HEALTH AND SAFETY COMMITTEE

9.30am on Tuesday 23 January 2018
Corporate Meeting Room, Headquarters, UHW

CARING FOR PEOPLE
KEEPING PEOPLE WELL

Health and Safety Committee
9.30am on 23rd January 2018
Corporate Meeting Room, Headquarters, University Hospital of Wales
AGENDA

PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral *Chair*
2	Apologies for Absence	Oral *Chair*
3	Declarations of Interest	Oral *Chair*
4	Minutes of the Health and Safety Committee meeting held on 24 October 2017	*Chair*
5	Action Log Review	*Chair*
Deliver Outcomes that Matter to People		
6	Results of Arjo Proact Audit	*Sara Thomas - Arjo UK Limited Representative*
Our Service Priorities		
Sustainability		
7	Pedestrian Safety Strategy	*Oral - Director of Capital, Estates and Facilities/Head of Health and Safety*
8	Fire Enforcement and Management Compliance Report	*Director of Capital, Estates and Facilities/Head of Health and Safety*
9	Shared Services Fire Safety Audit of University Hospital Llandough	*Director of Capital, Estates and Facilities*
10	Enforcement Agencies Correspondence Report	*Head of Health and Safety*
11	Health and Safety Improvement Plan - Exception Report	*Head of Health and Safety*
Culture and Values		

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE Papers are available on the Health Board website		
12	Work Programme 2018/19	*Director of Corporate Governance*
13	Health and Safety Improvement Plan (in detail)	*Head of Health and Safety*
14	Waste Management Compliance Report	*Director of Capital, Estates and Facilities*
15	EHO Report of Aroma Units, UHW on 17th November 2017	*Director of Capital, Estates and Facilities*
16	**Minutes from other Committees/sub-Committees/Groups** Operational Health and Safety Group – September 2017 Security and Personal Safety Strategy Group – September 2017	 *P Welsh* *C Dalton*
17	Updated Health and Safety Related Policies Schedule	*Director of Corporate Governance*
18	Review of the Meeting	Oral *Chair*
19	To note the date, time and venue of the next meeting:- • 9.30am on Tuesday 10th April 2018 in the Corporate Meeting Room, Headquarters, University Hospital of Wales.	
20	To note the date and time future meetings:- • 9.30am on Tuesday 10th July 2018 • 9.30am on Tuesday 9th October 2018 • 9.30am on Tuesday 22nd January 2019 • 9.30am on Tuesday 9th April 2019	

4

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am ON 24 OCTOBER 2017 IN CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

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

In attendance:

Charles Dalton	Head of Health and Safety
Carol Evans	Assistant Director of Patient Safety and Quality
Fiona Jenkins	Director of Therapies and Health Sciences
Catherine Salter	Staff Representative (RCN)
Geoff Walsh	Director of Capital, Estates and Facilities
Peter Welsh	Director of Corporate Governance

Apologies:

Steve Allen	CHC Representative
Charles Janczewski	Independent Member (Vice Chair)
Fiona Kinghorn	Deputy Director of Public Health
Claire Radley	Assistant Director of Organisational Development

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 17/082 WELCOME AND INTRODUCTIONS

Mr Imperato welcomed all present to his first meeting as Chair. He informed the members he had a very useful conversation with Mr Martyn Waygood who had been very helpful in providing him with guidance in taking the Committee forward.

HSC: 17/083 DECLARATIONS OF INTEREST

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

HSC: 17/084 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 18 July 2017 were **APPROVED** and **ACCEPTED** as a true record, with the exception of a minor amendment:

- HSC: 17/078 – the minute should read 'violence and aggression training is part of the mandatory training core modules'.

HSC: 17/085 UPDATED ACTION LOG

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

- HSC: 17/032 – the Head of Health and Safety informed the Committee that whilst the Health and Safety Executive were happy with the investigation into the pedestrian road traffic accident they raised concerns that the Health Board had no overall strategy for vehicle/pedestrian safety. Mr Dalton stated whilst a lot work had been undertaken in relation to safety in the tunnels the HSE were looking for a much broader strategy. The Director of Capital, Estates and Facilities added the tunnels were a particular issue as they were service tunnels and not pedestrian walkways, therefore the tunnels would be closed off to all non essential users. This action was supported by the Security and Personal Safety Strategy Group.

  A written progress report on the broader strategy was requested for the next meeting.

  ACTION – Mr G Walsh/Mr C Dalton

  The Independent Member – Trade Union stated he was not happy for the concern he raised at the last meeting to be closed on the action log. Mr Egan stressed that he and the former Chair of the Committee had witnessed cars mounting the pavement as the turning circle was not big enough. Mr Walsh advised he would look at this again but added the safety of the whole area needs to be taken into consideration.

  ACTION – Mr G Walsh

- 17/036 – the Head of Health and Safety advised the one page guidance in respect of wedging fire doors open had been produced and circulated to the Fire Safety Group and Deputy Fire Safety Managers. Mr Dalton stated he would verify that the guidance had been added to the intranet and also the induction and mandatory training modules.

  ACTION – Mr C Dalton

4

17/058 – the Assistant Director of Patient Safety and Quality informed the Committee that by the next meeting a timeframe for the risk module would be available, the Chair stated this should be considered as a high priority.

ACTION – Mrs C Evans

17/061 – the Head of Health and Safety advised the trial had not yet commenced as the Mental Health Clinical Board were assessing whether the replacement of cigarettes with e-cigarettes would have an impact on the risk of violence and aggression to staff. It was hoped to commence this trial in early November.

HSC: 17/086 CORPORATE RISK ASSURANCE FRAMEWORK DOCUMENT (CRAF)

The Director of Corporate Governance informed the Committee the high risks associated to this Committee had not changed since the last meeting. Mr Welsh added a major review of risk was currently being undertaken with a new approach to be commenced in April 2018.

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

ASSURANCE was provided by:

- The mitigation of Health Board risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF required strengthening.

HSC: 17/087 FIRE SAFETY – ASSESSMENT OF EXTERNAL CLADDING PANELS ON UHB BUILDINGS

The Director of Capital, Estates and Facilities informed the Committee in response to the Grenfell Fire, Welsh Government requested all Health Boards review their external cladding. Mr Walsh added this Health Board sent one sample to National Wales Shared Services Partnership – Specialist Estate Services (SES) who confirmed no further testing was required. The report had also been shared with the Management Executive Team meeting.

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

REASONABLE ASSURANCE was provided by:

- Reference to Operating & Maintenance (O&M) Manuals for the respective buildings including 'As Installed' drawings and specifications.

4

HSC: 17/088 UPDATED FIRE SAFETY ANNUAL REPOPRT

The Director of Capital, Estates and Facilities advised the updated Fire Safety Annual Report had been brought back to the Committee as requested at the last meeting.

In respect of unwanted fire signals Mr Walsh informed the Committee South Wales Fire Service were now taking strong action, they previously sent numerous appliances to an alarm but were now only sending one appliance as well as not attending site for a 5 minute period so that the alarm could be investigated and confirmed as an actual fire. Mr Walsh confirmed this was happening at a number of Health Boards. The Head of Health and Safety added this approach had been strongly debated by the South Wales Concordant. Mr Walsh stated the Fire Service now wants Health Boards to make the decision to reset the alarm.

The Chair queried what other Fire Services were doing. Mr Walsh advised North Wales and the Midlands were not responding to unwanted fire signals and others were considering their options.

The Independent Member – Trade Union stressed he was concerned at the reduction of service and SWFS had a duty of care to all. Mr Egan advised the Health Board must make sure in writing SWFS were aware that this situation was not acceptable and be very clear concerning the potential risk. Mr Imperato concurred with this and made clear to SWFS that the Health Board cannot support these actions.

ACTION – Mr G Walsh

The Staff Representative (RCN) still considered the Fire Safety Annual Report did not give appropriate assurances as the training statistics did not cover the reporting period and have not changed from the previous report. The action plan had also been removed from the report as opposed to timeframes being added which was requested at the previous meeting. Mr Walsh advised it proving difficult to get all the training information but that he would liaise with the Learning Education Department (LED) once again, Mr Dalton added there was a general concern in relation to the accuracy of ESR data.

The Director of Therapies and Health Sciences informed the Committee mandatory training compliance was reviewed at every Clinical Board Performance Review and Mr Martin Driscoll the new Human Resources Director could not understand why figures were so low, and it was concluded that ESR was not reliable at this time. Clinical Boards were also not assured that the data was accurate. Mrs Jenkins suggested that a review of statutory and mandatory health and safety training was considered at the next committee meeting.

ACTION – Mr Martin Driscoll

Mr Walsh advised he was not aware of why the action plan had been removed and would investigate further. Mrs Salter added whilst it was interesting to view the annual report the reassurances came from the action plan. Mr Walsh stressed it was difficult to add timeframes to the action plan as these would be financial/resource driven. Mr Dalton suggested the Board should be made aware actions could not be completed due to resources so that the Board had risk with knowledge. Mr Egan suggested the action plan reflected when the actions would be completed if funding was available. The Assistant Director of Patient Safety and Quality stated it all came back to the corporate risk framework and having a detailed record of risks.

The updated Fire Safety Annual Report was **RECEIVED** and **NOTED** by the Committee.

ASSURANCE was provided by:

- Fire Safety aspects being monitored and progressed as appropriate.

HSC: 17/089 FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT

The Director of Capital, Estates and Facilities advised the Chair this was a regular report that was bought to the Committee.

Mr Walsh informed the Committee the enforcement notice at Hafan y Coed related to a smoking incident and had been resolved by the Mental Health Clinical Board and therefore the notice had been rescinded by South Wales Fire Service.

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

ASSURANCE was provided by:

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

HSC: 17/090 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

The Director of Capital, Estates and Facilities informed the Committee the action plan had been progressed since the last meeting. The Chair referred to progress in item 9.3.3 that states not started to date and queried when this would be commenced, Mr Walsh stated this statement did not reflect the current position as it was also linked to a number of other items on the action plan.

