Safety Management	5	1	2	2
Sharp Safety	1	1	0	0
Total	35	9	20	6

The Priority Action Plan has been reviewed and updated; this includes removing all progressed areas during the year. The above demonstrates of the revised total of 35 requirements 9 have been resolved and 6 are a high priority and non compliant. A further 20 are identified as amber, thus meaning that the risk has been reduced as a result of action taken but further control measures are required.

Red Areas

	Requirement	Progress	Action required	Accountable Lead
1.1	A comprehensive programme of risk assessments to be completed with identified control measures implemented	E-Datix risk has been purchased but it is understood there is no agreed implementation date.	Review of Risk Register and E-datix implementation.	Director of Corporate Governance
1.4	Health and Safety Management Training	Training course under development with an aim of offering the course during July/August.	Complete course and place on ESR	Head of Health and Safety
5.6	Bariatric Patient Care	Meeting with Assistant Director of Nursing – progressing issues on care basis with Nursing Director.	Progress UHW risk.	Assistant Director of Nursing
6.1	Firecode	Fire Policy submitted for approval. Training improvements being pursued through PPP.	Planned "toolbox" talks to wards by Fire Advisers to enhance local knowledge. Each Clinical Board to monitor local compliance. Fire Policy approved at July 2015 meeting	Director of Planning
7.3	Back log maintenance of the UHB Estate Impact: Resources available to estates in line with an increasing burden of ageing physical infrastructure, bringing increased maintenance costs and increased refurbishment costs.	Regular reviews of estate condition via Estate Property Appraisals. Health and Safety Committee informed at October 2013 meeting that backlog maintenance items include equipment that has passed it replacement date but was still functional	Report to be prepared to identify that there is an appropriate system for prioritising and monitoring failed equipment with Health and Safety implications. Results of the property appraisal presented to October 2014 Health and Safety Committee. Committee updated on scale of problem, priorities reflected in the IMTP. A complete "risk based" Service Board – "Building Services Review" currently taking place for submission of a Business Case to Health Board and Welsh Government.	Director of Capital, Estates and Facilities/ Director of Therapies and Health Sciences (for medical equipment) Director of Planning

7.5	Legionella Survey and Risk Assessment	Survey initiated has identified a number of remedial actions are required. 10 new risk assessments for UHW carried out this year in high risk areas. Risks currently being prioritised and some actions taken.	Remaining original RA for UHW and UHL (2 year to 4 year old) is currently having urgent and high risks collated and prioritised. RA to all clinics currently in progress. Completion due in next two weeks.	Director of Capital, Estates and Facilities

APPROVAL OF INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY
Name of Meeting : Health and Safety Committee **Date of Meeting:** 18/07/2017

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety - 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: The Incident Data System is managed within the existing resource and budget of the Health Board. Failure to manage incidents can have significant financial risks, which is not justifiable.
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 2.1
CRAF Reference Number 6.4.1
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided through:

- The continued monitoring of incidents and data submitted to the Committee and the Operational Health and Safety Group, including the Annual Report.

The Health and Safety Committee is asked to:

- **APPROVE** the Incident, Hazard and Near Miss Reporting Policy
- **APPROVE** the full publication of the Incident, Hazard and Near Miss Reporting Policy in accordance with the UHB Publication Scheme

SITUATION

The Health Board has a legal obligation to provide a mechanism and structure for reporting, investigating and management of adverse incidents, near misses and incidents.

This requirement is mandated both within the Health and Safety and Patient Safety remit. The previous policy was approved by the Quality and Safety Committee, however by agreement the reviewed policy is brought to the Health and Safety Committee for approval.

BACKGROUND

The reporting of Incidents, Diseases and Dangerous Occurrence Regulations 1995 places a direct responsibility on the Health Board to report certain types of incidents and this is also embedded in the Health and Safety at Work Act.

ASSESSMENT

The document has been modified to the new format of policy and both the policy and procedure amended to reflect the introduction of the E-Datix electronic reporting mechanism.

The Policy has been jointly composed by both the Health and Safety and Patient Safety Departments and circulated through the relevant Groups.

The Procedure modification reflects a simplification and recognizing that much of the previous procedure was guidance, which is readily available through the Intranet pages.

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholders and 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 5th June and 30th June 2017;
- The document was shared with the Operational Health and Safety Group.

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

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

Reference Number: UHB 138 **Version Number:** 2	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to the health, safety and welfare of its staff, patients, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.

We consider that it is essential that all incidents, near misses and hazards are reported so that appropriate action can be taken to try to prevent their reoccurrence, improve the environment, patient experience and services where appropriate action can be taken to reduce risk of recurrence.

The Policy defines Incidents, Hazards and Near misses:-

- **Incident**

  An *Adverse Incident* is defined as "any unplanned event that resulted in, or had the potential to result in, an injury or the ill health of any person, or the loss of, or damage to, property"

  Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care". (NPSA 2011)

- **Hazard**

  A hazard is a source of potential harm or damage or a situation with potential for harm or damage.

- **Near Miss**

  A *near miss* is an occurrence, which but for the luck or skilful management would in all probability have become an incident.

We encourage an open and fair culture. The aim of reporting and investigating incidents, near misses and hazards is not to blame but rather learn from the event and to minimise risk of reoccurrence.

Policy Commitment

To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive sound governance-framework.

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To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff safety and patient well-being.

To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting

Supporting Procedures and Written Control Documents

- Incident, Hazard and Near Miss Reporting Procedure
- Health and Safety Policy
- Policy for Reporting Research Related Events
- Being Open Policy
- Records Management Policy
- Risk Management Policy

Other supporting documents are:

- Procedure on Reporting Research Related Adverse Events
- Risk Assessment and Risk Register Procedure
- Investigation Procedure

Scope

This policy applies to all staff employed by the UHB, including those with honorary contracts. It also applies to students and locum/agency staff working within UHB facilities/under contract to the UHB.
This Policy also applies to contractors who have a statutory responsibility to report accidents that have occurred on UHB sites.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be 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 Clinical Board Health and Safety Groups and Patient Quality and Safety Groups
Accountable Executive or Clinical Board Director	Director of Corporate Governance Executive Director of Nursing

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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	18/09/2012	26/09/2012	Trust Incident Reporting and Investigation Procedure reviewed and updated. Replaces previous Trust document reference no: 108
1.1	09/04/2013	14/06/2013	New Appendix 9 added – Internal Management of HM Coroner Rule 43 Reports by Patient Safety Team
2			To reflect changes as a result of the introduction of E Datix and to simplify by segregating the policy from the procedure

Equality & Health Impact Assessment for

INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Incident, Hazard and Near Miss Reporting Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Services – Director of Corporate Governance Author- Head of Health and Safety – 43751
3.	Objectives of strategy/ policy/ plan/ procedure/ service	• To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework. • To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff safety and patient well-being. • To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting
4.	Evidence and background information considered. For example	

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	• 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[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 Staff and Patients

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

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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 Incident Reporting database details age of victim, which allows for subsequent analysis.		
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	No Impact		

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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
6.3 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 incident report database details gender of victims, which allows for subsequent analysis.		
6.4 People who are married or who have a civil partner.	No Impact		

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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
6.5 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.	No Impact		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The incident reporting database records incidents which are related to racial aspects.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a	As above		

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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
religious or philosophical belief			
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The incident reporting database does cover homophobic and sexual related incidents.		
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 database includes a racial aspect, which has included welsh.		

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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
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No Impact		
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 incident reporting database does consider events related to patient medical condition and capacity.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Incident reporting is available to all staff, through all UHB electronic outlets i.e. computers.		

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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

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			

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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
Well-being Goal - A more equal Wales			
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 vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc	The incident reporting database allows for analysis of events with a clear aim to improve patient care and staff working conditions.		

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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
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	No Impact		
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	The incident reporting database collects data in relation to environmental events, which allows for analysis and appropriate resolution.		

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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
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;	No Impact		

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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
cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
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	No Impact		

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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	Positively supports equality issues, through facilitating reporting of related events and requires managers to progress actions, towards resolution.

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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?	To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to the health, safety and welfare of its staff, patients, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.			

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
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			

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	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				

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

INCIDENT, HAZARD AND NEAR MISS REPORTING PROCEDURE

Introduction and Aim

The Cardiff and Vale University Health Board (UHB) is committed to the health, safety and welfare of its staff, patients, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.

It considers that it is essential that all incidents, near misses and hazards are reported so that appropriate action can be taken to try to prevent their reoccurrence, improve the environment, patient experience and services where appropriate.

It is the policy of the UHB to ensure that staff feels comfortable about reporting incidents, hazards and near misses, therefore the UHB encourages an open and fair culture the aim of reporting and investigating incidents, near misses and hazards is not to blame but rather learn from the event and to minimise risk of reoccurrence.

A key aim is to encourage staff to report incidents without fear of personal reprimand or detriment and for staff to know that by sharing their experiences, others will be able to learn lessons and improve patient safety. The emphasis is on the "how" and “why” rather than the "who".

However, the UHB will act on information to protect the safety of other staff, patients and visitors where appropriate. Disciplinary action may result from incidents such as those relating to criminal activity, malicious activity and patient care or treatment contrary to the relevant professional code of conduct.

Objectives

- To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework.
- To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff safety and patient well-being.
- To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting.

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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	• Incident, Hazard and Near Miss Reporting Policy • Health and Safety Policy • Policy for Reporting Research Related Events • Being Open Policy • Records Management Policy • Risk Management Policy **Other supporting documents are:** • Procedure on Reporting Research Related Adverse Events • Risk Assessment and Risk Register Procedure • Investigation Procedure
Approved by	Health and Safety Committee

Accountable Executive or Clinical Board Director	Director of Corporate Governance
Author(s)	Head of Health and Safety
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**
	Date of Committee or Group Approval	*TBA*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*

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1. DEFINITIONS

1.1 An *Adverse Incident* is defined as “any unplanned event that resulted in, or had the potential to result in, an injury or the ill health of any person, or the loss of, or damage to, property” “Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care”. (NPSA 2011)

1.2 A hazard is a source of potential harm or damage or a situation with potential for harm or damage.

1.3 A *near miss* is an occurrence, which but for the luck or skilful management would in all probability have become an incident.

1.4 A *Patient Related Serious Adverse Incident* is defined as “an event or situation where one or more patients are involved in an event which is likely to produce serious legal or media interest or the involvement of a statutory body.

1.5 *RIDDOR* is the recognised abbreviation for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

2. ROLES AND RESPONSIBILITIES

2.1 The **Chief Executive** is ultimately responsible for ensuring compliance with the Health and Safety at Work etc Act 1974 and associated legislation, and that this procedure along with the policy is implemented and effective within Cardiff and Vale University Health Board.

2.2 The **Executive Director of Nursing**, jointly with the **Executive Medical Director** and **Executive Director of Therapies and Health Sciences** have Board level responsibility for clinical governance/patient safety and quality, which includes clinical risk and patient safety.

2.3 The **Director of Corporate Governance** has Board level responsibility for health and safety which includes health and safety risks and incident management.

2.4 The **Assistant Director of Nursing, Patient Safety and Quality** supports the development of arrangements for incident reporting and gives assurance to the Executive Directors that incident reporting is being effectively managed . The post

holders will also support the Clinical/Service Boards facilitating adequate technical advice.

2.5 The **Head of Health and Safety** supports the development of arrangements for incident reporting and gives assurance to the Director of Corporate Governance that health and safety related incident reporting is being effectively managed.

2.6 The **Patient Safety Department** and **Health and Safety Department are responsible for** supporting the development of this policy/procedure. They will also undertake to raise staff awareness and training on incident reporting.

2.7 The **Clinical/Service Board Management teams** are responsible for ensuring that staff within their Board are briefed on their individual and collective responsibilities within the incident reporting process. They must ensure that all incidents are reported, investigated and analysed, so that learning and improvements can be embedded in practice.

2.8 **Department/Line Managers** are responsible for cascading the policy/procedure to staff ensuring that they are fully conversant with the process to be followed for all incidents.

They are also responsible for ensuring that an appropriate investigation is undertaken for all incidents that have occurred in their area of responsibility and ensuring that measures to prevent recurrence are implemented within the shortest appropriate time scale.

The Line/Departmental Manager responsible for the area must provide feedback to the individual that has made the report including action(s) taken to prevent recurrence.

2.9 **All employees** are responsible for reporting incidents in a timely manner and ensuring that the immediate area is made safe and the senior member of staff made aware of the incident. Employees may be required to provide additional information on incidents during investigations; this may include provision of statements or attendance at interviews.

Under the Safety Representatives and Safety Committees Regulations 1977, **Safety Representatives** are also allowed to investigate potential hazards, dangerous occurrences, and causes of accidents and occupational ill-health within the area of their responsibility

2.10 **Contractors** such as estates and equipment maintenance contractors and building contractors have a statutory responsibility to report adverse incidents, hazards and near misses that have occurred on UHB sites to the UHB in line with their contract arrangements.

3. TRAINING

3.1 Incident reporting will be provided to all levels of staff on induction and mandatory training through the e-learning induction module or via face to face presentation.

3.2 Training on the manager's responsibilities and functions will also be provided and supported through guidance and advice.

4. ADVERSE INCIDENT, HAZARD AND NEAR MISS REPORTING AND MANAGEMENT

4.1 When an incident occurs staff must first ensure the people or area concerned are made safe. The incident must be reported through the recognised UHB incident reporting mechanisms this being E Datix system available on the intranet.

All incidents will be graded according to the actual impact on the individual(s) involved and the potential future risk to individuals and to the organisation. All incidents are assessed using the agreed UHB matrix.

4.2 A duty (of candour) to tell a patient

If adverse events have occurred to patients the incident should be communicated to the patient or their representative as soon as is practicable. In exceptional circumstances, if it is deemed that the impact of disclosure will adversely affect the patient's psychological well being, a decision may be taken not to inform the patient; reasons for this decision must be clearly documented in the patient's health records.

4.3 Post Serious Incident Support

The organisation recognises that a serious untoward incident may be potentially stressful and difficult for staff, patients and their families both directly and indirectly involved. It is essential that appropriate and timely support is offered and made available to all who identify that they require it.

4.4 Legal Status and Retention of Incident Reports

It is a requirement of WHC 2000(71) that Incident Reports relating to adults will be retained for 10 years after the date of the incident, and Incident Report s relating to incidents involving children will be retained until the child is 25 years of age or for 8 years after the death of the child (whichever is the sooner).

The E-Datix system fulfils the requirement of the UHB to maintain accident book(s) at strategic locations in accordance with the Social Security (Claims and Payments) Regulations 1979.

4.5 Reporting Information Governance breaches

Events of failure to comply with information governance requirements are considered as an Incident and should be reported using the Datix reporting system. These events will be passed to the Head of Information Governance for appropriate monitoring of investigation and remedial actions.

4. INVESTIGATION

All serious incidents will be investigated appropriately. Investigations may also be undertaken if there is repetition of similar incidents or clusters of incidents.

The investigation process is focussed on being fair and equitable by identifying the root causes and addressing system failures rather than individuals. The UHB recognises that human error is a contributory factor to some incidents and staff will not, as a routine be disciplined for incidents due to human error. However, staff are accountable for their actions and are expected to be open about incidents they are involved in.

An incident investigation may reveal action that is required which will have an impact on other areas within the organisation. Lessons learnt should be disseminated via the UHB quality and safety and/or health and safety arrangements to ensure that the UHB can learn from incidents that have occurred to prevent similar occurrences and promote continued improvement in service provision and patient care.