It was also noted that the action plan was monitored by the Fire Safety Group.

It was **AGREED** this would remain an agenda item until the Committee was **ASSURED** that all actions had been completed.

ACTION – Mr G Walsh

ASSURANCE was provided by:

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

HSC: 17/091 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee there were currently 4 active issues, 1 of which was being pursued by the Health and Safety Executive. The HSE had informed the Health Board they were applying fees for intervention in respect of the contractor fall which they were still investigating.

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: 17/092 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN EXCEPTION REPORT

The Head of Health and Safety informed the Committee there were nine red areas on the plan and highlighted key progress made.

In respect of bariatric patients Mr Dalton informed the Committee the Manual Handling Adviser was working with the Internal Medicine Directorate in developing and equipping a suitable area.

Mr Dalton advised significant investment made been made to purchase 60 new hoists. The Pro-act Audit had also recently been repeated and the results would be brought to the next Committee meeting.

ACTION – Mr C Dalton

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

REASONABLE ASSURANCE was provided by:

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

4

PART 2

HSC: 17/093 COMMITTEE WORK PROGRAMME FOR 2017/18

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

HSC: 17/094 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN (DETAILED)

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

HSC: 17/095 ENVIRONMENTAL HEALTH REPORT OF ROOKWOOD HOSPITAL ON 13TH JULY 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: 17/096 ENVIRONMENTAL HEALTH REPORT OF WARD BASED CATERING, UNIVERSITY HOSPITAL OF WALES ON 14TH SEPTEMBER 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: 17/097 ENVIRONMENTAL HEALTH REPORT OF AROMA UNITS, UNIVERSITY HOSPITAL OF WALES ON 14TH SEPTEMBER 2017

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

The Director of Capital, Estates and Facilities informed the Committee the score was being appealed as a 5 had been given to the Aroma Unit in University Hospital Llandough.

HSC: 17/098 ENVIRONMENTAL HEALTH REPORT OF CENTRAL FOOD PRODUCTION UNIT (CFPU), UNIVERSITY HOSPITAL OF WALES ON 12TH SEPTEMBER 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.

The Director of Therapies and Health Sciences stated she was very pleased with the sustained improvement in catering services.

4

HSC: 17/099 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF JUNE 2017

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

HSC: 17/100 FIRE SAFETY GROUP MINUTES OF MAY 2017

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

HSC: 17/101 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF MAY 2017

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

HSC: 17/102 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

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

HSC: 17/103 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

Mr Imperato thanked everyone for their contribution to today's meeting. He stated going forward he would welcome member's ideas on short presentations in respect of staff stories as it was important to understand the mechanics of what was going on at ground level. He was also keen for good practices to be shared. He would also like for the Board walkabouts to have a staff health and safety perspective.

Mr Welsh advised the patient safety walkabouts were being discussed at the next Quality, Safety and Experience Committee and also the Board Development day in December. Mrs Jenkins stated whilst the patient safety walkabouts focused on quality and safety there was availability to incorporate health and safety or for a separate programme to be developed. Mrs Evans concurred it would be good to have staff presentations.

A number of ideas were put forward by members and Mr Imperato requested that any suggestions were forwarded to Miss Daniel so that they could be collated and considered.

ACTION – All Committee Members

HSC: 17/104 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 23rd January 2018 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……………………………………

Date ……………………………………

4

5

UP DATED ACTION LOG

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

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/032	25/04/17, 18/07/17 & 24/10/17	Pedestrian Safety	Pedestrian Safety Strategy to be developed	Mr Charles Dalton/Mr Geoff Walsh	**ACTION STILL UNDERWAY** Oral update to be provided to the meeting
HSC: 17/032	18/07/17 & 24/10/17	Pedestrian Safety	18/07/17 - concerns raised in relation to lack of space for turning by the mini roundabout outside the Emergency Unit. 24/10/17 - Independent Member – Trade Union was not happy for the action to be closed as he considered this still to be a risk. Director of Capital, Estates and Facilities agreed to revisit this.	Mr Geoff Walsh	**ACTION STILL UNDERWAY** Oral update to be provided to the meeting.

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/034	25/04/17, 18/07/17 & 24/10/17	Fire Safety	One page guidance to be developed in respect of wedging fire doors open.	Mr Geoff Walsh	**COMPLETED**
HSC: 17/058	18/07/17 & 24/10/17	CRAF - E-Datix Risk Module	To clarify the status of the e-datix risk module.	Mrs Carol Evans	**ACTION STILL UNDERWAY** Timeframe to be provided to the Committee.
HSC; 17/061	18/07/17 & 24/10/17	Fire Enforcement and Management	Feedback on trial of e-cigarettes in the Mental Health Clinical Board.	Mrs Fiona Kinghorn	**ACTION STILL UNDERWAY** Mental Health Clinical Board to present to the April Committee meeting
HSC: 17/088	24/10/17	Fire Safety Annual Report	South Wales Fire Service to be made aware that the Health Board had concerns with the proposed reduced service.	Mr Geoff Walsh	**COMPLETED**
HSC: 17/088	24/10/17	Fire Safety Annual Report	A review of statutory and mandatory health and safety training to be considered at a future meeting.	Mr Martin Driscoll	**ACTION STILL UNDERWAY** On the Work Programme for April 2018 meeting
HSC: 17/090	24/10/17	Shared Services Fire Safety Audit of UHL	To remain on the agenda until all actions have been completed	Mr Geoff Walsh	**ACTION STILL UNDERWAY**

5

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/092	24/10/17	Priority Action Plan	Results of Pro-act Audit to be brought to next meeting.	Mr Charles Dalton	**COMPLETED** On the agenda
HSC: 17/103	24/10/17	Review of Meeting	Chair requested members to send suggestions for future staff stories and examples of good practices for sharing so that they could be incorporated into the Work Programme for 2018/19.	Committee Members	**ACTION STILL UNDERWAY**

5

FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT
Name of Meeting : Health and Safety Committee **Date of Meeting** 23/1/2018

Executive Lead : Director of Planning
Author : Head of Health and Safety – 02920 743751
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

8

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).

The Health Board are mandated under both legislation and NHS Fire Code to ensure all staff undertake (relevant to their position) Fire Training.

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

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.

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.

The Health Board undertakes a programme of Fire Training. Training Records are maintained on the NHS Electronic Staff Record (ESR) programme and both training compliance and fire service actions are monitored at the Fire Safety Group.

The Fire Advisory Team also undertakes Fire Risk Assessments for all Health Board premises and findings of these assessments are circulated for action to both the local manager and the designated Deputy Fire Safety Manager (DFSM).

8

ASSESSMENT

Fire Training

Fire Training (1 year refresher) data as at the 31st December 2017

Clinical Boards	July - %	August %	September %	October %	November %	December - %
Children & Women	51.75%	54.51%	56.09%	59.11%	64.23%	67.02%
Capital, Estates & Facilities	46.32%	46.61%	47.57%	52.08%	56.34%	58.88%
CD&T	67.91%	71.53%	72.72%	74.61%	73.05%	72.18%
Corporate	54.32%	57.04%	58.88%	63.24%	67.69%	68.82%
Dental	69.89%	69.57%	75.14%	80.00%	78.27%	79.93%
Medicine	37.23%	38.45%	39.29%	44.41%	52.63%	55.87%
Mental Health	50.63%	51.33%	52.48%	54.96%	54.75%	54.53%
PCIC	50.62%	52.37%	54.06%	61.72%	64.81%	64.97%
Specialist Services	50.44%	52.56%	48.26%	52.55%	55.07%	55.20%
Surgical Services	41.24%	42.74%	43.35%	46.13%	48.90%	51.29%
UHB Total	**51.08%**	**52.99%**	**53.64%**	**57.39%**	**60.16%**	**61.55%**

Data cleansing work has been completed with no reported backlog of tutor led training attendance sheets updates.

As can be seen from the above table compliance is steadily increasing each month. These are considered at each Fire Safety Group Meeting.

Fire Enforcement Notices

The Enforcement Notice in relation to Whitchurch Hospital was lifted during October 2017.

During the period no further enforcement actions were issued or pending, as a result there are currently no Fire Enforcement Notices within the Health Board.

THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005 - INO1 and INO2 Notices

During the period there were 2 reported fire audits undertaken by the South Wales Fire and Rescue Service, these relate to 24 Taff Embankment and The Phoenix Centre, both of these resulted in the Service raising an INO1 report (minor or simple issue). As can be seen from the information below these have been appropriately responded to.

8

INO1 Notice: 24 Taff Embankment, Cardiff, CF11 7BE - report received 6th December 2017

Inadequate training provided to nominated competent persons to successfully implement fire-fighting measures. The staff did not feel confident in the use of extinguishers.

The Senior Fire Advisor has responded that we do not own or run the building and our staff only visits to support the residents. We are of the opinion we have no duty to train our staff on the use of the portable firefighting equipment - **No Further Action Required.**

INO1 Notice: Phoenix Centre, 34 Wordsworth Avenue, Cardiff - report received 3rd January 2018

Emergency/exit doors cannot be easily and immediately opened in an Emergency - the door marked as an emergency/exit door from the rear garden area should not be secured by any means other than push-bar-type devices; padlocks are not permitted on such doors and the fire resisting door to the ground floor laundry room should be fitted with a positive action self-closing device.

The Building Manager immediately rectified the concerns, which was confirmed by the Local Manager on the 4th January 2018.

In addition to the above Notices a complaint was received to the SWFRS from a member of the public or staff relating to the accessibility of fire keys to exercise effective evacuation within the Mental Health Hospital at University Hospital Llandough. The complaint was forwarded onto the Health Board and

the DFSM for Mental Health (Head of Operations and Delivery) is reviewing the protocols in liaison with the Fire Safety Adviser.

Fire Risk Assessments

Managerial Action Summary October 17 - January 18

During the period there were a total of 21 areas assessed of which 130 managerial actions were identified.

These will be considered at the Fire Safety Group Meeting on the 15th January 2018. DFSMs are required to submit confirmation of progress towards resolving those issues identified.

ENFORCEMENT AGENCIES REPORT
Name of Meeting: Health and Safety Committee **Date of Meeting:** 23/01/2018

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

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Health and Safety Committee is asked to:

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

10

SITUATION

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

During the period there was an additional new event raised by the Health and Safety Executive (HSE) relating to an assault on a member of staff in Mental Health. One longstanding intervention continues to be actively pursued by the HSE (Contractor Fall) and a further three, remain within the scope of the report because not all the actions agreed within the submitted action plans have been completed.

This report updates the Committee on progress for each event.

BACKGROUND

The Health Board is mandated under the Reporting of Incidents, Diseases and Dangerous Regulations to report specified events to the Health and Safety Executive. In addttion the HSE may contact the Health Board following a concern raised to them by staff or the public.

The Health and Safety Executive are empowered under section 20 of the Health and Safety at Work Act 1974 for the purpose of carrying into effect any of the relevant statutory provisions and may exercise their powers to make such examinations and investigations as may be necessary.

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

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

ASSESSMENT

Road Traffic Accident at UHW

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

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

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

The remedial actions and the pedestrian strategy have yet to be completed and therefore the item remains active.

Legionella

Previous reports to the Committee informed the meeting the HSE had issued an Improvement Notice under the Control of Substances Hazardous to Health (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.

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.

A review of the Leginonella Policy to a Water Safety Policy was completed and approved by the Health and Safety Committee.

The Water Safety Plan was approved at the Water Safety Group meeting and an enhanced regime for auditing and monitoring shortfalls was implemented to reflect the commitment given to the HSE.

Audit findings submitted to the Water Safety Group continue to show high level of awareness but some areas have yet to implement the recording of flushing. Attendance of Clinical Boards to the Water Safety Group did not allow for assurance to be given that remedial actions were implemented to close out the HSE Action Plan.

Hydrotherapy Pool

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

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

Contractor Fall

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

The HSE wrote to the Health Board on the 17th December 2017 stating that they had now completed their investigation and has offered the Health Board the opportunity make a formal submission by 14th February 2018, prior to the HSE making any decision in relation to any further action. Legal advice has been sort and is subject to a separate agenda item.

New Event - Assault in Mental Health

The HSE has written to the Health Board following the submission of a RIDDOR event, where a nurse was attacked as she escorted a patient back to his room.

The Patient on PICU had been displaying a continued violent manner towards staff. It was considered that his chunky jewellery was potentially a dangerous

weapon, and so he was therefore denied the ability to wear them during his inpatient stay. He immediately went to a side room and smashed up the stereo; staff intervened.

The nurse was escorting the patient in safehold, with another member of staff to the high care room. On arrival he attemped to spit and was thrashing around. He was taken to the floor but as nobody was holding his legs he was able to kick the nurse several time on the leg and shoulder; the nurse subsequently was absent from work for longer than 7days**.**

- The HSE has been given the care plan and the violence and aggression assessment for this patient; which showed that an assessment and control measures were considered against the violence risk.
- The nurse was in compliance with her SIMA Training.
- Staff responded appropriately to his escalating behavior.
- Four staff would be normal for take down techniques in the immediate need of the situation, although the escalation of his behavior was not anticipated.
- The HSE are reviewing the information to consider if further intervention is justified.

10

HEALTH AND SAFETY PRIORITY IMPROVEMENT PLAN 2017/18
Name of Meeting: Health and Safety Committee **Date of Meeting:** 23/01/2018

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

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

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

RECOMMENDATION

The Health and Safety Committee is asked to:

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

11

SITUATION

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

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

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

BACKGROUND

The Health and Safety Department has been working to integrate the plan with the Corporate Risk Assessment Framework (CRAF) Risk Assessment, the plan in detail includes those areas that were yet to be resolved together with a number of areas where it was considered that strategically health and safety should be evolving.

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

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

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

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

The Clinical Boards and Capital, Estates and Facilities Risk Registers are under review with an aim of a consolidated approach form within the Governance Department by the commencement of the new fiscal year. These should continue to include identified risks within this Health and Safety Improvement Plan, whilst centrally managed risks are included within the Corporate Management Risk Register.

ASSESSMENT

The below summary should be considered for this meeting as a draft that will require some further development during the coming period. However, it does highlight a number of additional key items, considered at the initial meetings of the advisory team as areas of importance.

Below summarises the status of the plan by the strategic area

Table 1

	Total no of requirements	Green	Amber	Red	Overall Strategy Status
Health and Safety Policy Management and Organisational Arrangement	4	0	2	2	Reasonable assurance
Violence and Aggression (inc Lone worker)	12	2	8	2	Limited assurance
Manual Handling	10	1	7	2	Reasonable assurance
Health Issues	6	1	3	2	Reasonable assurance
Patient and Environment Health and Safety	8	3	4	1	Limited assurance
Fire Safety Management	3	1	1	1	Reasonable assurance
Estate Health and Safety Management	8	1	2	5	Limited assurance
Sharp Safety	1	1	0	0	Substantial assurance
Total	52	10	27	15	

The Priority Improvement Plan has been reviewed and updated; this includes removing all progressed areas during the year. This period we have also added a column to reflect the overall strategy status, based on the number of reds and outstanding issues. The above demonstrates of the revised total of 52 requirements 10 have been resolved and 15 are a high priority and non compliant. A further 27 are identified as amber, thus meaning that the risk has been reduced as a result of action taken but further control measures are required.

11

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
2.2	If risk assessments are not undertaken there is a significant potential for serious incident and prosecution.		Launch new violence and aggression risk assessment form with basic guidance to staff, through the HB Intranet and case management presentations	Personal Safety Manager

2.3	If serious incidents are not investigated properly there is significant potential for Harm.		Develop violence and aggression guidance checklists for most common types of serious violence and aggression incidents.	Personal Safety Manager
3.6	Management of the Hoverjacks in Llandough & UHW. Corporately owned but not corporately managed. There is no corporate responsibility for training staff in their use – all done very ad –hoc by Manual Handling Advisers, not an effective process		Identify responsible persons/teams for the management of the 2 corporately owned Hoverjacks to deal with day to day managements/faults/repairs etc. Develop a robust UHB wide training programme for the use of the Hoverjacks and identify who will be delivering this.	To be Agreed
3.9	Update UHB Procedure for the inspection of patient hoist slings	The Procedure is out of date –was due for review in 2014 No assurance of compliance of legislation.	A review of the procedure as a matter of urgency. To re-publish after a UHB decision has been made as to whether sling inspections are awarded to external company.	Manual Handling Advisers
4.5	Staff wellbeing and stress support is developed in a proactive mode.	The annual report identified that there are areas where staff shortage and stresses exist, which are being tackled via sub groups in HR, Patient Safety and Occupational Health	A meeting to be established with Health and Safety to consider joint approaches of proactive intervention in stress management.	Head of Health and Safety
4.6	Staffing/patient safety compromised	Audit report of Mental Health identified that staff rotas were not including any breaks. Audit Committee recommended this be progressed to appropriate committee	Mental health to review rotas to include sufficient time to allow staff to take breaks.	Director of Operations - Mental Health Clinical Board
5.6	Bariatric Patient Care	Meeting with Assistant Director of Nursing – progressing issues on care basis with Nursing Director.	Internal Medicine and Manual Handling to work closely in actioning an ward area better designed to care for bariatric patients	Assistant Director of Nursing
6.1	Firecode	Fire Policy submitted for approval. Training	Planned "toolbox" talks to wards by Fire Advisers to	Director of Planning

11

		improvements being pursued through PPP.	enhance local knowledge. Each Clinical Board to monitor local compliance. Fire Policy approved at July 2015 meeting	
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
7.6	Development of a pedestrian strategy for the 2 major Health Board sites in relation to their traffic risks.	Pedestrian safety in tunnels being pursued by Estates Department.	An overall strategic approach to be developed.	Director of Capital, Estates and Facilities
7.7	Road Safety in relation to deliveries.	Concerns around deliveries to both Stores on Academic Drive and by Outpatients.		Director of Capital, Estates and Facilities
7.8	Control of contractors	Contractor Control	Re establish the	Director of

11

		Group formed, however deferred due to Estates Health and Safety Manager appointment.	Contractor Control Group with the new estates health and safety team and agree priority actions.	Capital, Estates and Facilities

11

HEALTH AND SAFETY COMMITTEE WORK PROGRAMME 2018 - 2019

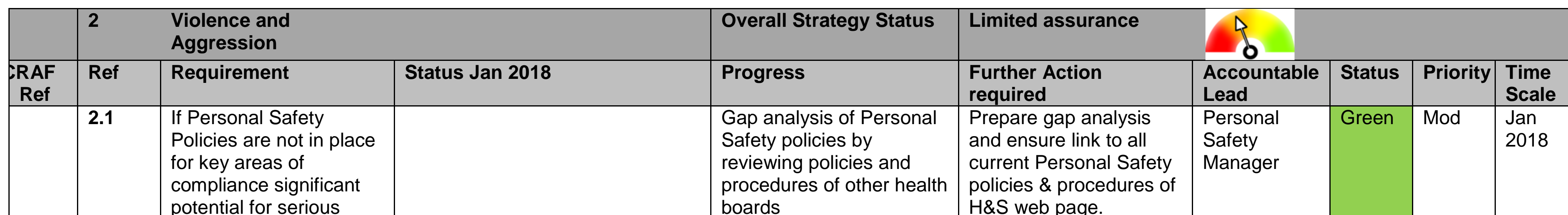
Meeting Date / Agenda Item	**January 2018**	**April 2018**	**July 2018**	**October 2018**	**January 2019**
Presentation/Staff Story	Arjo Proact Survey Findings	Mental Health CB – Trail of No Smoking			
Review of Committee's Term of Reference		√			
Priority Action Plan – **CRAF No's: 8.1.4, 6.4.7, 6.4.5, 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**		√		√	