5. REPORTING TO EXTERNAL AGENCIES

Some specified incidents are required to be reported to external agencies. This will be undertaken through the agreed UHB incident reporting mechanisms by the appointed persons.

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External Agency	Requirement	Appointed Department
National Reporting Learning System (NRLS)	All patient safety incidents (irrespective of seriousness and degree of harm) to the National Patient Safety Agency (NPSA) Reporting and Learning System	Patient Safety Department
Health and Safety Executive - RIDDOR The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995	Work related deaths, specified injuries, dangerous occurrences and accidents resulting in over 7 day injury which results in incapacity to undertake normal work duties Also specified diseases	Health and Safety Department Occupational Health Department
Welsh Government (April 2012) *Guidance on the Reporting and Handling of Serious Incidents and Other Patient Related Concerns/No Surprises*	Patient-Related Serious Adverse Incidents as defined within 24 working hours of a serious adverse incident. Reporting of Serious Incidents and No Surprise/Sensitive Issues to the Welsh Government	Patient Safety Department
Medicines and Healthcare Products Regulatory Agency (MHRA)	Where a serious incident involves a medical device the MHRA must be contacted within 24 hours	UHB nominated liaison officer
Communicable Diseases	In the event of an infectious disease outbreak and any serious single infection with public health implications	Consultant in Communicable Disease Control, Health Protection Agency (HPA) should be contacted
Healthcare Inspectorate Wales – Ionising Radiation Medical Exposure Regulations (IRMER	Breaches in IRMER to Healthcare Inspectorate. Such incidents will also be reported to Welsh Government in line with Serious Adverse Incident reporting	Patient Safety Department

6. RESOURCES

6.1 This Procedure provides an update of current practices. It is therefore unlikely that any additional resource will be required to ensure staff report incidents.

6.2 *Database* - the UHB uses the DATIX risk management system for recording incidents. Updating and maintenance of this system has resource implications which at present is managed within the UHB.

7. IMPLEMENTATION

This Procedure reflects existing practice across the UHB and will therefore be implemented with immediate effect. The requirements of this Procedure will be re-enforced within Clinical/Service Boards Directorates/Departments by local risk management and health and safety arrangements.

8. EQUALITY

We have undertaken an Equality Impact Assessment and received feedback on the policy and procedure and the way it operates. We wanted to know of any possible or actual impact that this procedure may have on any 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 no impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

9. MONITORING

It will be necessary to ensure that Clinical/Service Boards are adhering to the requirements of this procedure and its policy. This will be monitored via a number of agreed performance indicators.

The Quality and Safety Committee and Health and Safety Committee will monitor implementation of this procedure.

10. DISTRIBUTION

10.1 This Procedure will be on the UHB Clinical Portal, Intranet and Internet Site.

10.2 Line Managers/Departmental Managers/Lead Nurses/Directorate Managers/Clinical Directors are responsible for ensuring that all staff has access to this document.

11. REVIEW

This Procedure will be reviewed every 3 years or sooner if required.

12. FURTHER INFORMATION/REFERENCES

HSE (1994), *Management of Health and Safety in the Health Service*, Health Service Advisory Committee, Health and Safety Executive.

HSE (1995) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.*

HSE Reporting injuries, diseases and dangerous occurrences in health and social care – Guidance for employer. HSE Health Services Information Sheet No 1 (Revision 2)

Department of Health (2006), *Ionising Radiation (Medical Exposure) Regulations (amended 2006).*

NPSA (2006), *Being open: Communicating patient safety incidents with patients, their families and carers* (Re-launched 2009)

NPSA (2004), *Seven Steps to Patient Safety*

Social Security (1987), Claims and Payments Regulations No 1968

Welsh Government *Putting Things Right/NHS Redress (Guidance April 2012)*

Welsh Government (2010) *Standards for Health Services in Wales: Doing Well, Doing Better*

Welsh Government (2004) *Medical Device Alert 054: Reporting Adverse Incidents – Guidance on New Arrangements for NHS Wales Organisations*

Welsh Government (2000) *Reporting Arrangements for Serious Adverse Incidents* (71)

APPROVAL OF SHARPS MANAGEMENT POLICY	
Name of Meeting : Health and Safety Committee	**Date of Meeting:** 18/07/2017

Executive Lead : Director of Corporate Governance
Author : Health and Safety Adviser - 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: £12k is allocated within the existing Health and Safety budget for First Aid Training.
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 2.1
CRAF Reference Number 6.4.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided through:

- Annual reports and incident data.

The Health and Safety Committee is asked to:

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

SITUATION

The previous Sharps Management Policy is due for review. This policy reflects existing practice and requirements and therefore only contains minimal updates to the procedural arrangements, reflecting organisational changes.

BACKGROUND

Cardiff and Vale University Health Board (UHB) is committed to ensuring the protection from sharps injuries, 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.

The 2010/32/EU Directive has been introduced in order to prevent injuries and the risk of blood-borne infection to healthcare workers from sharps instruments such as needles.

The purpose of the Directive is to implement the Framework Agreement to ensure that injuries of workers by all medical sharps (including needle sticks) are prevented to protect workers at risk and to establish procedures in risk assessment, risk prevention, training, information awareness and monitoring.

To deliver this requirement the Health Board must have an appropriate policy. The current policy has been reviewed and updated. The purpose of this report is to seek approval of the revised policy by the Health and Safety Committee.

In operating this policy it is the intention of the Cardiff and Vale University Health Board to comply with the European Council Directive 2010/32EU 'Prevention from sharp injuries in the hospital and healthcare sector', and other legal and professional requirements relating to Sharps Safety.

The scope of the policy is applicable to all premises, staff and users within the Health Board.

ASSESSMENT

It is the aim of the policy of Cardiff and Vale UHB to provide effective safe management of sharps. In particular the need to assess the risks, provide appropriate information and training in consultation with Health Board staff, patients and any other users of Health Board premises/services

The policy aims to:-

Comply with the legal duties in relation to protection against sharps injuries placed on the UHB by the following:-

- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
- Control of Substances Hazardous to Health Regulations 2002
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

Effectively manage Safer Sharps provision through the risk assessment process and appropriate control measures.

To ensure there are adequate first aid facilities and competent response for staff that maybe injured at work within the UHB.

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholders and 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 5th June and 30th June 2017;
- The document was shared with the Operational Health and Safety Group.

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

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

Reference Number: UHB 269 **Version Number:** 2	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *N/A*

SHARPS MANAGEMENT POLICY

Policy Statement

The Health Board is committed to ensuring safe practice by effective sharps management in accordance with the European Council Directive 2010/32/EU 'Prevention from sharp injuries in the hospital and healthcare sector', which has formed part of the national legislation since 11th May 2013.

The Health Board shall assess the risk of exposure to biological hazards including blood-borne viruses and risk of sharps injuries from procedures and activities.

The Health Board will substitute traditional, unprotected medical sharps with a 'safer sharp' where it is reasonably practicable to do so. If a suitable safer sharp is not available to reduce the risk of injury, the Health Board will ensure that safe procedures for working and disposal of the sharps are in place.

The Health Board fully supports the introduction of devices with engineered safety mechanisms to reduce incidents of needlestick injuries. Staff are expected to use safety lancets, safety cannulas, safety hypodermic needles or other devices with engineered safety mechanisms.

Conventional needles should only be used in exceptional circumstances and a Risk Assessment for each activity/procedure where non safety sharps are used must be completed, recorded and regularly reviewed.

Policy Commitment

The 2010/32/EU directive has been introduced in order to prevent injuries and the risk of blood-borne infection to healthcare workers from sharps instruments such as needles.

The purpose of the Directive is to implement the Framework Agreement to ensure that injuries of workers by all medical sharps (including needlesticks) are prevented to protect workers at risk and to establish procedures in risk assessment, risk prevention, training, information awareness and monitoring.

It is the responsibility of all Health Board employees to be aware of and adhere to this Policy within the remit of the Health and Safety at Work Act 1974.

Supporting Procedures and Written Control Documents

This Policy and the Infection Control Procedure for Needlesticks and Similar Sharps

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Injuries describe the following with regard to Sharps Safety.

- Roles and Responsibilities
- General Arrangements – Sharps Management
- Training
- Reporting of Sharps Injuries
- Monitoring and Measuring Performance

This Policy is supported by the following documents:

- Health and Safety Policy
- Infection Control Standard Precautions Procedure
- Incident, Hazard and Near Miss Reporting Policy
- Risk Assessment and Risk Register Procedure
- Waste Management 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	Consulted via the Operational Health and Safety Group and Infection Control Group
Accountable Executive or Clinical Board Director	Director of Nursing/Director of Corporate Governance

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

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Equality & Health Impact Assessment for

SHARPS MANAGEMENT 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	
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The objective of the policy is to ensure safe practice by effective sharps management in accordance with the European Council Directive 2010/32/EU 'Prevention from sharp injuries in the hospital and healthcare sector', which has formed part of the national legislation since 11th May 2013. The Health Board shall assess the risk of exposure to biological hazards including blood-borne viruses and risk of sharps injuries from procedures and activities.
4.	Evidence and background information considered. For example • population data	Considered all staff groups that could come into contact with sharps – clinical and non clinical staff. The UHB's usual arrangement with regard to consultation was followed

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	• 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[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	(ie. 28 days on the intranet).
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All UHB Staff and those with honorary contracts

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

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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 medical conditions such as diabetes	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	

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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
6.3 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.		
6.4 People who are married or who have a civil partner.	There appears not to be any impact		

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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
6.5 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, gypsies/travellers, migrant workers	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 written word, good management would dictate that alternative arrangements be made,	

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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
		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); • the same sex (lesbian or gay); • both sexes (bisexual)	There appears not to be any impact		

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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
6.9 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, people who are unable to work due to ill-health	There appears not to be any impact		
6.11 People according to where they live: Consider people living in areas known	There appears not to be any impact		

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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
to exhibit poor economic and/or health indicators, people unable to access services and facilities			
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.

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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 non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention).	N/A	N/A	

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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
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	
7.4 People in terms of their use of the physical	N/A	N/A	

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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
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 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	**N/A**	N/A	

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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
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			
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	**N/A**	N/A	

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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
Well-being Goal – A globally responsible Wales			

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			

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
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			

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	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.			

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

Sharps Management Procedure

Introduction and Aim

The aim of this Procedure is to support the Sharps Management Policy to provide effective safe management of sharps. In particular the need to assess the risks, provide appropriate information and training in consultation with Health Board staff, patients and any other users of Health Board premises/services.

Objectives

The Objectives of the procedure are to:-

- Comply with the legal duties in relation to protection against sharps injuries placed on the UHB by the following:-

  Health and Safety at Work etc Act 1974
  Management of Health and Safety at Work Regulations 1999
  Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
  Control of Substances Hazardous to Health Regulations 2002
  Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

- To ensure there are adequate first aid facilities and competent response for staff that maybe injured at work within the UHB.

- Effectively manage Safer Sharps provision through the risk assessment process and appropriate control measures

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	Sharps Management Policy Health and Safety Policy Infection Control Standard Precautions Procedure Incident, Hazard and Near Miss Reporting Policy Risk Assessment and Risk Register Procedure Waste Management Policy

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Approved by	Operational Health and Safety Group
Accountable Executive or Clinical Board Director	Director of Nursing/Director of Corporate Governance
Author(s)	Head of Health and Safety

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**
	Date of Committee or Group Approval	*TBA*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*

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1 ROLES AND RESPONSIBILITIES

1.1 Chief Executive - the Health Board's Health and Safety Policy sets out the responsibilities for Chief Executive, Executive Directors, Managers, Employees and Working Groups for all health and safety policies, procedures and working guidelines, and has the same relevance to this procedure.

1.2 Director of Nursing has delegated responsibility for ensuring:

- This procedure is appropriately disseminated throughout the Health Board.
- The approach to the provision of safer sharps is both systematic and appropriate.

1.3 Executive Directors, Clinical Board Directors, Clinical Board Managers, Clinical Board Nurses, and Directorate Managers must ensure that this procedure is followed in all areas under their control, and ensure that adequate resources are made available to implement this procedure effectively.

1.4 Clinical Leads

The use of non-safer sharps is only permitted if a suitable safer sharp is not available, or a risk assessment demonstrates that there is a clear clinical reason why a safer sharp cannot be used.

The Clinical Leads for each Clinical Board are responsible for ensuring that where a safer sharp is not being used a risk assessment has been carried out and that these risk assessments are reviewed and updated as necessary.

1.5 Line/Departmental Managers

The Line Manager will be responsible for ensuring that a 'Safer Sharps' risk assessment is undertaken wherever clinical activity involves the use of sharps.

This should include the selection of equipment and the safe placement of sharps containers in addition to ensuring correct assembly and disposal.

Line managers shall investigate the circumstances and causes of any incidents and take action required to prevent reoccurrence, ensuring

that a risk assessment is conducted and subsequently safe systems of work are devised and implemented within their area.

1.6 Procurement Department

The Procurement Department is responsible for ensuring:

- That appropriate safer sharps are procured.
- The withdrawal from service of non-safety sharps where appropriate alternatives have been identified.
- Those mechanisms are in place to ensure non-safety sharps are not procured, where there are agreed safer alternatives.
- The procurement department would be responsible to maintain records of usage, by department of safety and non safety sharps and provide reports to the health and safety department on this data.

1.7 The Learning Education and Development Department shall be responsible for:

- Maintaining a record of Mandatory Training in Infection, Prevention and Control.

1.8 Health and Safety Department

The Head of Health and Safety shall be responsible for:

- Providing advice and information with regard to potential hazards in the workplace.
- Advising on methods of risk assessment.
- Monitoring and reviewing this procedure and advising on the UHB's position with regard to compliance with the Regulations and Guidance.

1.9 Occupational Health Department

The Occupational Health Department shall be responsible for:

- The provision of an appropriate vaccination programme for those staff at risk of sharps injury.
- Ensuring the provision of post exposure and any follow up treatment service.

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1.10 Infection Prevention and Control

The Infection Prevention and Control Department shall be responsible for:

- The preparation and delivery of the protocol for needlestick and similar sharps injuries.
- For the preparation and delivery of Standard Infection Prevention Precautions Procedure.

1.11 Employees

All employees have a responsibility to:

- Be aware of the necessary action to take in the event of a sharps injury as per the information in the Infection Control Protocol for Needlestick and Similar Sharps Injures.
- Familiarise themselves with this procedure regarding the management of sharps and relevant procedures/protocols.
- Adhere to safe working practices in order not to harm either themselves or others.
- Inform their Line/Department Manager and First Aider/Appointed Person of any conditions that would personally affect their ability to be treated.
- Ensure all incidents of sharps injury are reported in accordance with the UHB Incident, Hazard and Near Miss Reporting Policy and reported via e-datix.
- Undertake mandatory infection prevention and control training.

2 GENERAL ARRANGEMENTS - Sharps Management

2.1 Avoidance

Line Managers should review practices to eliminate or reduce unnecessary use of sharps, this includes the use of needle free equipment such as catheter bags and not re-sheathing needles.

2.2 Use of Safer Sharps

Where it is not reasonably practical to avoid the use of medical sharps, the use of safer sharps incorporating a protection mechanism must be used where it is reasonably practical to do so, e.g. safety lancets, safety cannula, safety needles etc. The following factors should be considered:

- The device must not compromise patient care;

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- The reliability of the device;
- The care giver should be able to maintain appropriate control over the procedure;
- Other safety hazards or sources of blood exposure that use of the device may introduce;
- Ease of use;
- Is the safety mechanism design suitable for the application - i.e. if activation of the safety mechanism is straightforward, it is more likely to be used.