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

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

Health and Safety Improvement Plan 2017/18

	1	Health and Safety Management		Overall Strategy Status	Reasonable assurance				
CRAF Ref	Ref	Requirement	Status Jan 2018	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. Agreement to review Corporate risk register within financial year.	Director of Corporate Governance	Red	High	April 2018
	1.2	Monitoring of Mandatory Training	Steering Group formed to enhance staff training compliance to target 85%+	Enhanced ESR has been implemented by IED/IMT – this has led to a lack of availability of data.	Progress mechanism for enhanced monitoring and accountability for increasing compliance at Clinical Boards	Director of Workforce and OD	Amber	High	April 2018
	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	April 2018
	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	April 2018

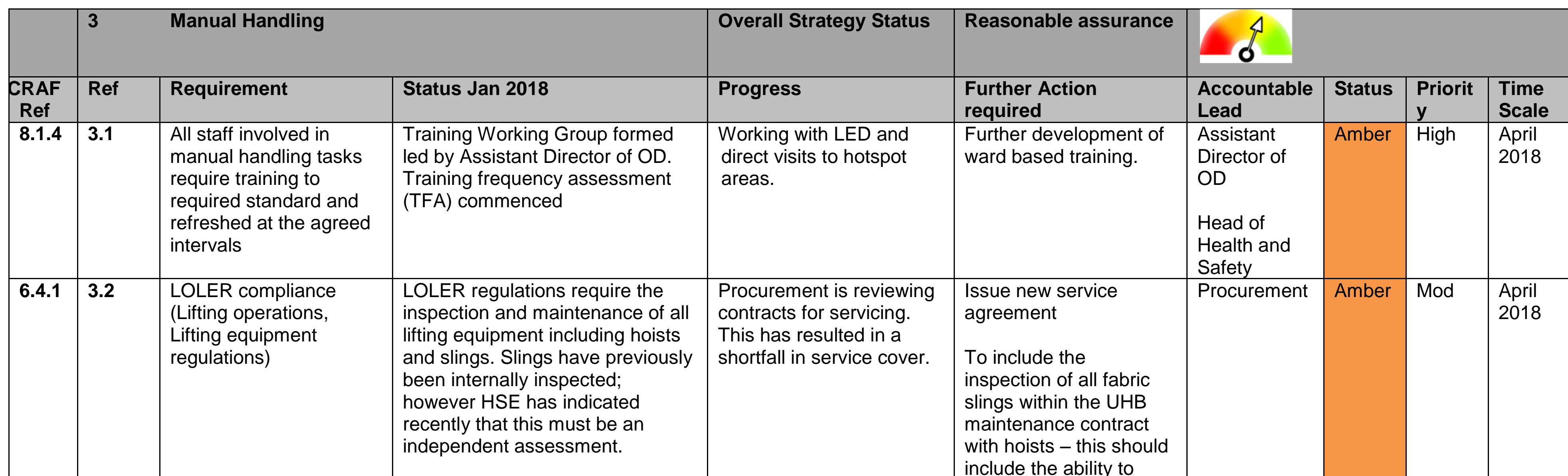


	2	Violence and Aggression		Overall Strategy Status	Limited assurance				
CRAF Ref	Ref	Requirement	Status Jan 2018	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
	2.1	If Personal Safety Policies are not in place for key areas of compliance significant potential for serious		Gap analysis of Personal Safety policies by reviewing policies and procedures of other health boards	Prepare gap analysis and ensure link to all current Personal Safety policies & procedures of H&S web page.	Personal Safety Manager	Green	Mod	Jan 2018

		incident							
	2.2	If risk assessments are not undertaken there is a significant potential for serious incident and prosecution.	Review of personal safety on clinical/service boards risk register and ensure high risk items included on priority improvement plan. New violence and aggression risk assessment form developed.		Launch new violence and aggression risk assessment form with basic guidance to staff, through the HB Intranet and case management presentations	Personal Safety Manager	Red	Mod	April 2018
	2.3	If serious incidents are not investigated properly there is significant potential for harm.	Providing assistance for more serious investigations and ensure lessons learnt communicated through health and safety reports to clinical boards health and safety meetings via the Health and Safety Advisors and Security and Personal Safety Strategy Group.		Develop violence and aggression guidance checklists for most common types on serious violence and aggression incidents.	Personal Safety Manager	Red	Mod	July 2018
9.2	**2.4**	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.	Update in line with charges imposed to non attendees.	Review of training frequency and means of enhancing attendance.	Head of Health and Safety /Chairs of Clinical Boards Health and Safety Group	Amber	High	April 2018
6.4.6	**2.5**	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	April 2018

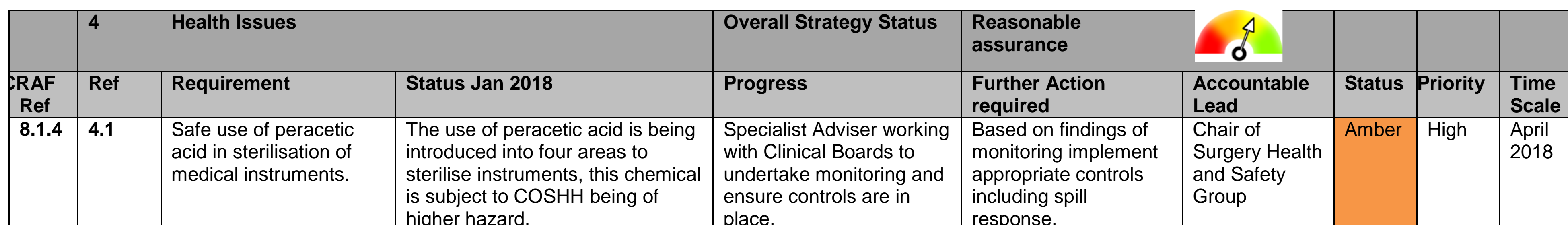
	2.6	Ensure suitable protocol/procedure for restraint of patients with capacity.	The HB has protocols for the restraint of mental health patients, similar procedures are required for patients with capacity	Training course for paediatrics established. Preparation of procedure based off MH document being initiated. National project 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	April 2018
6.4.6	**2.7**	Safe Haven facility	Safe Haven facilities available however there is a lack of facilities to treat high risk patients outside of Safe Haven requirements.	Issue raised and discussed at the Personal Safety and Security Strategy Group. Need for an additional area identified. Security available by arrangement. Meeting with LCM regarding better communication.	Personal Safety Adviser has progressed with Estates for suitable location. Estates have still not identified a suitable area	Personal Safety Adviser	Amber	Mod	April 2018
	2.8	Develop enhanced guidance on non gratuitous violent incidents to demonstrate enhanced support to staff on violent events, relating to patient medical conditions, where legal intervention is inappropriate.	The Case Management Team is actively supporting staff in a significant number of these events.	A working group is set up nationally to revise the MOU to include these events.	Local Plans to be delegated through the Personal Safety Strategy Group and communicated.	Personal Safety Manager	Amber	High	April 2018
	2.9	Develop and Implement revised MOU	Significant lack of communication with partner agencies if not developed and communicated correctly		Participate in review of MOU via meeting attendance/workshops. Re-launch the MOU to increase awareness to the Public, Police, Staff and CPS via meeting attendance, road shows, intranet, departmental presentations, social media.	Personal Safety Manager	Amber	Mod	Dec 2018

	2.10	Violent Warning Markers	Failure to cascade known risk of violence could result in the potential for serious incidents.	There is planned work to introduce the VWM procedure to the Dental and Radiology patient management systems	Gap analysis on Patient Management systems to ensure information is cascaded to all staff specialties.	Personal Safety Manager	Amber	Mod	August 2018
		Lone Worker							
6.4.6	**2.11**	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 77% compliance. Target of 75% reached, although pockets below this level still exist.	Clinical Boards to focus on low compliant areas.	V&A Group/ Chairs of Clinical Boards Health and Safety Group	Amber	Mod	April 2018
	2.12	Staff at risk have 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**		**Overall Strategy Status**	**Reasonable assurance**				
CRAF Ref	**Ref**	**Requirement**	**Status Jan 2018**	**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	April 2018
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 To include the inspection of all fabric slings within the UHB maintenance contract with hoists – this should include the ability to	Procurement	Amber	Mod	April 2018