2.3 Prevention of recapping of needles

Needles must not be recapped after use unless a risk assessment has identified that recapping is required to prevent a risk.

2.4 Staff must ensure a secure container for the safe disposal of sharps must be available at the point of use

Provide information and training to staff

This should include:

- Risks of injuries
- Good practice in preventing injury
- Benefits and drawbacks of vaccination
- Support available if injured
- The correct use of safer sharps
- Safe use and disposal of medical sharps
- What to do in the event of a sharps injury
- Arrangements for health surveillance

2.5 Safety Precautions when Using and Disposing of Sharps

Safer sharp devices should be stored separately from any non-safety sharp devices in the area.

Staff involved in providing care should adhere to hand decontamination and use standard infection prevention and control precautions to include the use of gloves and aprons in conjunction with the safe use and disposal of sharps.

Select the relevant size **and colour** of sharps container most appropriate to your needs. Refer to waste guidance if necessary.

Discard sharps directly into a sharps container **immediately after** and **at the point of use.**

Do not re-sheath a needle.

Dispose of needle and syringe as a complete unit – never detach unit by hand unless a risk assessment has been completed.

Do not pass sharps directly from hand to hand, or pass to another person, handling should be kept to a minimum. **The passing of sharps directly hand to hand to another person should be kept to a minimum, using a container such as a kidney dish whenever practicable.**

2.6 Sharps Container

All staff must ensure that:

- Containers are **correctly** and **securely** assembled (follow manufacturers' instructions).
- The label is completed fully to identify date of assembly - this also identifies source and enables an audit trail.
- When not in use (between treatment sessions) containers should be stored with the lid in the 'temporary closed' position to prevent spillage of sharps if the container is knocked over.
- Dispose of container when it is three-quarters full (shown by a "fill line" on each container), ensure secure closure and locking and ensure the label is fully completed. Sharps bins **should never** be placed in any waste bags or waste bins other than those designated for the collection of full rigid sharps containers prior to their consignment for disposal.
- Fluids of any sort are not discharged into bags or containers.
- Containers are not stored on the floor.
- Avoid prolonged use of sharps containers - maximum period of use is three months.
- Always store in a safe designated secure area i.e. in a locked area. Containers should never be placed in corridors or areas with access to the general public unless a specific risk assessment identifies the need.
- Sharps containers that are used at multiple sites and used by community teams should never be left at a patient's home.
- A sharps container that is left at patients own home for their own use needs to be risk assessed and consideration taken for positioning and storage.
- Whenever possible when a sharps container is not in use it should be stored securely/wall mounted to prevent risk of spillages.

- Ideally the sharps container should be taken to the point of care (unless this is identified as a risk) to ensure that the sharp is disposed of immediately following use.
- Disposal of sharps containers to be completed safely in accordance with Health Board procedures.

2.7 Information

The Sharps Regulations require the Health Board to provide health and safety information to staff. The information provided must cover:

- The risks from injuries involving medical sharps
- Relevant legal duties on staff
- Good practice in preventing injury
- The benefits and drawbacks of vaccination

3 TRAINING

- Training will be given to all staff in the use of safer sharps devices in use within their work area.
- Staff will receive training on the safe disposal of medical sharps and what to do if they receive a sharps injury.
- Training will be determined upon the level of risk that has been identified by the risk assessment. Training plans will be developed in line with annual training plans/training needs analysis in collaboration with Learning Education and Development and monitored via the normal performance management arrangements within the Clinical Boards.
- All staff must undertake Mandatory Infection Prevention and Control training on appointment and every three years.
- Training for those responsible for undertaking assessments will be undertaken as part the UHB programme of “Working Safely” courses.

4 REPORTING

All incidents of sharps injuries or near misses must be reported on the UHB Incident Reporting E Datix system. In the event of a needlestick or similar sharps injuries they must also be reported to the Occupational Health Department.

5 COMMUNICATION

Line Managers will be responsible for ensuring that staff are informed of the arrangements made in connection with the provision of Safe

Sharps Management on recruitment and periodically throughout their employment.

Notices of the location of first aid boxes and who the designated first aider is for the area shall be posted at prominent locations throughout the area.

The Sharps Management Procedure shall be available on the UHB intranet site. Paper copies of the procedure are also available from the Health and Safety Unit.

The requirements of the procedure shall be cascaded down to staff through the Clinical Board's Health and Safety and Quality and Safety Groups.

6 MONITORING AND MEASURING PERFORMANCE

Senior Managers, supported by Staff Health and Safety Representatives, will carry out monitoring of this procedure at annual intervals.

Safer Sharps arrangements for each area will be monitored as part of the UHB's Workplace Joint Health and Safety Audit Inspection Schedule.

The performance outcomes will be monitored by the Operational Health and Safety Group/Infection Prevention and Control Group and measured in line with the UHB Health and Safety Policy and reviewed on a regular basis.

7 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.

APPROVAL OF POLICY FOR FIRST AID AT WORK	
Name of Meeting : Health and Safety Committee	**Date of Meeting:** 18/07/2017

Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety - 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: £12k is allocated within the existing Health and Safety budget for First Aid Training.
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 2.1
CRAF Reference Number 6.4.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided through:

- Annual reports and training compliance.

The Health and Safety Committee is asked to:

- **APPROVE** the Policy for First Aid at Work
- **APPROVE** the full publication of the Policy for First Aid at Work in accordance with the UHB Publication Scheme

SITUATION

The previous First Aid at Work Policy is due for review. This policy reflects existing practice and requirements and therefore only contains minimal updates to the procedural arrangements, reflecting organisational changes.

BACKGROUND

The Health Board has a statutory obligation under the Health and Safety at Work etc Act 1974 to prepare and review its Health and Safety Policies, including the Policy for First Aid at Work.

The Health and Safety (First-Aid) Regulations 1981 require employers to provide adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work.

To deliver this requirement the Health Board must have an appropriate policy. The current policy has been reviewed and updated. The purpose of this report is to seek approval of the revised policy by the Health and Safety Committee.

In operating this policy it is the intention of the Cardiff and Vale University Health Board to comply with the Health and Safety (First Aid) Regulations 1981 and other legal and professional requirements relating to First Aid.

The scope of the policy is applicable to all premises, staff and users within the Health Board. The policy includes Executive, Manager and Staff responsibilities and resources.

ASSESSMENT

It is the policy of the Health Board to ensure adequate provision is made to enable administration of first aid in the event of a work related accident. This is achieved by ensuring that:

- There is adequate first aid provision and facilities for employees who may become ill or are injured at work.
- There are a suitable number of adequately trained persons for the rendering of first aid to staff if they are injured or become ill and training courses available.
- Staff is informed of the arrangements for the provision of first aid, including the location of equipment, facilities and personnel.
- Risk assessments of hazards within the workplace are undertaken.
- Information is communicated to all employees regarding the procedures to be followed in the event of an accident requiring first aid.
- Records of first aid administered are maintained utilising the Health Board Incident, Hazard and Near Miss Reporting Policy and form.

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholders and 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 5th June and 30th June 2017;
- The document was shared with the Operational Health and Safety Group.

Where appropriate comments were taken on board and incorporated within the draft document.
The primary source for dissemination of this document within the Health Board will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the Health Board internet site.

Reference Number: *UHB 093* **Version Number:** 3	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** 207

POLICY FOR FIRST AID AT WORK

Policy Statement

The Health and Safety at Work etc Act 1974 places a duty on the employer to ensure so far as is reasonably practicable the health, safety and welfare at work of all his employees. The Health and Safety (First Aid) Regulations 1981 requires that the Health Board provide such equipment and facilities are adequate in the circumstances for enabling first aid to be rendered to his employees if they are injured or become ill at work and ensure there is such number of suitable persons as is adequate for rendering first aid.

Policy Commitment

It is the policy of the UHB to ensure adequate provision is made to enable administration of first aid in the event of a work related accident.

It is the aim of the policy of Cardiff and Vale UHB to provide, such equipment, facilities and suitable number of persons as is adequate and appropriate for rendering first aid to our staff if they are injured or become ill at work.

Supporting Procedures and Written Control Documents

- Incident, Hazard and Near Miss Reporting Policy
- Procedure for First Aid at Work
- Risk Assessment and Risk Register Procedure

Other supporting documents are:

- The Health and Safety (First Aid) Regulations 1981
- The Guidance of the Regulations of First Aid

Scope

This policy applies to all of our 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 no impact

Policy for First Aid at Work	2 of 2	Approval Date: dd mmm yyyy
Reference Number: UHB 093		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

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	Director of Corporate Governance

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	May 2011	January 2012	3 yearly review of Policy
2	08/07/2014	20/05/2016	3 yearly review of Policy
3			

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

PROCEDURE FOR FIRST AID AT WORK

Introduction and Aim

This Procedure supports the Policy for First Aid at Work.

It is the aim of the policy and the procedure to provide, such equipment, facilities and suitable number of persons as is adequate and appropriate for rendering first aid to our staff if they are injured or become ill at work.

Objectives

The Objectives of the policy and procedure are to comply with the legal duties in relation to First Aid placed on the UHB by the following:-

- Health and Safety at Work etc Act 1974
- First Aid at Work Regulations 1981
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. Cardiff and Vale University Local Health Board
- To ensure there is adequate first aid facilities and competent response for staff that maybe injured at work within the UHB.
- Effectively manage first aid provision through the risk assessment process incorporated within the risk rating and risk profiling process.

Scope

This procedure applies to all of our 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 no impact.
Documents to read alongside this Procedure	• Policy for First Aid at Work • Incident, Hazard and Near Miss Reporting Policy

	• Risk Assessment and Risk Register Procedure • The Guidance of the Regulations of First Aid • The Health and Safety (First Aid) Regulations 1981
Approved by	Operational Health and Safety Group

Accountable Executive or Clinical Board Director	The Director of Corporate Governance
Author(s)	Head of Health and Safety

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			

1. INTRODUCTION

1.1 The Health and Safety at Work etc Act 1974 places a duty on the employer to ensure so far as is reasonably practicable the health, safety and welfare at work of all his employees. The Health and Safety (First Aid) Regulations 1981 requires that the Health Board provide such equipment and facilities as are adequate in the circumstances for enabling first aid to be rendered to his employees if they are injured or become ill at work and ensure there is such number of suitable persons as is adequate and for rendering first aid.

1.2 In October 2013 the First Aid Regulations were amended, removing the requirement for the Health and Safety Executive (HSE) to approve first aid training and qualification allowing the Health Board to be more flexible in how it manages the provision for first aid at work. It still however requires adequate number of First Aiders to be trained and available.

1.3 The number of first aiders is determined by the hazards present in each particular ward/department/workplace. Where there is no First Aider available an 'Appointed Person' must be provided at all times when employees are at work.

1.4 The need for the correct response and the provision of First Aid treatment once an accident has occurred can be of vital importance and in certain circumstances can mean the prevention of further injury or even death.

1.5 Where first aid is administered as a result of an accident at work, Cardiff and Vale University Local Health Board (UHB) is required by virtue of the Social Security (claims and payments) Regulations 1979 and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, to maintain records of the event, include details of the treatment given and those rendering assistance. The current incident reporting form meets the requirements of these statutory provisions.

1.6 First Aid treatment has two functions. Firstly, it provides treatment for the purpose of preserving life and minimising the consequences of injury or illness until professional help can be obtained. Secondly, it provides treatment of minor injuries which do not need the help of a Medical Practitioner or Nurse.

1.7 It is an inappropriate use of resource to use the Occupational Health Department and the Accident and Emergency Unit as an initial response to first aid needs. These services should normally only be accessed as a referred on service after treatment by a first aider.

1.8 This procedure applies to all directly and indirectly employed staff that are engaged by the UHB. This includes trainees and students and work experience staff, but excludes contractors who are required to have their own provision in place.

1.9 This policy does not relate to the provision for first aid response cover for patients and non employees, although UHB first aiders would normally respond within their skill limits to injuries to such people**.** In-patients would be treated by the clinical team. Cardiff and Vale University Local Health Board

2 DEFINITION OF TERMS

"First-aid" means:

(a) in cases where a person will need help from a medical practitioner or nurse, treatment for the purpose of preserving life and minimising the consequences of injury and illness until such help is obtained, and
(b) treatment of minor injuries which would otherwise receive no treatment or which do not need treatment by a medical practitioner or nurse;

3 POLICY STATEMENT

It is the policy of the UHB to ensure adequate provision is made to enable administration of first aid in the event of a work related accident.
This is achieved by ensuring that:-

3.1 There is adequate first aid provision and facilities for employees who may become ill or are injured at work.

3.2 There are a suitable number of adequately trained persons for the rendering of first aid to staff if they are injured or become ill.

3.3 Staff are informed of the arrangements for the provision of first aid, including the location of equipment, facilities and personnel.

3.4 A risk assessment of the hazards within the workplace is undertaken.

3.5 Ensuring that information is communicated to all employees regarding the procedures to be followed in the event of an accident requiring first aid.

3.6 Records of the first aid administered are maintained.

4 ROLES AND RESPONSIBILITIES

4.1 **Chief Executive** has overall responsibility for ensuring the arrangements are in place for the implementation of the First Aid Procedure.

4.2 **Director of Corporate Governance** has delegated responsibility at Executive Board level for the managing of health and safety and is responsible for ensuring;

4.2.1 There are sufficient resources for the implementation of this Procedure.

4.2.2 That this Procedure is appropriately disseminated throughout the Health Board.

4.2.3 The approach to first aid is both systematic and appropriate.

4.2.4 There are sufficient competent first aiders or appointed persons and trainers to support the Procedure.

4.3 **Executive Directors, Clinical Board Directors, Clinical Board Managers, Clinical Board Nurses, and Directorate Managers** have responsibility for managing the risk management process by:-

4.3.1 Ensuring that Risk Assessments have been undertaken which identify the hazards.

4.3.2 Ensuring the adequate provision of first aid equipment, facilities and First Aiders/Appointed Persons.

4.3.3 Ensuring that First Aiders/Appointed Persons are provided with appropriate training and attend regular re-qualification courses (every 3 years) and refresher courses (annually).

4.3.4 Ensuring that records of training provided to First Aiders/Appointed Persons are maintained.

4.3.5 Ensuring that all incidents requiring first aid are reported in accordance with the UHB Incident, Hazard and Near Miss Reporting Policy.

4.4 **Line/Departmental Managers**

4.4.1 The Line Manager will be responsible for ensuring that staff are informed of the arrangements made in connection with the provision of First Aid. This will include informing them of:

- Where the First Aid equipment is kept,
- What facilities there are, and
- The people appointed to provide the First Aid or take charge.

4.4.2 Ensuring that a risk assessment is conducted and subsequently safe systems of work are devised and implemented within their area.

4.4.3 Ensuring that adequate first aid boxes are provided and designated staff are appointed to control and maintain these boxes at all times.

4.4.4 Ensuring that approved notices are sited at prominent locations in their area, of:

- Location of First Boxes and
- Who are the Designated First Aiders for that location.