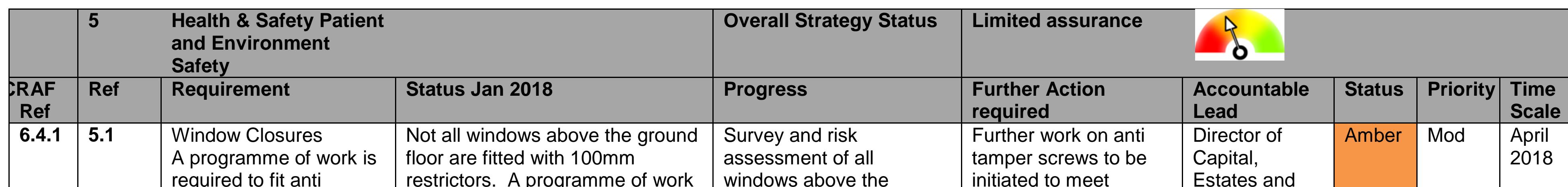
					have inspection records for each sling readily available within the UHB				
8.4.1	**3.3**	LOLER – suitable and sufficient patient handling equipment is available.	Restricted finance has resulted in aged hoisting stock.	Delivery dates for new equipment established.	Verify that the additional hoists has significantly improved status of Pro-act audit findings	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 review service contract has progressed during the period.	Completion of procurement process	Director of Capital, Estates and Facilities	Amber	High	April 2018
	3.5	Profile of hoisting facilities meeting for service demand	Change in patient needs will affect manual handling risk.	Pro-act audit undertaken and findings to be considered.	Review Pro-act findings and implement remedial action.	Clinical Boards Head of Operations and Delivery	Amber	High	April 2018
	3.6	Management of the Hoverjacks in Llandough and UHW	Corporately owned but not corporately managed. There is no corporate responsibility for training staff in their use – all done very ad –hoc by Manual Handling Advisers, not an effective process		Identify responsible persons/teams for the management of the 2 corporately owned Hoverjacks to deal with day to day managements/faults/repairs etc. Develop a robust UHB wide training programme for the use of the Hoverjacks and identify who will be delivering this.	To be Agreed	Red	Mod	June 2018
	3.7	Generic Manual Handling Risk Assessments	There is a lack of adequately completed Manual Handling Generic Risk Assessments and little assurance of compliance with legislation.		Further investigative audit to be undertaken in specialist areas by Manual Handling Advisers	Manual Handling Advisers	Amber	Mod	June 2018
	3.8	Patient Handling Risk Assessments and handling plans in Community Nursing	All staff that attend a patient's home and are required to move and handle that patient requires up to date information which		Manual Handling Adviser has agreed with the Director of Nursing PCIC to review current	Director of Nursing PCIC/Manual Handling	Amber	High	July 2018

			should be readily available to follow on how that person should be moved. Currently handling plans are available on PARIS – not all staff have PARIS – therefore can lead to inconsistency of care provided when handling by variety of staff and increase risk of injury to both patients and staff		arrangements with handling plans – to look at a more robust process so all staff have access to documented information	Advisers			
	3.9	Update UHB Procedure for the inspection of patient hoist slings	The Procedure is out of date – was due for review in 2014. No assurance of compliance of legislation.		A review of the procedure as a matter of urgency. To re publish after a UHB decision has been made as to whether sling inspections are awarded to external company.	Manual Handling Advisers	Red	High	April 2018
	3.10	Suitability of current slings used	Recent ProAct audit carried out within the UHB identified a lack of standing hoist slings leading to an increase in the risk of infection when used from patient to patient. The same audit also identified an excess in some areas of passive fabric slings particularly in long stay patient areas.		Wipeable and patient specific standing hoist slings to be trialled to assess suitability of use. Excess numbers of fabric slings in specific areas to be rationalised as if not used waste of time & expense carrying out LOLER inspections	Manual Handling Advisers	Amber	Mod	June 2018



	4	**Health Issues**		**Overall Strategy Status**	**Reasonable assurance**				
CRAF Ref	**Ref**	**Requirement**	**Status Jan 2018**	**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 on findings of monitoring implement appropriate controls including spill response.	Chair of Surgery Health and Safety Group	Amber	High	April 2018

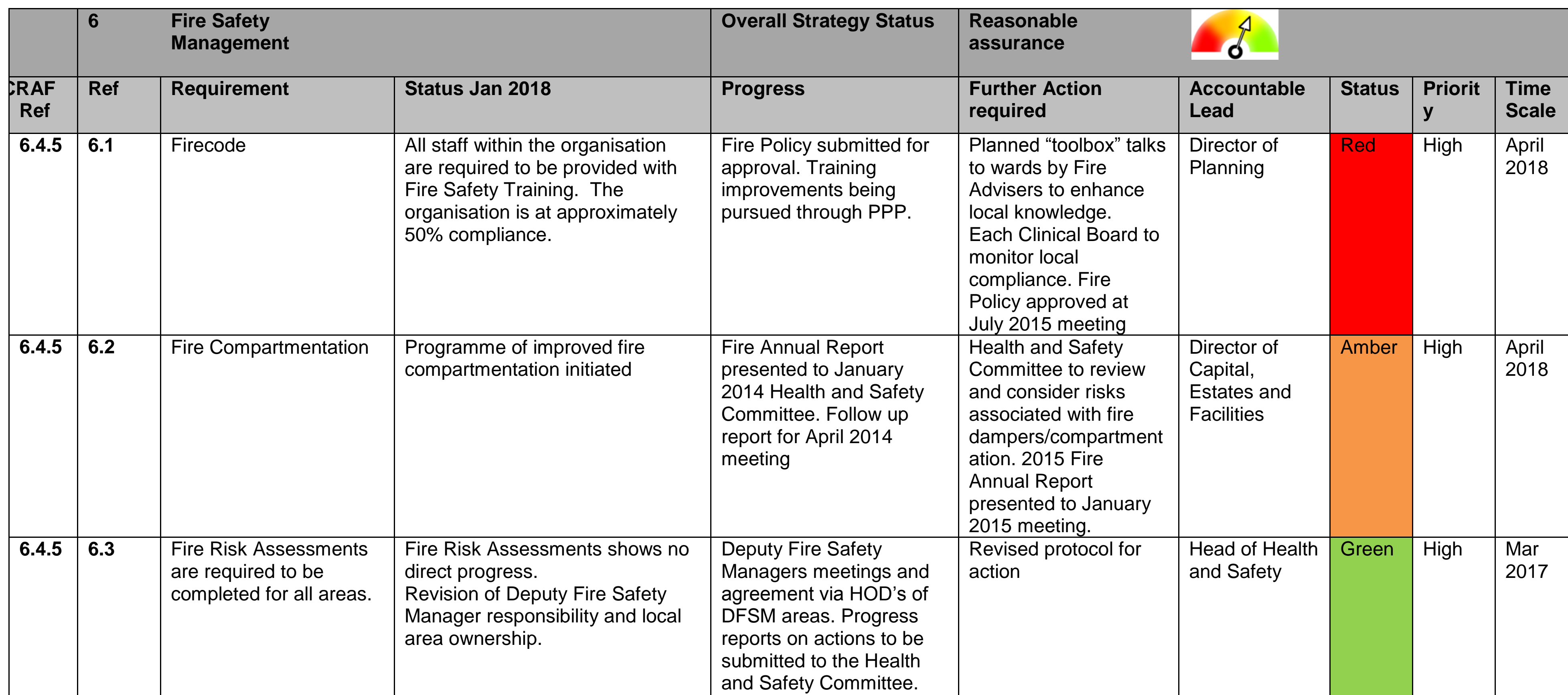
	4.2	Adherence to the No Smoking Policy.	Smoking policy in place and Enforcement Officer appointed. Smoking breaches being reported through fire and smoking meetings.	Position on E-ciggs clarified, supporting its controlled use.	Develop guidance on usage to include fire risk.	Head of Health and Safety/ Director of Public Health	Amber	High	April 2018
	4.3	DSEAR compliance to regulations requires area of potential explosives to be assessed and control measures in place.	Reports have identified that some areas within Laboratories require assessment.	Environmental form developed	Implement form.	Head of Health and Safety/ Health and Safety and Environmental Adviser	Amber	High	April 2018
	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.		HOD for CD&T/ Director of Capital, Estates and Facilities	Green	High	July 2017
	4.5	Staff wellbeing and stress support is developed in a proactive mode.	The Health Board's wellbeing service actively supports staff that has stress and wellbeing issues.	The annual report identified that there are areas where staff shortage and stresses exist, which are being tackled via sub groups in HR, Patient Safety and Occupational Health	A meeting to be established with Health and Safety to consider joint approaches of proactive intervention in stress management.	Head of Health and Safety	Red	High	April 2018
	4.6	Staffing/ patient safety compromised	Audit report of Mental Health Clinical Board identified that staff rotas were not including any breaks. Audit Committee recommended this be progressed to appropriate committee		Mental health to review rotas to include sufficient time to allow staff to take breaks.	Director of Operations - Mental Health Clinical Board	Red	High	April 2018