4.5 **Learning Education and Development**

The Learning Education and Development Department shall be responsible for:

4.5.1 Monitoring the effectiveness of first aid at work training.

4.5.2 Co-ordinating a Training Needs Analysis of First Aid provision.

4.5.3 Maintaining a record of appointed first aiders.

4.6 **Health and Safety Department**

The Head of Health and Safety shall be responsible for:-

4.6.1 Providing advice and information with regard to potential hazards in the workplace.

4.6.2 Advising on methods of risk assessment.

4.6.3 Auditing records of incidents involving first aid.

4.6.4 Monitoring and reviewing this Procedure, and advising on the UHB's position with regard to compliance with the Regulations and Approved Code of Practice.

4.6.5 Ensuring training providers are appropriately competent to deliver the required training and refresher training.

4.7 Occupational Health Department

The Occupational Health Department shall be responsible for:-

4.7.1 Ensuring the provision of counselling if required by a First Aider/ Appointed Person after responding to a major incident/accident.

4.8 Employees

All employees will comply with the provisions of the Health and Safety (First Aid) Regulations 1981 and the Approved Code of Practice 1997, in accordance with training and advice received. Every employee has a duty to:-

4.8.1 Ensure they are aware of their department/work areas procedures in the event of an incident requiring first aid.

4.8.2 Ensure they are aware of the department's first aid facilities and co-operate with the First Aider/Appointed Person.

4.8.3 Inform their Line/Department Manager of any conditions that would personally affect their ability to be treated by a First Aider/Appointed person.

4.8.4 Ensure all incidents are reported in accordance with the UHB Incident, Hazard and Near Miss Reporting Policy.

4.9 First Aiders/Appointed Persons

Employees who have been designated as First Aiders/Appointed Persons must ensure that:-

4.9.1 They attend an approved course as directed by the UHB.

4.9.2 Attend requalification and refresher courses as determined by the UHB.

4.9.3 The contents of First Aid Boxes and First Aid Rooms (where applicable) are fully stocked and replenished when stocks are used. Information can be found on the Health and Safety Intranet pages.

4.9.4 Records are kept of all incidents where they are required to administer first aid/respond to an emergency in accordance with the UHB Incident, Hazard and Near Miss Reporting Policy.

5 GENERAL ARRANGEMENTS

5.1 Risk Assessments

All workplaces will be subjected to an ongoing process of risk assessment in order to determine what first aid measures are necessary, and new or significantly changed workplaces will be assessed at the planning stages.

5.2 First Aider Provision

5.2.1 Those persons volunteering to undertake responsibilities as defined under the Health & Safety (First Aid) Act 1981 shall be properly trained and competent to perform their duties.

5.2.2 The regulations recognises that a qualified medical doctor (registered with the GMC) and a registered nurse, midwife or specialist community public health nurse registered with the NMC as having suitable qualifications for them to administer first aid. However if such staff are to be utilised, it will be necessary to verify that those staff have maintained their competency for carrying out first aid. This is achieved by mutual agreement between the Line Manager and the proposed First Aider.

5.2.3 All other staff designated as a First Aider must have attended an approved Health and Safety Executive “First Aid at Work (FAW)” Course and attends a FAW Requalification course at appropriate intervals (currently a maximum of three years). It is highly recommended that staff attend an annual 3 hour refresher course in order to maintain their FAW skills.

5.3 The Amount of First Aider Provision

5.3.1 The basic requirement for First Aider cover is that there is a designated person at all times staff are in that workplace. In low risk areas and times it may be sufficient to only have an appointed person.

5.3.2 Staff numbers should not be used as a sole basis for determining first aid needs, as even when a few people are involved at work there needs to be sufficient cover. First aid provision will be affected by:

- The geographical distribution of staff and remoteness from medical services.
- Past history and consequences of accidents.

- The nature and experience of staff.
- The particular need for/of employees potentially at greater risk, for example trainees and people with disabilities.
- The nature of any shift system in-place.
- The nature of the environment.

5.4 **Staff Working Away From Their Main Base**

Directorates will be responsible for ensuring that adequate arrangements are in place to meet the first aid needs of staff working away from their base. Where the risks to health and safety of regular travellers are comparatively low, the first aid available at their base is sufficient.

5.5 **Shared Location**

In shared or multi directorate locations, managers will be assigned responsibilities for their staff at such locations. It is however sensible for employers/managers to agree shared arrangements and staff will need to be informed. A written agreement between the UHB and other employers will be required in order to avoid misunderstanding. In these cases a full exchange of the risks and hazards involved should help to make sure that the shared provision is suitable and sufficient.

5.6 **Facilities and Equipment**

5.6.1 First Aid boxes are to be suitably and sufficiently stocked at all times as indicated by the risk assessment for any particular workplace. Information on required stock and stock levels can be found on the health and safety pages of the UHB intranet site.

5.6.2 Every department will assess whether a first aid room(s) is necessary. This may be a designated ward or treatment room.

5.6.3 The First Aiders/Appointed Persons are responsible for the contents of first aid boxes and first aid rooms at all times whilst at work.

5.6.4 First Aid kits should be fitted to all UHB owned vehicles and staff adequately trained in its suitable use.

6 TRAINING

6.1 Training will be determined upon the level of risk that has been identified by the risk assessment. Training plans will be developed in line with annual training plans/training needs analysis in collaboration with Learning Education and Development, and monitored via the normal performance management arrangements within the Clinical Boards.

6.2 All Appointed First Aider training must be provided by a competent organisation that meets the specified criteria within the First Aid Regulations. Accredited first aid certificates are valid for 3 years.

6.3 Training for those responsible for undertaking first aid risk assessments will be undertaken as part the UHB programme of “Working Safely” courses.

6.4 Appointed Persons will be given basic first aid training as part of the UHBs Resuscitation and Emergency First Aid training programme.

7 REPORTING

All incidents, including those requiring first aid, must be reported via the e-datix electronic reporting system.

8 COMMUNICATION

8.1 Line Managers will be responsible for ensuring that staff are informed of the arrangements made in connection with the provision of first aid on recruitment and periodically throughout their employment.

8.2 Notices of the location of first aid boxes and who the designated first aider is for the area shall be posted at prominent locations throughout the area.

8.3 The First Aid at Work Procedure shall be available on the UHB intranet site. Paper copies of the procedure are also available from the Health and Safety Unit.

8.4 The requirements of the procedure shall be cascaded down to staff through the Clinical Board Health and Safety Groups.

9 MONITORING AND MEASURING PERFORMANCE

9.1 Senior Managers, supported by Staff Health and Safety Representatives, will carry out monitoring of this procedure at annual intervals.

9.2 First Aid arrangements for each area will be monitored as part of the UHB's Workplace Joint Health and Safety Audit Inspection Schedule.

9.3 The performance outcomes will be monitored by the Operational Health and Safety Group and measured in line with the UHB Health and Safety Policy, and reviewed on a regular basis. It is essential that the management of first aid at work arrangements are discussed at local health and safety meetings.

10 RESOURCES

It is unreasonable to expect a department to fund training if the cover is geographic and benefits other areas. There is an identified resource to cover the costs of generic courses.

11 EQUALITY & DIVERSITY STATEMENT

Cardiff and Vale UHB 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 against individuals or groups on the basis of their ethnic origin, physical or mental abilities, gender, age, religious beliefs or sexual orientation.

Should a member of staff or any other person require access to this procedure in another language or format (such as brail or large print) they can do so by contacting the Health, Safety and Environment Department. Cardiff and Vale UHB will do its utmost to support and develop equitable access to all policies and procedures.
The Procedure has had an equality and health impact assessment and has shown there will be no adverse effect or discrimination made to any particular or individual group.

12 REVIEWING THE PROCEDURE

This procedure will be reviewed every three years or more frequently if required to ensure continued compliance with risk management guidance and health and safety legislation. It will be reviewed within the three year period if there are significant changes in legislation and/or an incident occurs that requires improvement in practices.

Equality & Health Impact Assessment for

Policy and Procedure for First Aid at Work

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Procedure for First Aid at Work
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive - Director of Corporate Governance Author - Head of Health and Safety 43751
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The Objectives of the policy and procedure is to comply with the legal duties in relation to First Aid placed on the UHB by the following:- • Health and Safety at Work etc Act 1974 • First Aid at Work Regulations 1981 • Management of Health and Safety at Work Regulations 1999 • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. Cardiff and Vale University Local Health Board • To ensure there is adequate first aid facilities and competent response for staff that maybe injured at work within the UHB. • Effectively manage first aid provision through the risk assessment process incorporated within the risk rating and risk profiling process.
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[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 of our staff in all locations including those with honorary contracts

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	No impact		

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] 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	No impact		
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	No impact		
6.4 People who are married or who have a civil partner.	No 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
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 FAW Policy does support training to staff to deal with expectant mothers.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	No impact		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No impact		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes	No 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
(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	No impact		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No impact		
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	No 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
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No impact		

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	No impact		

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
7.2 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 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	No impact		
7.3 People in terms of their income and employment status: Consider the impact on the	No impact		

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
availability and accessibility of work, paid/ unpaid employment, wage levels, 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 and safety of play areas and open spaces	FAW includes community workers.		

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
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	No impact		
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic	No impact		

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
development; biological diversity; climate Well-being Goal – A globally responsible Wales			

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 FAW Policy is overall natural; however it does support staff and enhances our ability to respond to pregnant staff at work and injuries.

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?	To continue to provide, such equipment, facilities and suitable number of persons as is adequate and appropriate for rendering first aid to our staff if they are injured or become ill at work.			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
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 proposa
  ○ continues unchanged as there are no significant negative impacts
  ○ adjusts to account for the negative impacts
  ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  ○ stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review				

HEALTH AND SAFETY COMMITTEE WORK PROGRAMME 2017 - 2018

Meeting Date / Agenda Item	January 2017	April 2017	July 2017	October 2017	January 2018
Priority Action Plan – **CRAF No's: 8.1.4, 6.4.7, 6.4.5, 6.4.4**	√	√	√	√	√
Policy Schedule **- CRAF No: 8.2.3**	√	√	√	√	√
Fire Enforcement Report – **CRAF No: 6.4.5**	√	√	√	√	√
Environmental Health Inspection Report – **CRAF No: 8.1**	√	√	√	√	√
Corporate Risk Assurance Framework Exceptions Report – **CRAF No: N/A**	√	√	√	√	√
Health & Safety Annual Report and presentation - **CRAF No's: 8.1.4, 6.4.7, 6.4.5, 6.4.4**			√		
Regulatory and Review Body Tracking Report – **CRAF No: 8.1**	√	√	√	√	√
Enforcement Agencies Report – **CRAF No: 8.1.4**	√	√	√	√	√
Review of Violence and Aggression Policy - **CRAF No: 8.2.3**		√			

Meeting Date / Agenda Item	January 2017	April 2017	July 2017	October 2017	January 2018
Review of Lone Worker Policy - **CRAF No: 8.2.3**		√			
Review of Minimal Manual Handling Policy - **CRAF No: 8.2.3**		√			
Review of Safe Working with Electricity Policy – **CRAF No: 8.2.3**	√				
Review of Waste Management Policy **– CRAF No: 8.2.3**		√			
Review of Water Safety Policy **– CRAF No: 8.2.3**		√			
Review of Stress and Mental Health Wellbeing in the Workplace Policy – **CRAF No: 8.2.3**			√		
Review of Management of Asbestos Policy – **CRAF No: 8.2.3**			√		
Review of First Aid at Work Policy – **CRAF No: 8.2.3**			√		
Review of Fire Safety Policy – **CRAF No: 8.2.3**			√		
Review of Sharps Management Policy – **CRAF No: 8.2.3**			√		

Meeting Date / Agenda Item	January 2017	April 2017	July 2017	October 2017	January 2018
Review of Incident, Hazard and Near Miss Reporting Policy – **CRAF 8.2.3**			√		
Waste Management Compliance Report – **CRAF No: 8.1.1**			√		√
Fire Annual Report - **CRAF No: 6.4.5**			√		
Healthcare Standards – **CRAF No: 5.16**					
Public Health Targets – Smoking - **CRAF No: 1.2.1**				√	
Internal Audit Reports with Health & Safety Inference – **CRAF No: 8.1**					
Lone Worker Devices Report – **CRAF No: 9.2**	√		√		
Health and Safety Management Audit – **CRAF Nos: 8.1.4, 6.4.7, 6.4.5, 6.4.4**					
Legionella/Water Safety Enforcement – **CRAF No: 8.1.4**	√				
Shared Services Fire Audit – UHL – **CRAF No: 6.4.5**			√		

REGULATORY AND REVIEW BODIES TRACKING REPORT – 1 APRIL 2017 – 31 MARCH 2018

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

RECOMMENDATION

The Committee is asked to:

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

SITUATION

This report is presented to the Committee to track that relevant Board Committees are receiving reports and information regarding inspections undertaken by the various inspection/review bodies as a key source of assurance. The report provides information for the period 1 April 2017 and 30 June 2017 and includes:-

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

BACKGROUND

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

- Food hygiene inspections undertaken by the Local Authorities;

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

ASSESSMENT

The attached report provides evidence that each category of review is assigned to an appropriate Board Committee or sub-Committee. It contains a summary of 3 inspections or regulatory visits of which:

- All took place during the period.

Fire Service Informal Notices

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

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Regulatory and Review Bodies Tracking Report - Reports Received and Inspections/Visits Undertaken - 1 April 2017 - 31 March 2018															
2	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 18th July 2017 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Comp lete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
3	**Health and Safety Executive**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety*** **Theme 3: Effective Care** ***Standard 3.5 Record Keeping***								
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2	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 18th July 2017 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Comp lete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
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9	**South Wales Fire and Rescue**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety***							
10	3 May 2017	27 April 2017	Ward B6 & C6 UHW	Surgery Clinical Board Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2 x Management		Director of Planning	IN02: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x Mangement actions dismissed by Fire Officer	On-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	18th July 2017		Yes
11	14 June 2017	8 June 2017	Hafan Y Coed Adult Mental Health Unit UHL	Mental Health	Audit of Fire Safety Arrangements	Failure to comply with the Regulatory Reform (Fire Safety) 2005		Director of Planning	Enforcement Notice	12 Point Action Plan developed	2 action points outstanding	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	18 July 2017	60 days from date of notice	Yes
12																
13	**Environmental Health - Cardiff and Vale County Councils**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety***							
14	20 June 2017	21 June 2017	Aroma Coffee Outlet, UHL	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed	Complete	Health and Safety Committee - Martyn Waygood		18 July 2017		
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2	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 18th July 2017 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
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32	**Environmental Health Office**								**Health and Care Standards**							
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154						Audit Committee - Ivar Grey										
155						Quality & Safety - Prof Elizabeth Treasure										
156						Strategic Planning & Performance - Prof Howard Young										
157						Workforce & Organisational Development - Prof Howard Young										
158						Mental Health Act Monitoring - Mutale Merrill										
159						Charitable Funds - Martyn Waygood										
160						Health and Safety - Martyn Waygood										
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165						Cardiff Council										
166						Clinical Pathology Accreditation (UK) Ltd										
167						Environment Agency										
168						General Medical Council (GMC)										
169						Health and Safety Executive										
170						Healthcare Inspectorate Wales										
171						Embryology Authority										
172						Human Tissue Authority										
173						Medicines and Healthcare Products Regulatory Agency										
174						South Wales Fire and Rescue										
175						Vale of Glamorgan Council										
176						Wales Audit Office										
177						Other										

HEALTH AND SAFETY PRIORITY ACTION PLAN 2017/18

1. Health and Safety Management

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**1.1**	A comprehensive programme of risk assessments to be completed with identified control measures implemented	Risk Assessment Procedure expanding the requirement so that assessments greater than 10 are validated and monitored	E-Datix risk has been purchased but it is understood there is no agreed implementation date.	Review of Risk Register and E-datix implementation.	Director of Corporate Governance	Red	High	Sep 2017
	1.2	Monitoring of Mandatory Training	Steering Group formed to enhance staff training compliance to target 85%+	Enhanced ESR has been implemented by lED/IMT – this has led to a lack of availability of data.	Progress mechanism for enhanced monitoring and accountability for increasing compliance at Clinical Board	Director of Workforce and OD	Amber	High	Sep 2017
	1.3	Health and Safety Compliance	Health and safety audit undertaken in hospital setting in 2016. Audit to be expanded to cover community and Estates areas.	Health and Safety and Estates are progressing a GAP analysis of statutory compliance.	Complete analysis	Head of Health and Safety	Amber	Mod	Sep 2017
	1.4	Health and Safety Management Training	The only formal management training offered by the Health and Safety Department is the Risk Assessment/Working Safely Course. The Estates Department Managers all undertake the IOSH Managing Safely Course	Training course under development with an aim of offering the course during July/August.	Complete course and place on ESR	Head of Health and Safety	Red	Mod	Sep 2017

2. Violence and Aggression

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
9.2	**2.1**	Have in place an action plan to ensure full and ongoing compliance with requirements of the All Wales Violence and Aggression Passport Scheme.	Lack of ability to release staff for training has also reduced compliance. A number of specialist programmes for training have been initiated. It has subsequently reviewed its prioritisation of training.	Training needs analysis is 100% complete. Trainers have been allocated CBs within the UHB to support Departments in improving their compliance	Review of training frequency and means of enhancing attendance.	Head of Health and Safety Chairs of Clinical Boards Health and Safety Group	Amber	High	Dec 2017
6.4.6	**2.2**	Sufficient Trained Staff to respond to personal attacks and safely restrain	Security Team not trained to required standard. Security team required to be of suitable size and deployed to respond to events.	Meeting between EU and Security and trainers has agreed a programme of developing a combined response team, with a two day training course on module D. Validation of suitability of Mental Health training completed. Training dates have been set up for January 2017. Further dates will be rolled out over the following months.	Issues around releasing staff to attend training. Commitment to undertake training required from EU and Security Services.	Head of Security Services	Amber	High	Sep 2017
	2.3	Ensure suitable protocol/procedure for restraint of patients with capacity.	The HB has protocols for the restraint of mental health patients, similar procedures are required for patients with capacity	Training course for paediatrics established. Preparation of procedure based off MH document being initiated. National project in calming the storm covering this feature.	Ongoing, awaiting the outcome of Calming the Storm process.	Head of Health and Safety/ Personal Safety Adviser	Amber	High	Sep 2017
6.4.6	**2.4**	Safe Haven facility	Safe Haven facilities available however there is a lack of facilities to treat high risk patients outside of Safe Haven	Issue raised and discussed at the Personal Safety and Security Strategy Group. Need for an additional area identified. Security available by arrangement. Meeting with	Personal Safety Adviser has progressed with Estates for suitable location. Estates have still not identified a suitable area	Personal Safety Adviser	Amber	Mod	Sep 2017

			requirements.	LCM regarding better communication.					
		Lone Worker							
6.4.6	**2.5**	Ensure effective implementation of Lone Worker system.	Each Clinical Board is given data of individual usage to pursue improvement. Target of 75%	Current compliance showing 74% compliance. Request sent to all CB's requesting confirmation that all lone workers at risk have suitable arrangements in place.	Response required from Clinical Boards regarding their arrangements.	V&A Group/ Chairs of Clinical Boards Health and Safety Group	Amber	Mod	Sep 2017
	2.6	Staff at risk has access to suitable lone worker system	Success of new system in demand outstripping budget.	Monitoring each Clinical Board and effective distribution of current budgeted devices.	If target of 80% usage is exceeded, make business case for management team to expand budget.	Head of Health and Safety/ Director of Corporate Governance	Green	Mod	July 2017

3. Manual Handling

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**3.1**	All staff involved in manual handling tasks require training to required standard and refreshed at the agreed intervals	Training Working Group formed led by Assistant Director of OD. Training frequency assessment (TFA) commenced	Working with LED and direct visits to hotspot areas.	Further development of ward based training.	Assistant Director of OD Head of Health and Safety	Amber	High	Dec 2017
6.4.1	**3.2**	LOLER compliance (Lifting operations, Lifting equipment regulations)	LOLER regulations require the inspection and maintenance of all lifting equipment including hoists and slings. Slings have previously been internally inspected, however HSE has indicated recently that this must be an independent assessment.	Procurement is reviewing contracts for servicing. This has resulted in a shortfall in service cover.	Issue new service agreement	Procurement	Amber	Mod	Oct 2017

8.4.1	**3.3**	LOLER – suitable and sufficient patient handling equipment is available.	Restricted finance has resulted in aged hoisting stock.	Delivery dates for new equipment established.	Complete and evaluate findings. **As 3.2**	Head of Health and Safety	Green	High	April 2017
6.4.1	**3.4**	The Health Board has a contract to maintain hoists.	A procurement review of maintenance contract has resulted in delays in repairs to key items which compromises patient care.	Meeting held with procurement to discuss a change to the servicing contract to a gold contract, this would speed up repairs this was decided against for cost reasons, existing level of service maintained , servicing only However with the replacement of 60 old hoists within the UHB it is anticipated the breakdowns will be less, but not diminished.	Complete management programme and mechanisms for speedy repairs.	Director of Capital, Estates and Facilities	Amber	High	Sep 2017

4. Health Issues

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**4.1**	Safe use of peracetic acid in sterilisation of medical instruments.	The use of peracetic acid is being introduced into four areas to sterilise instruments, this chemical is subject to COSHH being of higher hazard.	Specialist Adviser working with Clinical Boards to undertake monitoring and ensure controls are in place.	Based findings of monitoring, implement appropriate controls including spill response.	Chair of Surgery Health and Safety Group	Amber	High	Sep 2017
	4.2	Adherence to the No Smoking Policy.	Smoking policy in place and Enforcement Officer appointed. Smoking breaches being reported through fire and smoking meetings.	Position on E-ciggs clarified, supporting it's controlled use.	Develop guidance on usage to include fire risk.	Head of Health and Safety/ Director of Public Health	Amber	High	Sep 2017
	4.3	DSEAR compliance to regulations	Reports have identified that some areas within	Environmental form developed	Implement form.	Head of Health and	Amber	High	Sep 2017

		requires area of potential explosives to be assessed and control measures in place.	Laboratories require assessment.			Safety/ Health and Safety and Environmental Adviser			
	4.4	Hydrotherapy Pool	Evidence shows variance of agreed standards – lack of monitoring at the required frequency and outstanding maintenance issues.	Work has been initiated.		Head of Operations and Delivery for CD&T/ Director of Capital, Estates and Facilities	Green	High	July 2017

5. Health & Safety Patient and Environment Safety

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
6.4.1	**5.1**	Window Closures A programme of work is required to fit anti tamper devices to the in place ligature closures.	Not all windows above the ground floor are fitted with 100mm restrictors. A programme of work has been undertaken to replace all high risk areas. Medium and lower risk areas are still required for action	Survey and risk assessment of all windows above the ground floor has been completed. Action has been taken to rectify those windows which failed to meet the required standard.	Further work on anti tamper screws to be initiated to meet hazard alert guidance.	Director of Capital, Estates and Facilities	Amber	Mod	Sep 2017
6.4.4	**5.2**	Legionella – Legionella Policy and Water Safety Group	Legionella Policy approved and Water Safety Group established	Policy approved at Health & Safety Committee, making Water Safety Group a subcommittee of said Committee. The HSE has lifted the enforcement notice.	Review of flushing and auditing of compliance. Water Safety Group to monitor compliance.	Director of Capital, Estates and Facilities/ Head of Health and Safety	Amber	High	Sep 2017

	5.3	Low use water outlets are flushed at agreed intervals.	HSE inspection and audit show poor compliance to flushing regime	Estates are developing a revised log sheet and have implemented a monthly regime of compliance monitoring.	Implement Action Plan	Clinical Boards	Amber	High	Sep 2017
	5.4	Record Storage - The organisation has the requirement to safely store its mandated records for the agreed periods.	There is insufficient suitable storage for all records particularly in relation to archived records in the community.	Further storage procured at Nant Garw and project to enhance greater usage of scanning.		Head of Operations and Delivery - CD&T	Green	Mod	July 2017
	5.5	Patient showering equipment	An audit of the Manual Handling Equipment identified that some of the showers in inpatient care did not have suitable shower trolleys and chair for the patient type in that area amounting to 92 shower chairs and 17 shower trolleys	Shower chairs due for delivery in June to enhance patient experience.		HOD's – Clinical Boards	Green	Mod	July 2017
	5.6	Bariatric Patient Care	Risks have been identified of emergency evacuation of bariatric patients in care above the 1st floor. Limited availability for weighing patients	Meeting with Assistant Director of Nursing – progressing issues on care basis with Nursing Director.	Progress UHW risk.	Assistant Director of Nursing	Red	Mod	Sep 2017

	5.7	Moving fallen patients	Hover Jacks have been procured for UHW & UHL to safely move fallen patients with risk of spinal injuries	2 devices purchased from CB budget.		Head of Health and Safety	Green		March 2017
	5.8	Monitoring Schedule	A programme schedule of environmental monitoring to confirm health and safety compliance.	A priority monitoring programme has been introduced to ensure that these areas of risk are completed.	Implement Priority Programme	Head of Health and Safety	Amber	Mod	Sep17

6 Fire Safety Management

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
6.4.5	**6.1**	Firecode	All staff within the organisation are required to be provided with Fire Safety Training. The organisation is at approximately 50% compliance.	Fire Policy submitted for approval. Training improvements being pursued through PPP.	Planned "toolbox" talks to wards by Fire Advisers to enhance local knowledge. Each Clinical Board to monitor local compliance. Fire Policy approved at July 2015 meeting	Director of Planning	Red	High	Sep 2017
6.4.5	**6.2**	Fire Compartmentation	Programme of improved fire compartmentation initiated	Fire Annual Report presented to January 2014 Health and Safety Committee. Follow up report for April 2014 meeting	Health and Safety Committee to review and consider risks associated with fire dampers/compartmentation. 2015 Fire Annual Report presented to January 2015 meeting.	Director of Capital, Estates and Facilities	Amber	High	April 2018
6.4.5	**6.3**	Fire Risk Assessments are required to be completed for all areas.	Fire Risk Assessments shows no direct progress. Revision of Deputy Fire Safety Manager responsibility and local area ownership.	Deputy Fire Safety Managers meetings and agreement via HOD's of DFSM areas. Progress reports on actions to be submitted to the Health and Safety Committee.	Revised protocol for action	Head of Health and Safety	Green	High	March 2017

7. Estates H&S Management

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
6.4.7	**7.1**	Asbestos	Implement Asbestos Management Plan	The Asbestos Management Plan has been implemented. The Asbestos Management Group meets quarterly. Permanent resources now recruited and AMP and Policy updated. Internally provided UKATA accredited Category A (Asbestos Awareness) and externally provided UKATA Category B (Asbestos Non-licenced Tasks) training undertaken. Training is complete for all estates maintenance staff. Asbestos Permit to Work procedures and book in place for work undertaken by contractors and all contractors are required to have attended UKATA Asbestos Awareness as a minimum.	Re-inspection program is ongoing with completion anticipated at the end of December including all database updates. Newly identified ACM's require remediation and/or implementation of appropriate management controls. Audit processes have been reviewed and enhanced. Asbestos Permit to Work procedure needs to be audited and monitored. Additional audit forms are completed by the independent analyst for most asbestos removal projects undertaken.	Director of Capital, Estates and Facilities	Amber	High	Sep 2017
6.4.7	**7.2**	Asbestos compliance	Policy and AMP requires only controlled breach of asbestos	Enhanced contractor control introduced.	Each Clinical Board to ensure implementation requirements of Contractors Control Procedure.	All	Amber	High	Sep 2017
6.4.1	**7.3**	Back log maintenance of the UHB Estate Impact: Resources available to estates in line with an increasing burden of ageing physical infrastructure,	A programme of estate rationalisation and modernisation in place across the UHB estate. Wherever possible capital projects are linked to	Regular reviews of estate condition via Estate Property Appraisals. Health and Safety Committee informed at October 2013 meeting that backlog maintenance items include equipment that has passed it replacement date but was still	Report to be prepared to identify that there is an appropriate system for prioritising and monitoring failed equipment with Health and Safety implications. Results of the property appraisal presented to	Director of Capital, Estates and Facilities/ Director of Therapies and Health Sciences (for medical	Red	High	Sep 2017

		bringing increased maintenance costs and increased refurbishment costs.	improvement and eradication of backlog maintenance to maximise impact of investment. Major refurbishment programme being developed but will require significant WG investment. Maintenance funds are subject to a rigorous risk assessment procedure to establish prioritisation of resources.	functional	October 2014 Health and Safety Committee. Committee updated on scale of problem, priorities reflected in the IMTP. A complete “risk based” Service Board – “Building Services Review” currently taking place for submission of a Business Case to Health Board and Welsh Government.	equipment) Director of Planning			
6.4.2	**7.4**	Passenger lift safety	The Health Board operates a system of maintaining its responsibilities to inspect and maintain lifts through a planned inspection and maintenance programme. Recent inspections identified defects that require these to be taken out of service.	Current regime showing improved HSE Compliance.	Continued monitoring of lift failures and HSE concern.	Director of Capital, Estates and Facilities	Green	High	July 2017
6.4.4	**7.5**	Legionella Survey and Risk Assessment		Survey initiated has identified a number of remedial actions are required. 10 new risk assessments for UHW carried out this year in high risk areas. Risks currently being prioritised	Remaining original RA for UHW and UHL (2 year to 4 year old) is currently having urgent and high risks collated and prioritised. RA to all clinics currently in	Director of Capital, Estates and Facilities	Red	High	April 2018

				and some actions taken.	progress. Completion due in next two weeks.				

8. Sharps Safety

CRAF Ref	Ref	Requirement	Status July 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**8.1**	Enhanced protection for staff against needlestick injuries and implement requirements of the EU Directive	Improvements in protocols and safer sharp boxes noted in annual report. Progress reports submitted to Health and Safety Committee	Safety Cannula, needless catheter bags and safety lancet implemented.	Review of other safety devices. Audits received from clinical areas to be reviewed to identify further use of safety sharps devices.	Head of Health and Safety/Health and Safety Adviser – Sharps Lead	Green	Mod	July 2017

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WASTE COMPLIANCE REPORT	
Name of Meeting: Health and Safety Committee	**Date of Meeting** 18 July 2017

Executive Lead : Director of Planning
Author : Facilities Manager, 029 20741831
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Service Priorities" elements of the Health Board's Strategy.
Financial impact : £1k and £250k per offence for non compliance
Quality, Safety, Patient Experience impact : • Sharps boxes not identifiable to the area where waste is being produced • Contamination of landfill sites may result with a significant financial cost to the UHB for disinfection. • Waste not packaged for transportation correctly • UHB reputation could be brought in to disrepute through negative press or illegal disposal of waste.
Health and Care Standard Numbers 1.1, 2.1, 2.4, 2.6, 2.8, 2.9 and 3.1
CRAF Reference Number 8.1.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE RECOMMENDATION

The Health and Safety Committee is asked to approve the Waste Compliance report as assurance of compliance against the Hazardous Waste Regulation 2005 (Amended 2009) and other associated waste Legislation.