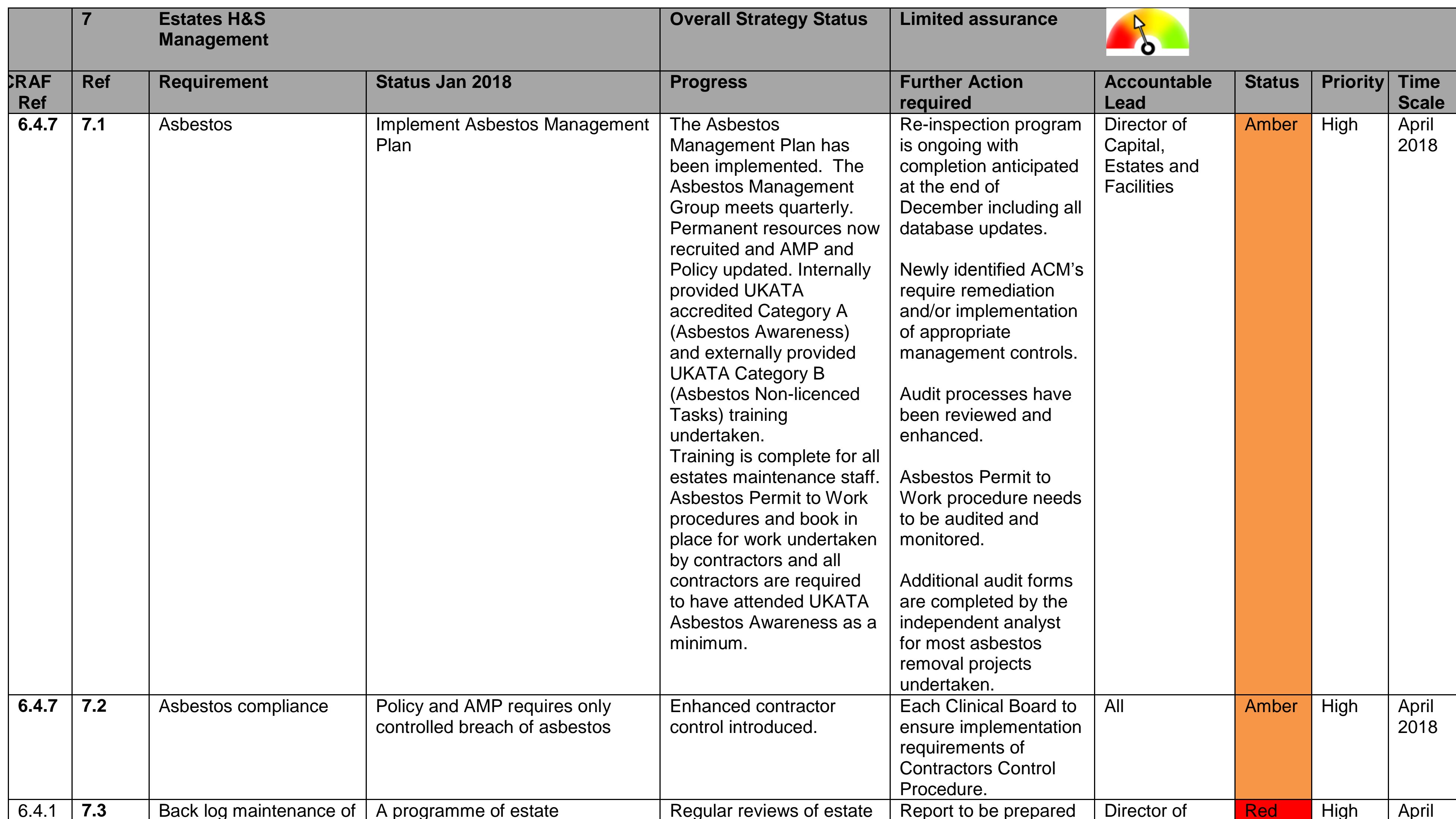
	5	Health & Safety Patient and Environment Safety		Overall Strategy Status	Limited assurance				
CRAF Ref	Ref	Requirement	Status Jan 2018	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
6.4.1	5.1	Window Closures A programme of work is required to fit anti	Not all windows above the ground floor are fitted with 100mm restrictors. A programme of work	Survey and risk assessment of all windows above the	Further work on anti tamper screws to be initiated to meet	Director of Capital, Estates and	Amber	Mod	April 2018

		tamper devices to the in place ligature closures.	has been undertaken to replace all high risk areas. Medium and lower risk areas are still required for action	ground floor has been completed. Action has been taken to rectify those windows which failed to meet the required standard.	hazard alert guidance.	Facilities			
6.4.4	**5.2**	Legionella – Legionella Policy and Water Safety Group	Legionella Policy approved and Water Safety Group established	Water Safety Policy approved at Health and 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	April 2018
	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	April 2018
	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 Clinical Board	Green	Mod	July 2017
	5.5	Patient showering equipment	An audit of 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.		Clinical Boards Heads of Operations and Delivery	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.	Internal Medicine and Manual Handling to work closely in actioning an ward area better designed to care for bariatric patients	Assistant Director of Nursing	Red	Mod	April 2018
	5.7	Moving fallen patients	Hover Jacks have been procured for UHW & UHL to safely move	2 devices purchased from Clinical Board budgets.		Head of Health and Safety	Green		Mar 2017

			fallen patients with risk of spinal injuries						
	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	April 2018



	6	**Fire Safety Management**		**Overall Strategy Status**	**Reasonable assurance**				
CRAF Ref	**Ref**	**Requirement**	**Status Jan 2018**	**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	April 2018
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	Mar 2017



	7	**Estates H&S Management**		**Overall Strategy Status**	**Limited assurance**				
CRAF Ref	**Ref**	**Requirement**	**Status Jan 2018**	**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	April 2018
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	April 2018
6.4.1	**7.3**	Back log maintenance of	A programme of estate	Regular reviews of estate	Report to be prepared	Director of	Red	High	April

		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.	rationalisation and modernisation in place across the UHB estate. Wherever possible capital projects are linked to 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.	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	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.	Capital, Estates and Facilities/ Director of Therapies and Health Sciences (for medical equipment) Director of Planning			2018
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	Remaining original RA for UHW and UHL (2 year to 4 year old) is currently having urgent and high risks collated and	Director of Capital, Estates and Facilities	Red	High	April 2018

				high risk areas. Risks currently being prioritised and some actions taken.	prioritised. RA to all clinics currently in progress. Completion due in next two weeks.				
	7.6	Development of a pedestrian strategy for the 2 major HB sites, in relation to their traffic risks.	Local pedestrian control arrangements are implemented, however recent incidents have identified a lack of an overall strategy, including roadways and tunnels	Pedestrian safety in tunnels being pursued by Estates Department.	An overall strategic approach to be developed.	Director of Capital, Estates and Facilities	Red	High	April 2018
	7.7	Road Safety in relation to deliveries.	Concerns around deliveries to both Stores on Academic Drive and by Outpatients.	Meeting arranged with Shared Services regarding safe system of work.		Director of Capital, Estates and Facilities	Red	High	June 2018
	7.8	Control of contractors	Contractor Control Group formed, however deferred due to Estates Health and Safety Manager appointment.		Re establish the Contractor Control Group with the new estates health and safety team and agree priority actions.	Director of Capital, Estates and Facilities	Red	High	April 2018

		8. Sharps Safety		**Overall Strategy Status**	**Substantial assurance**				
CRAF Ref	**Ref**	**Requirement**	**Status Jan 2018**	**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

WASTE MANAGEMENT COMPLIANCE REPORT	
Name of Meeting: Health and Safety Committee	**Date of Meeting** 23/01/2018

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 (England and Wales) (Amendment) Regulation 2016 and other associated waste Legislation.

Overall compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 and other waste legislation remains consistently high at 99%. Compliance has remained consistent to the previous report presented to the Health and Safety Committee in July 2017.

ASSURANCE

During the period May 2017 and October 2017 a total of 270 internal waste audits have been undertaken, 5297 samples were taken to assess compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016, the overall compliance was 99%.

Of the 5297 samples taken 20 non conformities (0.4%) were identified against the Environmental Protection (Duty of Care) Regulations (1991) and Hazardous Waste (England and Wales) (Amendment) Regulation 2016 were identified, of those;

- 7 orange sharps (0.13%) were identified as containing medication or unidentifiable to the area.
- 6 yellow sharps (0.11%) were unidentifiable to the area where waste was

produced.

- 4 black bags (0.08%) were identified as containing recyclable materials and/or waste not appropriate for landfill.
- 3 purple sharps (0.06%) were in use whilst three months following their assembly.

Samples audited:-

Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
694	1041	59	43	1171	532	859	674	224

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

2017	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
May	100	100	100		98	100	99	99	100
June	100	100	100	100	100	100	100	100	100
July	100	100	100	100	100	100	100	100	100
Aug	100	100	100	100	100	100	98	100	100
Sept	100	100	100	100	100	100	99	96	100
Oct	100	100	100	100	100	100	100	98	93
Total	**100**	**100**	**100**	**100**	**99.7**	**100**	**99.3**	**98.8**	**98.8**

The table below shows comparative compliance per waste stream between November 2016 and April 2017, compliance against the Environmental Protection (Duty of Care) Regulations 1991 and Hazardous Waste (England and Wales) (Amendment) Regulation 2016 was 95%.

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**

Overall compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 and other waste legislation remains consistently above 95%.

AROMA UNITS, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 17th November 2017
Name of Meeting: Health & Safety Committee. **Date of Meeting:** 23/01/2018
Executive Lead: Director of Planning
Author: Catering 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 Number: 2.1 and 2.5
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

The maintenance of the Food Hygiene Rating score of **4 (Good).**

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Food & Port Health) report.

SITUATION

An inspection of Aroma Units at the University Hospital of Wales took place on the 17th November 2017 the outcome of which was confirmed in writing in a letter report dated 21st November 2017 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Aroma Units at The University Hospital of Wales were given a score of **4 (Good)** in the National Food Hygiene Rating Scheme.

15

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 Catering Services Manager to address the issues raised and is attached as an appendix 1 to this report. This will be monitored within the service.

Appendix 1

Action Plan from Food Safety Inspection on 17th November 2017 (Report dated 21st November 2017)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures	**Response / Action**	**Time Scale**	**Update**
It was noted at the time of the visit that a selection of crusty rolls and flatbreads were displayed at room temperature. As discussed, whilst it is not good practice to keep foods out of refrigeration, I would confirm that high-risk foods intended to be served cold, such as rolls and flatbreads can be kept for service or on display for sale for up to 4 hours if the temperature of the food is above 8°C. After 4 hours, the food must be refrigerated until it is sold, served or thrown away. The food must not be displayed again at room temperature. *Food Safety and Hygiene (Wales) Regulations 2013 Schedule 4 para 5 (1)*	• Sandwiches are produced, displayed and served within the 4-hour timescale; this is supported with a new robust monitoring form from production through to service or disposal.	Immediate	Completed

Structural / Cleaning Issues	**Response / Action**	**Time Scale**	**Update**
There was no soap at the wash hand basin in the Children's Hospital unit. Wash hand basins must be provided with soap (and hygienic hand drying facilities). *Regulation (EC) No 852/2004 Annex II Chapter I Para 4*	• WHB had been moved previously and the soap dispenser hadn't, new soap dispenser fitted above WHB.	Immediate	Completed

Aroma Units UHW September 2017

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations; A number of monitoring forms on the units weren't dated and didn't indicate which unit they were for; Whilst in practice staff were applying the 5°C critical limit for fridges, your HACCP document needs to be updated to reflect this; You are currently applying the 4 hour exemption for display of certain sandwiches and rolls in the Aroma units. Whilst the Listeria Guidance below discourages this practice in health care settings, if you are to continue with this practice you need to ensure that your monitoring and recording procedure is improved so that you know with certainty when the 4 hours has lapsed and food needs to be removed from sale. Please note that the 4 hour time starts when the sandwiches are in the process of being made and not when delivered to the units. Despite implementing new monitoring forms since my inspection in September, I don't feel the current monitoring records are robust enough to demonstrate this. It needs to be clear on the form at what time sandwiches were all sold, or if at the end of the 4 hour period how many sandwiches were thrown away;	• HACCP Document amended by the Catering Services Manager, reissued and monitored daily by Restaurant Manager to ensure correct daily records are maintained • HACCP Document amended to reflect the 5°C critical limit • Sandwiches are produced, displayed and served within the 4-hour timescale; this is supported with a new robust monitoring form from production through to service or disposal. This is supported with the daily checks by the Senior Supervisor and weekly checks by the Restaurant Manager.	Immediate Immediate Immediate	Completed Completed Completed

□ I strongly suggest you have regards to the listeria guidance document that I emailed to you and review your HACCP in light of this, we would expect you to be able to maintain the chill chain of sandwiches at 5°C especially as the units in the Women's unit caters for pregnant women who are a risk group for Listeria, failure to do so may affect your ability to demonstrate you have taken 'all reasonable precautions' in the event of a Listeria case associated with eating sandwiches from one of your units;	• Listeria guidance document reviewed, added to the HACCP file to reflect understanding. The removal of homemade prepared sandwiches from the women's unit reduces the risk and ensures the chill chain is maintained for the pre packaged foods.	Immediate	Completed
□ Many of the products that were heated prior to serving were being made and given a 3 day shelf life (flat breads on the children units were kept in a tray and covered with cling-film stickered with a made on date 16/11/17 and use by 18/11/17) these sandwiches must be kept below 5˚C throughout their shelf life, so you must ensure the display units they are put into are capable of keeping them below 5˚C, I suggest the use of a dummy food for temperature monitoring purposes;	• Temperature of refrigeration display units are recorded throughout the day to ensure they're consistent and in range	Immediate	Completed
□ A monitoring form from the Women's Unit on the 6/11/17 had the time sandwiches were made at 7:15am then the time disposed at 12:20pm, the 12:20pm had then been crossed out and a new time of 11:15am documented, this was done for 4 different food items on the unit, the original time documented indicated that sandwiches had been on display for over 5 hours, no explanation was given for the crossings out;	• All staff has been retrained to ensure understanding of recording procedures and the need to do so.	Immediate	Completed
□ Your monitoring sheets state that all sandwiches are prepared in accordance with the Listeria Guidance stating	• Monitoring forms amended to reflect the four hour rule and not the listeria guidelines, although they are available for reference.	Immediate	Completed

15

that storage at ambient mustn't exceed 4 hours. The Listeria Guidance discourages the use of the 4 hour rule in Healthcare settings. *Regulation (EC) 852/2004 Article 5*			

Schedule B – Recommendations, Advice & Information

Recommendations	Response / Action	Time Scale	Update
No recommendations at time of visit.			

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

Present:

Peter Welsh- Chair	Director of Corporate Governance
Charles Dalton	Head of Health and Safety
Caroline Murch	Environmental Health and Safety Adviser
Rachael Sykes	Health and Safety Adviser
Frank Barrett	Senior Fire Adviser
Nicola Bevan	Occupational Health
Catherine Salter	Staff Representative
Stuart Egan	Staff Representative
Clinical/Service Board Representatives	
Emma Stone	Dental
Heather Gater	Women and Children
Ian Wile	Mental Health
Mathew Price	Specialist Services
Rhys Davies	Primary, Community and Intermediate Care

In Attendance:

Suzanne Wicks	Claims Manager
Robert Jenkins	NWSSP – Solicitor

Apologies:

Rachael Daniel	Health and Safety Adviser
Jon McGarrigle	Estates Services
Rowena Griffiths	Dental Services
Tina Bayliss	Surgery Services
Sue Morgan	Primary, Community and Intermediate Care
Mathew Price	Specialist Services

OHSG: 27/17 Minutes of the Meeting held March 2017

The minutes of the meeting held on the 5th June 2017 were accepted as a true record with a slight amendment - page 3 - OHSG: 17/17 this should read Local Inspector to meet with UHB Staff Safety Representatives and not with Clinical Boards.

OHSG: 28/17 Action Log

All items on Action Log that were completed with except of two, which were discussed as agenda items.

16.1

OHSG: 29/17 Feedback from Health and Safety Committee

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

The Head of Health and Safety informed the Group that the Health and Safety Annual Report was presented at the Health and Safety Committee in July 2017. He then proceeded to give a presentation on the report's findings.

He highlighted that there are eight strategic key areas that continue to be prioritised and worked too, these are; Health and Safety Management, Violence and Aggression, Manual Handling, Health Issues, Patient and Environment, Fire Safety, Estates and Sharps.

It was noted that although Fire Safety is a key area, it had not been included within the Annual report; this is a separate report submitted to the Committee.

The Group were informed that in line with the eight strategic areas, the Priority Action Plan is reviewed and updated each period and reported to both the Health and Safety Committee and this Group. It was reported that at the end of the finical year (2016/17), there were 6 high priority areas out of a total of 35 requirements. A total of 5 had been resolved with the remaining 24 identified as amber.

It was highlighted that health and safety related Policies continue to be monitored and reviewed at its agreed timeframe; however there are a number of policies that are out of date, and although they are health and safety related they are approved by other Committees of the Board.

He also reported that there was a total of 19969 incidents reported during the period, this is an increase of 9.2% on the previous year. He highlighted that although there is an increase, it also identified that reporting of incidents had not been effected by the introduction of EDATIX.

He continued to give a breakdown of these incidents, reporting 136 were Injuries affecting visitors, or the public, 3537 Incidents affecting the staff/contractors, 15157 were patient incidents and the remaining 1139 were relating to the organisation.

It was highlighted that Violence and Aggression incidents accounted for 60% of all incidents. It was also noted that Work Stressors, workloads and low level of staffing showed an increase.

He reported that 116 RIDDOR events were reported during the period, with Medicine Clinical Board showing a significant increase over the year.

Concerns were raised in relation to Training compliance (63% for Manual Handling Tutor led and 47% for V&A), it was noted that percentage for attendance remains low although all courses are booked up until November. It

was highlighted that although the demand is there, staff are not being released for training due to short staff issues and other factors.

The Head of Health and Safety confirmed that this is being looked at and had been raised by the Health and Safety Committee; a paper had been submitted and is an agenda item, for discussion later on in the meeting.

The Group were informed of other progress during the period such as the Lone worker System, it was reported that usage continues to be high at around 73%; an improvement of 62% against the old system Reliance.

Another reported improvement was the Glide Sheets; it was highlighted that £23k funding was secured for the purchase of glide sheets in 2015 and also additional funding for both replacement hoists and special shower chairs.

The Chair thanked the Head of Health and Safety for his presentation and informed the Group that the full report had been circulated and can also be found on the Intranet.

OHSG: 30/17 Enforcement Agencies Correspondence Report

The Head of Health and Safety informed the Group that Health and Safety Executive (HSE) correspondence had increased over the year, with the HSE visiting sites on a number of occasions and intervention fees being applied.

It was noted that there were six areas of concerns over the year and the Head of Health and Safety gave an overview of each of these areas and their status; many of these areas had been closed out although some areas were still being progressed in-house.

It was highlighted that the incident relating to Contractor fall was still ongoing, with the HSE visiting site approximately on a monthly basis to meet with staff.

The Head of Health and Safety informed the Group that intervention fees had been applied and further fees are expected. It was noted that intervention fees are around £135 an hour.

OHSG: 31/17 Fire Safety Management and Enforcement Report

The Senior Fire Adviser reported that in light of the recent tragic event in London – Grenfell Tower, the Welsh Government has requested a survey be conducted to identify any building with Aluminium Composite Material (ACM) cladding.

It was confirmed that none of the panels on any of the Health Board sites were ACM.

The Senior Fire Adviser also updated the Group on the Fire Service's response to fire alarms.

It was noted that as of the 1st April 2017, the Fire Service confirmed that they would only send a single appliance during the day for auto call and full appliance for confirmed fires, however it was reported that at a recent meeting between the Fire Service and the Health Board, the Fire Service expressed that they may have to escalate this to only attend for confirmed fires, due to the high number of false alarms the Health Board generates per year.

The Staff Representative – Mr S Egan raised concerns in the delay this would have in the event of a real fire.

The Group agreed with this concern; however it was noted that full appliances would be dispatched during the night and for confirmed fires and this was out of the Health Boards hands.

The Chair requested that this information be cascaded for staff to be vigilant.

The Senior Fire Adviser reported that this information is now being included in training and will also be put on to the Intranet.

It was requested that this concern be taken to the Health and Safety Committee in October. **Action PW/CD**

The Group were informed that there were two Enforcement Notices in situ, one for Whitchurch Hospital; which should be lifted shortly in line with its closure and another for Hafan Y Coed, due to a patient smoking.

It was reported that the Fire Service would be re-visiting Hafan Y Coed at the beginning of September and an Action Plan is in place to improve and comply with the findings of the Fire Risk Assessments, in-order for the Enforcement Notice to be lifted.

The Group noted and received both the Holding Open Fire Doors Guidance and the Guidance on the Safe Use of Portable Heaters for information and cascading.

OHSG: 32/17 Glide Sheets

The Group was asked to support the proposal that Clinical Boards pursue the purchase of further batches of Material glide sheets, to maintain stock from within their budgets; this document was supported by the Group.

The Head of Health and Safety re-iterated the benefit of these materials glide sheets, highlighting that since their introduction; there have been no reported incidents to either patient or staff and subsequently no personal injury claims.

OHSG: 33/17 Health and Safety Priority Action Plan

The Report was received and noted by the Group.