Overall compliance with the Hazardous Waste Regulations 2005 (Amended 2009) and other waste legislation remains consistently high at 99%. Compliance has improved by 0.5% compared to the previous report presented to the Health and Safety Committee in September 2016.

ASSURANCE

During the period November 2016 and April 2017 a total of 265 internal waste audits have been undertaken, 4,883 samples were taken to assess compliance with the Hazardous Waste Regulations 2005 (Amended 2009) the overall compliance was 99%.

Of the 4883 samples taken 9 non conformities (0.2%) were identified against the Environmental Protection (Duty of Care) Regulations (1991) and Hazardous Waste Regulation 2005 (Amended 2009) were identified, of those;

- 5 yellow sharps (0.7%) were unidentifiable to the area where waste was produced
- 4 orange sharps (0.8%) were identified as containing medication or

unidentifiable to the area

Samples audited:-

Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
654	914	32	27	1175	675	715	521	170

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

2016-17	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
Nov	100	100			100	100	100	83	100
Dec	100	100	100		100	100	100	100	100
Jan	100	100	100	100	100	100	100	100	100
Feb	100	100	100	100	100	100	100	100	100
March	100	100	100	100	100	100	98.1	98.7	100
April	100	100	100	100	100	100	100	100	100
Total	**100**	**100**	**100**	**100**	**100**	**100**	**99.7**	**97**	**100**

The table below shows comparative compliance per waste stream between March and August 2016, the compliance against the Environmental Protection (Duty of Care) Regulations 1991 and Hazardous Waste Regulation 2005 (Amended 2009) was 99.1%.

2016	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
March	100	100	100	100	99.2	100	95.9	99	100
April	100	99.4	100	100	98	98	100	94.7	100
May	100	100	100		98.8	100	100	100	100
June	100	100	100		100	100	95	94	95.5
July	100	100	100	100	100	100	95.5	100	93.5
Aug	100	100	100	100	100	100	96	100	100
Total	**100**	**99.9**	**100**	**100**	**99.3**	**99.7**	**97.1**	**97.95**	**98.17**

Overall compliance with the Hazardous Waste Regulations 2005 (Amended 2009) and other waste legislation remains consistently above 95%.

Lone Worker System Progress Report
Name of Meeting : Health and Safety Committee **Date of Meeting** 18/07/2017

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

The Health and Safety Committee is asked to:

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

SITUATION

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

BACKGROUND

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

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

A new lone worker contract was implemented in June 2016 replacing the previous system which was five years old and many devices had a short battery life. The new system has a much improved device and greater flexibility of system.

Some concern was raised in relation to the poor usage for these devices which was shown to be at around 25%.

ASSESSMENT AND ASSURANCE

A Lone Worker Subgroup has continued to meet and have agreed suitable performance indicators of 80% utilisation and to respond by device against any non usage.

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

Number of Contracted Devices

	Nov	Dec	Jan	Feb	Mar
Reliance 15/16	626	604	600	600	600
Skyguard 16/17	457	480	487	576	613

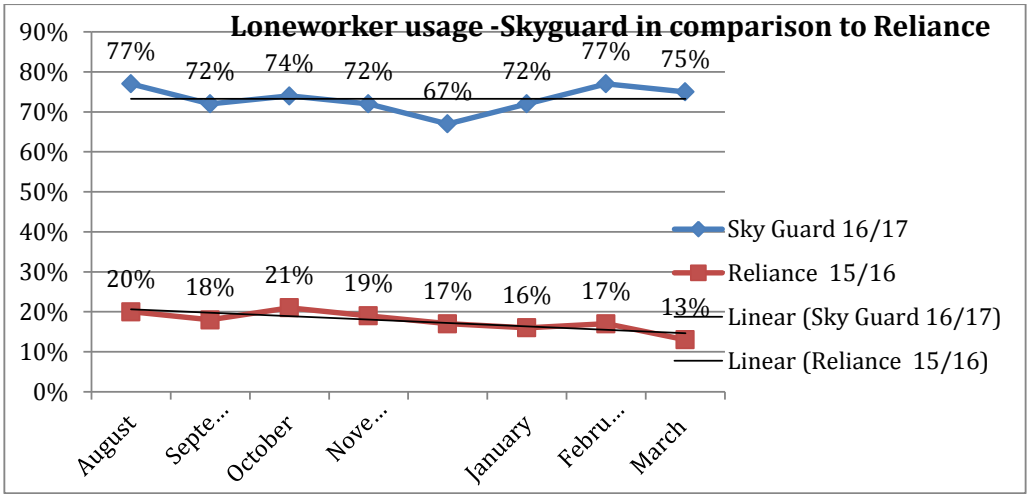
The Clinical Boards currently have 613 Skyguard devices in use, this compares to the 600 devices which were in use prior of the Reliance System (excluding the termination period).

To give assurance to the Committee the Head of Health and Safety wrote to all relevant Clinical Boards and Managers asking for confirmation that those people in lone worker situations in the community at risk, were either issued with a lone worker device or the Local Manager had undertaken an appropriate risk assessment and instituted suitable alternative arrangements.

This was reiterated at the Operational Health and Safety Group and the Health and Safety Department are progressing those areas that have yet to formally respond.

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

Percentage Utilisation



The above overall data shows that average utilisation was 73.25%, for the 8 month period from 1st August 2016 to the 31st March 2017.

This demonstrates a significant improvement over the previous system and relates to an extremely high level of compliance given the likelihood of non usage due to holidays and term time working and sickness absence.

The system administrator passes details on to each Clinical Board of non usage by name, for local review and remedial action.

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

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

FOOD HYGIENE INSPECTION BARRY HOSPITAL KITCHEN
Name of Meeting : Health and Safety Committee **Date of Meeting** 18 July 2017

Executive Lead : Director of Planning
Author : Operational Services Manager (South) 02920 716357
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact : Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient, staff and visitor experience. A UHB food safety document template has been finalised and is being used throughout catering services.
Health and Care Standard Number 2.1 and 2.5
CRAF Reference Number:
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The maintenance of the current Food Hygiene Rating of 5 (very good)

The Health and Safety Committee are asked to:

- **NOTE** the Food Hygiene Rating of 5/5 and remedial actions have been completed

SITUATION

An inspection of the Barry Hospital Kitchen, Colcot Road, Barry, took place on 21st February 2017, the outcome of which was confirmed in writing in a letter report dated 2nd March 2017, from the Commercial Services Officer – Food Safety & Port Health (Cardiff).

In this report it was noted that the Barry Hospital Kitchen was given a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an annual inspection by the Environmental Health department.

ASSESSMENT AND ASSURANCE

On receipt of the letter report from the Commercial Services Officer, an action plan was developed by the Operational Services Manager (South) to address the issues raised and is attached as an appendix to this report**.** This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Estates & Facilities

SCHEDULE A			
Food Hygiene & Safety Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
On discussing the handling of raw foods it was identified that the breakfast staff may be handling raw eggs in the main kitchen area. As discussed this should be in the raw preparation area as this will limit any risk of cross contamination. *EC Regulation 852/2004, Annex II, Chapter IX, paragraph 3*	• Staff informed 28/02/17	Immediate/Completed	OSM
The cling film dispenser for the raw area was missing at the time of my visit and could not be located. I was concerned that, as there were several other dispensers in the kitchen, that it could have been moved to another area. A replacement dispenser should be obtained, labelled as for raw only, and kept in the raw meat area. *EC Regulation 852/2004, Annex II, Chapter IX, paragraph 3*	• Staff informed 28/02/17 • Dispenser replaced for raw use only and sign placed on top of the dispenser.	Immediate/Completed Immediate/Completed	OSM OSM
Please also ensure the use of separate cling film is detailed within your Food Safety Management system in relation to the control of cross contamination.	• Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 • Amended HACCP document implemented and staff informed 03/03/17	Immediate/Completed Immediate/Completed	OSM OSM

Structural / Cleaning Issues	Management Response / Action	Time Scale / Update	Lead
No issues were identified under this category at the time of the inspections			
Confidence in Management / Control Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
The temperature monitoring records indicate that temperatures of 0-8°C are used for chilled foods (other than sandwiches). I would draw your attention to the Listeria Guidance issued by the Food Standards Agency where all ready to eat foods must be kept at below 5°C to reduce the risk. The records and Food Safety Management System should be amended to address this. *EC Regulation 852/2004, Article 5* *A copy of the full guidance can be found at https://www.food.gov.uk/science/microbiology/listeria for your reference.*	• Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 • Amended HACCP document implemented and staff informed 03/03/17	Immediate/Completed Immediate/Completed	OSM OSM
It was identified that staff are not using the defrosting monitoring sheets. In compliance with your own procedures these sheets must be used when defrosting foods. *EC Regulation 852/2004, Article 5*	• Staff informed 28/02/17 and re-training of how the form is to be completed for defrosting	Immediate/Completed	OSM

When asked about cooking temperatures the kitchen staff directed me to a chart on the wall which indicated three time / temperature combinations for cooking. However the temperature records only make reference to 75°C for 30 seconds. There is a possibility that staff may pick different temperatures from that required by the system, and so the wall chart should be removed to avoid confusion and the paperwork made clear on the time / temperature combination required. *EC Regulation 852/2004, Article 5*	• Chart removed and paperwork amended	Immediate/Completed	OSM
The hot holding monitoring form needs to be revised to remove the mention of serving periods / checks that are no longer required due to a change in how the food service operates (for example the mid-service temps are redundant). *EC Regulation 852/2004, Article 5*	• Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 • Amended HACCP document implemented and staff informed 03/03/17	Immediate/Completed Immediate/Completed	OSM OSM
SCHEDULE B - RECOMMENDATIONS			
These recommendations provide advice on good practice. I would recommend that any equipment that is used for raw foods (i.e. the red board, knives etc) is kept separate from all other equipment after washing. As you currently wash all items through the dishwasher this is only a recommendation of further good practice at this stage – however if you need to wash	• All raw equipment i.e. the red board, knives, etc. kept separate in the raw food preparation area	Immediate/Completed	OSM

by hand (for example in the event of the dishwasher breaking down) then this would become a requirement.			
I was advised that a black handled knife is used for cutting open packs of raw food. I would strongly recommend that you stick to colour coding for all utensils to avoid confusion and obtain a red handled knife for this purpose.	• Staff informed 28/02/17 • Red handled knife in place	Immediate/Completed Immediate/Completed	OSM OSM
At the time of the inspection I asked about any food being prepared or stored on the wards and was advised that this didn't take place. However on reviewing the HACCP documentation that was subsequently sent to me I note that there is a section in the monitoring records which includes a section for monitoring fridges in ward based kitchens. It also appears in the cleaning schedule. If this does not occur any more then any redundant sections should be removed.	• Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 • Amended HACCP document implemented and staff informed 03/03/17	Immediate/Completed Immediate/Completed	OSM OSM

Key - OSM Operational Services Manager (South)

Barry Hospital Food Hygiene Inspection Report Action Plan (March 2017)

Schedule A - Food Hygiene and Safety Procedures	Management Response / Action	Time Scale / Update	Lead
On discussing the handling of raw foods it was identified that the breakfast staff may be handling raw eggs in the main kitchen area. As discussed this should be in the raw preparation area as this will limit any risk of cross contamination.	Staff informed 28/02/17.	Immediate / Completed	**OSM**
The cling film dispenser for the raw area was missing at the time of my visit and could not be located. I was concerned that, as there were several other dispensers in the kitchen, that it could have been moved to another area. A replacement dispenser should be obtained, labelled as for raw only, and kept in the raw meat area.	Staff informed 28/02/17. Dispenser replaced for raw use only and sign placed on top of the dispenser.	Immediate / Completed Immediate / Completed	**OSM** **OSM**
Please also ensure the use of separate cling film is detailed within your Food Safety Management system in relation to the control of cross contamination.	Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 Amended HACCP document implemented and staff informed 03/03/17	Immediate / Completed Immediate / Completed	**OSM** **OSM**
Confidence in Management / Control Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
The temperature monitoring records indicate that temperatures of 0-8°C are used for chilled foods (other than sandwiches). I would draw your attention to the Listeria Guidance issued by the Food Standards Agency where all ready to eat foods must be kept at below 5°C to reduce the risk.	Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 Amended HACCP document implemented and staff informed 03/03/17	Immediate / Completed Immediate / Completed	**OSM** **OSM**
It was identified that staff are not using the defrosting monitoring sheets. In compliance with your own procedures these sheets must be used when defrosting foods.	Staff informed 28/02/17 and re-training of how the form is to be completed for defrosting.	Immediate / Completed	**OSM**
When asked about cooking temperatures the kitchen staff directed me to a chart on the wall which indicated three time / temperature combinations for cooking. However the temperature records only make reference to 75°C for 30 seconds. There is a possibility that staff may pick different temperatures from that required by the	Chart removed and paper work amended.	Immediate / Completed	**OSM**

Barry Hospital Food Hygiene Inspection Report Action Plan (March 2017)

system, and so the wall chart should be removed to avoid confusion and the paperwork made clear on the time / temperature combination required.			
The hot holding monitoring form needs to be revised to remove the mention of serving periods / checks that are no longer required due to a change in how the food service operates (for example the mid-service temps are redundant).	Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 Amended HACCP document implemented and staff informed 03/03/17	Immediate / Completed Immediate / Completed	**OSM** **OSM**
Schedule B – Recommendations, Advice and Information			
I would recommend that any equipment that is used for raw foods (i.e. the red board, knives etc) is kept separate from all other equipment after washing. As you currently wash all items through the dishwasher this is only a recommendation of further good practice at this stage – however if you need to wash by hand (for example in the event of the dishwasher breaking down) then this would become a requirement.	All raw equipment i.e. the red board, knives, etc. kept separate in the raw food preparation area.	Immediate / Completed	**OSM**
I was advised that a black handled knife is used for cutting open packs of raw food. I would strongly recommend that you stick to colour coding for all utensils to avoid confusion and obtain a red handled knife for this purpose.	Staff informed 28/02/17 Red handled knife in place	Immediate / Completed Immediate / Completed	**OSM** **OSM**
At the time of the inspection I asked about any food being prepared or stored on the wards and was advised that this didn't take place. However on reviewing the HACCP documentation that was subsequently sent to me I note that there is a section in the monitoring records which includes a section for monitoring fridges in ward based kitchens. It also appears in the cleaning schedule. If this does not occur any more then any redundant sections should be removed.	Barry Hospital Hazard Analyses Critical Control Point (HACCP) document amended 03/03/17 Amended HACCP document implemented and staff informed 03/03/17	Immediate / Completed Immediate / Completed	**OSM** **OSM**

Key - OSM Operational Services Manager (South)

AROMA COFFEE OUTLET UNIVERSITY HOSPITAL LLANDOUGH (UHL) FOOD HYGIENE INSPECTION – 20th June 2017
Name of Meeting : Health & Safety Committee **Date of Meeting :** 18 July 2017

Executive Lead : Director of Planning
Author : Commercial Services Manager
Caring for People, Keeping People Well Consistent implementation of the documented Food Safety Management System will ensure compliance with Food Safety Regulations and provide a safer experience for all stakeholders.
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard : 2.1 and 2.5 **CRAF Reference Number**
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The maintenance of the Food Hygiene Rating score of **5 (Very Good).**

RECOMMENDATION

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Environmental Health, Food Safety) report.