The Head of Health and Safety highlighted that during the period, three items had been added to the Priority Action Plan. These were, item 2.5 in relation to developing enhanced guidance on non gratuitous violent incidents and also revision of the MOU. Item 4.5 required a meeting be established to consider joint approaches of proactive intervention in stress management. Item 7.6 a development of a pedestrian strategy for the major Health Board sites, in relation to their traffic risks.

The Staff Side Representative – Mr S Egan felt that item 4.5 should be of a high priority and expressed that item 5.4 in relation to record storage is an ongoing issue for staff working in this area.

OHSG: 34/17 Pedestrian and Industrial Vehicle Safety Operating Instructions in the UHW Tunnels

The Group received and noted the Work Instructions.

The Environmental Health and Safety Adviser highlighted that the Instructions had been put together by a Group of Main tunnel users and Security Staff that had concerns in relation to vehicle operations and pedestrians in the tunnels. It was noted that the Group meets on a Monthly basis and a paper had been pulled together to be taken to the Board.

It was noted that the main purpose of this Work Instruction is to minimise risk of injury associated to vehicles and pedestrians being in a close proximity.

It was reported that a number of actions have been implemented such as identifying unrestricted access and limiting access, re-marking and the installation of more mirrors.

The Chair asked the Clinical Boards to take this back to their Health and Safety Meetings.

OHSG: 35/17 Tutor Led Training

The Head of Health and Safety reminded the Group that a report was submitted to the December 2016 meeting in relation to fixed penalties for non attendance for training. He reported that the paper suggests a meaningful fine to be applied.

It was noted that these fines will only be applied to those who do not attend, without notice.

The Group were asked to note the implementation of charging Clinical/Service Boards for staff who fail to attend pre-booked Health and Safety training.

The Group were happy to support this paper with an implementation date of the 1st October.

The Staff Side Representative – Mr S Egan suggested that findings are recorded and reviewed in six months. It was agreed an update be brought to this meeting in six months time.

The Representative for Occupational Health informed the Group that LED are looking at offering a text service from ESR to staff, to remind them of upcoming courses, they are booked onto with the aim to improve attendance.

OHSG: 36/17 PI Claims Report

The report was received and noted by the Group.

The Claims Manager reported that the Health Board had received 29 new personal injury claims since the last report in March 2017, with 18 cases settled between March and August 2017. She then gave an overview of some of these cases.

It was noted that personal injury file review is taking place to benchmark against other Health Boards.

OHSG: 37/17 Lone Worker

The Chair made reference to two reports submitted to this Group; the first report relating to Progress. He informed the Group that 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. He also highlighted that current usage for Skyguard compliance is around 73% as to the previous Reliance devices, which was around 14%. The Group agreed that this was a significant improvement.

The Chair informed the Group that the second report is in relation to performance. He highlighted that the report looked at usage by Clinical Board on a monthly basis. He asked that Members take this back to their areas and asked that continued efforts are made to improve usage.

OHSG: 38/17 Clinical/ Service Board Feedback

Staff Side – Work Place Inspections

Staff Side Representative – Mr S Egan informed the Group that the Staff side had given commitment to include environments/communal areas as part of the Workplace inspections.

It was also noted that he had recently met with Medical Records around concerns associated with storage. It was highlighted that

16.1

Treforest is now open for additional storage and talks are taking place around long term plans.

PCIC- Concerns at Whitchurch
PCIC representative raised concerns in relation to general security at Whitchurch Hosiptal. It was highlighted that there are no street lighting, only one Security Officer on site and concerns around medical records (data protection) and arson was also raised.

The Head of Health and Safety suggested that they meet with the Security Manager to highlight these concerns and it also be raised at the Security Personal Safety Strategy Group.

Occupational Health

Concerns were raised in relation to Hep B vaccination shortage. It was reported that this is a Global issue and will affect all Clinical Boards due to routine Hep B vaccinations not being carried out.

The Occupational Health Representative highlighted that this has been put onto the Risk Register and escalated and information cascaded through Intranet and Clinical Board Health and Safety meetings.

It was also reported that the Next Corporate Health Assessment will take place on the 11th and 12th September at UHW, Llandough and CRI.

Mental Health

The Representative – Mental Health – Mr I Wile informed the Group that a lot of work is taking place around piloting the smoking ban within Mental Health. He highlighted that an implementation meeting had been established with an aim to introduce the ban from end of October. It was noted that nicotine replacements will be offered and that E-cigarettes will be allowed in the gardens and around the building.

Staff Side Representative – Mr S Egan raised concerns in relation to violence, whereby patients may become violent towards staff trying to impose the smoking ban.

The Chair asked that an update on the implementation of the no smoking within Mental Health is reported back at the next meeting.
Action IW

OHSG: 39/17 Policies and Procedures

It was noted that the Incident Reporting Procedure was due for approval; however, due to comments received from Patient Safety Team, this procedure will need to be updated and brought back to the December meeting.

OHSG: 40/17 DATE AND TIME OF NEXT MEETING
4th December 2017 – 9.30AM – Corporate Meeting Room HQ, UHW

MINUTES OF THE SECURITY & PERSONAL SAFETY STRATEGY GROUP HELD AT 14:00 12th SEPTEMBER 2017 IN THE MANUAL HANDLING UNIT, DENBIGH HOUSE, UHW

Present:	Charles Dalton	Head of Health and Safety **(Chair)**
	Damien Winston	Security Manager
	Emma Foley	Case Manager Officer
	Emma Thomas	Representative - PCIC
	Heather Hancock	Representative - Mental Health
	PC Tom Haigh	South Wales Police
	Raymond Cockayne	Assistant Security Manager
	Catherine Salter	RCN Representative
	Sarah Congreve	Representative –PCIC
Apologies:	Peter Welsh	Director of Corporate Governance
	Carl Ball	Personal Safety Manager
	Wayne Parsons	Emergency Unit
	Ian McMullin	Business Manager – Therapies
	Rowena Griffiths	Dental Nurse Manager
	Eleri Crudgington	Assistant Locality Manager
	Steven Meek	Cardiff University
In Attendance:	Zoe Brooks	Health and Safety

17/22 Minutes of the last meeting

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

17/23 Action Log

Developing a Protocol for Security Specialling for long Periods
It was reported that due to Security re-location and other matters arising, there had been no development during the period.

The Chair asked that this be looked into and reported back at the next meeting in December. **Action DW**

V&A Training for A&E and Security Staff
The Security Manager highlighted that three courses had been cancelled during the period; Security staff were booked on. It was reported that a meeting was planned for the 15th September to discuss and progress.

V&A Risk Assessments – Home Visiting
It was reported that Guidance was being developed and the document would be brought to the next meeting for comments. **Action: CB**

17/24 Priority Action Plan/ Risk Register

The Group received and noted the Updated Priority Action Plan for Violence and Aggression.

The Chair gave an overview of these items and their current status.

The Chair highlighted that in relation to item 2.1health and safety training, the Health and Safety Annual Report had been submitted to the H&S Committee in July, which identified the following:-

- Training compliance was at 64%, it was noted that although this was an improvement on last year's statistics, training continues to be a concern for the Health Board.

In addition to this, the Group was informed of the recently submitted paper that went to the Operational Health and Safety Group earlier that week, asking the Group to support the implementation of charges for non attendance. It was noted that this paper was supported by the Operational Group and as of 1st October 2017 fees will be implemented for non attendance to all Health and safety training. These changes aim to increase overall compliance.

In relation to item 2.3, the Group was informed that there is a Policy/Procedure for the Search of Patients/Persons and belongings. The Chair felt that this needed to be updated to expand to all areas, as this document predominantly relates to the Mental Health setting.

It was agreed that this would be an agenda item for the next meeting, to discuss producing an UHB wide Policy/Procedure for the Search of Patients/Persons and belongings.

17/25 Presentation on Security/Staff Interventions.

The Chair gave a brief overview of the presentation delivered by Mr A Haynes – Legal and Risk Services on security and staff intervention including the use of force and rights. He agreed to circulate to the presentation to the Group for information. **Action: CD**

17/26 Security feedback

The Security Manager raised concerns in relation to a number of trespass and vandalism incidents at Whitchurch hospital. It was noted that the main problems are occurring in the evenings and on weekends, and as a result CCTV is being installed shortly as well as police carrying out daily checks.

16.2

RCN Representative – Mrs C Salter raised data protection issues around medical records stored on site. It was noted that plans are in place for these to be moved to Treforest; this is being carried out in stages.

The Security Manager reported a recent suspected package in Concourse incident and highlighted that protocol was worked too and the incident was dealt with appropriately.

17/27 Case Management

The Chair informed the Group that a workshop has been arranged for December for the revision of the Memorandum Of Understanding to revise the current document to include both practical and strategic aspects.

Case Management Officer – Mrs E Foley highlighted that partnership working with the Police was improving and mechanisms have been put in place to share relevant information. She also queried the number of incident forms being completed by Security as these appear to have dropped over the period and offered to attend Security Team Meetings to discuss with staff if management feel this would be beneficial.

17/28 Lone worker

Case Management provided an overview on the current status and circulated a July and August compliance report. Compliance remains above 70% however certain areas are not meeting the required level. The Case Management Officer has arranged to meet with these areas to progress.

It was highlighted that in areas where devices are not being utilised the allocation of additional devices will not be possible until consideration has been given to reallocating unused devices or sharing devices.

RCN Representative – Mrs C Salter reported good feedback from staff in relation to these devices.

17/29 Police Partnership

No Feedback was reported.

17/30 Local Feedback

Representative - Mental Health Mrs Heather Hancock reported that the Clinical Board was imposing a no smoking ban at Hafan Y Coed; meetings are taking place to implement.

17/31 Policy and Procedures

The Group noted and approved the Care of Adults (Over 18) with Capacity who are Violent or Abusive Procedure.

17/32 Date and Time of Next Meeting

7th December 2017 – 9:30AM – Manual Handling Unit, Denbigh House UHW

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

17

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

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

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

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

17

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