SITUATION

An inspection of the Aroma Coffee Outlet at the University Hospital Llandough took place on 20th June 2017 the outcome of which was confirmed in writing in a letter report dated 21st June 2017 from the Commercial Services Officer, Environmental Heath Food Safety, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Aroma Coffee Outlet at the University Hospital Llandough was given a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

BACKGROUND

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

ASSESSMENT AND ASSURANCE

On receipt of the letter report, an action plan was developed by the Commercial Services Manager to address the issues raised and is attached as appendix 1 to this report**.** This will be monitored within the service.

Appendix 1

Action Plan from Food Safety Inspection on 20th June 2017 (Report dated 21st June 2017)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures	Response / Action	Time Scale	Update
1. At the start of the inspection the wash hand basin was obstructed with a blue cutlery tray. Then later in the inspection a sink filter was placed in the wash hand basin. In addition the large green bin was stored in front of the wash hand basin. As discussed on site the wash hand basin must be used for hand washing only. In addition you must not store items in front of the wash hand basin as this can obstruct easy access. The bin was moved during the inspection. You must ensure the wash hand basin remains free at all times. ***Regulation (EC) No. 852/2004, Annex II Chapter 1 Para 4***	Staff instructed to ensure that access to wash hand basin is maintained and wash hand basin is used for hand washing only.	Immediate	Completed
2. One of the tubs of probe wipes in circulation had dried out as the lid had been removed. You must ensure that the lid of the probe wipes is replaced after use to ensure the probe wipes remain moist and effective in sanitising the probe. ***Regulation (EC) No. 852/2004, Annex II Chapter V Para 1(a)***	Staff instructed to ensure that lid to tub of probe wipes is kept closed when not in use. Staff to further check that wipes are moist.	Immediate	Completed

Structural / Cleaning Issues	Response / Action	Time Scale	Update
1. There was food debris to the casing of the	Probe to be cleaned thoroughly.	Immediate	Completed

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temperature probe. You must ensure the probe and probe casing remains clean at all times. ***Regulation (EC) No. 852/2004, Annex II Chapter V Para 1(a)***			
2. There was some debris and coffee beans under the main fridge. You must ensure that when the floors are cleaned attention is paid to under and around appliances. ***Regulation (EC) No. 852/2004, Annex II Chapter 1 Para 1***	Floor under main fridge to be cleaned thoroughly.	Immediate	Completed
3. There was a build-up of debris to the corner of the open sandwich chiller. You must ensure attention is paid to the corners of the chiller unit when cleaning. ***Regulation (EC) No. 852/2004, Annex II Chapter V Para 1(a)***	Sandwich chiller fridge to be cleaned thoroughly including internal corners.	Immediate	Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
1. It was pleasing to note that you were implementing your HACCP document and that your temperature records were completed and up to date, however the following gaps were identified: • You stated that all food is prepared in the main hospital kitchen and transported to the café on a trolley. You had not included the process of transportation in your HACCP document. You advised that your controls were to use heat boxes to ensure the food is transported above	Aroma HACCP documentation to be updated accordingly with main food production area.	Immediate	Completed

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63^{o}C. You must ensure these control measures are documented in your HACCP.			
• You stated that in the summer months you may prepare smoothies. You must ensure that the mixer and other equipment used for making smoothies are included in your cleaning schedule.	Smoothies not sold at current time. If implemented the HACCP document will be amended to reflect use of mixer and other equipment.	Immediate	Completed
• The cleaning schedule was very basic and stated that D10 and blue roll was used. As discussed on site cleaning of surfaces is a 2 stage cleaning process which you state you follow, therefore this should be documented. This can then be used by staff as a point of reference to ensure all equipment and fixtures are cleaned correctly.	HACCP documentation to be amended to include and clearly outline two stage cleaning process.	Immediate	Completed
• Chopping boards had not been included in your daily cleaning schedule. You must ensure all equipment is included in your cleaning schedule. For complex equipment such as meat slicers/mixers you must have a written detailed cleaning regime. ***Regulation (EC) No. 852/2004, Article 5***	Cleaning of equipment including chopping boards to be clearly outlined with suitable instructions to follow for staff.	Immediate	Completed

Schedule B – Recommendations, Advice & Information

Recommendations	Response / Action	Time Scale	Update
• At the time of the inspection you had one sandwich and cake display unit which was held	Products in ambient storage held for no more than 4 hours. Products for refrigeration to be	Immediate	Completed

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at ambient. You advised that you ensure the sandwiches are used within 4 hours (including preparation time). You advised that this is done for product quality reasons only. As advised on site the safest method to store high risk sandwiches is under refrigeration below 8^{o}C. I would recommend storing these products in the chiller.	reviewed.		
• You had started to compile an Allergen information chart for products on site and had assessed all the cakes and some sandwiches. I would recommend continuing this for all products sold within the Coffee bar. Guidance in relation to how to comply with the allergen labelling requirements can be found at https://www.food.gov.uk/business-industry/allergy-guide An interactive food allergy training tool can be found at food.gov.uk/allergy-training	Document in situ but information chart with additions to be completed for all Aroma products.	21 July 2017	In progress

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MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9.30AM on THURSDAY 15th MARCH 2017 – HEALTH AND SAFETY TRAINING UNIT - LLANDOUGH

Present:

Peter Welsh	**Director of Corporate Governance – Chair**
Charles Dalton	Head of Health and Safety
Caroline Murch	Health and Safety Adviser
Rachael Daniel	Health and Safety Adviser
Rachael Sykes	Health and Safety Adviser
Karen Lewis	Claims Manager
Stuart Egan	Staff Representative
Catherine Salter	Staff Side Representative
Clinical/Service Board Representatives	
Jon McGarrigle	Estates Services
Ian Wile	Mental Health Services
Linda Walker	Surgery Services
Heather Gater	Women and Children
Rowena Griffiths	Dental Services
Nikky Bevan	Occupational Health
Faye Mortlock	Infection Control

Apologies:

Clive Morgan	Assistant Director of Therapies
Tina Bayliss	Deputy Director of Operations
Frank Barrett	Senior Fire Adviser

OHSG: 01/17 Minutes of the Meeting held December 2016

The minutes of the meeting held on the 1st December 2016 were accepted as a true record.

OHSG: 02/17 Action Log

All items were completed or agenda, with the exception of Item 45/16 PI Claims, progress and report was submitted however, Chair requested a report to include an analysis of the trend for the year.

OHSG: 03/17 Feedback from Health and Safety Committee

The Health and Safety Adviser – Miss R Daniel brought the Groups attention to the Health and Safety Committee feedback report, highlighting items that were discussed at the Committee in January 2017.

Here is a list of items discussed and noted in the report:-

- Corporate Risk Assurance Framework
- Legionella Enforcement Notice Report
- Fire Safety Management and Enforcement Report
- Health and Safety Priority Action Plan
- Lone Worker Progress Report

It was noted that many of these items are also an Agenda item for this meeting and will be discussed in full.

OHSG: 04/17 Enforcement Agencies Correspondence Report

The report was presented and considered by the Group.

The Head of Health and Safety – Mr C Dalton updated the Group on the Health Boards position in relation to the following issues:-

Passenger Lifts
It was reported that Estates were making improvements in relation to passenger lifts and the HSE were happy with the Health Boards efforts. It was noted that an action plan is being implemented to replace some of the problematic lifts with the aim to prioritise high risk areas.

It was highlighted that this is not site specific, but a Health Board Wide approach.

Hydrotherapy Pool
The action plan continues to be progressed with an aim of standardising the approaches across the Health Board. The Estates Department initiated an independent report, their findings have been evaluated and a joint action plan with Estates and Therapies has been agreed and implemented.

Contractor Fall
The HSE are very actively progressing their investigation and have come to site on two occasions to take formal statements and to review the Contractor and Health Board interaction.

The Contractor concerned was no longer being used and the Estates Department has significantly enhanced their Contractor Control Protocols. The Head of Health and Safety has met with the NWSSP - Legal and Risk Services team, with regards to a potential Personal Injury Claim.

OHSG: 05/17 Contractor Control

The Health and Safety Adviser – Mrs C Murch reported that in line with the previous agenda item in relation to Contractor fall, the Health Board has made significant improvements with Contractor controls.

It was noted that the Estates Department had employed a full time Contractor Control Officer to manage the protocols and guidelines in relation to contactors working on site.

Concerns were raised around the number of contractors on site that had been brought in by Clinical Boards and not through the proper channels; this causes issues and risks as they are not fully briefed on the building safety aspects such as asbestos. It was noted that the policy for Contractor Control requires the same standard for contractors brought in by Clinical Boards as adopted by the Estates Department.

The Health and Safety Adviser made the Group aware of the Contractor Control Policy and asked that Clinical Boards inform Estates if they require any work completing. She also asked members to take this back to their Local Health and Safety meetings.

Action: CM to circulate the Contractor Control Policy to the Heads of the Clinical Boards Health and Safety Groups.

26.1

OHSG: 06/17 Revised Changes to Fines and Sentences

The Head of Health and Safety updated the Group on the changes to fines and sentences being imposed by the HSE as a result of non compliance and negligence claims. He reminded the Group of the presentation provided by Legal Risk services back last year.

It was noted that there had been an increase in the total amount organisations were being fined and gave a few examples.

The Chair asked members to report this back to their Local Health and Safety meetings and asked that the report be circulated to the Group.

OHSG: 07/17 Legionella Enforcement Notice

The report was presented and considered by the Group

The Group were informed that The Health and Safety Executive (HSE) visited the University Hospital of Wales on the 16th November 2016, to investigate a case of Legionnaires Disease to a patient which was linked back to a stay on Ward C4 North; subsequently the HSE issued an Improvement Notice.

It was noted that as a result the following actions have been implemented:-

- legionella is managed through the Water Safety Group and is continuing to be monitored.
- Water Safety Plan has been completed.
- A Legionella Improvement Notice Implementation Group has been formed.
- An Action Plan was being progressed.

- The Water Safety Policy had been updated and will go to April's Health and Safety Committee for approval.
- The Estates department were planning to audit every area over a 12 month period.
- Flushing and logging by areas using a RAG (red,amber,green) system to identify little used outlets and frequently used.

The Head of Health and Safety highlighted that the Estates Department has at the request of the area removed the little used en-suite shower on C4, The Energy Advisor – Representative for Estates added, that if areas have non used outlets to raise a request for Estates to have these removed as this eliminates the risk and eliminates the need to flush.

OHSG: 08/17 Fire Safety Management and Enforcement Report

The Group noted and considered the report.

It was noted that the Senior Fire Officer had sent his apologies.

The Head of Health and Safety raised concerns around the South Wales Fire Service's revised plans in relation to their response to fire alarm activations. It was noted that their intention was that during the day instead of sending three fire appliances to our hospitals they will send just one to carry out an investigation, unless we can confirm there is an actual fire. During the night when people are at the greatest risk from fire they will continue sending the full pre-determined attendance of three appliances; their aim is to reduce unwanted fire signals.

It was highlighted that a pilot trial is now running at Aneurin Bevan Health Board and a Concordat meeting with all relevant Health Boards and South Wales Fire Service had been arranged to discuss the issue.

The Staff Side Representative – Mr S Egan expressed his concern in relation to the number of occasions he had been informed that Fire Advisers were advising areas that it was acceptable to wedge open fire doors.

He felt that there needed to be a standard guidance across the Health Board as this was being picked up on Work place inspections.

Action: The Chair asked that this be brought to the attention of the Senior Fire Adviser for comment and resolution. **CD**

OHSG: 09/17 Health and Safety Priority Action Plan

The report was received and noted by the Group.

The Head of Health and Safety alerted the Group to the two new items that have been added to the Priority Action Plan during the period. These being:-

- **1.4** Health and Safety Management Training - a training course for managers was being developed specifically around ensuring that they recognise their duties under the relevant H&S policies and their broader legislative compliance duties.
- **5.8** Monitoring Schedule - a programme of sampling had been initiated but due to demands on the Environmental Adviser the full monitoring programme had not been met.

The Chair requested that any items that were Red be discussed in detail at the next meeting.

OHSG: 10/17 Health and Safety Tutor Led Training

The Head of Health and Safety informed the Group to the potential charges incurred for non attendance to Health and safety training.

It was noted that the training is running to its training needs analysis, however the department receives a lot of DNA's.

It was reported that charges were to be imposed to hopefully improve attendance and to cover the cost of providing additional training for classes that were cancelled.

Discussions ensued and it was agreed that the paper would be revised and brought to a future meeting. Action CD

OHSG: 11/17 PI Claims Report

The Claims Manager tabled a reported on PI Claims, including some successful defences which had recently been achieved.

The Chair asked if a more detailed report analysing trend for the year, be brought to the next meeting.

OHSG: 12/17 Health and Safety Management Training

The Head of Health and Safety informed the Group that it had been identified that a specialised course for Managers on both their statutory obligation and their role implementing the Health Boards Policies was needed.

It was noted that the Estates Department Managers had completed the IOSH Managing Safely Course and was looking to expand this to its Operational Service Managers.

A long discussion ensued and the Chair asked the Group to support the development proposal for a Health and Safety management course.

The Staff Side Representative – Mr S Egan stated that he fully supported this and felt that Managers required more guidance on their Health and Safety requirements.

The Head of Health and Safety reported that a full proposal of course details and duration will be brought to the next meeting in June.

OHSG: 13/17 Hoist Renewal and Pro-Act Audit

The meeting was informed that following the Pro-Act Audit in 2015, the Health Board had been able to secure funding from the Welsh Government to renew its obsolete hoisting stock. This would be on a replacement basis and details of areas receiving new hoists would be sent out shortly.

It was agreed that the Pro-act Audit would be repeated in July 2017.

OHSG: 14/17 DATE AND TIME OF NEXT MEETING

5th June 2017 at 9:30AM – Corporate Meeting Room – HQ - UHW

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

MINUTES OF THE FIRE SAFETY GROUP HELD AT 9:30AM ON 6 FEBRUARY 2017 IN THE CORPORATE MEETING ROOM, UHW

Present:	Geoff Walsh	Dir of Capital, Estates and Facilities **(Chair)**
	Charles Dalton	Head of H&S/Fire Safety Manager
	David Hanks	DFSM Child & Women
	Dale-Charlotte Moore	DFSM - Critical Care
	Ian Wile	DFSM Mental Health/ Head of Delivery & Service
	Richard Steed	Cardiff University – Fire Adviser OSHEU
	Rowena Griffiths	DFSM Dental /Nurse Manager
	Catherine Salter	Staff Representative
	Nick Gidman	DFSM Cardiac
Apologies:	Abigail Harris	Executive Director of Planning
	Matthew Temby	DFSM – CD&T
	Ian Fitsall	DFSM Facilities
	Peter Welsh	DFSM Executives - Director of Governance
	Frank Barrett	Senior Fire Safety Officer
	Cheryl Evans	DFSM C&W– O&G Directorate
	Sarah Maggs	DFSM Facilities
	Sarah Congreve	DSFM PCIC Vale Locality Manager
	Rhys Davies	DFSM PCIC Locality Manager

In Attendance:

Zoe Brooks	Health and Safety

26.2

17/01 Minutes of the Meeting

The minutes of the meeting held on the 9th December 2016, were accepted as a true record.

17/02 Action Log

16.10.2 Vertical Evacuation

It was noted that the Senior Fire Safety Manger had given his apologies for this meeting and unfortunately there was no update provided for this item.

16.10.3 DFSM Training

This item is being progressed by the Senior Fire Adviser who will give an update at the next meeting

16/23 Fire Warden Training and 16/29 Fire Training Stats

The Fire Safety Manager reported that a Mandatory Training Meeting took place in January, where concerns in relation to accuracy of the data compliance were raised.

It was noted that the funding for the Wired System comes to an end in March 2017 and the Health Board is not looking to continue with this; the ESR system is being updated and it was agreed that other modules can be added to this system to include Fire Warden Training.

It was also noted that there is a delay with the data being put onto the system as this is being done manually and will affect the accuracy of the data.

16/30 Smoking on Site

The Fire Safety Manager informed the Group that there has not been a Smoking Group since our last meeting and that he will take the raised concern to the next meeting.

17/03 Enforcement Notice Status

The Chair advised that there were no Enforcement Notices issued during the period. However, there is still the longstanding Enforcement Notices in place for Whitchurch Hospital which would be revoked when the site was unoccupied, for compliance an extension has been granted until July 2017.

17/04 Fire Risk Assessment Status

The Group received and noted the minutes of the DFSM Meeting for the 19th January 2017.

The Fire Safety Manager highlighted some of the items discussed and agreed in that meeting:-

- **Fire Risk Assessments risk rating 15+ -** There were no reported FRA rated at 15 or above during the period. However there is an outstanding 15 rated action for the Executive DFSM in relation to the travel distances for staff occupying the PSA Government Building. A number of meetings have taken place and temporarily changes have been implemented.

- **Fire Risk Assessments risk rating 12+ -** There were 125 raised during the period. This following concerns were raised:-

    - Use of E-Cigarettes – No clear guidelines as to whether these are permitted to be used on site.

    - Smoking on site remains and issue.

- Concerns raised in relation to patients and staff brining in their own chargers to charge their electrical devices. A long discussion took place

- It was agreed that any risk assessments 12 and above will be followed up by the Fire Adviser and a formal CAR (Corrective Action Report) will be raised with agreed immediate actions, and actions to stop future events.

- **Fire Risk Assessments (FRA) 6 -10 – The following was agreed:-**

  - It was agreed a Flow Chart to be created and circulated for clear guidance of the process of managing and reporting Fire Risk Assessments.

  - Mental Health received 74 Managerial actions during the period. It was agreed that due to the high number, the DFSM meets with the Local Managers on a monthly basis and will directly feedback to the Group Secretary any updates.

26.2

The Fire Manager raised concern in relation to no representative for Surgery. The Chair agreed to take this back to the Executive Director of Planning for resolution.

Action GW

It was noted that Estates actions are being managed through the Estates Maintenance Request System and are being completed and signed off on a priority basis.

17/05 Planned Evacuations

This item, including the sourcing of suitable dummies is being progressed by the Senior Fire Adviser. It was therefore agreed to deferred any progress report until the next meeting

17/06 Compartmentation & Action Log

This item has been deferred until the next meeting as no representative to advice.

17/07 NWSSP-FS Audit 17/18

The Chair advised the Group that the NWSSP-FS Audit for 2017/18 is due in May and asked that areas complete their audits in a timely manner, ready for submitting.

17/08 DFSM/ Local Fire Safety Group Feedback

South Wales Fire Service response

The Chair updated the Group on the South Wales Fire Service proposal to reduce the number of fire appliances they send out to a Hospital setting, in a bid to reduce false alarms.

It was noted concerns have been raised by the Health Board and a meeting is taking place shortly to discuss these issues.

The Chair also raised concerns around location of toasters and re-iterated the importance of these only being used in designated areas such as kitchens.

17/09 Date of Next Meeting

19th May 2017 - HQ Boardroom, UHW – 9:30AM

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

Present:	Charles Dalton	Head of Health and Safety **(Chair)**
	Carl Ball	Personal Safety Manager
	Emma Foley	Case Manager Officer
	Rowena Griffiths	Dental Nurse Manager
	Raymond Cockayne	Acting Ast Security Manager
	Peter Cockburn	Head of Commercial Services
	Eleri Crudgington	Assistant Locality Manager
	Ian McMullin	Business Manager – Therapies
	Emma Frost	A&E Department
	Rob Elmer	South Wales Police
	Catherine Salter	RCN Representative
	George Oliver	Clinical Lead OP MSK Physiotherapy
Apologies:	Peter Welsh	Director of Governance
	Wayne Parsons	Emergency Unit
	Natalie Williams	Gabalfa CMHT
	Steven Meek	Cardiff University
	Geraint White	South Wales Police
	Sarah Congreve	Assistant Vale Locality Manager

In Attendance: Zoe Brooks Health and Safety

17/1 Minutes of the last meeting

The notes of the Security and Personal Safety Strategy Group held on in November 2016 were **APPROVED** and **ACCEPTED** as a true record.

17/2 Action Log Review

All Actions Closed out at previous meeting.

17/3 Priority Action Plan/ Risk Register

The Group received the Updated Priority Action Plan for V&A. The following updates were provided:

2.1 Training needs analysis is 100% complete. Trainers have been allocated CBs within the UHB to support Departments in improving their compliance target of 85%.

2.2 General training – how do we get a sufficient response in particular within A&E around clinical needs and security? The Personal Safety Manager reported that training is provided, however it has been problematic releasing Security Staff due to 12 hours shifts. It was reported that new dates have been arranged and dates have been sent out to Security. Courses have been successful; however a number of courses have been cancelled due to low numbers of attendance.

It was noted that this course is not mandatory; therefore it is more difficult getting staff to attend, although they are encouraged as it is beneficial to their role.

2.3 – It was reported that there is no update on this - awaiting outcome of calming the storm. The Chair gave a quick overview of the Calming the Storm Project and stated that any updates or feedback will be reported to this Group.

2.4 – No update - Action CD to take this back to the Health and Safety Committee in April.

26.3

17/4 V&A Risk Assessments

The Personal Safety Manager reported that the form is available on the Intranet and had been simplified to three pages. It was noted that the form was piloted in Mental Health and feedback was positive.

17/5 Security feedback

The Interim Assistant Security Manager highlighted recent incidents involving patient's spitting at Security Officers. It was reported that there has been an increase in the number of these types of incidents over the past few week.

He suggested looking into suitable spit protectors. It was agreed that Case Management team would look into this and report back at the next meeting.

Action: EF/CB

It was reported that an incident took place recently where the Security Officers spent an entire shift with a patient in A&E. It was noted that the A&E Department had raised a request for specialling, however there was a delay and as a result 50% of the sites cover was used to stay with the patient, leaving very little resource for other incidents.

The Interim Assistant Security Manager queried whether a protocol could be implemented with clear guidelines as to how long Security are with each patient and the processes involving other specialists/clinical bodies.

Head of Commercial Services suggested that a cost be implemented as part of the agreed protocol for areas that require Security presence for longer than the agreed time frame as cover/overtime will need to be pulled in to cover the rest of the site.

The Personal Safety Manager agreed to look into developing a protocol.

Action: CB

The Group were informed of a recent Serious Incident at CRI, where a Safe Haven patient pulled out a knife – the Police responded immediately and the incident was de-escalated with no casualties, however concerns were raised in relation to protocol not being followed and it was apparent that lessons are to be learnt from the incident.

A long discussion took place detailing the event and staff actions, in particular the issue around the security door being left open. It was noted however, that as the patient was known to the Clinic and would have been let in.

The Head of Commercial reiterated the importance of following protocols and security systems that are in place.

The Group were informed that a Serious Incident Meeting has taken place and are awaiting recommendations – further meetings will take place to look at these and implement further controls/ensure that current systems in place are being worked too.

26.3

The Operational Support Manager – Mental Health queried what will be the security arrangements for Whitchurch, once all services relocate, in particularly as Park Road will still be occupied.

The Head of Commercial informed the Group of the following arrangements:-

- A fence will be put up around the main building.
- CCTV will be upgraded and monitored through Council.
- Contractors to manage the site.
- UHB Security will no longer be present or patrolling the site.

The RCN representative queried whether cameras could be monitoring Park Road and surrounding buildings. The Head of Commercial Services confirmed that this was not part of the remit, as the capital is on Whitchurch Hospital; anything outside of this would need to be perceived as a risk and a case would need to be brought forward to support the capital investment.

17/6 Communicating Potential Lone worker Risk in Community Settings

The Case Management Officer raised concerns in relation to how we cascade information to our lone workers in the community on incidents that have occurred.

It was noted that there is no central database or list of high risk areas and as a result there is no information sharing between services (for example if an incident occurs within Health Visiting, Dietetics may not be aware of an incident involving the same patient).

The Case Manager stated that there needs to be a formal process, where information that is being shared is controlled based on risk.

It was highlighted that workers in the community are concerned that there is places in the community that the Police would not attend. The Sergeant from South Wales Police confirmed that there is no area that they would not go. It was noted that there are geographical risks and Cardiff Council have been approached to provide a list of high risk areas with no success.

The Chair stated that the Welsh Ambulance service has some form of database, highlighting high risk areas, where further control measures are needed whilst attending. It was agreed that the Chair would arrange for the Case Management Officer to meet with the new Case Manager of the South Wales Ambulance Service.

Action: CD

17/7 Case Management/ Personal Safety Statistics

26.3

The Personal Safety Manager informed the Group that there are no Case management statistics available at present due to difficulties in obtaining the information from the police due to their Data protection protocols.

It was noted that this information has been provided in the past as well as discussions around information sharing. It was highlighted that due to this lack of information our systems are not being updated.

The Personal Safety Manager stated that this is being raised at the next All Wales Case Management meeting.

The Chair requested that a report on Personal Safety / UHB V&A Incidents be brought to the next meeting.

17/8 Relocation of Physiotherapy from Whitchurch – Security Arrangements

Clinical Lead OP MSK Physiotherapy – Mr G Oliver informed the Group that currently there is a Physio Outpatients Department at Whitchurch Hospital and also at Longcross.

It was noted that these department will be relocated to a space at CRI; however this will not be available for around two years and as a result in the interim period they will occupy the space at the old Star Leisure Centre site in Splott.

The Clinical Lead OP MSK Physiotherapy raised the following concerns:-

- Who will be responsible for opening and closing the site – he informed the Group that suggestions were going around that all members of staff would have keys – this raised concerns around the lost of keys. There were also concerns around lone worker.

- Concerns were raised in relation to the closing of the car park as residents may use it for parking – this could lead to staff being verbally abused.

It was noted that emails have gone back and forth with Estates to get clear feedback on the above issues, however nothing has been formally agreed.

The Head of Commercial Services responded and highlighted the following:-

- There are no Security presence in community setting, this included opening and closing the buildings – Security only have a response function.
- The Security aspect of the site will be included within the relocation plans and as such the Estates will look at the building needs and will involve security if needed – it was noted that the Star Centre currently has shutters on windows and doors and also has a CCTV system.
- It was considered that the best form of security for opening and closing the building would be a electronic locking system such as TDSI– It was agreed that Security will look into this and link in with Estates and Personal Safety.

26.3

Action: PC/RC

- It was noted that there is no means of managing the locking up of the car park, however signage should be in place to inform residence that the car park will be locked at certain times.

17/9 Lone Worker

The Case Management Officer updated the Group on the new Skyguard lone worker devices. She reported that 562 units have been issued to staff with a further 85 unassigned, however these will be allocated shortly.

It was highlighted that the current usage compliance is at 72% and Managers continue to receive monthly usage reports.

The Chair reported that a paper went to the January Health and Safety Committee highlighting that area's that previously did not use the old system have now shown an interest in the new device.

It was noted that there is no further funding to support this demand and as a result the Committee has asked for a further report be presented to the next Health and Safety Committee in April to give assurance that those people who require a lone worker device has been allocated one - this will require that the Health and Safety Team insure that they are appropriately allocated; this may result in Clinical Boards accepting the cost responsibility for devices that are no being utilised.

17/10 South Wales Police Feedback

The Sergeant reported that there has been a reduction in the number of bike theft related incidents recently; this is as a result of education and monitoring.

He did report however that there has been an increase in shop theft in Concourse, specifically in Boots and WH Smiths – this continues to be monitored by the Onsite PCSO and The Police.

The Interim Assistant Security Manager raised awareness of the upcoming UEFA Champions League Final that is taking place in Cardiff and queried if there is any information available in relation to on site presence during that time.

The Sergeant of South Wales Police stated that nothing has been mentioned, however stated that presence on site will continue as normal.

17/11 Local Feedback

The RCN Representative raised concern around CCTV at HYC and the Children's Hospital, it was note that it is up and running however there is networking issues.

The Interim Assistant Security Manager confirmed that this is being addressed and the issue at HYC will be rectified by the end of the week. He stated that he would look into the issues with CCTV for the Children's Centre.

Action: RC

26.3

17/12 Policies/Procedures

Bomb Threat Procedure

- Concerns around the lack of guidance on Email Threats.
- A&E felt that a specific Protocol should be progressed for A&E
- The Document need to be put into the new format.

Issues to be fed back to Angela Richards

ID & TDSI Policy

Any Comments to be sent to Raymond Cockayne by the 15th March in readiness for April's Health and Safety Committee.

17/12 Date and Time of Next Meeting

11th May 2017 – 9.30AM – Manual Handling Unit, Denbigh House UHW

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE
Management of Stress & Mental Health Wellbeing in the Workplace	UHB 071	Employee Wellbeing	July 2014 (2nd review)	July 2014	July 2017
Management of Asbestos	UHB 072	Director of Planning	July 2014 (2nd review)	July 2014	July 2017
First Aid at Work	UHB 093	Head of Health and Safety	July 2014 (2nd review)	July 2014	July 2017
Sharps Management Policy	UHB 269	Head of Health and Safety	October 2015	September 2015 (Chair's Action)	September 2017
Incident, Hazard and Near Miss Reporting	UHB 138	Head of Health & Safety	July 2018 - previously Quality & Safety	September 2012	August 2015
Fire Safety	UHB 022	Director of Planning	July 2015 (2nd review)	July 2015	July 2018
Latex Allergy	UHB 127	Health and Safety Adviser	October 2015 (2nd review)	October 2015	October 2018
Environmental	UHB 143	Director of Planning	October 2015 (2nd review)	October 2015	October 2018

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE
Closed Circuit Television (CCT V)	UHB 303	Head of Health and Safety	October 2015	October 2015	October 2018
Security Services	UHB 037	Head of Health and Safety	January 2016 (2nd review)	January 2016	January 2019
Contractor Control	UHB 163	Director of Planning	July 2016 (3rd review)	July 2016	July 2019
Health & Safety	UHB 021	Head of Health and Safety	July 2016	November 2016 (Board approval)	November 2019
Safe Working with Electricity	UHB 208	Director of Planning	October 2013 (3rd review)	January 2017	January 2020
Management of Violence & Aggression	UHB 035	Personal Safety Adviser	January 2014 (3rd review)	April 2017	April 2020
Lone Worker	UHB 034	Health and Safety Adviser	January 2014 (3rd review)	April 2017	April 2020
Minimal Manual Handling	UHB 036	Manual Handling Advisers	January 2014 (2nd review)	April 2017	April 2020
Waste Management	UHB 038	Patient Experience Manager	January 2014 (2nd review)	April 2017	April 2020
Water Safety (previously Control of Legionella)	UHB 091	Estate Asset Manager	April 2017	April 2017	April 2020

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	December 2016	December 2019
Safety Notices & Important Documents	UHB 069	Head of Corporate Risk & Governance	Quality & Safety	August 2011	August 2014
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